

Long Island University

Digital Commons @ LIU

Selected Full Text Dissertations, 2011-

LIU Post

2023

Shared Screens: A Qualitative Study of Therapist Self-Disclosure Over Telehealth

Nathan Fordsham M.S.

Follow this and additional works at: https://digitalcommons.liu.edu/post_fultext_dis



Part of the [Clinical Psychology Commons](#)

Shared Screens:

A Qualitative Study of Therapist Self-Disclosure Over Telehealth

Nathan Fordsham, M.S.

A DOCTORAL DISSERTATION SUBMITTED TO THE FACULTY OF
THE CLINICAL PSYCHOLOGY DOCTORAL PROGRAM
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PSYCHOLOGY
LONG ISLAND UNIVERSITY – POST CAMPUS

DATE: March 30, 2023

Department: PSYCHOLOGY

COMMITTEE:

Danielle Knafo, Ph.D., Chair

Date

Eva Feindler, Ph.D.

Date

Zvi Weiss, Psy.D.

Date

Acknowledgments

During the lengthy and demanding process of writing a doctoral dissertation, the highlight was interviewing my participants. I would like to express my sincere appreciation to the eleven psychoanalysts who graced me with their time, openness, and rich clinical and personal experiences.

My deepest gratitude to Dr. Danielle Knafo, who has been far more than my dissertation chair. Dr. Knafo taught, supervised, and mentored me throughout the past five years, providing invaluable advice, encouragement, and critique that has shaped me as a student, writer, and clinician. Thank you for believing in me.

I extend my thanks to my committee members, Dr. Eva Feindler and Dr. Zvi Weiss. Thank you to Dr. Feindler for her thought-provoking feedback and perspective on this project. Her encouragement and praise have infused me with confidence and countered my imposter syndrome. Dr. Weiss was my first psychodynamic supervisor and this project's origin-idea was born during a supervision session in his office. Dr. Weiss has modeled curiosity, humility, and genuineness and I am grateful for his impact on my training and development.

I would like to thank Topaz Baumvoll, Sophia Inkles, Mehrnaz Mirhosseini, and Miriam Smith for their many hours of work and dedication to this project. They worked efficiently and eagerly, proving to be the coding dream team. I would also like to thank my friend Ali Kresch-Levine for the countless hours of side-by-side coding, writing, procrastinating, and "dissertating" together. See you at the finish line!

Although I did not have the fortune to know him, I would like to acknowledge the late Dr. Lewis Aron. His writing, particularly "A Meeting of Minds: Mutuality in Psychoanalysis," was central to this dissertation and many of his ideas have made me think, evaluate, and reevaluate my motivations, true thoughts, and feelings about entering this field.

Finally, and most importantly, I would like to thank my wife Ayala for her consistent support, love, and patience with me, in all areas, but especially with my doctoral journey. Thank you for juggling our home life with your busy career so that I could sit and work in Starbucks for days. Thank you for sacrificing weekends to allow me to focus. And thank you for always being there at the end of the day. You were a doctor before me (by just two years), and you showed me this was possible. Lastly, my love and thanks to my dear son Coby. You are the joy of my life, and you make all of this work meaningful. I hope I make you proud.

Table of Contents

Abstract.....	5
1. Introduction and Literature Review	6
1.1. Forms of Therapist Self-Disclosure	7
1.2. History of Therapist Self-Disclosure.....	10
1.3. Empirical Research on Therapist Self-Disclosure	20
1.4. Technology and Telehealth	22
1.5. Coronavirus (COVID-19) and Teletherapy.....	25
1.6. Personal Bias	26
2. Method	27
2.1. Participants	27
2.2. Design.....	29
2.3. Procedure.....	29
2.4. Measures.....	30
2.5. Data Analyses.....	31
3. Results	32
3.1. DETERMINANTS OF SELF-DISCLOSURE	35
3.2. TELEHEALTH AND SELF-DISCLOSURE	40
3.3. THE FRAME	46
3.4. THE IMPACT OF SELF-DISCLOSURE.....	49
3.5. RESPONSES TO SELF-DISCLOSURE	54
4. Discussion.....	57
4.1. DETERMINANTS OF SELF-DISCLOSURE	58
4.1.1. Self-Disclosure is Determined by Both Patient and Analyst Factors.....	58
4.1.2. Forms of Self-Disclosure.....	62
4.1.3. Motivations for Self-Disclosure Over Telehealth	67
4.2. TELEHEALTH AND SELF-DISCLOSURE	69
4.2.1. Self-Disclosure Over Telehealth is Inevitable.....	69
4.2.2. Increased Self-Disclosure Over Telehealth	71
4.3. THE FRAME	76
4.3.1. Telehealth Has Changed the Frame of Therapy	76
4.3.2. Replicating and Protecting the Frame Over Telehealth	79
4.4. THE IMPACT OF SELF-DISCLOSURE.....	81

4.4.1. The Benefits of Self-Disclosure	81
4.4.2. The Intrusion of Self-Disclosure	84
4.4.3. The Neutral Impact of Self-Disclosure.....	88
4.5. RESPONSES TO SELF-DISCLOSURE	90
4.5.1. Watching for Patient Reactions to Self-Disclosure	90
4.5.2. Processing and Reflecting on Self-Disclosure	92
4.6. Clinical Implications	94
4.7. Limitations of Research	96
4.8. Future Research.....	97
5. Conclusion	98
References	100
Appendices	
Appendix A: Recruitment Flyer	113
Appendix B: Participant Screener	114
Appendix C: Demographic and Clinical Questionnaire.....	115
Appendix D: Informed Consent	116
Appendix E: Hierarchical Data Organization	119

Abstract

The following qualitative study explored how psychodynamic clinicians approach and use self-disclosure with patients over telehealth platforms. There is an abundance of research on therapist self-disclosure, with discussion of this topic dating back as early as Freud (1912) and Ferenczi (1933), and since spanning the spectrum of theoretical orientation and practice. There is some literature on psychotherapy over telehealth, with a recent surge in research as a response to the COVID-19 pandemic. There is less research on psychodynamic therapy or psychoanalysis over telehealth (Wolson, 2021), and to the author's knowledge, no research on therapist self-disclosure and telehealth. This study aimed to uncover what clinicians are actually doing on the other side of the screen and will hopefully inform future therapists working over telehealth, as teletherapy appears to be a wave of the future. For this study, 11 doctoral level clinical psychologists and psychoanalysts participated in individual interviews with the author via online video conferencing. Individual interviews were conducted to: (a) investigate whether clinicians' use of self-disclosure changes when using telehealth, (b) explore whether telehealth creates greater opportunities for both deliberate and inevitable disclosures, and (c) better understand the way clinicians process the impact of self-disclosure. Using a grounded theory approach to qualitative research (Auerbach and Silverstein, 2003), all interviews were transcribed, coded, and analyzed to extrapolate themes and theoretical constructs, and to create a narrative. Results yielded five theoretical constructs, 12 themes, and 56 repeating ideas that combine to create the narrative. Discussion contextualizes the data using aspects of relational theory, particularly mutuality in psychoanalysis (Aron, 1996).

Shared Screens: A Qualitative Study of Therapist Self-Disclosure Over Telehealth

*Should it be only the patient who self discloses? What might
happen if therapists were to reveal themselves more extensively?*

—Irvin D. Yalom (1999, p. 253)

1. Introduction and Literature Review

Following a one-hour intake session it is not unusual for a therapist to gain information about a patient that others may never know. After several sessions, months, or years of therapy, it is expected and almost guaranteed the therapist will know patient particulars that even one's close family or friends never will. This is the unique and confidential nature of the therapeutic relationship. While the patient discloses sensitive information, entrusts the therapist with personal secrets, and reveals hidden fantasies and desires, what, or perhaps how much, does the patient know about their therapist? Name and credentials are a given. Perhaps some information about professional background, approach to therapy, and previous experience is also expected. Yet, do patients know anything about their therapist's personal life? Relationship status? Political standing? Children? Pets? Feelings and reactions in the therapy room? And say a patient does glean some of this information, how have they come to obtain it? Through Internet searches? Reading professional writing? Mistaken revelations in session? Or maybe through therapist self-disclosure (TSD).

This study explored psychoanalysts' use of and approach to self-disclosure, particularly disclosures over telehealth platforms. With the recent increase in therapy over telehealth video platforms (e.g., Zoom, VSee, Doxy.me), changes to the rules, boundaries, and general

environment of therapy are experienced on both sides of the screen. Patients might attend sessions from their homes, wearing pajamas, and even from their beds. While patients may disclose more, or differently, over telehealth, increases or changes in TSD have the potential to significantly impact treatment. Whether this impact is positive, negative, or neutral is yet to be discovered. Through a qualitative exploration of TSD over telehealth, some of these questions will hopefully become more nuanced, colorful, and dynamic.

1.1. Forms of Therapist Self-Disclosure

1.1.1. Definitions

Therapist self-disclosure (TSD) is a highly controversial concept that has received much attention from clinicians and researchers across orientations and modalities. Several definitions of TSD have been suggested. While the concept of TSD can be found in the literature as early as the 1920s, the first to call the revelation of personal information to others “self-disclosure” was Sidney Jourard (1971), who further defined the process as permitting one’s true self to be known to others. Self-disclosure by the therapist has similarly been defined by Hill & Knox (2002) as “verbal statements that reveal something personal about the therapist” (p. 256). Many definitions of TSD exist (see Farber, 2006), but from a psychoanalytic framework, Miletic (1998) defines self-disclosure as “what an analyst actively chooses to make explicit to a patient in a deliberate and conscious way” (p. 594). In practice, however, self-disclosure can mean much more than simply sharing something personal. Meissner (2002) outlines several forms of self-disclosure including answering questions (see Epstein, 1995; Jacobs, 1999), revealing personal emotions (see Bollas, 1987; Marcus, 1997), expressing countertransference (see Aron, 1992; Ehrenberg, 1992), and dealing with real personal factors in the analyst’s life (see Dewald, 1982; Pizer, 1997).

1.1.2. Inevitable Disclosure

Therapists will inevitably disclose a great amount about themselves, oftentimes without deliberate choice or conscious awareness. Subtle changes in tone of voice, foreign accent, physical appearance, or any observable disabilities all tell the patient something about the therapist, without a deliberate decision to disclose. Office décor, manner of dress, visible tattoos, wedding rings, and wearing a cross, star of David, or any other symbol are other ways therapists reveal themselves to patients (Tillman, 1998; Zur, 2007). Additionally, it is not uncommon for psychotherapy or psychoanalysis to take place in the clinician's home office, a setting that almost guarantees extensive self-disclosures about economic status, family structure, and glimpses at family members, service people, pets, or other features of life outside the therapy room. Announcing vacation or time away from the office, professional writing, and community presence also present unavoidable disclosures.

Another potential source of self-disclosure that is outside the therapist's control is patients' deliberate actions towards learning more about their therapist (see Zur, 2007). Whether getting to know people in the therapist's circles or initiating Internet searches, patients can reveal a wide range of professional and personal information ranging from normal curiosity to criminal stalking. Modern-day technology has redefined the meaning and application of therapist self-disclosure and transparency (see Zur, 2009) with large amounts of online information readily available including family history, criminal records, community involvement, political affiliation, and much more.

Within the therapy room, patients can also learn a great deal about their therapist's personality, conflicts, and narcissistic needs through conscious and unconscious inferences from non-verbal changes in voice, body language, facial expression, and choices of intervention (see

Crastnopol 1997; McWilliams, 2004; Thompson, 1956). McWilliams (2004) describes a memorable story about a patient who figured out psychoanalyst Ralph Greenson's (1967) political preferences when he only asked for associations when the patient said anything favorable about a Republican politician. On the other hand, when the patient said anything hostile about a Republican, Greenson remained silent, as if in agreement. McWilliams (2004) states that "Greenson had been completely unaware of this pattern" (p. 181). In order to circumvent such inevitable and subtle disclosures, the traditional analytic layout had the analyst sitting behind the patient lying on the couch, in an effort to maintain neutrality and anonymity. Nonetheless, even for psychoanalysts who strive to minimize any form of self-disclosure, every interaction hides some things and reveals others (see Aron, 1991).

1.1.3. Disclosure of Countertransference

The controversy surrounding self-disclosure is perhaps most prominent in discussions of whether and under what circumstances a therapist should reveal emotional reactions in interaction with the patient or in relation to the patient, at any particular time. Eherenberg (1995) and other contemporary interpersonal thinkers point out that anything a therapist says or does, including silence, can be a form of countertransference enactment. Perhaps the most difficult and controversial countertransference reaction to manage is sexual attraction. Many are of the opinion that confessing sexual attraction to a patient is virtually never therapeutic (see Gabbard, 1998; Maroda, 1991; McWilliams, 2004) with the emotional power imbalance making this disclosure difficult to discriminate from actual seductiveness. Still, others (Cooper, 1998; Ehrenberg, 1995; Gorkin, 1987) have argued for value of judicious types of countertransference disclosure, even including disclosure of erotic countertransference. In her well-known paper, "Love in the Afternoon," Davies (1994) explores the idea of erotic countertransference self-

disclosure from several perspectives, using a clinical vignette to illustrate the utility of erotic self-disclosure at a particular impasse in therapy.

1.1.4. Disclosure of Personal or Biographical Information

Therapist self-disclosure is often first associated with disclosure of personal information, also known as autobiographical self-disclosure. Much of the psychoanalytic literature discusses other forms of self-disclosure and seems to agree that revealing personal information should be restricted and abstained from. Still, there has been some advocacy for the value of selective personal disclosure regarding sexual orientation (see Isay, 1991; Jeffery & Tweed, 2015) religious beliefs (Tillman, 1998), political orientation (Solomonov & Barber, 2018), and race and ethnicity (Leary, 1997). Across all forms of self-disclosure, clinical and theoretical opinions are many and varied, ranging from complete abstinence to full advocacy, with moderating positions filling the spectrum. Before understanding what motivates one analyst to quash an urge to self-disclose and another to indulge, an examination of the history of therapist self-disclosure throughout psychology and psychoanalysis is necessary.

1.2. History of Therapist Self-Disclosure

1.2.1. One-Person Psychology

In the early 1900s, Sigmund Freud wrote a series of papers, attempting to document a technical methodology of psychoanalysis. In his recommendations to physicians practicing psychoanalysis, Freud (1912) began by specifying that the rules he was suggesting had been arrived at from his own experiences and were suited to his individuality. Among several rules such as maintaining evenly suspended attention and relying on unconscious memory over notes, Freud suggested the adoption of a distant, surgeon-like approach where “the doctor should be opaque to his patient, and like a mirror, should show them nothing but what is shown to him” (p.

117). This cautionary instruction, to remain an opaque, blank screen, is the original position in the long and ongoing debate surrounding therapist self-disclosure. Freud (quoted by Greenburg, 1995) cited four specific problems likely to arise in response to analyst self-disclosure: 1) It makes resistances harder to overcome; 2) in severe cases it makes the patient insatiable to know more; 3) the patient finds analyzing the analyst more interesting than analyzing themselves; and 4) it makes resolving the transference more difficult (see Greenburg, 1995, p. 193).

Classical psychoanalysis abides by the Freudian position with the analyst as an observer of the patient's pathology, rather than a participant in the process. Emotions and behaviors of the patient are of utmost importance, whereas emotions and behaviors of the analyst are irrelevant and at most a hindrance to the therapeutic process (Goldstein, 1997). It therefore follows that traditional psychoanalytic clinicians caution against disclosure of personal information. Still, the question of analyst or therapist self-disclosure is psychologically and logically tied to the question of the analyst's capacity for neutrality (see Freud, 1915; Hanly, 1998).

1.2.2. Anonymity, Neutrality, and Self-Disclosure

Central to classical psychoanalytic technique is the aim of limiting the analyst's "contamination" of the patient's associations (Davis, 2002). The Freudian blank screen was intended as the canvas for a patient's projections, conflicts, and transferences. In order to maintain a clean canvas, traditional psychoanalysis has stressed the importance of an almost antiseptic anonymity. Self-disclosure has therefore been viewed as the contamination of the anonymous screen, blocking a patient's freedom of association (Schwaber, 1998) and compromising the ideal analysis of transference (Arlow, 1969).

Psychoanalytic neutrality was first formally defined by Anna Freud (1936), who said that the analyst "takes his stand at a point equidistant from the id, the ego, and the superego" (p. 28).

This definition of neutrality, however, is rarely given consideration by those who employ it (see Greenberg, 1986). A more popular and practical definition by Moore and Fine (1990) describes neutrality as “keeping the countertransference in check, avoiding the imposition of one’s own values upon the patient, and taking the patient’s capacities rather than one’s own desires as a guide” (p. 127). This is the ideal stance generally recommended as essential for the analytic work and process (Chused, 1992) and has also been characterized by many as a “one-person” approach to psychoanalysis (see Davis, 2002; Safran, 2012).

One-person psychology encompassed both anonymity and neutrality by viewing the analyst as an objective and neutral observer, hence the image of Freud’s blank screen splattered with the patient’s projected transferences. Naturally, early approaches to anonymity and neutrality strongly discouraged any form of deliberate self-disclosure, and encouraged awareness and control of unintentional, accidental, or inevitable sources of disclosure. In later years, the question of whether complete neutrality is even possible, let alone ideal, would be challenged by more contemporary psychoanalytic thinkers (see Hanly, 1998; Meissner, 2002; Shill, 2004).

1.2.3. Two-Person Psychology

Far before neutrality was even properly defined, an early and remarkable departure from one-person psychology and the convention of traditional, Freudian psychoanalysis occurred when Hungarian psychoanalyst Sandor Ferenczi (1928) pioneered the concept of analyst self-disclosure and proposed its use as a clinical technique. This deviation not only changed the nature of clinical interaction between analyst and analysand but marked a drastic shift from Freud’s model of a surgeon to a newer model of an empathic mother (Rachman, 1998). The development of analyst self-disclosure actualized through the shift from one person to two-person psychology. While traditional psychoanalysis maintained neutrality, detachment, and

control, Ferenczi's two-person experience held fundamentals that placed essential importance on mutual participation in the analysis. Countertransference and empathy were elevated to the center of the analytic process. Ferenczi even went so far as to encourage mutuality, or the analysis of the analyst by the analysand (Rachman, 1998), for ultimate personal and professional growth through genuine openness and honesty.

Analyst self-disclosure for Ferenczi was inseparable from empathy. In his famous work "The Confusion of Tongues" (1933/1949) he wrote:

I may remind you that patients do not react to theatrical phrases, but only to sincere sympathy... they show a remarkable, almost clairvoyant knowledge about the thoughts and emotions that go on in their analyst's mind. To deceive a patient in this respect seems to be hardly possible and if one tries to do so, it leads only to bad consequences (p. 227).

While his peers and teachers viewed self-disclosure as detrimental to the patient, Ferenczi believed it would improve matters and prevent a repetition of the parents' original insincerity (Goldstein, 1994). Later on, others would take a more judicious approach to analyst self-disclosure (e.g., Bridges, 2001; Little, 1951; Rachman, 1998), but this point in history marks a full and dramatic swing of the self-disclosure pendulum from the anonymous to the involved analyst.

1.2.4. Interpersonal, Relational, and Intersubjective Approaches

Two-person psychology gained traction and acceptance as interpersonal (Searles, 1986; Sullivan, 1953), relational (Greenberg & Mitchell, 1983), and intersubjective (Atwood & Stolorow, 1984) theorists began discussing the importance of the therapist being genuine and

spontaneous, and free from rigid, non-responsive, conventional behavior (Goldstein, 1994). The two-person approach views the therapist as a full participant in the therapy dyad who will inevitably influence the psychoanalytic process in one way or another. There is also a greater display of tolerance for therapist self-disclosure among these theorists.

Interpersonal psychotherapy, most closely associated with Harry Stack Sullivan (1953), was born through the idea that interpersonal relationships have a significant impact on personality development. Noting how individuals carried distorted views and unrealistic expectations of others, Sullivan's solution was to become a "participant observer" in dealing with his patients, taking a more active therapeutic stance than the traditional psychoanalytic "blank screen" (Morgan, 2014). Embedded in a more active therapeutic stance is a less rigid approach to self-disclosure, especially once the therapist is acknowledged as a full and active participant in the therapeutic interaction.

Although approaches to self-disclosure dramatically changed with the shift away from one-person psychology, not all advocated for the Ferenczi-like, untethered enthusiasm surrounding TSD as a clinical technique. In Britain, Winnicott (1949) hinted at use of countertransference disclosure not just restricted to feelings which are justified or objective. Winnicott was followed by Margaret Little (1951) who further advocated for judicious countertransference recognition and interpretation:

"The subjectivity of the feelings needs to be shown to the patient, though their actual origin need not be gone into... but above all the important thing is that they should be recognized by both analyst and patient" (p. 39).

Little's idea of helping the patient recognize the therapist's countertransference is consistent with the ongoing shift in recognizing two people mutually interacting and impacting the therapeutic

relationship. Still, Little stressed the tentativeness with which she put forward her ideas and suggestions, highlighting the unpopularity of any shift away from traditional views of self-disclosure at that time.

In the United States, paralleled encouragement for use of therapist self-disclosure was provided by interpersonal psychoanalysts (see Singer, 1977; Tauber, 1954) who argued in favor of a marked reduction of therapist anonymity. Decreasing rigidity around traditional tenets of anonymity at this time did not necessarily translate into full advocacy for the use of self-disclosure. For example, Searles (1975) wrote that “while being relatively freely revealing of feelings and fantasies I experience during the analytic session itself, I tell patients very little of my life outside the office” (p. 458). This distinction between self-disclosures about content or process transpiring in the session and those about the therapist’s life outside of session has become one of the key distinctions in pursuing the question of whether or not to self-disclose (Aron, 1996). In other words, different forms of self-disclosure garner diverse reactions and contribute to the lack of consensus among psychoanalytic and psychodynamic clinicians.

Searles may have taken a more conservative approach to self-disclosure, yet he is also known for being one of the first to explore his erotic experiences and his reactions to those experiences with both male and female patients. As Jody Davies (1994) describes in her famous paper “Love in the Afternoon”, Searles (1959) believed that with reference to the oedipal situation, the analyst’s awareness of such feelings is sufficient, that the patient will “sense” them, and that overtly expressing such countertransferential experiences puts the analyst on “shaky” ground (p. 291). While awareness of countertransference and potential self-disclosure are important, actually disclosing such feelings was discouraged, if not dangerous.

In following years, Winnicott (1965), Kohut (1971), and others began discussing the

importance of the therapeutic holding environment and the therapist's broader use of the self in the treatment process. These approaches represented the continuing shift away from psychoanalytic orthodoxy and precipitated a literary explosion of contemporary opinions and approaches to therapist self-disclosure.

1.2.5. Contemporary Psychoanalytic Approaches

Contemporary approaches to therapist self-disclosure are abundant and heterogeneous, with little consensus across approach and opinion. Debate on this topic covers a wide range of activities that fit into the category of self-disclosure, with much diversity of personal style and technical approach (Aron, 1996). In other words, therapists with different personalities, theoretical orientations, and patient populations can be expected to differ in use of and experimentation with self-disclosure. In some ways, the core differences between Freud and Ferenczi are repeated in contemporary discussion about TSD and are maintained by strongly held, anecdotally supported, and diametrically opposed precepts (Greenburg, 1995). The scope of contemporary psychoanalytic opinion on self-disclosure spans from unequivocal endorsement (see Renik, 1999) to traditional restriction and strict neutrality (see Rothstein, 1997). Between yay and nay, advocacy for occasional (Cooper, 1998), cautious (Jacobs, 1995), judicious (Ehrenberg, 1995; Rachman, 1998), and selective (Gorkin, 1987) use of self-disclosure are discussed. Beyond these many positions, each a step further in one direction or another, some have been reluctant to even take a stance or position, claiming that a one-size-fits-all technical approach or general technique is not a helpful or possible solution to the complexities of TSD (see Greenburg, 1995; Hanly, 1998; Jacobs, 1995).

From the most conservative viewpoint, Rothstein (1997) maintains that any self-disclosure constitutes an erroneous intervention and always represents an unwarranted

countertransference enactment. Thus, TSD would be viewed as improper behavior that has no place in psychoanalytic technique or practice. This stance is not unpopular when viewed in the traditional and long historical context of Freudian psychoanalysis, neutrality, and anonymity. Still, it is extreme in its rigidity when considered contemporarily.

As a contemporary step away from complete restriction and abstinence, Jacobs (1995) argues in favor of restrained and cautious use of self-disclosure, while still maintaining “relative anonymity.” Referencing several clinical anecdotes, Jacobs states that sometimes conveying something to the patient in the form of a self-disclosure allows the patient to experience the analyst’s message as more authentic and more personal, and thus has a greater impact on the patient. Still, in later years, Jacobs (1997; 1999) has acknowledged that in practice, the act of self-disclosure turns out to be something quite different from the concept of it, as formulated theoretically. Therefore, while he recognizes and discusses the potential benefits of TSD, Jacobs also highlights the consequences and harms of self-disclosure, leading to the suggestion that TSD cannot be prescribed as a general technique or tool. Instead, decisions on whether to disclose can only be made by the therapist at a given moment in the clinical situation.

While some are cautioned by the potential for both benefit and harm from TSD, others highlight the benefits of selective self-disclosure as rationale for sparing use of this intervention. Gorkin (1987) summarizes arguments in favor of TSD as opportunities that can provide “therapeutic traction.” In discussing Gorkin’s stance on self-disclosure, Aron (1996) organizes these benefits as: 1) Therapeutic traction through confirming the patient’s sense of reality; 2); establishing the therapist’s honesty and genuineness; 3) modeling that the therapist too is human and has transferences; 4) clarifying the nature of the patient’s impact on the therapist on people in general; and 5) for breaking through treatment impasses and deeply entrenched resistances.

Ehrenberg (1995), another previously mentioned advocate for self-disclosure, describes the benefits of accessing a realm of information otherwise elusive and achieving new levels of analytic rigor. Furthermore, similar benefits of self-disclosure have been discussed in the context of patients working through existential issues (see Geller, 2003; Jourard, 1971; Yalom, 2002). It should be noted that the arguments for judicious self-disclosure put forth by Ehrenberg and Gorkin were suggested in the context of countertransference disclosures, or in other words, material that is internal to the analysis. A greater level of TSD endorsement has also been discussed with the suggestion that even material external to the analysis may be used productively (e.g., Wachtel, 1993).

The benefits of self-disclosure have been written about extensively, if not exhaustively. Still, the potential for harm is ever present. Some of the many problems with TSD relate to underlying issues with boundaries, power, and mutuality, the risk of replacing the patient's inner experiences with the analyst's subjectivity, and the creation of a multitude of unconscious fantasies, among other risks of harm (see Ginot, 1997). Gutheil and Gabbard (1998) regard the issue of self-disclosure as a boundary issue, with the potential for a harmful and unethical role reversal in the therapy dyad. Consideration of both the costs and benefits of TSD has propelled some to develop guidelines and structure around the use of SD, while others remain wary of constructing rules around something so nuanced and elusive. Maroda (1991), a relational theorist and advocate for explicit disclosure, suggests that analysts first share only their immediate affective experience (i.e., countertransference), second, the analysis of the impact of this disclosure on transference and the therapeutic relationship, and finally, in the termination phase of analysis, the analyst's deliberate analysis of the countertransference in terms of its origins. In addition, Maroda recommends that the analyst only disclose countertransference at the patient's

request or following careful consultation with and approval by the patient. Other advocates for TSD have also suggested cautions and guidelines around its use. Bollas (1989) encourages greater disclosure of the internal analytic process to patients and argues that if self-disclosure is congruent with who the therapist is as a person, then the disclosure is unlikely to cause harm.

A major concern and criticism of guidelines around TSD is the hazard of guidelines becoming rules. Critics like Greenberg (1995) and Hanly (1998) argue that it is not particularly useful or advantageous to proffer a one-size-fits-all technical prescription for TSD. Skepticism about TSD being used as a specific therapeutic tool is founded on the premise of “it depends.” The appropriateness of self-disclosure, at any given time, depends on the therapist’s motivation, the patient’s conflicts and needs, and the therapeutic relationship, as well as the greater context at that point in treatment. To properly prepare for and make decisions about self-disclosure, prior to the act, may be unrealistic if not counterproductive and a hindrance to treatment. In contrast, TSD that stems from the active therapy process of urgency and intensity can be a very powerful alternative to interpretation (see Ginot, 1997). This intervention, however, is preferred by some as an unplanned technique with decisions made spontaneously.

One commonality across several contemporary psychoanalytic approaches is the dance between rejecting traditional concepts of abstinence and total restriction of TSD and still preserving a sense of analytic anonymity. The conflicting precepts of anonymity and disclosure might explain the myriad stances, opinions, and dissents evident throughout the literature on TSD. While many assume a medial stance on self-disclosure and anonymity, renegade psychoanalyst Owen Renik (1995) takes the most radical position, suggesting that we should not merely discard the principle of analytic anonymity, we should actively contradict it. Renik advocates for an ethic of self-disclosure and authentic candor as the norm in therapy. Throughout

his many papers on this topic, Renik (1993; 1995; 1996; 1999) describes a style of “playing one’s cards face up,” or a consistent willingness to make personal views explicitly available to the patient. This attitude towards TSD contradicts not only the long-standing traditional principle of anonymity, but also the more contemporary idea that it is helpful to be selective, occasional, judicious, or cautious about self-disclosure, maintaining “relative anonymity” (Jacobs, 1999).

While contemporary psychoanalytic approaches to TSD widely and wildly differ, Aron (1996) points out other commonalities in that all seem to approach self-disclosure in a way that promotes the analytic process, protects patients from harm, and preserves the analytic space as a place that predominantly serves the patient’s therapeutic needs. Several guidelines for use of TSD have been suggested (e.g., Maroda, 1991). Still, it seems that most contemporary clinicians maintain that the choice of what, when, and how to disclose to patients is an individual decision that varies from therapist to therapist, patient to patient, and session to session in any treatment.

1.3. Empirical Research on TSD

Empirical research on the effectiveness of TSD is limited (see Barret & Berman, 2001; Ziv-Beiman & Shahar, 2006; Ziv-Beiman et al., 2017). Yet, more than 90% of therapists report having disclosed to patients at some time (Henretty & Levitt, 2010). While some argue that TSD impedes treatment, others have suggested that it enhances the effectiveness of therapy. To test these competing positions Barrett and Berman (2001) examined outcomes in treatment between patients ($N = 36$) receiving different conditions of TSD. Specifically, therapists at a university counseling center were instructed to increase the number of self-disclosures they made during treatment of one patient and refrain from making self-disclosures during treatment of another patient. Analyses revealed that patients receiving psychotherapy with heightened therapist self-disclosure reported lower levels of symptom distress and more affection for the therapist than

patients in restricted disclosure conditions. It is debatable whether greater affection for the therapist is a positive consequence and such implications for treatment outcome and therapeutic relationship have been discussed.

In a first randomized clinical trial, Ziv-Beiman et al. (2017) examined the effect of immediate and non-immediate TSD in the context of brief integrative psychotherapy. Patients (N = 86) were randomly assigned to three conditions: 1) Therapists using immediate self-disclosure (affective expression towards the patient, treatment, or relationship); 2) therapists using non-immediate self-disclosure (expressing personal/factual information); or 3) therapists refraining from self-disclosure altogether. Results indicated that immediate TSD reduced psychiatric symptoms among patients with elevated pretreatment symptoms and bolstered a favorable perception of the therapist. Again, implications for therapeutic alliance and treatment outcomes are to be considered (Ziv-Beiman et al., 2017).

A survey study by Mathews (1988) examined the perceptions of therapists (N = 342) regarding their use of self-disclosure with their patients. Findings showed that the most frequently cited reasons for utilizing self-disclosure were to promote feelings of universality and to provide reality testing. Common reasons for not disclosing included removing the focus from the patient and interfering with the transference. The themes in these survey responses are consistent with earlier research by Arlow (1969) and later by Greenburg (1995) that highlights the interference of TSD on development and resolution of transference.

In an investigation of TSD in interpersonal psychodynamic psychotherapy, Pinto-Coelho et al. (2016) examined 185 TSD events in 16 clinical cases. Findings indicated that one disclosure occurred approximately every other session, with the most frequent type being disclosure of facts. Overall feelings disclosure occurrence (i.e., countertransference) was

positively related to working alliance and relationship from the patient's perspective, while factual disclosure occurrence was negatively related (Pinto-Coelho et al., 2016).

Research on patients' perspectives of TSD across a variety of psychotherapy orientations has found both positive and negative effects related to helpfulness, amount, and relevance of disclosures (see Audet, 2011; Audet & Everall, 2010; Barrett & Berman, 2001; Hanson, 2005; Knox et al., 1997). These findings have led to several patient indicated conclusions (see Pinto-Coelho et al., 2016) including: 1) TSD being rated as more helpful than all other therapist response modes; 2) positive effects appearing more prevalent than negative; 3) TSD relating to the quality of the therapeutic relationship; 4) failure to disclose as potentially detrimental to alliance; and 5) consequences of TSD appearing to be affected by contextual factors like patient expectations, preferences, and working alliance prior to the disclosure.

The impact of TSD on therapy boundaries has also been discussed in the context of psychodynamic psychotherapy and psychoanalysis. Aron (1991) writes that the patient's experience of the analyst's subjectivity in the psychoanalytic situation is both essential and problematic, with implications for self-revelation, countertransference, and disclosure. Aron highlights that self-revelation is an inevitable and continuous aspect of the analytic process, rather than a choice, and that deliberate or surplus self-revelations are always highly ambiguous and are enormously complicated. Regarding patients' perspectives of TSD, Aron firmly suggests that it would be presumptuous to judge the accuracy of patients' perceptions of us, since "our own psychologies are as complicated as those of our patients, and our unconscious [sic] are no less deep" (p. 50).

1.4. Technology and Telehealth

In discussing the analyst's use of self, subjectivity, and the problem of self-disclosure,

Ginot (1997) writes:

“In many ways the erosion of the more traditional delineation of boundaries and roles between patient and analyst has made the analyst job difficult... the analyst has to walk the fine line between being part of the interpersonal experience and retaining his or her unique and essential therapeutic functions” (p. 372).

This “erosion of traditional boundaries” could not be more relevant in the current era of psychotherapy, revolutionized by the intersection of therapy and technology and the advent of teletherapy. Before discussing the impact of technology on therapy dynamics, a brief review of the research on telehealth is necessary. Terms like tele-mental health, telepsychology, teletherapy, and other catchy portmanteaus can be found throughout the literature. Here, teletherapy and telehealth are used interchangeably with other variations and refer to the broad definition of the provision of psychotherapy using telecommunication technologies. Teletherapy can be delivered via a range of technologies including telephone, Internet and email, virtual reality simulators, and videoconferencing. This review of the literature is most interested in teletherapy communication via videoconferencing, or therapy over video (i.e., Zoom).

Therapy over the Internet has been receiving attention for a long time (see Barak, 1999; Pergamot, 1998), far preceding the recent telehealth upsurge in response to the global Coronavirus (COVID-19) pandemic. The American Psychological Association (APA) has published guidelines for the practice of telepsychology (Joint Task Force, 2013), as has the American Telemedicine Association (Yellowlees et al., 2010). Regarding the efficacy and acceptability of teletherapy, previous findings have demonstrated that such services are satisfactory to patients and clinicians, improve outcomes, and are cost effective (see Richardson et al., 2009). Furthermore, a review of the research by Hilty et al. (2013) shows that tele-mental

health is effective for diagnosis and assessment across many populations and appears to be comparable to in-person care. While systematic reviews and meta-analyses have demonstrated the efficacy of teletherapy as equivalent to face-to-face treatment, these findings relate to Internet-delivered cognitive behavior therapy (Carlbring et al., 2018; Käll et al., 2021; Paris et al., 2018), online application of family therapy (Comer et al., 2017; Sapru et al., 2018), and web-based behavioral couples therapy (Doss et al., 2016; Roddy et al., 2020). Many of the procedures in these online applications of therapy bear little resemblance to traditional psychotherapy, especially psychoanalytic work. There is little to no empirical literature to date that compares the efficacy of live and telehealth applications of “classical” treatments (Burgoyne & Cohn, 2020).

While the majority of clinical trials, systematic reviews, and meta-analyses involve CBT, two studies focused on psychodynamic treatment (Andersson et al., 2012; Johansson et al., 2012). Even so, these treatments were only based on psychoanalytic principles and do not fully resemble or mirror the traditional format of face-to-face psychotherapy. In their systematic review of online psychotherapy, Machado et al. (2016) take a psychodynamic perspective on the limited tele-psychoanalytic literature and suggest that “psychodynamic treatments are based on assumptions that are often difficult to sustain in virtual relationships” (p. 86). For example, technological difficulties with a Wi-Fi connection may hinder the perception and interpretation non-verbal communication, resistance, affective expression, and therapeutic alliance, not to mention the total absence of the lower body, hidden below the camera (see Rees & Stone, 2005; Scharff, 2012; Sfoggia et al., 2014).

Although there is little to no quantitative research on web-based psychoanalysis, several case studies, anecdotal reflections, and theoretical explorations exist (see Brottman, 2012; Gabbard, 2001; Migone, 2013; Suler, 2004). Discussion of online psychoanalysis highlights not

only the potential harms and associated cautions, but also the less apparent benefits of the online clinical situation. For example, online therapy, in its most ideal form, can work the way classical Freudian analysis works, with the analyst as an electronically, evenly hovering, neutral presence. Additionally, the online setting of Internet-based therapy can disinhibit a patient's defenses, allowing for regression to primary-process thinking, as well as greater disclosure (on the patient's end at least) than in ordinary, face-to-face clinical interaction. The pros and cons of therapy online, and psychoanalysis in particular, have been a long-standing matter of debate: a debate recently roused by the global COVID-19 pandemic.

1.5. Coronavirus (COVID-19) and Teletherapy

Since March 2020, the ongoing and lasting impact of the COVID-19 pandemic has been felt in almost every domain of human life, affecting, and forever changing the way we interact. Even though telehealth existed long before the global pandemic, the speed with which entire practices, clinics, and even hospitals transitioned to online therapy was startling. As the urgency and immediacy of this transition settles into a "new normal," it seems that online therapy may be here to stay. According to a recent survey from the American Psychological Association (APA, 2021), three-quarters (76%) of clinicians say they are now solely providing teletherapy services, and another 16% say they are also offering remote services in addition to seeing some patients in person. Parallel to the many news articles and blogs emerging about seeing a therapist over a screen, recent research has also been discussing pros, cons, and recommendations for conducting therapy sessions online (see Burgoyne & Cohn, 2020; Geller, 2020).

Specific to psychoanalytic teletherapy, Wolson (2021) brings attention to several benefits including the convenience of teletherapy and the opportunity of seeing patients in their natural environments which vary considerably and can enrich the analysis. Wolson describes the

increasingly common situation of a patient presenting to session from their bed, shortly after waking. Analytic exploration of therapy in bed may uncover a patient's desire to be seen authentically, a fantasy of intimacy or heightened closeness with the therapist, or the ultimate wish fulfillment of "waking up, and having your analyst at your bedside on your iPhone, like a loving parent, perhaps" (p. 109). At the same time, many vital functions of analysis are largely absent over the screen, (i.e., Winnicott's (1953) holding environment and Bion's (1962) containment), technical difficulties are unavoidable, and for some patients, analytic depth is sacrificed. Wolson admits to the possibility that the practice of psychoanalysis has been radically transformed by COVID-19. This recognition marks a significant step for the field of psychoanalysis and represents the next contemporary step towards accepting the foreseeable future, where teletherapy is here to stay.

1.6. Personal Bias

My personal biases are tied to my own opinions about self-disclosure, my developing clinical style and theoretical orientation, and my past and current uses of self-disclosure. As a novice therapist, I have made inevitable, accidental, and mistaken disclosures to patients, as well as deliberate and intentional self-disclosure on occasion. Most of the time, I try to reflect on specific disclosures, individually, and through professional and peer supervisory relationships. Still, my bias surrounding therapist self-disclosure is significantly influenced by the literature I consume, my developing theoretical orientation, and my experiences in supervision. In addition, I must recognize the impact my own therapist's self-disclosures have on me, both consciously and unconsciously. My personal therapy, clinical supervision, and sessions with my own patients have all vacillated between in-person and telehealth platforms. It is likely that these contrasting experiences bias my thinking about telehealth, and self-disclosure over telehealth. In sum, I

believe in the utility of sensible self-disclosure, not used as a specific tool or planned intervention, but rather as a spontaneous act of clinical judgment that is always reflected upon afterward. Lastly, I would be remiss if I did not acknowledge my intense interest in self-disclosure as at least somewhat rooted in my own conflicts in relationships and the desire to know and be known by another.

2. Method

2.1. Participants

A sample of 11 doctoral level clinical psychologists and psychoanalysts were recruited from online listservs including the New York University Postdoctoral Program in Psychotherapy & Psychoanalysis, the American Psychological Association, Division 39, Society for Psychoanalysis and Psychoanalytic Psychology, the Institute for Psychoanalytic Training and Research (IPTAR), and Adelphi University postgraduate programs. Convenience and snowball sampling strategies were utilized until new participants did not produce new data and theoretical saturation was achieved. Inclusion criteria required participants to be psychodynamically or psychoanalytically trained, currently licensed and practicing, and to have a minimum of 5 years licensed clinical experience, with at least one year of experience providing treatment over telehealth. Exclusion criteria included clinicians with integrative theoretical orientations, telehealth experience limited to telephone sessions, and clinicians who primarily treat children.

The sample included some diversity in age and theoretical orientation but was mostly homogenous in race and ethnicity. Of the eleven participants, two identified as male and nine identified as female. Ten participants identified as White/Caucasian and one participant identified as Asian. Participants' ages ranged from 35 to 65+. All participants were doctoral level psychologists and psychoanalysts; nine PhDs and two PsyDs. Participants completed their

degrees at a variety of schools including Long Island University, Adelphi University/Derner Institute, New York University, and The New School for Social Research, among others.

Psychoanalytic orientations included Contemporary Freudian, Ego Psychology, Self Psychology, Interpersonal, and Relational. All participants were actively providing psychodynamic and psychoanalytic treatment in outpatient, private practice settings to adult populations.

Demographic characteristics of the sample are displayed below in Table 1.

Table 1

Demographic Characteristics of Participants

Category	N	%
Gender		
Female	9	(81.82)
Male	2	(18.18)
Age		
35-44	2	(18.18)
45-54	2	(18.18)
55-64	1	(9.09)
65+	6	(54.55)
Racial/Ethnic Identity		
White/Caucasian	10	(90.91)
Asian	1	(9.09)
Degree		
Ph.D.	9	(81.82)
Psy.D.	2	(18.18)
University		
Long Island University	4	(36.36)
Adelphi University/Derner Institute	2	(18.18)
Ferkau/Yeshiva University	1	(9.09)
Michigan State University	1	(9.09)
New York University	2	(18.18)
New School for Social Research	1	(9.09)

Psychoanalytic School

Contemporary Freudian	3	(27.27)
Ego Psychology	1	(9.09)
Self Psychology	1	(9.09)
Interpersonal	4	(36.36)
Relational	2	(18.18)

2.2. Design

This study used a qualitative, grounded theory method (Auerbach & Silverstein, 2003) to generate hypotheses through theoretical coding. This methodology questioned participants about their subjective experience to generate hypotheses from the data provided.

2.3. Procedure

An instrument was created for this study using Qualtrics, an online survey software tool for data collection. The instrument combined an inclusion-exclusion criteria screener, a basic demographic and clinical questionnaire, and an informed consent form. Prospective participants completed the online screener to determine eligibility, before providing informed consent, and completing the demographic and clinical questionnaire. At the start of the study, participant confidentiality was assured, and the voluntary nature of the study was explained. Participants had the right to withdraw at any point during the study, for any reason, and without any prejudice or consequence. After providing informed consent and arranging scheduling technicalities, participants engaged in a 30 to 45-minute interview about their subjective experience with self-disclosure over telehealth. Interviews were conducted over a secure online platform (i.e., Zoom) for economical and practical convenience and accessibility. Interviews were recorded with participant consent and were destroyed following the completion of this study. Recordings were subsequently transcribed. All identifying information was de-identified during the transcription process. Participants were offered a modest incentive in the form of a \$20 gift card to Amazon.com or Starbucks. Participants were eligible to receive the incentive, even for partial

completion. Interview and Qualtrics data were stored securely, by use of password protection and digital encryption. To maintain confidentiality, each participant was identified by a unique numerical/alphabetical sequence.

2.4. Measures

Demographic and Clinical Questionnaire (see Appendix B). Participants completed a self-report demographics and clinical questionnaire. First, they reported their age range (i.e., 25-34, 35-44, 45-54, etc.), gender identity, ethnicity/race, and highest degree obtained. Next, they selected their clinical orientation from a drop-down list of choices: Contemporary Freudian; Ego Psychology; Self Psychology, Interpersonal; Relational; Object Relational; Intersubjective. They also responded to a question about the clinical population that they currently work with, and orientation of treatment. Next, they reported information about their professional training and education. Finally, participants reported their number of years of clinical experience practicing in person and over telehealth platforms.

Interview Questions. Data was collected using a semi-structured interview format. Interview questions included open ended questions about participants' approach to self-disclosure and specific use over telehealth platforms:

1. Can you talk to me about your approach to self-disclosure in therapy?
 - a. How is your use of self-disclosure determined?
 - b. What types of self-disclosure do you use or avoid?
2. Has your use of self-disclosure changed since using telehealth? How?
3. Can you give me an example of a time when you self-disclosed to a patient while using telehealth?

4. How did you feel about the disclosure afterwards?
 - a. Personally?
 - b. Therapeutically or clinically?
5. Can you tell me about any unintentional or accidental self-disclosures over telehealth?
6. Can you speak to the effects you believe your self-disclosures have had on treatment?
 - a. Intentional?
 - b. Unintentional?

2.5. Data Analyses

This study used Auerbach and Silverstein's (2003) grounded theory approach to qualitative research. Theoretical assumptions and hypotheses were avoided, with the goal of having the data unfold into meaningful theoretical constructs. Individual, semi-structured interviews were audio recorded and then transcribed by the author. A team of four coders (graduate students in the clinical psychology doctoral program at Long Island University - Post) joined the author in selecting relevant text from the interviews and then identifying repeating ideas and themes. Finally, the themes were used to form theoretical constructs, and to generate hypotheses about therapists' use of self-disclosure over telehealth platforms.

Three training sessions were conducted by the author with the team of coders, the first of which took place prior to the start of coding. Discussion of the research question ensured that coders were aware of the central question, allowing them to read through the raw text and highlight text relevant to the research question. Questions such as "Does this relate to the research question and does this text help me understand the participants better?" helped guide coders' decision on whether to deem text relevant or not (see Auerbach & Silverstein, 2003).

After relevant text was extracted from the raw interview transcripts, coders received a

second training on the process of identifying repeating ideas. When at least two participants use similar words or phrases to communicate the same idea, this is said to be a repeated idea (Auerbach & Silverstein, 2003). The relevant text extracted from each interview was compared across participants to see what ideas are repeated by multiple people. Repeated ideas were given a title and were then grouped together according to the content of ideas (Auerbach & Silverstein, 2003). The process of identifying relevant text and repeating ideas was conducted independently by each coder (Auerbach & Silverstein, 2003). However, coders and the author met periodically throughout the coding process to ensure inter-rater reliability.

A third training was conducted so that each coder could begin organizing repeated ideas into themes, which are implicit ideas or topics that describe what the repeating ideas have in common (Auerbach & Silverstein, 2003). This work of articulating themes was also done independently. Next, the author, in consultation with his advisor, constructed theoretical frameworks to best encapsulate the themes. At this point, it was often necessary to consolidate themes to prevent redundant or unnecessary theories (Auerbach & Silverstein, 2003). The final theoretical narrative, found in the next section, weaves together the theories and references the original text from which the ideas originated.

3. Results

Five theoretical constructs emerged from the data and are presented in this paper in ALL CAPS. These constructs are supported by 12 themes, which are displayed with underlined text. The 12 themes are supported by 56 repeating ideas, depicted in *italics*. See Appendix E for a hierarchical presentation of the data. Auerbach and Silverstein (2003) suggest the use of direct quotes from participants for naming repeating ideas. Brackets occasionally signal words that were not said by a participant directly, but complete or abbreviate the quote based on context.

In referencing the participants in this study, the terms psychologist, psychoanalyst, and participant are used interchangeably. Psychoanalysts spoke about their experience with self-disclosure in five distinct but overlapping domains: DETERMINANTS OF SELF-DISCLOSURE, TELEHEALTH AND SELF-DISCLOSURE, THE FRAME, THE IMPACT OF SELF-DISCLOSURE, and RESPONSES TO SELF-DISCLOSURE.

Table 2

Theoretical constructs and supporting data

Theoretical Construct I: DETERMINANTS OF SELF-DISCLOSURE
Theme A: Self-Disclosure is Determined by Both Patient and Analyst Factors (81.82%)
Repeating Ideas: <ol style="list-style-type: none"> 1. It depends on the patient 2. Some patients don't even notice 3. Taking theoretical and conceptual rules of the game a little less seriously 4. Self-disclosure over telehealth is determined by the analyst's personal life
Theme B: Forms of Self-Disclosure (100%)
Repeating Ideas: <ol style="list-style-type: none"> 5. Analyst generally avoids self-disclosure, but there are exceptions 6. Analyst will disclose countertransference in the moment, to facilitate insight and explore transference 7. Judicious self-disclosure is used spontaneously or intuitively, rather than strategically 8. Analysts are receptive to self-disclosures around race, culture, demographics 9. If they say, "Where are you going?" I find it weird to say, "Well what are your fantasies?" 10. Self-disclosure about health, sickness, and death 11. Disclosing pregnancy is a unique form of self-disclosure since it is initiated by the analyst
Theme C: Motivations for Self-Disclosure Over Telehealth (54.55%)
Repeating Ideas: <ol style="list-style-type: none"> 12. She could kind of picture me there and get back to herself, as opposed to this preoccupation that I wasn't available 13. Analyst is willing to self-disclose about location or in response to breach in the frame 14. If I feel I'm intruding on their space, I'm willing to reveal things 15. Is self-disclosure for the patient or for the analyst?
Theoretical Construct II: TELEHEALTH AND SELF-DISCLOSURE
Theme D: Self-Disclosure Over Telehealth is Inevitable (100%)
Repeating Ideas: <ol style="list-style-type: none"> 16. Pet intrusions: "When my cat walks across the screen" 17. Every once in a while, I might get a delivery in the middle of the session

<p>18. Child intrusions: There's a big sign right in front of my office saying, "Dear Mom, I hate you."</p> <p>19. Obviously in person I wouldn't be wearing a nightgown. It's a telehealth problem</p> <p>20. Use of self assumes inevitable self-disclosure; some amount of your realness is a good thing</p> <p>21. I don't think you're blank by being withholding, defended, or guarded</p>
Theme E: Increased Self-Disclosure Over Telehealth (100%)
<p>Repeating Ideas:</p> <p>22. Telehealth pulls for more sharing, to stay related, in spite of the distance of the screen</p> <p>23. In-person, that would have been just in the room, without my having to say it</p> <p>24. A sort of loosening of some of my therapeutic vigilance over telehealth</p> <p>25. Increased self-disclosure related to COVID anxiety</p> <p>26. Patients can pick up on analyst's countertransference over telehealth</p> <p>27. Changes to physical location present an opportunity for increased self-disclosure</p> <p>28. Creating and curating a background over telehealth includes contextual self-disclosure</p>
Theoretical Construct III: THE FRAME
Theme F: Telehealth Has Changed the Frame of Therapy (81.82%)
<p>Repeating Ideas:</p> <p>29. There are some things about people being invited into my own office or home</p> <p>30. People are not going to walk into my office in their underwear, but they might show up for a Zoom session in their boxers</p> <p>31. It's really hard to sit together in silence and stare at each other on a computer screen</p> <p>32. There is a greater strain to connect with patients over telehealth</p> <p>33. There was this alienation, disconnection from one's place in space and time</p> <p>34. Self-disclosure has decreased over telehealth due to less intimacy in therapy situation</p>
Theme G: Replicating and Protecting the Frame Over Telehealth (54.55%)
<p>Repeating Ideas:</p> <p>35. Instead of four walls of a room, you have four sides of a frame</p> <p>36. When the frame remains the same, self-disclosure has remained consistent between in-person and telehealth</p>
Theoretical Construct IV: THE IMPACT OF SELF-DISCLOSURE
Theme H: The Benefits of Self-Disclosure (63.64%)
<p>Repeating Ideas:</p> <p>37. I think it strengthens the relationship, when done judiciously</p> <p>38. When we're two humans, I think they feel freer to do that as well</p> <p>39. It's a different level of communication than exploration and analysis</p> <p>40. Benign personal self-disclosure can be used to break the tension or provide perspective</p> <p>41. Profound personal disclosures: "I was saying to her, I know it's true because I lived it"</p>
Theme I: The Intrusion of Self-Disclosure (81.82%)
<p>Repeating Ideas:</p> <p>42. Self-disclosure is unhelpful when it causes the patient to become concerned about caring for the analyst</p> <p>43. You become the needy, self-involved, impinging mother when it's done to meet your own needs</p>

44. Self-disclosure and transference: “It really flustered her image of me”
45. “But now I know you have somebody, and I didn't want to ever know that.”
46. One could question accidental, right?
Theme J: The Neutral Impact of Self-Disclosure (54.55%)
Repeating Ideas:
47. It's not like that disclosure was particularly meaningful
48. Self-disclosure can change the direction of analysis and beget further disclosure
Theoretical Construct V: RESPONSES TO SELF-DISCLOSURE
Theme K: Watching for Patient Reactions to Self-Disclosure (63.64%)
Repeating Ideas:
49. Gauging patients’ reactions to analyst self-disclosure
50. Negative reactions: “I was up in my country house, and they were in the middle of people dying. I think it was painful for them”
51. Positive reactions: “This was the best session we’ve ever had”
52. Patients can be forgiving of too much self-disclosure
Theme L: Processing and Reflecting on Self-Disclosure (90.91%)
Repeating Ideas:
53. Processing and exploring self-disclosure with patients models accountability and therapeutic communication
54. Analyst reactions: “I almost feel like I'm caught”
55. Analyst reactions: “I felt a little mixed, not as confident”
56. I was aware of that, so I didn't act on it

3.1. DETERMINANTS OF SELF-DISCLOSURE

When speaking with the psychologists in this study, one theoretical construct that emerged was DETERMINANTS OF SELF-DISCLOSURE. Most participants (81.82%) discussed how self-disclosure is determined by both patient and analyst factors. About half the participants (54.55%) expressed how their use of self-disclosure is determined by the patient (*It depends on the patient*) with determining factors including the patient’s level of functioning, the length of treatment, how “it might help the treatment or help them” (P9) and “what it will or will not do for the process” (P2). Some psychoanalysts explained that self-disclosure is used “on a very individual basis” (P9) that is “very much dependent on the patient” (P1) and is decided “case by case” (P7). Several participants (36.36%) reported that some of their patients don’t notice, acknowledge, or even want to know anything about them (*Some patients don’t even*

notice). One psychoanalyst said that she might ask patients whether they want to know something (P1), as people “vary in terms of what they feel comfortable asking or what they’re curious about” (P7). About half the participants (54.55%) reported that their approach to self-disclosure has changed since their training days, with several becoming more relaxed and selective over time (*Taking theoretical and conceptual rules of the game a little less seriously*). One psychologist expressed, “I’m not as avoidant of it, I’m not as fearful of it, as some theoretical approaches warn you about” (P2). Others expressed that their use of self-disclosure is influenced by their theoretical orientation, such as, “I roughly consider myself a contemporary Freudian analyst, and so, with the accent on the contemporary, there’s a little more leeway” (P5), or “I’m open to doing it. I’m not a classicist in that way. I’m more of a totalist” (P9). Lastly, a few participants (18.18%) acknowledged the influence of analyst factors on self-disclosure (*Self-disclosure over telehealth is determined by the analyst’s personal life*). One participant (P5) suggested that “self-disclosure has something to do with who are you, like as the analyst or therapist, who are you? Where are you located? Where are you located in space and time? Where are you located historically? Like so many levels.” Another (P2) added “what is going on in the analyst’s or therapist’s life during the pandemic” might make it “much harder not to be self-disclosing, not to share.”

In addition to most participants identifying patient and analyst factors as influences of self-disclosure, all participants (100%) spoke about how it really depends on the forms of self-disclosure in question, with different approaches to different forms of disclosure. About half the participants (54.55%) reported they generally abstain from self-disclosure, with some exception (*Analyst generally avoids self-disclosure, but there are exceptions*). In general, it appeared participants were least likely to disclose information about their personal life or experiences that

may be similar to the patient. Two participants reported avoidance of disclosing feelings or countertransference. Participant 6 said, “I definitely don’t reveal my feelings towards a patient, if something irritates me. I don’t think it’s therapeutic,” while Participant 5 similarly expressed, “I wouldn’t say I have a hard and fast rule against or for doing it, though I would say generally, I don’t talk about how I’m feeling.” The same participant (P5) added, “I mean, it’s not like it hasn’t happened,” later clarifying that “in general self-disclosure would be an exception, but not an unacceptable one or an unheard of one, but something really called for in the situation.” Others expressed similar ideas such as “I try not to self-disclose, unless I really feel like it would be beneficial” (P11). While some psychoanalysts reported avoidance of disclosing feelings, others (36.36%) reported they are more open to disclosing feelings, or countertransference, if it would be helpful to the patient (*Analyst will disclose countertransference in the moment, to facilitate insight and explore transference*). One participant (P1) clearly differentiated between forms of self-disclosure, stating “there are two different self-disclosures: one is the facts of your life and the other is your experience in the moment.” Several participants seemed open to using their internal reactions, general countertransference, and experience of the patient in the moment if it would help “facilitate their understanding of themselves and interaction between us in the transference” (P8). While these participants endorsed use of countertransference self-disclosure, several reiterated that they would not share “general information about myself” (P9) or “any kind of facts about my life” (P8). Within the different forms of self-disclosure, several participants (36.36%) spoke about finding a balance through intuition and spontaneity (*Judicious self-disclosure is used spontaneously or intuitively, rather than strategically*). One participant (P2) explained that his use of self-disclosure is not planned or strategic, but instead is “somewhat intuitive really” with “no clear criteria.” Similarly, Participant 5 expressed “when it (self-

disclosure) has happened, I think it's a good thing, as long as it isn't uncontrolled... an enactment." In other words, "you have to be careful, but not to be too fearful of it" (P2). An important form of self-disclosure that two participants (18.18%) elaborated on was self-disclosure around race, culture, and religion (*Analysts are receptive to self-disclosures around race, culture, demographics*). One participant (P5) reported that elements of self-disclosure like race or culture are obvious and are always in the room. As such, "it's important to be able to talk about these things, so I might say something or call attention to it at the beginning of treatment, to make an opportunity for it to be talked about." Another participant (P6) reported that disclosure about religious observance comes up when she tells patients she is taking time off for the Jewish holidays. This participant expressed, "I just feel much more comfortable doing that, than just saying, 'Well, next Tuesday and Wednesday I won't be in'." Several participants (45.45%) spoke about disclosing information surrounding superficial subjects like pets, television, and taking vacation (*If they say, "Where are you going?" I find it weird to say, "Well what are your fantasies?"*). One participant (P1) shared "when I was first trained you didn't tell your patient where you're going on vacation, and now it's like I don't even think twice about it." Others expressed that they will not necessarily volunteer information about their vacation destinations, but if a patient asks, they will tell them. Another two participants (18.18%) shared their thoughts on *self-disclosure about health, sickness, and death*, that may arise when the analyst falls ill, has a death in the family, or is approaching death themselves. Lastly, a few participants (18.18%) shared a specific form of self-disclosure surrounding pregnancy and maternity leave (*Disclosing pregnancy is a unique form of self-disclosure since it is initiated by the analyst*). Psychoanalysts differentiated this type of self-disclosures from others, as it was "one of the first times I initiated saying something about myself" (P11) and "I feel like that was a

big intrusion on their space” (P6). Psychoanalysts seemed less comfortable with this form of self-disclosure since it shifted the dynamic and did not feel like a choice. Furthermore, disclosing pregnancy was complicated by telehealth for one participant (P11) who was “concerned about how she (patient) would respond, especially because she wasn’t seeing me (analyst). So, it was sort of an abrupt topic. Meaning, she wasn’t seeing my belly expand, there was no sign other than me telling her this information.”

Participants (54.55%) also spoke about their motivations for self-disclosure over telehealth. A few psychoanalysts (18.18%) were willing use self-disclosure in a way they would not have done in-person. Seeing patients over telehealth assumes a change in location for both patient and analyst. Motivation for self-disclosure in this context was in some way to remind the patient of the analyst’s physical presence and allow the resumption of the patient’s free association (*She could kind of picture me there and get back to herself, as opposed to this preoccupation that I wasn't available*). Participant 1 shared an anecdote where she described her pull to hug a patient over telehealth:

“I think the hug comment was really effective. I think it put words on something, not that she needed to be reminded that I care about her, but in some way, it reminded her of our physical presence or something together, that I am still there for her.”

Similarly, Participant 5 described her physical location to patients, providing details of “what the room was like.” Participants reported that patients felt relieved when they could picture their analyst somewhere. This allowed patients to get back to free association and communication, without remaining stuck in the preoccupation that the analyst is not available or present.

Similarly, participants (36.36%) reported that switching to telehealth included several changes to the physical and virtual frame of therapy, and that in response to breaches in the frame they were

willing to disclose their location (*Analyst is willing to self-disclose about location or in response to breach in the frame*). For example, Participant 6 told patients about her country home in the Catskill Mountains and was willing to answer patients' questions about her location. Participant 7 compared changes in location to radically painting her office, one color to another; "most people would be aware of that and make some comment." Working in a different location comes with many inevitable breaches to the frame, and as Participant 11 put it, "at some point, you have to be transparent." In that vein, participants (18.18%) were more willing to self-disclose in response to intruding on the patient (*If I feel I'm intruding on their space, I'm willing to reveal things*). Participant 6 described this as a "separate category of things that I've caused." When intruding, changing the frame, or showing up to session with a radically different background, participants' motivation for self-disclosure came from a place of honesty, transparency, and containment: "If they're picturing my office and I'm not there, I feel it's deceptive" (P6). "If I'm working from home, sometimes my child will cry in the next room, and if a patient hears that and they ask about it, I have to be honest and say that that's my child or something along those lines. At some point, you have to be transparent" (P11). Lastly, a few participants (18.18%) raised the question, *is self-disclosure for the patient or for the analyst?* One participant (P6) highlighted the "slippery slope" in a more interactive treatment where motivations for self-disclosure can become blurry. Another (P10) added that she asks herself questions such as "Am I disclosing this for my patient or myself?" and "Do they need to be gratified or is it a need to gratify them?"

3.2. TELEHEALTH AND SELF-DISCLOSURE

When speaking with the psychologists in this study, a second theoretical construct that emerged was TELEHEALTH AND SELF-DISCLOSURE. All psychologists (100%) discussed how self-disclosure over telehealth is inevitable. Several participants (36.36%) described the

inevitable self-disclosure of pets (*Pet intrusions: “When my cat walks across the screen”*) with cats walking across the screen, dogs jumping up on laps, and lots of barking, with one psychoanalyst working from home with three dogs. Others (27.27%) shared that when working over telehealth from home, patients will inevitably overhear the intercom ringing, deliveries, and service people working in the background (*Every once in a while, I might get a delivery in the middle of the session*). For example, Participant 3 shared that unintentional disclosures can occur when “a workman had to come in to do some work somewhere else in the space...” and that this “reflects the comfort of just kind of being around all the time” when working over telehealth. At the end of the day, self-disclosure is unavoidable. “If you need a plumber... *laughter*” (P3). Several participants (27.27%) described unavoidable self-disclosure that occurred while working remotely, over telehealth, and with children at home (*Child intrusions: There's a big sign right in front of my office saying, “Dear Mom, I hate you.”*). These disclosures included sounds of children, someone yelling, and knocks on the door. Participants reported that when first working over telehealth, “that was not something I could control” (P8) or “I would kind of get almost anxious that shouldn’t be part of the scene” (P2). Participant 4 reflected on a humorous disclosure that occurred while working from home:

“I worked at home since I had a child. The patient walks out of the office, and there’s a big sign right in front of my office saying “Dear Mom, I hate you. Love, (child’s name).” Both of us laughed. It was a sophisticated patient, but it was sort of adorable” (P4).

Participants (36.36%) also described disclosures that would never occur had they been seeing patients in-person (*Obviously in person I wouldn't be wearing a nightgown. It's a telehealth problem*). These examples included “hearing footsteps” (P1), “wearing a nightgown” (P4), and disclosures around being late for session: “That wouldn’t happen in person because I wasn’t in

my home. I was already at work” (P8). While discussing self-disclosure over telehealth, participants (36.36%) discussed how the use of self assumes inevitable self-disclosure (*Use of self assumes inevitable self-disclosure; some amount of your realness is a good thing*).

Participant 5 spoke about how covert self-disclosure is happening all the time when “one is listening using oneself, one’s own feelings, one’s own body, as through listening to material and processing it, using these levels of experience and giving something back to the patient.” This participant added:

“In the movement from a state of omnipotence to the depressive position, which we are all in and out of and we’re all moving, hopefully towards, is a kind of a tolerance and an awareness of the subjectivity of the other. And in a way we want as the end, as a sign of health, for the patient to be able to take in more of us as a real person, which may or may not come with actual self-disclosures, but some amount of your realness that’s needed, wanted, called for, is a good thing” (P5).

Other self-disclosures that happen all the time include “betray[ing] a knowledge of something” (P1), “disclosing about politics; not intentionally” (P6), “what you’re wearing... what you respond to” and “what patients know about me from all the unspoken stuff too” (P11). Although self-disclosure is inevitable, Participant 5 expressed that “as analysts, part of our role is to not, for good reason, to not disclose and yet, it’s this fine line between one, just being seen more fully and then having there be room to show something of ourselves.” Lastly, in discussion of the inevitability of self-disclosure over telehealth, participants (45.45%) took issue with the idea of total anonymity and the blank screen (*I don’t think you’re blank by being withholding, defended, or guarded*). Participant 1 expressed how “no self-disclosure... can be mystifying and distancing” which makes it “much harder for patients to tell me if they’re angry at me.”

Participant 4 said, “I don’t keep a blank screen. I don’t know that therapists do anymore.”

Participant 6 felt strongly “that not revealing *certain* things to a patient, like if they ask you if you’ve seen a movie or where you’re going on vacation... I feel it’s insulting to the patient not to disclose things like that.” This participant (P6) added that no self-disclosure is “really like a dead treatment.” Participant 10 commented “neutrality doesn’t exist. I mean, you want neutrality, then you do therapy with a robot.” This participant (P10) further explained that “the need to project... the development of transference... the need for relationship, and the need for connection” are so robust and since “change in healing happens within the relationship” this “requires that one not be neutral.” Lastly, this psychoanalyst (P10) suggested “I don’t think you’re blank by being withholding... You’re withholding. You’re defended. You’re guarded.”

Regarding telehealth and self-disclosure, all psychologists in the study (100%) spoke about increased self-disclosure over telehealth. Most participants (72.73%) spoke about an increased urge, or pull, to self-disclose that occurs specifically over telehealth (*Telehealth pulls for more sharing, to stay related, in spite of the distance of the screen*). In some instances, this pull to self-disclose was unintentional: “It slipped out of my mouth” (P1), or “somebody told me about her cancer, it was a new person, and I volunteered that I had had similar experience. Now, would I have done that if she was in my office? I tend to think not” (P7). At the same time, intentional self-disclosures have also increased. While one participant (P10) denied changes to the frequency of self-disclosure, she did admit to an increased “urge to share” coming from “feeling disconnected and somewhat isolated” and a desire “to connect more” during the first year of the pandemic. Participant 4 described working over telehealth as “more objective” and “somewhat more depersonalized.” Similarly, Participant 9 described compensating for feelings of disconnect, isolation, and restricted mobility during the pandemic. Participant 7 described how

“the need to connect felt more imperative.” There is “something about telehealth,” explained Participant 2, “that does pull for more sharing because there is this, at least for me, more of a pull to stay related, in spite of the distance of the screen.” Other participants expressed similar ideas of self-disclosure as “a way of countering” or “trying to overcome whatever sense of distance one might experience on the screen versus the person physically being in your office” (P3). Similarly, another participant suggested that “there’s a pull to kind of be in the same room, so to speak” (P2). A few participants (27.27%) spoke about how telehealth creates a greater need to verbalize the nonverbal aspects of therapy (*In-person, that would have been just in the room, without my having to say it*). Participant 1 described this phenomenon as having “to put more words to things, sometimes.” Examples of verbalizing the nonverbal included commenting on nonverbal body language, describing a feeling or energy that might be in the virtual room, and bringing attention to the process of therapy. As Participant 5 put it, “it’s happening all the time when we see patients in the office, because you’re literally there, in space and time. Sometimes, the literal facts of what is happening in the room, two bodies in the room, becomes a point of focus.” This participant added, “the breach and the trauma of the pandemic, and the change, meant you have to highlight it more” (P5). Almost half the participants (45.45%) acknowledged increased frequency of self-disclosure due to *a sort of loosening of some of my therapeutic vigilance over telehealth*. Participants gave examples of “not wearing a tie... I usually am” (P2), “more openness” (P3), and “being more personal or more chatty than my usual style” (P7). A few participants reflected that something about telehealth, the pandemic, and feelings of isolation during COVID-19, contributed to “a sort of loosening of the boundaries a bit, with telehealth” (P9). Related to the pandemic, many participants (45.45%) also described *increased self-disclosure related to COVID anxiety*. Participants shared that they have been asked by patients

for guidance about the vaccine: “Are you getting the booster yet?” (P6), “are you going out to eat” (P10), and other steps taken in response to the pandemic. Participant 11 shared that wearing a mask and “talking about the fears of the pandemic” with patients “was like an equalizer, and it was also disclosing that there are these fears and unknowns for me too.” A few participants (27.27%) added that both in general, and specific to COVID-19, *patients can pick up on analyst’s countertransference over telehealth*. Participant 7 shared an anecdote:

“I have one patient who for her own reasons wasn’t getting vaccinated. And I increasingly felt I had a lot of reactions to this. First of all, I didn’t like it. But I also felt it was in some ways, compromising the treatment. I think she very much picked up my irritation.”

Participant 9 also had an example of “a patient who really pushes my buttons and can be kind of annoying... I became very real in a moment where my annoyance became apparent to him.”

Participants spoke about how part of their reaction may have been due to a growing intolerance of so much remote work during the pandemic. Several participants (36.36%) described increased self-disclosure elicited by changes to the analysts’ whereabouts (*Changes to physical location present an opportunity for increased self-disclosure*). Many analysts left the city at the beginning of the pandemic, which led to some patients learning about summer homes, while “others have no idea that I’m not in the city” (P1). Psychologists reported that patients are perceptive and can determine the location of their analyst by recognizing “construction going on outside my apartment” (P1), seeing “the green” (P7) that doesn’t belong in the city, or even comments about the weather that can give up one’s location. Another increase in self-disclosure over telehealth discussed by most participants (63.64%) related to contextual or background self-disclosures (*Creating and curating a background over telehealth includes contextual self-disclosure*).

Patients might ask “about the picture behind me” (P2), the “different visual landscape” (P5), and about “what I choose to include as the space between these four walls of the frame” (P8).

Participant 8 acknowledged that “there’s something important to me about having books behind me” which discloses something about himself to the patient.

3.3. THE FRAME

In addition to discussing ways in which self-disclosure has increased over telehealth, psychoanalysts also spoke about THE FRAME of therapy, in-person and over telehealth. Most participants (81.82%) described ways in which telehealth has changed the frame of therapy. A few participants (27.27%) indicated that personal self-disclosures have inevitably changed due to patients seeing more of the analyst’s personal life than they might have in-person (*There are some things about people being invited into my own office or home*). Participants described this phenomenon as “clearly, people see your home now” (P1), like “people being invited into my own office or home” (P2), and “it’s kind of automatically not 100% a neutral space that somebody might have if they were just in an office suite or something like that” (P3). Participant 2 summarized, “working on Zoom created a somewhat different frame.” Just as patients are exposed to the analyst’s personal life, several participants (38.36%) indicated that there is more for the analyst to react to, or disclose feelings about, when patients are in their own space (*People are not going to walk into my office in their underwear, but they might show up for a Zoom session in their boxers*). Participants described “being exposed to things that I wouldn’t necessarily be if I was in my office” (P9), like patients showing up to session “in t-shirts, yawning since it’s the first thing in the morning” (P2), “standing up and they’re in their boxers” (P8), and even presenting to session “in bed in their PJs” (P8). Analysts also reported seeing

more of patients' family space, with instances "where somebody in their family will walk into the screen" (P3). Participant 3 described the following anecdote:

"We were having a session, and something happened, actually off screen, between her and her mother. She came back onto screen. And then the mother came into the screen and actually gave my patient a hug. All of this happening on screen... That's the kind of thing that at least my experience with the patient has been... very different."

Participant 8 had a similar example where he felt less control over the frame of treatment:

"One patient was talking to me about their spouse for almost a whole session, and then I all of a sudden heard their spouse saying something, and I was like totally (stammering) what, what, where are you?? she was in the same room as her spouse and just talking about him as if he wasn't there in a pretty derogatory way."

Two participants (18.18%) reported that telehealth also changes their ability to listen and sit in silence (*It's really hard to sit together in silence and stare at each other on a computer screen*).

One participant reported that treatment "became much more content based" and that what she misses most is "just feeling each other's presence without having to speak" (P1). Similarly, another participant (P3) spoke about a patient who has a lot of silences and that "it makes a big difference when she's in the office and when she's on screen." For this participant (P3), telehealth has also changed the frame by making it more difficult to listen with "suspended attention." Other participants (18.18%) reported *there is a greater strain to connect with patients over telehealth*. Participants described needing to "work extra hard" over telehealth, feeling "less relaxed," and experiencing "a kind of strain" possibly due to "self-modulation" and not having "the optimal distance." Participant 7 elaborated, "it's not natural to talk to someone, you know, a

number of inches away.” Many participants (45.45%) described the transition to telehealth as disorienting and impacting the beginning and ending of sessions (*There was this alienation, disconnection from one's place in space and time*). Participants described feelings of “disorientation,” “alienation,” and “a sense of being sort of lost... dissociated” (P5). Regarding the start and end of session, participants reported that in-person it would be natural to let the patient know you are “running late” or “need a glass a water” before starting session, but over telehealth “they’re just mysteriously waiting for you.” Similarly, at the end of session there is this “very abrupt... horrible ending” where “they’re just gone” with each person back in their own space, without a natural transition. Lastly, while most participants reported increases in self-disclosure over telehealth, a few participants (18.18%) reported that certain types of intentional self-disclosure have decreased due to changes to the frame (*Self-disclosure has decreased over telehealth due to less intimacy in therapy situation*). For example, Participant 4 reported that “in the office... there’s more natural intimacy and therefore more self-disclosure...” Over telehealth, however, “there’s less of a texture, and I don’t reveal as much, not because I made a decision but because the situation doesn’t call for it.”

Most psychoanalysts in this study (54.55%) also discussed the significance of replicating and protecting the frame over telehealth. Several participants (36.36%) spoke about the literal “frame” of therapy as what you choose to include within the four sides of the computer screen (*Instead of four walls of a room, you have four sides of a frame*). One participant (P5) suggested that switching to telehealth required “finding the markers of the new space and time,” while another (P8) shared how a “certain sense of control over the background makes me feel like there is that frame.” As such, participants spoke about how they keep things “consistent” and “familiar” over telehealth. Participants also expressed the importance of protecting the frame of

treatment and “demonstrating the importance of having a frame going forward” in response to changes to the boundaries of therapy over telehealth. Participant 8 shared an example where telehealth provided an opportunity to discuss boundaries with a patient:

“Letting her know that I wasn’t comfortable not knowing who was in the room, and why I value the idea of having a space that is private... There’s so much communication in that, but also there is so much about boundaries. I have to kind of disclose my feelings about why a frame is necessary for therapy to work. Because I’m basically in their space and I’m seeing things that I don’t really have control over.”

Several participants (27.27%) reflected that *when the frame remains the same, self-disclosure has remained consistent between in-person and telehealth*. For example, one participant (P11) goes into her office to do remote therapy, so that patients will still see her in her office, even over telehealth. This participant shared that “in terms of the frame of the office, whether it’s Zoom or in person, I feel like self-disclosure has stayed the same” (P11).

3.4. THE IMPACT OF SELF-DISCLOSURE

During interviews with the psychoanalysts in this study, discussion centered around THE IMPACT OF SELF-DISCLOSURE. Most participants (63.64%) spoke about the benefits of self-disclosure, with some (45.45%) reporting that self-disclosure can strengthen the therapeutic alliance (*I think it strengthens the relationship, when done judiciously*). Participants reported that self-disclosure can be “helpful to people,” and a way to acknowledging “a shared experience,” “increase trust,” “normalize something for a patient,” or “accentuate or develop the bond” and the “therapeutic alliance” when done judiciously. One participant (P10) reporting using self-disclosure to model emotions for patients:

“I often disclose things around anger because I feel like anger is kind of a card-carrying member of the emotional register that most people don’t want to play nicely with. So sometimes I will disclose something about an experience of anger that I had or ways that I demonstrate it, to normalize it and model.

Participants (45.45%) reported another benefit that self-disclosure can humanize the analyst and foster patients’ emotional expression (*When we’re two humans, I think they feel freer to do that as well*). Participants will “use humor,” “play and laugh together,” and “talk philosophically about living a life” as ways of being human. One participant (P4) said, “I hope at my best, I do those kinds of self-disclosures or making a point about who you are as a human being, how you function as it relates to how we all function.” Another participant (P10) described being human with patients as satisfying “a need for them to be able to feel like they know me a little bit so that they can connect, something to kind of hold on to.” A few participants (18.18%) described self-disclosure as a form of extra-therapeutic communication (*It’s a different level of communication than exploration and analysis*). One participant (P1) described this extra-therapeutic communication as “a way of bonding... an adult-adult meeting of the minds... a very non regressed way of somebody who’s being more of their social self, but genuine and spontaneous, more of their adult self, and I’m being not in a caretaking role, particularly.” Another participant (P4) differentiated between “doing therapy and being therapeutic,” sharing that for one patient “to have a cheerleader is one of the things that are therapeutic for her.” A couple of participants (18.18%) shared examples of how *benign personal self-disclosure can be used to break the tension or provide perspective*. Participant 4 shared that she will tell a story about herself that is “benign,” “superficially relevant,” and “not deeply personal” to provide comic relief and “just to break the tension for her (the patient’s) sake, as well as mine.” This participant (P4) reported that

these stories are oftentimes “enormously therapeutic and it alleviates some kind of stress.”

Another participant (P9) deliberately disclosed personal information when she felt confident “it was important information that could be useful” to the patient. Lastly, a couple of participants (18.18%) reported that sometimes, even very personal self-disclosure can be effective (*Profound personal disclosures: “I was saying to her, I know it’s true because I lived it”*). Examples of very personal self-disclosures included telling patients about the death of a parent, adopting a child, or other profoundly personal experiences. Participants shared that these disclosures are “really much more profound than comic relief” (P4) and can at times “break through a huge defense” (P6). Highly personal self-disclosures can allow patients to “identify with someone when you feel alone in the world” or hear “examples that fit their experience when they can’t get it elsewhere” (P4). Participant 4 shared a clinical anecdote:

“Then I said, I adopted a traumatized child, and we are having the same experience.

That’s a lot of self-disclosure... It was *so* personal. But I was saying to her, I know it’s true because I lived it.”

In addition to discussing the benefits of self-disclosure, almost all participants (81.82%) addressed the intrusion of self-disclosure. A few participants (18.18%) conveyed that *self-disclosure is unhelpful when it causes the patient to become concerned about caring for the analyst*. Participants shared examples of unhelpful disclosures that “bring the patient right into my life,” or caused patients to be “worried,” “overly concerned,” and even “overwhelmed with the thought of me dying.” Participant 8 expressed, “I find it counterproductive if a patient needs to take care of me or protect me from my own... guilt.” Other participants (27.27%) strongly expressed that when self-disclosure deflects from the patient, the analyst becomes the self-involved, impinging-mother (*You become the needy, self-involved, impinging mother when it’s*

done to meet your own needs). One participant (P4) admitted to sharing a story, when “all of the sudden, I’m too deep into my experience, and I’ve lost sight of them,” reporting that she was too self-absorbed in that moment. Another participant (P8) also shared times where “I would disclose something where I afterwards thought I was just doing it to unburden myself of my own guilt or whatever I was feeling about having... disappointing them I guess.” Reflecting on this disclosure, Participant 8 stated “I generally don’t feel like that’s the best move, especially when it’s for my own benefit.” Participant 10 acknowledged feeling “tempted to share (an) example,” but choosing not to “because it deflected too much of the patient’s experience at that juncture.” Participants (27.27%) also discussed how self-disclosure in general, but particularly over telehealth, can interfere with patients’ fantasies, projections, and transference (*Self-disclosure and transference: “It really flustered her image of me”*). Participants described instances where self-disclosure, both deliberate and unintentional, intruded on the patient and on treatment.

Participant 5 shared:

“A long-term analytic patient had a lot of fantasies about my personal life, and assumed a lot of sameness. I never questioned it, I let her have her fantasies, and she never asked... So then my husband came into the apartment, and it was loud outside the glass door, and I don’t know what he said, but she took that sound to be the sound of a young child who is calling me. And the patient felt so heartbroken by this, that I have this other life, that all the possibilities were collapsed.”

Other participants commented on transference being impacted by self-disclosure, such as “a lot of that is transference” (P6), “it really flustered her image of me” (P11), and “she just was pretty set on who she thought I was” (P11). Similarly, participants (27.27%) described examples of self-disclosure that were unwanted and elicited feelings of envy (*“But now I know you have*

somebody, and I didn't want to ever know that"). Participants spoke about "instances where the example definitely bothered the person" (P7), where "one patient of mine got annoyed at the interruption" (P9), and some patients who "don't want to know that much about my personal life for different reasons" (P1). For traumatized or "fragile" patients, self-disclosure can feel like "an unwanted intrusion," "something out of her control," "a trigger," and even "a trauma reaction to being intruded on" (P1). Lastly, participants (18.18%) expressed that even accidental self-disclosures may not be fully accidental, but an intrusion (*One could question accidental, right?*). While discussing interruptions that occur while working remotely, one participant (P10) commented "I have a number of rooms in my house" implying that barking dogs and ringing phones could be avoided. This participant (P10) added, "I really could do whatever is necessary" to avoid interruption, "but I like having them (the dogs) there and it's just occasionally that they're a real pain in the ass, so, I run that risk. I don't really see that as accidental." Participant 11 echoed a similar idea stating, "everything's a choice" including how she curates her background, "putting the camera at a certain angle," and it is even a choice "in terms of why am I working from home that day versus not?" This participant (P11) concluded, "if I'm in a different room, I have to be okay to talk about the different rooms," highlighting that self-disclosure may be more of a choice than an accident.

About half the participants (54.55%) also acknowledged that self-disclosure is not always good or bad, rather there is the neutral impact of self-disclosure. Several participants (27.27%) expressed that when used spontaneously, self-disclosure is not always particularly meaningful (*It's not like that disclosure was particularly meaningful*). Participants elaborated, "I don't think it's been destructive. I think it may not have been necessary" (P4), "that disclosure may or may not have been helpful to him" (P9), and "it's not like that disclosure was particularly

meaningful” (P2). Participants (27.27%) also reported that in some cases, *self-disclosure can change the direction of analysis and beget further disclosure*. One participant (P5) described how self-disclosure about her partner and child has “entered the treatment” and changed the direction of treatment towards the patient’s “own needs in a relationship” and “own desires around having a child or not having a child.” Another participant (P6) reported that after telling a patient about her mother’s death in the context of taking time off, she felt “almost pushed to disclose something about my relationship with my mother,” although she did not. Lastly, Participant 11 spoke about how for one patient, self-disclosure related to maternity leave “really opened up more and more questions... and now she wants to know more.”

3.5. RESPONSES TO SELF-DISCLOSURE

The final theoretical construct that emerged from interviewing psychoanalysts in this study was RESPONSES TO SELF-DISCLOSURE. The majority of participants (63.64%) expressed that watching for patient reactions to self-disclosure was an important follow up. Several participants (27.27%) expressed that when *gauging patients’ reactions to analyst self-disclosure*, you receive feedback and “learn fairly quickly with whom you can be a little more self-disclosing and with whom you shouldn’t” (P2). Participants echoed, “I watch for people’s reaction” (P4) and “I could tell by the patient’s body language...” (P9). Participant 2 shared an anecdote where he received feedback by looking for a patient’s reaction:

“I’m thinking of one particular person who I learned fairly quickly is not very interested in hearing any kind of self-references. She wants to talk; she doesn’t necessarily want me to say very much. And when I tried at times to say something that may be a little more in reference to what she was saying, kind of trying to create, to let her see a different angle on things, it was just washed over.”

In gauging patient reactions, a few participants (18.18%) noticed that self-disclosure caused by change to location can highlight differences between patient and analyst and elicit negative patient reactions (Negative reactions: *“I was up in my country house, and they were in the middle of people dying. I think it was painful for them”*). Participants described how self-disclosure about their country house “brought up a class difference” and feelings of “envy.” Participant 1 reported that when patients “discovered I wasn’t in the city” or learned “that I have a partner,” they became upset and envious. Participant 6 reflected, “the fact that I have a country house... that I could get away...” caused feelings of hurt since some patients “are stuck in smaller spaces and don’t have choices.” In contrast, other participants (27.27%) spoke about patients’ positive reactions to self-disclosure over telehealth (Positive reactions: *“This was the best session we’ve ever had”*). Participants relayed that “on the whole it’s absolutely positive,” “most of them really like it,” patients have “very strong positive reactions,” and “the only responses I’ve gotten are positive.” Several participants (27.27%) shared that another reaction is when *patients can be forgiving of too much self-disclosure*. One participant (P3) said, “I think my patients are very kind and generally forgiving” in response to her self-disclosures. Another (P4) expressed, “sometimes I think I go too far, but my patients know me... they don’t care.” Similarly, Participant 1 shared examples of patients being understanding in response to unintentional self-disclosure, with one patient responding, “Oh, okay, yeah that happens.”

In addition to watching for patients’ reactions to self-disclosure, almost every participant in this study (90.91%) expressed the importance of processing and reflecting on self-disclosure, both privately and together with patients. Many participants (63.64%) expressed the idea that *processing and exploring self-disclosure with patients models accountability and therapeutic communication*. Participants reported that while they are open to answering questions, they

would follow up with “wonder(ing) why they’re asking” (P7) or exploring “what do they really want to know?” (P11). Some participants would explore where the question is coming from before answering, and others afterwards. Participant 10 expressed, “sometimes if they ask me a question, I’ll say I absolutely will answer that, but I want to explore it a little first. Often, I’ll answer it and then I’ll explore it.” After self-disclosing, participants described asking “what was it like for you when I shared that?” (P10), “was this helpful?” (P4), or other process-oriented questions that get at “understanding their experience of it and how it impacts them” (P8). Participants reported that processing self-disclosure with patients “has a positive effect” as it “demonstrates or models a certain type of accountability and type of... therapeutic relationship...” (P8). Psychoanalysts (36.36%) also explore and process their own reactions after self-disclosing (*Analyst reactions: “I almost feel like I’m caught”*). Regarding unintentional self-disclosures, participants expressed feeling “embarrass(ed) because I feel like it reflects that I’m not conscientious enough,” feeling “like I’m caught” revealing something, and residual feelings of self-judgment (P3). Others had similar negative reactions such as, “that made me feel tense and self-conscious and protective of the session” (P9), or describing unintentional self-disclosure as “a necessary evil... I find it annoying” (P10). In response to the doorbell ringing, Participant 5 reflected “I say this thing and it’s so... I always regret it. I say, ‘I know if I don’t get it, it will just keep ringing and no one else is going to get it.’ And I don’t think that ever lead to anything, but every time I say it, I know it will take care of the anxiety of having to pause, but I don’t feel good about it, but I keep doing it anyway.” Sometimes, psychoanalysts’ (18.18%) reactions to and reflections on self-disclosure over telehealth were less confident and more ambivalent (*Analyst reactions: “I felt a little mixed, not as confident”*). Participants described “times where I don’t feel confident that I made the right decision in disclosing something” (P8), feeling “a little

mixed, not as confident” (P9), and wondering whether self-disclosure was helpful or unhelpful. Lastly, several participants (27.27%) expressed the idea that reflecting on self-disclosure over telehealth helps them remain more mindful moving forward (*I was aware of that, so I didn’t act on it*). Participant 7 discussed “being aware of it... (urges to self-disclose) ...with a little more of like a red flag,” in order to “hopefully try to take a lesson for the next time to move more in the direction of making myself unobtrusive.” Similarly, Participant 10 reflected, “I tried to really be cognizant of that urge” and that “I was aware of that, so I didn’t act on it.” In sum, “the more self-reflection the analyst or therapist has, it usually doesn’t go poorly” (P5).

4. Discussion

The purpose of this study was to gain a better understanding of how psychoanalysts approach and use self-disclosure with patients over telehealth. Eleven doctoral level clinical psychologists and psychoanalysts were interviewed to investigate whether their use of self-disclosure changes over telehealth, to explore whether telehealth creates greater opportunities for both deliberate and inevitable disclosures, and to understand how they process the impact of self-disclosure. To the author’s knowledge, this was the first qualitative study to explore therapist self-disclosure over telehealth, in general, and specifically with a sample of psychoanalysts. Five theoretical constructs were generated from the individual interviews: 1) DETERMINANTS OF SELF-DISCLOSURE; 2) TELEHEALTH AND SELF-DISCLOSURE; 3) THE FRAME; 4) THE IMPACT OF SELF-DISCLOSURE; AND 5) RESPONSES TO SELF-DISCLOSURE.

Each theoretical construct will be discussed in detail. No one theory reflects the range of findings discovered. Therefore, Lewis Aron’s writings (1996), drawn from relational theory, are proposed as a theoretical lens that seems to fit well with the findings. Aspects of relational theory relevant to this study include mutuality, two-person approaches to psychoanalysis, and debates

on neutrality. Contemporary psychoanalytic opinions on self-disclosure will be referenced to supplement understanding of certain aspects of the participants' experiences.

In his book "A Meeting of Minds: Mutuality in Psychoanalysis," Lewis Aron (1996) distinguishes among a wide variety of meanings to which the term mutuality refers, making a single definition of the term difficult. Aron develops the point of view that psychoanalysis is a mutual endeavor based on a mutual relationship, and that the term mutuality may refer to an array of aspects of the psychoanalytic situation including "mutual transferences, mutual resistances, mutual regressions, mutual participation, mutual enactments, mutual regulation, and mutual recognition" (p. xiv). What these concepts have in common is a focus on the mutual, albeit asymmetrical, relationship between psychoanalyst and patient. Aron's discussion of mutuality begins with Ferenczi's (1932) theory of the mutuality of relationships and his clinical experiments with mutual analysis. Aron (1996) writes, "Ferenczi's clinical experiments with mutuality... led to theoretical, clinical, and technical discoveries concerning trauma, dissociation, the use of countertransference, and enactment... these still controversial ideas continue to occupy center stage in contemporary debates about psychoanalysis and psychoanalytic technique" (p. 161). These controversial and contemporary ideas about psychoanalytic technique, deliberated since Ferenczi's times, came to life in interviews with the participants of this study as they spoke about self-disclosure and telehealth.

4.1. DETERMINANTS OF SELF-DISCLOSURE

4.1.1. Self-Disclosure is Determined by Both Patient and Analyst Factors

What determines a psychoanalyst's thinking, approach, and choices around self-disclosure? While discussing DETERMINANTS OF SELF-DISCLOSURE, psychoanalysts first acknowledged that self-disclosure is determined by both patient and analyst factors. When

participants expressed that *it depends on the patient*, they elaborated that use of self-disclosure is determined by their *relationship* with the patient. Analysts seemed more willing to disclose to patients with whom they had a longer, established therapeutic relationship, if the nature of the relationship afforded a certain level of comfort with the patient, or if the patient was of a higher level of functioning. Participant 2 spoke about how “it depends”:

“It depends on how far along we are; It depends on my sense of what it will or will not do for the process; It depends on the person you are working with. It comes up a lot as a choice and I think it depends on how comfortable you are in self disclosure in general, and on the kind of relationship you have established with a person.”

In contrast, *some patients don't even notice*, acknowledge, or want to know anything about their analyst. As such, participants expressed that before deliberately or intentionally self-disclosing, it is important to determine whether the patient wants to hear it. Participant 1 shared, “I might say ‘do you want to know?’ Some people don't want to know, really.” This participant (P1) provided an example that highlighted how certain patients will not acknowledge or care about unintentional self-disclosure:

“Sometimes patients don't even pick up on things that I think they would... like I'll betray a knowledge of something... If I have a patient who works in a field close to what my husband does, and so I'll know certain languages and I'll understand things. I can ask things about what they're doing, and I'm thinking, ‘I shouldn't really know this,’ but then they don't seem to notice.”

Patients vary in terms of what they feel comfortable asking or what they are curious about.

Participant 8 brought this idea to light with an example about his office décor:

“This painting used to be something else *points to painting in the background* and I changed it at one point, and I thought it was interesting that some people had a real reaction to it and knew that something was different, or they knew right away that the picture was different. And other people either didn’t notice it, didn’t say anything, or weren’t sure, where they knew something was different but didn’t know what it was.”

In other words, the first determinant of therapist self-disclosure is the patient, the relationship with the patient, and the nature of the treatment with the patient.

The field of psychoanalysis has experienced significant movement and change over the years, from Freudian one-person psychology to Ferenczian two-person psychology to a plethora of contemporary relational approaches. On a smaller scale, participants described movement and change within the course of their own careers. About half the psychoanalysts reported that their approach to self-disclosure has changed since their training days, with some relaxing the frame and *taking theoretical and conceptual rules of the game a little less seriously*. While clinical training and theoretical orientation determined how participants approached self-disclosure, there appeared to be a shift towards selective, judicious use of self-disclosure, even for those trained in more classical modalities. Participant 9: “I’m open to doing it. I’m not a classicist in that way. I’m more of a totalist.” Participant 2: “Since my orientation is more interpersonal, self-disclosure is inevitable and not always undesirable.” Participant 4 described being influenced by her own analyst whose approach to self-disclosure was unorthodox for his time:

“When I was in graduate school, and in a formal analysis, my analyst who was an eminent psychiatrist of the old school, totally believed in self disclosure. That wasn’t common then. But he used it very well. And because of that, I’ve always sort of self-disclosed.”

Even for participants who did not identify with interpersonal or relational orientations, there appeared to be a shift away from classical and towards contemporary thinking about self-disclosure.

Participant 5: “I roughly consider myself a contemporary Freudian analyst, and so, with the accent on the contemporary, there’s a little more leeway.”

Participant 7: “My training was Contemporary Freudian, and so while it’s not classical, I think generally the thrust is not much or very little self-disclosure, but over many years, my own development, I think I’d become much more selective.”

While theoretical orientation determined how desirable, recommended, or useful self-disclosure might be, several participants became less avoidant, or fearful, of self-disclosure with time.

Participant 2 was most vocal about this “relaxing the frame” over time:

“I’m less concerned that making a wrong move, or a little extra self-disclosure, or not wearing a tie, or whatever, is going to be a dramatic event in the treatment...With time I came to trust that I can maintain the essence of the work without worrying about doing this right, doing that right, exactly this way that way.”

Although much depends on the patient, the relationship, and the orientation of treatment, participants also acknowledged that *self-disclosure, particularly over telehealth, is determined by the analyst’s personal life* and unconscious. Mutuality, from a relational perspective, assumes that psychoanalyst and patient mutually influence each other, consciously and unconsciously, and that who the analyst is will inevitably influence interpretations, enactments, and mutual participation in the treatment. It seems reasonable to extend these aspects of mutuality to self-disclosure. As much as patients influence the treatment, self-disclosure reveals a great deal about

the analyst's unconscious, personality, and subjectivity. Participant 5 spoke about multiple levels of analyst subjectivity as an influence on self-disclosure:

“Self-disclosure has something to do with who are you, like as the analyst or therapist, who are you? Where are you located? Where are you located in space and time? Where are you located historically? Like so many levels.”

The COVID-19 pandemic introduced another level of subjectivity where self-disclosure might depend on what is going on in the analyst's life during the pandemic:

Participant 2: “I'm able to work from home, life has not been disrupted all that much in terms of ability to make a living, ability to kind of maintain a structured life. But I know of a lot of therapists who are single, left alone, had COVID, were isolated, became depressed. I would suspect that for them, it would have been much harder not to be self-disclosing, not to share it, when you're sick, alone. And at the beginning of the pandemic when you couldn't visit anybody, nobody could visit you, you were alone 24/7.”

4.1.2. Forms of Self-Disclosure

In addition to patient and analyst factors as determinants of self-disclosure, every participant spoke about varying their approach based on different forms of self-disclosure. Within the literature, Meissner (2002) outlined several forms of self-disclosure including answering questions (see Epstein, 1995; Jacobs, 1999), revealing personal emotions (see Bollas, 1987; Marcus, 1997), expressing countertransference (see Aron, 1992; Ehrenberg, 1992), and dealing with real personal factors in the analyst's life (Dewald, 1982; Pizer, 1997). In this study, participants spoke of several forms of self-disclosure with about half the participants taking the traditional abstinence stance of *avoiding self-disclosure*, albeit *with some exception*. Participants

first differentiated between two different self-disclosures: “One is the facts of your life, and the other is your experience in the moment” (P1). Experience in the moment, or countertransference, appeared to be a dividing factor, both in the literature and within this study. A one-person approach to countertransference might view the analyst’s internal reactions as data about the patient’s functioning or relational dynamics. Still, this data is not explicitly disclosed to patients, but rather may inform interpretations. Sharing countertransference reactions with patients seems to be more of a two-person, collaborative form of communication rooted in mutuality. Aron (1996) summarizes Mitchell (1995) who contrasts interpersonal and Kleinian positions on self-disclosure. In sum, Mitchell views the Kleinians as emphasizing the analyst’s restraint and silent processing, containing the countertransference, and using it to inform appropriate interpretation. In contrast, interpersonal analysts might be more likely to express immediate affective experiences as a form of self-disclosure. This contrast was mirrored in the findings, with participants differing on how they used countertransference.

Participant 6: “I definitely don’t reveal my feelings towards a patient, if something irritates me. I don’t think it’s therapeutic... I’m much more inclined to think, it’s very strange that I’m getting irritated, or if I’m tired, I think all of that is something going on in the process. And I don’t find that anything about my affects is a good thing to reveal.”

Participant 5: “I wouldn’t say I have a hard and fast rule against or for doing it, though I would say generally, I don’t talk about how I’m feeling.”

While several participants expressed restraint as a baseline, some acknowledged exceptions to this rule. Participant 11 expressed, “I don’t generally self-disclose... unless I really feel like it would be beneficial.” Even Participant 5 who generally avoids countertransference disclosure

admitted, “I mean, it’s not like it hasn’t happened.” When asked to elaborate, Participant 5 shared the following exception to the rule:

“Though, maybe if the tensions are really high because let’s say something traumatic happens to the patient where there’s a conflict in the room between us and automatically the temperature is up, and different in the room. I mean, I think I do at least acknowledge that my feelings are expressed, you know. I think I do probably disclose a feeling.”

Later Participant 5 clarified, “in general self-disclosure would be an exception, but not an unacceptable one or an unheard of one, but something really called for in the situation.”

Participants who view self-disclosure as the exception seem to land between Rothstein (1997) and Jacobs (1995) on the spectrum of contemporary opinions about self-disclosure. Rothstein (1997) maintained that any self-disclosure constitutes an erroneous intervention and an unwarranted countertransference enactment, while Jacobs (1995) argued in favor of restrained and cautious use of self-disclosure, while still maintaining relative anonymity. In later years, Jacobs (1997; 1999) acknowledged that in practice, the act of self-disclosure turns out to be something quite different from the concept of it, as formulated theoretically. This seems consistent with how some psychoanalysts in this study described self-disclosure as an exception that must be called for in the given moment and clinical situation.

In contrast to the approach of abstinence and restraint, other psychoanalysts in this study were more open to disclosing *countertransference in the moment, to facilitate insight and explore transference*.

Participant 8: “My ideal work is, in terms of self-disclosure, using it not to talk about any kind of facts about my life, or about me necessarily, but about an experience that I’m

having with the patient and an experience of them that helps facilitate their understanding of themselves and interaction between us in the transference.”

Participant 9: “I do work a lot with countertransference, so I do most frequently share my reactions, my internal reactions, not all the time and not with everyone, but in terms of the content of the types of things I share, that’s probably the one that I share most frequently, as opposed to just general information about myself.”

This approach is consistent with Mitchell’s (1995) discussion of the interpersonal take on self-disclosure, as well as those who advocate for judicious use of countertransference disclosure as more than an exception, but as a powerful alternative to interpretation (see Cooper, 1998; Ehrenberg, 1995; Gorkin, 1987).

Participants also discussed using self-disclosure *spontaneously or intuitively, rather than strategically*, with no clear criteria. Jacobs (1997; 1999) similarly expressed that self-disclosure cannot be prescribed as a general technique, rather decisions can only be made at a given moment in the clinical situation. Greenberg (1995) also suggested that the analyst must rely on what they know about the patient, themselves, and the relationship in deciding how to respond. Viewing self-disclosure as an aspect of mutuality with no rules or prescriptions of technique is a bold, but not foreign idea. Bion (1990) wrote, “In the practice of psychoanalysis, it is difficult to stick to the rules. For one thing, I do not know what the rules of psychoanalysis are” (p. 139). The only “rules” Bion (1967) spoke of were his notes on memory and desire, commenting that “every session attended by the psychoanalyst must have no history and no future” (p. 17). It would be reasonable to presume that in a session with no history or future, self-disclosure can only be used intuitively and spontaneously.

Other forms of self-disclosure that came up in interviews reflected the literature, with participants discussing self-disclosure around race and culture (Leary, 1997), religion, (Tillman, 1998) health, sickness, and death, (Dewald, 1982; Pizer, 1997) and different types of leave, such as taking vacation (Geller, 2003) or disclosing pregnancy ahead of maternity leave (Farber, 2006). Regarding race and culture, Participant 5 shared:

“It’s important to be able to talk about these things, so I might say something or call attention to it at the beginning of treatment, to make an opportunity for it to be talked about.”

Similarly, Participant 7 preferred to be open and honest with patients when taking time off, even if it disclosed something about her religion and level of observance:

“I take off for all the Jewish holidays and over the years, I say that I’m taking off because of the Jewish holiday. I just feel much more comfortable doing that, than just saying, “Well, next Tuesday and Wednesday I won’t be in... Yes, it does give information if they didn’t know before, that I’m Jewish, or that I’m observant.”

On self-disclosure about health, sickness, and death, participants raised questions of whether to disclose personal illness, death in the family, or other meaningful things in the analyst’s life, including if/when the analyst contracts COVID-19. On self-disclosure in the context of taking time off, Participant 6 reflected “If they say, where are you going?, I find it weird to say, well what are your fantasies?” Lastly, self-disclosure regarding pregnancy and maternity leave came up in two of the interviews. Participants highlighted how *disclosing pregnancy is a unique form of self-disclosure since it is initiated by the analyst*, and not in response to a patient’s request.

Participant 11: “I knew I had to say it, it wasn’t a choice, but I wouldn’t say I felt comfortable with that... It’s one of the first times I initiated saying something about myself, or something that I need. Like, I need to go on maternity leave, she doesn’t need that. But I do. So that felt uncomfortable, too, because the dynamic is different with that.”

Participant 11 added that disclosing her pregnancy was complicated by therapy over telehealth:

“I definitely was concerned about how she (the patient) would respond, especially because she wasn’t seeing me. So, it was sort of an abrupt topic. Meaning, she wasn’t seeing my belly expand, there was no sign other than me telling her this information, so it was sort of out of the blue in her mind.”

4.1.3. Motivations for Self-Disclosure over Telehealth

A third determinant is the psychoanalyst’s motivations for self-disclosure over telehealth. Participants described using self-disclosure to remind the patient of their physical presence and allow the resumption of the patient’s free association. Participant 1 shared an anecdote where she described her pull to hug a patient over telehealth:

“I think the hug comment was really effective. I think it put words on something, not that she needed to be reminded that I care about her, but in some way, it reminded her of our physical presence or something together, that I am still there for her.”

Reminding the patient of the analyst’s physical presence is akin to what Mathews (1988) writes about giving certain patients a picture of where the analyst is in space, to stabilize their ego and help with low frustration tolerance. In another example, Participant 5 used self-disclosure to describe her physical location to patients over telehealth:

“I described it as a room with a door that can lock, and it has windows... It was like the door and the windows... the separateness. It’s more about that it was separated... She was relieved and then she could kind of picture me there. And she could get back to herself, as opposed to this preoccupation that I wasn’t available.”

Other motivations for self-disclosure over telehealth were in response to a breach in the frame or an intrusion on the patient’s space. Aron (1996) writes that for Ferenczi, it is the analyst’s emotional honesty and goodwill that establishes the bedrock of trust essential to the analytic relationship. Similarly, participants spoke about self-disclosure coming from a place of honesty, containment, and transparency:

Participant 6: “I’ve definitely told my patients when I went upstate to my house in the Catskills... I have a certain feeling of containment... if they’re picturing my office and I’m not there, I feel it’s deceptive.”

Participant 11: “If I’m working from home, sometimes my child will cry in the next room. If a patient hears that and they ask about it, I have to be honest and say that that’s my child or something along those lines. At some point, you have to be transparent.”

Lastly, in discussing motivations for self-disclosure participants raised the question, *is self-disclosure for the patient or for the analyst?*

Participant 10: “I want to make sure that my motivation for doing it is for the patient and the treatment’s betterment... Am I disclosing this for my patient or myself? Do they need to be gratified or is it a need to gratify them?”

Similarly, in one of several objections to the analyst’s self-disclosure, Aron (1996) writes “There

are some very good reasons for the analyst not to self-disclose to a patient... it reflects the analyst's needs and not the patient's... It may be to gratifying to the patient" (p. 230).

4.2. TELHEALTH AND SELF-DISCLOSURE

4.2.1. Self-disclosure Over Telehealth is Inevitable

Aron (1991; 1996) and others (i.e., Crastnopol 1997; McWilliams, 2004) write about the inevitability of self-disclosure. Aron extends communication theory (see Watzlawick et al., 1967 and Bateson, 1972) to the psychoanalytic situation, describing how "one cannot *not* communicate" (p. 229), and how all communication involves metacommunication that conveys relational content. In other words, the analyst is always and inevitably communicating something about their internal states, personality, or subjectivity. In this sense, the analyst is never neutral or anonymous but is always self-disclosing and co-constructing the relationship with the patient. In this study too, every participant discussed the inevitability of self-disclosure, particularly over telehealth. Psychoanalysts described inevitable and sometimes accidental self-disclosures unique to telehealth including pets entering the frame, phones and doorbells ringing, service people working in the background, children making themselves known, patients hearing footsteps, and even being caught wearing a nightgown (Participant 4: "Obviously in person I wouldn't be wearing a nightgown. It's a telehealth problem"). Participants described frustrating, embarrassing, and occasionally humorous examples of self-disclosure over telehealth and working from home. Participants reflected that many of these disclosures would not occur when they were working in-person but were unique to therapy over telehealth.

Participants spoke about how the analyst's use of self in session assumes the inevitability of self-disclosure. Participant 5 echoed Aron's (1996) extension of communication theory to relational psychoanalysis:

“If one is listening using oneself, one’s own feelings, one’s own body, as through listening to material and processing it, using these levels of experience and giving something back to the patient. Even if I’m not saying, ‘I thought this, I felt this...’ there is something disclosed, even if it isn’t overt, that is happening all the time.”

Aron (1996) also discusses self-disclosure as a form of the analyst’s authenticity in connecting with the patient in an intense, personal engagement, an affectively responsive relation, and existential encounter. It is difficult to determine, or prescribe, what is “authentic,” as “one analyst’s authenticity and spontaneity is another analysts impulsiveness and self-indulgence” (p. 251). Participant 5 provided a theoretical rationale, advocating for some amount of the analyst’s authenticity or realness:

“In the movement from a state of omnipotence to the depressive position, which we are all in and out of and we’re all moving, hopefully towards, is a kind of a tolerance and an awareness of the subjectivity of the other. And in a way we want as the end, as a sign of health, for the patient to be able to take in more of us as a real person, which may or may not come with actual self-disclosures, but some amount of your realness that’s needed, wanted, called for, is a good thing.”

With self-disclosure over telehealth, there seems to be an elusive duality between remaining neutral, anonymous, or “blank” and connecting with the patient in a profoundly personal way. There may not be a correct or optimal amount of self-disclosure in psychoanalysis, yet either extreme (total anonymity vs. full disclosure) appears to be limiting. In interviews with psychoanalysts, discussion of self-disclosure over telehealth led to the issue of total anonymity and the blank screen. Participant 1 expressed how “no self-disclosure is frustrating and can be

mystifying and distancing” which makes it “much harder for patients to tell me if they're angry at me.” This is directly in line with Aron (1996) who quotes Ferenczi (1932) on the concept of total anonymity, stating that keeping ones reactions secret “makes the patient distrustful” (Aron, 1996, p. 164; Ferenczi, 1932, p. 11). Aron elaborates that secrecy leaves the patient mystified, whereas disclosure allows the patient to know where they stand in the relationship in terms of self and other. Furthermore, “the growing openness and naturalness that Ferenczi’s approach evoked created an atmosphere in which patients felt free to see and speak about his limitations” (pp. 164-165), or like Participant 1, it permits patients to communicate when they are angry with her. Other participants agreed that not only is self-disclosure inevitable if the analyst is a mutual participant, but a total absence of self-disclosure can be “insulting” or “rejecting,” and being blank is “withholding, defended, and guarded.” On neutrality, Participant 10 expressed:

“I work very hard at not being judgmental. But neutrality doesn't exist. I mean, you want neutrality, then you do therapy with a robot... The need for relationship and the need for connection, because I think that change in healing happens within the relationship, requires that one not be neutral.”

In one of his notes, Ferenczi (1932) wrote that mutual analysis was initially undertaken in response to a patient’s complaints that he lacked “any real empathy or compassion” and that he was “emotionally dead” (p. 86). Participant 6 similarly had strong words for any analysis with a total absence of self-disclosure, calling it “a dead treatment.”

4.2.2. Increased Self-Disclosure Over Telehealth

From a relational perspective self-disclosure is inevitable. As discussed, this inevitability extends to self-disclosure over telehealth. One of the purposes of this study was to explore

whether telehealth creates more opportunities for, or in some way contributes to, more analyst self-disclosure. Data yielded from interviews with participants suggest that not only are there more opportunities for self-disclosure over telehealth, but something about telehealth pulls for increased deliberate and inevitable disclosure on the part of the analyst. This finding was discussed by nearly three-quarters of the psychoanalysts in this study. Participants described the *pull* or urge to self-disclose as a need to connect, stay related, and compensate for feelings of distance over the screen:

Participant 2: “Something about telehealth does pull for, I think, more sharing because there is this, at least for me, more of a pull to stay related, in spite of the distance of the screen. I think there’s a pull to kind of be in the same room, so to speak.”

Participant 3: “When a person is in your office, in person, there is that kind of sensing of where they may be emotionally, you are relating to your own experience, minute to minute or second to second... and sometimes you are feeling a little bit of that being lacking on telehealth. There may be a way in which I become even more personable, more open... It’s a way of countering the experience of the distance.

For some, this pull was not only attributed to the virtual nature of telehealth, but to a need to compensate for feelings of disconnect, isolation, and restricted mobility during the first year of the COVID-19 pandemic:

Participant 7: “There were so many different needs that came to the surface during this pandemic. I’m thinking of one person in particular who lives an extraordinarily isolated life, has no living relatives, has really no friends. Now, her constant pattern is to check in with me, “have you had that experience?” and “what would you think and what you do?”

I engage with that because that's the kind of connection that I think is important to her, to get more information from me also, or to connect in some way."

While some deliberately self-disclosed to compensate for the distance and depersonalization of telehealth, others found themselves disclosing more to patients without consciously choosing so:

Participant 7: "Somebody told me about her cancer, it was a new person, and I volunteered that I had had similar experience. Now, would I have done that if she was in my office? I tend to think not... There are a number of people where I felt like as I was saying something, I felt now why am I doing this?"

One possible explanation for why telehealth pulls for more self-disclosure is because the screen obstructs nonverbal communication. A few participants spoke about self-disclosure as a way of putting more words to things (*In-person, that would have been just in the room, without my having to say it*), commenting on body language, describing a feeling or energy that might be in the virtual room, or bringing attention to the process of therapy:

Participant 5: "It's happening all the time when we see patients in the office, because you're literally there, in space and time. Sometimes, the literal facts of what is happening in the room, two bodies in the room, becomes a point of focus... The breach and the trauma of the pandemic, and the change, meant you have to highlight it more."

Participant 1: "I said to her, 'If we were in the room, you could feel my pull to hug you. I wouldn't. But you'd be able to feel my body wanting to go hug you right now.' I really missed feeling, there's so much body energy, there's so much work that happens nonverbally."

Another explanation for increased intentional and unintentional disclosures may be due to a sort of loosening of therapeutic vigilance over telehealth. Five participants contributed to this idea, endorsing more frequent self-disclosure over telehealth in the context of a loosening of the boundaries:

Participant 8: “I feel there was something about telehealth, where this might have been part of the pandemic happening, where I felt like it gave me an excuse.”

Participant 9: “I do feel like there’s a sort of loosening of the boundaries a bit, with telehealth.”

Again, participants attributed this loosening of the boundaries to both the virtual nature of telehealth and the COVID-19 pandemic (*Increased self-disclosure related to COVID anxiety*):

Participant 2: “Especially at the beginning of COVID when the anxiety was so palpable, and everybody was looking for “how are we going to survive this,” I think there was more self-disclosure, more sharing of anxiety.”

Participant 11: “This (wearing a mask) was like an equalizer. And it was also disclosing that there are these fears and unknowns for me too. And we don’t know. But it will be. And how can we talk about this?”

As discussed, patients can pick up on the analyst’s unspoken feelings, reactions, and countertransference. Disclosing countertransference is not always a bad thing (see Ehrenberg, 1995; Greenberg, 1995), yet some analysts had a hard time hiding their reactions due to a growing intolerance of so much remote work during the pandemic:

Participant 7: “I have one patient who for her own reasons wasn’t getting vaccinated.

And I increasingly felt I had a lot of reactions to this. First of all, I didn't like it. But I also felt it was in some ways, compromising the treatment. I think she very much picked up my irritation. I did acknowledge... that it was very much coming out of really my own growing intolerance of so much remote work. I would say that was very useful to her.”

Participant 9: “I’m working with a patient who really pushes my buttons and can be kind of annoying. And I became very real in a moment where my annoyance became apparent to him... It was easy for him to see that I was kind of feeling impatient with them.”

On Ferenczi’s approach to transference and countertransference, Aron (1996) writes how “the patient can observe the analyst’s countertransference responses and character traits, and in turn, react to them” (p. 169). Even without deliberate disclosure, it seems patients can pick up on their analyst’s countertransference, over telehealth, despite the virtual distance of the screen.

Other ways that telehealth creates increased opportunities for self-disclosure are in the context of changes to physical location (*Changes to physical location present an opportunity for increased self-disclosure*) and visual background (*Creating and curating a background over telehealth includes contextual self-disclosure*). In other words, patients might ask or comment about the analyst’s location, or different visual landscape over telehealth, especially as several participants reported conducting telehealth sessions from summer homes, far from the city noise. The idea that everything contains some element of disclosure about the analyst (see Crastnopol, 1997; McWilliams, 2004; Zur, 2007) was supported by psychoanalysts’ experiences:

Participant 8: “When it comes to working remotely or doing virtual therapy, there are the contextual self-disclosures that aren't overt or direct... what my background looks like,

my literal background behind me, and what I choose to include as the space between these four walls of the frame... There's something important to me about having books behind me... I'm not sure exactly what it discloses about myself, but that's sort of like an artifact, I guess."

Earlier, Participant 11 spoke about the facemask as an equalizer between analyst and patient. There may also be an equalizing effect with the new "frame" of telehealth. There are no assigned seats, rather, both analyst and patient show up in their respective frames, equally contained by telehealth. Depending on how one configures their screen, implicit disclosures might equalize the psychoanalytic encounter, more than it may have in-person. One can wonder what Ferenczi might have thought about the implicit mutuality of two heads (and shoulders), contained in two boxes, within one frame of the computer screen.

4.3. THE FRAME

4.3.1. Telehealth Has Changed the Frame of Therapy

The frame is one of the most important elements that characterizes psychoanalysis. This frame determines the layout of the room, the behavior of the analyst, and what is expected to occur within the therapeutic hour. A Freudian frame might have the patient on the couch, with the analyst sitting behind the patient, outside of their line-of-vision. A relational frame might include a face-to-face layout, but all frames are intended to provide confidentiality, containment, a holding environment, and contractual boundaries that enable the patient to be open and vulnerable. The frame refers to the psychoanalytic environment as well as the relationship between analyst and patient. There is an agreed upon focus on the patient's experience in a distraction-limited, comfortable space. While the analyst works to maintain the frame, this study highlighted ways in which telehealth has changed the frame of therapy, figuratively and literally.

Firstly, patients see more of the analyst's personal life over telehealth than they might in-person (*There are some things about people being invited into my own office or home*). At the same time, analysts are more exposed to other parts of patients' lives, providing much more for the analyst to react to, or disclose feelings about. For example:

Participant 8: "People are not going to walk into my office in their underwear, but they might show up for a Zoom session and halfway through say, could you hold on a sec, I have to go to the bathroom and then stand up and they're in their boxers."

In-person, the psychoanalyst has more control over the frame, and patient choices are limited to choosing a seat. Telehealth can lead to a loss of control on the analyst's end, and occasional breaches to the frame:

Participant 3: "We were having a session, and something happened, actually off screen, between her and her mother. She came back onto screen. And then the mother came into the screen and actually gave my patient a hug. All of this happening on screen ... That's the kind of thing that at least my experience with the patient has been... very different."

Participant 8: "One patient was talking to me about their spouse for almost a whole session, and then I all of a sudden heard their spouse saying something, and I was like totally (stammering) what, what, where are you?? she was in the same room as her spouse and just talking about him as if he wasn't there in a pretty derogatory way... I felt almost like I didn't have any control over... It wasn't like I could say can you please leave now? I'm just sitting there, just watching this conflict escalate."

For some participants, changes to the frame over telehealth have also changed their ability to listen with suspended attention and sit with silences. For others, it caused a greater strain to connect with patients:

Participant 7: “I feel a strain. The naturalness of it, that you don't even have the optimal distance. It's not natural to talk to someone, you know, a number of inches away...

There's a kind of strain and I'm doing something more. It's more difficult. I don't know. Maybe there's self-modulation.”

In-person, patients sit at an optimal distance and may choose to move closer or further from the analyst, but often by choice of cushion on a three-seater sofa. Over the computer, patients can hold their analyst inches from their face, on their laps, in their bedrooms, and even in the bathroom (see Lori Gottlieb's (2020) article in The New York Times, “In psychotherapy, the toilet has become the new couch”). Many participants seemed to detest the switch to telehealth, for a variety of reasons, one being the unnatural start and stop to sessions over telehealth:

Participant 1: “If they're waiting for you to enter your (Zoom) room, they don't know and you don't tell them and then you just say sorry I was running late. Little things like that, or you know “oh wait, I want to get a glass of water” like you'll say that to your patient in person. But (over telehealth) they're just mysteriously waiting for you.”

“At the end of the session too, it's like this very abrupt, it's a horrible ending, still, even after two years, I feel like they're just gone. you both know that that person is now in their own space. It's different than when they leave your office and they know you're still in the office space... and it's a transition for both. So that transition, it's a different kind of self-disclosure on both ends.”

While most participants described increased self-disclosures over telehealth, a few reported that certain types of intentional self-disclosures have actually decreased due to changes to the frame.

For example:

Participant 4: “I think it has, moving to less, because it feels like a more objectified experience or putting it the other way, a less intimate experience... There’s less of a texture, and I don’t reveal as much, not because I made a decision but because the situation doesn’t call for it.”

4.3.2. Replicating and Protecting the Frame Over Telehealth

On the impact of COVID-19 on psychoanalysis, Wolson (2021) points out a major risk of telehealth, as “the boundaries of the frame might become too loose and there is some sacrifice of analytic depth when compared to psychoanalysis in a professional office” (p. 110). Some amount of analyst self-disclosure or realness is a good thing from the perspective of mutuality in psychoanalysis, but only when the frame allows and encourages mutuality. Most psychoanalysts in this study reflected on the importance of the frame, discussing ways of replicating and protecting the frame over telehealth. An interesting idea raised by several participants was the literal “frame” of therapy, as what you choose to include within the four sides of the computer screen (*Instead of four walls of a room, you have four sides of a frame*). Psychoanalysts make different choices to keep things consistent, replicate the frame, and minimize change over telehealth:

Participant 8: “I’m needing more of a frame or more of a consistency in some way, like there’s something familiar about coming to an office and being in the waiting room with everything about it and I want to try to replicate that as much as possible. But it discloses

something about myself... There is something that I need, I feel like a certain sense of control over the background that makes me feel like there's that frame."

When adjusting to the switch from in-person to telehealth, some Freudian (and Contemporary Freudian) analysts chose the phone over telehealth video, to maintain the traditional layout and avoid inevitable self-disclosures:

Participant 6: "The ones on the phone, because they're on the couch normally, it didn't seem right to be doing face to face and they didn't want it either."

Telehealth has created a need to reestablish the frame, find "new markers of space and time" (P5), and protect the importance of a frame in response to the loosening of boundaries. Communicating the importance of a frame to patients over telehealth can include a form of self-disclosure:

Participant 8: "Letting her know that I wasn't comfortable not knowing who was in the room, and why I value the idea of having a space that is private... There's so much communication in that, but also there is so much about boundaries. I have to kind of disclose my feelings about why a frame is necessary for therapy to work. Because I'm basically in their space and I'm seeing things that I don't really have control over."

A few analysts reported that they were able to go into their offices during the pandemic to see patients over telehealth. In these few examples, where there was less deviation from the frame, self-disclosure also remained more consistent between in-person and telehealth:

Participant 11: "No, I actually think it's pretty much the same, especially because I've kept my office so patients will see me if it's on Zoom in my office... In terms of the

frame of the office, whether it's zoom or in person, I feel like self-disclosure has stayed the same."

There is good reason for creating and maintaining a psychoanalytic frame. Telehealth makes this more challenging. If done properly, it seems possible for the frame over the screen to mirror the in-person experience. Still, others might argue that telehealth will never replicate the in-person experience. Perhaps this divide is what influences psychoanalysts' decisions when it comes to returning to the office, working from home, or creating hybrid-models moving forward.

4.4. THE IMPACT OF SELF-DISCLOSURE

4.4.1. The Benefits of Self-Disclosure

Aron (1996) reviews both the advantages and disadvantages of self-disclosure in Chapter 8 of his book on mutuality in psychoanalysis. Aron summarizes benefits of self-disclosure as confirming the patient's sense of reality (see Gorkin, 1987; Mathews, 1988), establishing the therapist's honesty and genuineness, modeling that the therapist too is human and has transferences, clarifying the nature of the patient's impact on the therapist on people in general, and for breaking through treatment impasses and deeply entrenched resistances. Other advantages of self-disclosure discussed in the literature include helping patients work through existential issues (see Geller, 2003; Jourard, 1971; Yalom, 2002), accessing a realm of information otherwise elusive and achieving new levels of analytic rigor (see Ehrenberg, 1995), allowing the patient to experience the analyst's message as more authentic and more personal (see Jacobs, 1995), and improving the working alliance and relationship (see Pinto-Coelho et al., 2016). In discussion of the benefits of self-disclosure, participants in this study shared clinical examples and ideas in parallel with many of the advantages discussed by Aron (1996) and others. First, participants reported that self-disclosure can strengthen the relationship (*I think it*

strengthens the relationship, when done judiciously) by increasing trust, acknowledging a shared experience, normalizing something for the patient, or accentuating the therapeutic bond:

Participant 10: “A lot of times people will say, ‘it felt really good, it felt like you trusted me with something’... I think it's a point of bonding in a sense, you know, they like to know something about you that they can refer to and think about and kind of hold.”

Participant 9: “I try to only do it if I think it'll help them in some way; help them think about their own situation in a new way or help with our bond and the therapeutic alliance... I wanted her to feel like she's normal and she's not alone and that there is a reality to what she's going through...”

Second, participants discussed how self-disclosure can humanize the analyst and foster patients' emotional expression (*When we're two humans, I think they feel freer to do that as well*) through humor, laughter, play, and talking philosophically about living a life:

Participant 1: “Oftentimes patients will say you know, ‘I don't know anything about you, and I have to tell you everything about me,’ and I'll say ‘What are you talking about you don't know anything about me? You know what makes me laugh. You know, the kind of humor I come back with. You know, what makes me sad. You've seen me get frustrated. You know a whole lot about me...’”

Participant 4: “The idea of being the dork at that moment, was allowing her to be able to stumble and to be able to not find her way... I hope at my best, I do those kinds of self-disclosures or making a point about who you are as a human being, how you function as it relates to how we all function.”

Returning to the idea of extending communication theory to psychoanalysis (see Section 4.2.1.), it has been discussed how the analyst is always and inevitably communicating with the patient. As such, therapeutic communication extends beyond interpretation. The participants in this study described self-disclosure as a form of extra-therapeutic communication (*It's a different level of communication than exploration and analysis*):

Participant 1: “There are things that seem sort of extra-therapeutic... I mean, it’s still a way of bonding, relationship building in that way, that adult-adult meeting of the minds. I think that matters also. But it’s not intentional. It just happens... It’s sort of a very non regressed way of somebody who’s being more of their social self, but genuine and spontaneous, more of their adult self, and I’m being not in a caretaking role, particularly.

If any one participant best described the mutually inherent in self-disclosure, it was Participant 1’s comment of the “adult-adult meeting of the minds.” Each participant appeared to extend this idea based on their orientation, experience, and clinical style. Take Participant 4 for example:

“For her to have a cheerleader is one of the things that are therapeutic for her... There’s a difference between doing therapy and being therapeutic. That’s not called therapy, but that is being therapeutic.”

A few participants shared examples of how *benign personal self-disclosure can be used to break the tension or provide perspective*:

Participant 4: “I laughed and said, ‘I don’t see what’s so bad about being a dork? Personally, everybody I know including me are dorks. Why would we be the kind of professionals we are unless we’re dorks?’ Then I laughed and said, ‘The dorks succeed.’

And she was giggling... which is part of what I want to do with her because it's not only comic relief, it's just *relief*."

Participant 9: "I shared with her that I went to (name/location of university) and I have a wonderful career, and I do things that are fun. I go skiing, I travel. So, I wanted her to know that information so she could see a live person who went to a "good" school, but it's certainly not Yale or Vassar."

Lastly, a few participants reported that at times, even very personal self-disclosure can be effective (*Profound personal disclosures*: "I was saying to her, I know it's true because I lived it") and can access a deeper realm of analytic rigor:

Participant 6: "Some of them dealt with it fine, and it actually brought up a lot of crying about when their father died, someone they had never mourned. It just broke through a huge defense."

Participant 4: "Then I said, I adopted a traumatized child, and we are having the same experience. That's a lot of self-disclosure... It was *so* personal. But I was saying to her, I know it's true because I lived it.

4.4.2. The Intrusion of Self-Disclosure

In contrast to the benefits of self-disclosure, Aron (1996) and many others in the literature discuss the disadvantages or hazards of analyst self-disclosure. There are some very good reasons for the analyst not to self-disclose to the patient. Reasons given include that it burdens the patient with the analyst's problems, it deflects attention from the patient's concerns, it reflects the analyst's needs and not the patient's, it is a form of acting out or enactment (see

Rothstein, 1997) and it can obscure the nature of the patient's transference. Again, this study's participants discussed similar disadvantages, described here as the intrusion of self-disclosure. First, participants agreed that *self-disclosure is unhelpful when it causes the patient to become concerned about caring for the analyst*:

Participant 6: (About disclosing her mother's death) "They were really overly concerned about me... Some patients were overwhelmed at the thought of me dying. Their mother figure... It was not helpful. They just kept talking about it... Are you okay?"

Participant 8: "I find it counterproductive if a patient needs to take care of me or feels that they need to take care of me or protect me from my own... because I'm expressing some sort of guilt or feeling apologetic about something."

Aron (1996) and others point out that detracting focus from the patient likely "stems from the analysts own needs for attention" and that this may be a "reenactment of the very problem that many patients have suffered as children, their parents, too, having forced them to adapt to their (parent's) needs" (p. 245). Self-disclosure, therefore, can be an intrusion or impingement on what should be the patient's potential space. Participants expressed that when self-disclosure deflects from the patient and is done to meet the analyst's needs, *you become the needy, self-involved, impinging mother*:

Participant 4: "When I feel it becomes about me more than about what's right for them. I get into a story and all of a sudden, I'm too deep into my experience, and I've lost sight of them."

Participant 8: “There were times where I disclosed about something that was happening in my life, in order to explain some way that I felt I was being not as good as, for lack of a better word, not as up to my standards, my typical standards for myself as a therapist, like being excessively late... seeming more tired or even maybe missing a session where then I would disclose something where I afterwards thought I was just doing it to unburden myself of my own guilt or whatever I was feeling about having... disappointing them I guess.”

Another hazard raised by Aron (1996) and others before him (i.e., Arlow, 1969) is the impact of self-disclosure on the development of transference. In classical psychoanalysis, transference is seen as a distortion that originates from the patient based on previous objects and is displaced or projected on to the analyst. A contemporary understanding of transference recognizes that patients will still project, displace, and distort the analyst, despite information the analyst might self-disclose. Still, as Aron (1996) writes, “too much information about the analyst may inhibit or restrict the patient’s fantasies and reactions” (p. 230). Similarly, participants discussed the hazard of self-disclosure in general, but particularly over telehealth, as interfering with the patient’s fantasies, projections, and transference (*Self-disclosure and transference: “It really flustered her image of me”*):

Participant 5: “A long-term analytic patient had a lot of fantasies about my personal life, and assumed a lot of sameness. I never questioned it, I let her have her fantasies, and she never asked... Then my husband came into the apartment, it was loud outside the glass door, and I don’t know what he said, but she took that sound to be the sound of a young child who is calling me. The patient felt so heartbroken by this, that I have this other life, that all the possibilities were collapsed... She asked, “I hear you have a child” and I just

agreed. I mean, I wasn't going to deny it, even though that's not what it was... And then she did ask if I had a partner. And I said I have a husband. It would have just felt like a lie to sort of keep it vague when she did have this kind of concrete experience. Even though she misinterpreted it, she was so distraught, and I felt she needed some reality. I didn't clarify the whole story, or who was who, and I let her think it was a young child."

Participant 11: "We haven't seen each other since pre-COVID. And when I told her about me going on maternity leave, it really flustered her image of me. She wondered whether I had a partner or whether... there were all these other questions she kind of didn't let herself think about because she just was pretty set on who she thought I was."

Participants also described examples of self-disclosure that elicited feelings of envy in the patient. Moreover, for fragile or traumatized patients, self-disclosure can feel like something out of their control and even elicit "a trauma response to being intruded on" (P1).

In applying the axioms of communication theory to the psychoanalytic situation, Aron (1996) considers the ways both patient and analyst co-construct the relationship. With regard to self-disclosure as a form of inevitable communication, he comments, "the line between deliberate and inadvertent (conscious and unconscious) self-disclosure is highly ambiguous" (pp. 229-230). Similarly, while discussing the intrusion of self-disclosure, participants expressed that even accidental self-disclosures may not be fully accidental, but an intrusion in reality (*One could question accidental, right?*):

Participant 10: "I have a number of rooms in my house, so really, I could make sure they're (pets) not there. I really could do whatever is necessary, but I like having them

there and it's just occasionally that they're a real pain in the ass. So, I run that risk. I don't really see that as accidental."

Participant 11: "It is a choice in terms of why am I working from home that day versus not?"

4.4.3. The Neutral Impact of Self-Disclosure

The debate in the literature about the advantages and disadvantages of self-disclosure is well documented. For some, self-disclosure impedes the patient's ability to project, fantasize, and develop transference. For others, including participants in this study, "the need to project and the development of transference is so robust that people will turn me (the analyst) into whatever they need to turn me into" (P10). In other words, while self-disclosure has an impact, it is not necessarily a negative impact. Participants discussed the neutral impact of self-disclosure as not particularly meaningful to treatment:

Participant 2: "I don't think that the self-disclosure was a kind of a marker in the relationship like that he'll remember it as like, oh, things changed or things were particularly meaningful."

As discussed, self-disclosure may at times signify or highlight a moment of human mutuality, intimacy in the relationship, or deep validation of the other's experience. When self-disclosure is a spontaneous, in-the-moment reaction, the impact is not always so profound. This is understandable when viewed through the lens of mutuality. When the analyst is acknowledged as a mutual participant in the psychoanalytic encounter, a second unconscious, personality, and level of subjectivity is introduced to the space. Not every interpretation will land, not every response will be therapeutic, and similarly, not every self-disclosure is particularly meaningful.

Other participants expressed their ambivalence about the impact of certain self-disclosures on treatment:

Participant 9: "...but that disclosure may or may not have been helpful to him."

Participant 4: "I don't think it's been destructive. I think it may not have been necessary."

The other neutral impact of self-disclosure that participants raised was self-disclosure as something that changes the direction of analysis, but not in a "good" or "bad" way, per se. Analysts try to evenly hover, without purposely pushing the patient in any particular direction. Still, when the analyst is experienced as a mutual other, their impact on the direction of the patient's free associations is inevitable. Self-disclosure can similarly shift the direction of the analysis, open up more in reaction to the disclosure, or access different parts of the patient's life and experience:

Participant 5: "Now that has kind of entered the treatment. It's opened up more about her own needs in a relationship, her own desires around having a child or not having a child.

Participant 11: "She has a hard time permitting herself to do certain things that she wants in her life. And knowing that I had a child has led her to think more about feeling permitted herself to do things that she wants to do... Not even just related to having a child, but in so many different things that she wants in her life, permitting herself to go for it. A lot of that has happened post my maternity leave."

Again, if the goal is to remain completely neutral, anonymous, or "blank," then self-disclosure constitutes an erroneous intervention or unwarranted countertransference enactment. If the ideal of total neutrality is rejected, there is more room for self-disclosure, and the inevitable impact on

the direction of treatment is not intrinsically erroneous or beneficial, but something that depends on the plethora of factors previously discussed.

4.5. RESPONSES TO SELF-DISCLOSURE

4.5.1. Watching For Patient Reactions to Self-Disclosure

One of the focuses of this study was better understanding how psychoanalysts process and react to the impact of self-disclosure, be they positive, negative, or neutral. This final construct encompasses two themes, the first, watching for patient reactions to self-disclosure. Participants described looking for and gauging patient reactions through body language, patterns of associations, and explicit reactions as different forms of in-vivo feedback:

Participant 2: You learn fairly quickly with whom you can be a little more self-disclosing and with whom you shouldn't. And you learn that by seeing how the person reacts to it... I'm thinking of one particular person who I learned fairly quickly is not very interested in hearing any kind of self-references. She wants to talk; she doesn't necessarily want me to say very much. And when I tried at times to say something that may be a little more in reference to what she was saying, kind of trying to create, to let her see a different angle on things, it was just washed over."

Just as the benefits, disadvantages, and impacts of self-disclosure depend on a multitude of factors, patients' reactions to analyst self-disclosure similarly vary. While watching for patient reactions, a few participants noticed that self-disclosure caused by change to location highlighted differences between patient and analyst and elicited negative patient reactions, particularly feelings of envy:

Participant 1: “She heard my husband's footsteps one day, and she freaked out... It also meant that she knows now that I have a partner that I don’t have a limited life... which she sort of would have suspected but she never wanted to know for sure that I don’t have the lonely, limited life she has. I’m one of those people out there in the world that she envies.”

Participant 6: “I think it’s brought up envy – you could get away. Definitely, when all the sirens were going on in the beginning of Covid. I was up in my country house and they were in the middle of people dying. I think it was painful for them... The economic, or sociological part is there anyway for some of them, but it’s not so apparent when everything is geared to what is going on with them and they don’t have to think about me *that* much.”

On the other hand, several analysts noticed positive responses when watching for patient reactions:

Participant 4: “She said “this was the best session we’ve ever had.”

Participant 9: “She felt relieved... She has a very strong positive reaction...”

Participant 10: “So, the only responses I’ve gotten are positive.”

There are times when self-disclosure is warranted, there are occasions where the utility of self-disclosure is unclear, and there are instances where the psychoanalyst can over-disclose. Participants reported noticing that some patients can be forgiving of accidental, or over-disclosure:

Participant 1: “I think my patients are very kind. And generally forgiving, so I don’t notice.”

Participant 4: “Now sometimes I think I go too far, but my patients know me. They don’t care.”

Whether patients’ forgiveness reflects a human meeting of the minds, or an enactment (or both), may only be determined on a case-by-case basis, in the context of the relationship.

4.5.2. Processing and Reflecting on Self-Disclosure

Psychoanalysts are always watching for changes in sessions; changes to affect, body language, verbal language, and even “energy” in the room. But what do analysts do with their own reactions to self-disclosure? What about shared or mutual reactions? The final theme generated by the findings of this study was the importance of processing and reflecting on self-disclosure, after the fact. “Processing and reflecting” is an active stance psychoanalysts take during the therapy hour, as well as between sessions, on their own, or perhaps in supervision. This approach is suggested by many (see Ehrenberg, 1992; Maroda, 1991) who advocate for analyzing, with and without the patient, what the impact on the analytic process and relationship has been. In this study, most participants expressed that *processing and exploring self-disclosure with patients models a certain form of accountability and a level of therapeutic communication*:

Participant 1: “I was certainly willing to ask, was this hard for you to hear? Was this helpful?”

Participant 8: “When I process a self-disclosure with a patient... understanding their experience of it, how it impacts them... helping them understand the reason for it... It demonstrates or models a certain type of accountability and type of communication... it’s

more of a therapeutic relationship type of communication for many people, or something that they don't commonly engage in, the type of dialogue that they don't commonly engage in about what's happening in the relationship."

Participant 10: "Sometimes if they ask me a question, I'll say I absolutely will answer that, but I want to explore it a little first. Often, I'll answer it and then I'll explore it."

In addition to processing self-disclosure with patients, psychoanalysts also reflected on how they felt in response to both intentional and unintentional self-disclosures. Reactions to unintentional self-disclosures over telehealth varied from annoyance and aggravation to anxiety and embarrassment:

Participant 3: "These are kind of embarrassing because I feel like it reflects that I'm not conscientious enough... Maybe one as I say that I could be more cognizant of and not have happened but then again... If anything, the residual for me is just this bit of self-judgment of I should be less casual."

Participant 5: "I say this thing and it's so... I always regret it. I say, "I know if I don't get it, it will just keep ringing and no one else is going to get it." And I don't think that ever lead to anything, but every time I say it, I know it will take care of the anxiety of having to pause, but I don't feel good about it, but I keep doing it anyway."

Participant 9: "That made me feel tense and self-conscious and protective of the session."

At times during interviews, several psychoanalysts were less confident reflecting on their use of self-disclosure over telehealth.

Participant 8: “There are other times where I don’t feel confident that I made the right decision in disclosing something, either about something that was happening in my life.”

Participant 9: “and I... How did I feel about it? I felt a little mixed, not as confident... I wondered how she felt about my sharing that information? And if she wondered, you know, would I talk about her? Not that I would ever mention names to anybody.”

Lastly, participants highlighted that reflecting on self-disclosure allows them to be more mindful moving forward:

Participant 10: “I tried to really be cognizant of that urge... But I was aware of that, so I didn’t act on it.”

Participant 5: “The more self-reflection the analyst or therapist has, it usually doesn’t go poorly.”

Aron (1996) suggests that more important than the analyst’s self-disclosure is “the analysis of the patient’s experience of the analyst’s subjectivity” (p. 87). This last construct, RESPONSES TO SELF-DISCLOSURE, reflects the participants’ focus on processing self-disclosure with patients, reflecting on their own subjectivity, and keeping the analytic focus on the patient’s experience.

4.6. Clinical Implications

The findings of this study point to several theoretical, practical, and clinical implications. Firstly, there is the notion that people behave differently than they may espouse. This idea is not new. Freud, for example, wrote several strict recommendations to physicians about maintaining a distant, surgeon-like approach, where in reality, he was known to go on walks with patients (Jones, 1955), feed them (Kanzer, 1980), and even send them postcards while on vacation

(Beigler, 1975). Freud's critics have found fault in his being too intimate and cordial, and his handling of analytic neutrality. Winnicott was known to urge caution regarding the analyst's intrusiveness, yet he also worked in a highly idiomatic way, "verbally squiggling" with his patients (see Bolas, 1987). These examples point to paradoxes between theory and practice, rigidity and flexibility, and intimacy and distance. These dualities were all mirrored in the subjective experiences of this study's participants. Behind closed doors, or perhaps, behind the screen, many psychoanalysts behave spontaneously, intuitively, and more flexibly than the rules of psychoanalysis might dictate with regard to self-disclosure. One implication of this study's findings would be to include self-disclosure over telehealth in dialogue within psychoanalytic supervision, academic instruction, and clinical interaction.

Secondly, self-disclosure over telehealth raises questions about theoretical and clinical changes to psychoanalysis. Telehealth on its own has radically transformed the practice of psychoanalysis, with patient and analyst joining in cyberspace. Less traditional definitions of concepts like containment, the holding environment, and even neutrality may be necessary when considering the future of psychoanalysis over telehealth. Telehealth exposes both patient and analyst to new levels of subjectivity, figuratively and literally, and poses a challenge to maintaining the frame of therapy. Continued integration of these changes, or perhaps, creating a new frame altogether, will be required to facilitate effective and meaningful psychoanalysis.

Lastly, psychoanalysis over telehealth appears to be a wave of the future. At the start of the COVID-19 pandemic, many psychologists transitioned to seeing patients over the screen. Now, several years later, many have given up their brick-and-mortar offices to remain online. For those who have returned in-person, some have adopted hybrid models with a smaller percentage of patients still seen over telehealth. The conveniences of telehealth are many

(accessibility, flexibility, cost, no commute, etc.), and for better and worse, it is likely here to stay. As such, it is important for clinicians to consider issues of curating a telehealth background, staying mindful of increased and inevitable disclosures, exploring feelings of distance elicited by the screen, noticing changes to urges to self-disclose, and processing the broader impact of losing much of the nonverbal experience that we took for granted with in-person therapy.

4.7. Limitations of Research

Several limitations should be considered when reviewing and interpreting the results of this study. While there are several benefits to the qualitative nature of this research, including the emphasis on participants' subjective experiences, one limitation may be the difficulty in generalizing the experience of eleven individuals to all psychoanalysts' experience of self-disclosure over telehealth. Because of the focus on the individual and the laborious nature of coding qualitative interviews, the sample size was kept small. The eleven interviews conducted represent a small window into the experience of psychoanalysts, intended to generate ideas and hypotheses about self-disclosure over telehealth, rather than uncover the truth of what the majority of psychoanalysts do on their side of the screen. A quantitative study would be better suited to answer such questions. A second limitation is the self-selected nature of the participant sample in this study. Recruitment targeted a group of participants who were willing to self-disclose about their clinical experiences and were more giving of their time. As such, the data generated by this study may be reflective of psychoanalysts who are more open about their experiences and more giving of their time. Other shortcomings of this study include limitations related to any self-report study, in that participant responses may have been influenced by social desirability, adherence to theoretical rules, and ambivalence elicited by being asked to reflect on clinical experiences, mistakes as a clinician, and other private thoughts and feelings. As this

project coincided with the COVID-19 pandemic and an upsurge of telehealth, findings should be considered in the context of coders' limited experience with in-person therapy. Finally, the sample for this study was limited in its demographic diversity. There was some diversity of age, clinical experience, and theoretical orientation, but the sample was mostly homogeneous in race and ethnicity. Again, results represent a glimpse into the experiences of eleven psychoanalysts but cannot and should not be generalized to other populations without further quantitative data.

4.8. Future Research

This study used a qualitative, grounded theory method (Auerbach & Silverstein, 2003), with the goal of generating hypotheses through theoretical coding. Future research can take a quantitative approach to better understanding psychoanalysts' approach to and use of self-disclosure over telehealth. Within this study there appeared to be an anecdotal connection between one's theoretical orientation and approach to TSD. One potential study might examine the relationship between theoretical orientation and use of TSD, to determine whether the degree of change to self-disclosure caused by telehealth can be predicted by one's training and orientation. Hypotheses might include greater reports of TSD from relational and interpersonal analysts, with less TSD among Contemporary Freudian analysts. It would be interesting to see if there is still a relationship, albeit a weaker one, between Contemporary Freudian orientations and increased self-disclosure over telehealth, as the findings of this study support some increase in self-disclosure over telehealth across multiple orientations.

Another future direction would be to study the effects of telehealth on therapist self-disclosure, while controlling for the influence of the COVID-19 pandemic. This study took place over the course of the first few years of the COVID-19 pandemic (approximately 2020-2023), and several participants spoke of telehealth and the pandemic synonymously. Parsing out these

two variables would allow for a more accurate understanding of correlations between platform of therapy (categorical variable: in-person vs. telehealth) and use of self-disclosure (categorical variable: type of TSD; continuous variable: frequency of use). Hypotheses might include a positive correlation between telehealth and most types of TSD (deliberate, and inevitable) with stronger correlations between telehealth and inevitable self-disclosure, and telehealth and countertransference disclosure, with weaker correlations between telehealth and disclosure of personal information.

5. Conclusion

Psychoanalysis is a mutual yet asymmetrical endeavor between two people. One aspect of mutuality in psychoanalysis is self-disclosure. Psychoanalysts in this study discussed determinants of self-disclosure, including patient and analyst factors, different forms of TSD, and varying motivations for disclosures. Participants spoke of telehealth and self-disclosure, recognizing the inevitability and the increase of TSD over telehealth. Psychologists expressed thoughts and feelings about the frame of therapy and the impact of technology, the COVID-19 pandemic, and self-disclosure on the frame of therapy. They explored the impact of self-disclosure over telehealth, describing many benefits, several hazards of intrusion, and the influence of TSD on the direction of treatment. Lastly, psychoanalysts reflected on responses to self-disclosure and the value of self-reflection and processing disclosures with patients.

In 1932, Ferenczi expressed his ambivalence concerning mutual analysis, writing in his clinical diary, “must every case be mutual—and to what extent?” (p. 213). The issue of self-disclosure over telehealth contains a similar question of must every case be necessary, helpful, avoidable—and to what extent? This study depicted several dualities related to self-disclosure and telehealth. Participants spoke of dualities of closeness and distance, intimacy and isolation,

benefits and hazards, spontaneity and rigidity, subjectivity and neutrality, and disclosure and anonymity. For some, telehealth pulls for more deliberate self-disclosure. For others it increases the inevitability of certain disclosures. For a few who were regularly freer with TSD, telehealth decreased the level of intimacy over the screen and in turn, decreased self-disclosure. For the most part, however, telehealth changed the frame of therapy and with it the way psychoanalysts approach and use self-disclosure with patients over the screen.

The range of opinions shared by participants in this study about self-disclosure over telehealth mirrored the myriad stances, opinions, and dissents outlined in the literature, with approaches along the spectrum from total abstinence to open, spontaneous disclosure. Some amount of self-disclosure may be inevitable, but telehealth creates even more opportunities for both deliberate and unintentional disclosures. Self-disclosure can be profoundly helpful or a harsh intrusion. Self-disclosure can enter and impact the treatment, or it can be missed or dismissed by the patient. Self-disclosure can complicate the analysis or enhance the alliance. On the question of self-disclosure, Greenberg (1995) comments, “Freud was right about self-disclosure, sometimes. Ferenczi was right about self-disclosure, sometimes.” With much debate surrounding the theory and practice of self-disclosure, a more practical summary might be Aron’s (1996) suggestion that self-disclosure is ultimately “left open to be resolved within the context of each unique psychoanalytic situation” (p. 87). Psychoanalysis over telehealth seems to be the wave of the future and as COVID-19 hopefully becomes a thing of the past, telehealth will likely remain current and will continue advancing in tandem with the field of psychoanalysis. Much is shared in the mutual space between analyst and patient. Mutuality over telehealth means that “shared screens” will occur, deliberately and inevitably, but as long as self-disclosure is processed and reflected upon, it may all be grist for the psychoanalytic, virtual mill.

References

- American Psychological Association. (2020, June 5). *Psychologists embrace telehealth to prevent the spread of COVID-19*.
<http://www.apaservices.org/practice/legal/technology/psychologists-embrace-telehealth>
- Andersson, G., Paxling, B., Roch-Norlund, P., Östman, G., Norgren, A., Almlöv, J., Georén, L., Breitholtz, E., Dahlin, M., Cuijpers, P., Carlbring, P., & Silverberg, F. (2012). Internet-based psychodynamic versus cognitive behavioral guided self-help for generalized anxiety disorder: A randomized controlled trial. *Psychotherapy and Psychosomatics*, 81(6), 344–355.
- Arlow, J. A. (1969). Fantasy, memory, and reality testing. *Psychoanalytic Quarterly*, 38(1), 28–51.
- Aron, L. (1991). The patient's experiences of the analyst's subjectivity. *Psychoanalytic Dialogues*, 1(1), 29–51.
- Aron, L. (1992). Interpretation as expression of the analyst's subjectivity. *Psychoanalytic Dialogues*, 2(4), 475–507.
- Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ/ London: Analytic Press.
- Atwood, G. & Stolorow, R. (1984). *Structures of subjectivity*. Hillsdale, NJ: The Analytic Press.
- Audet, C. T. & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance and Counselling*, 38(3), 327–342.
- Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, 24(2), 85–100.

- Auerbach, C. F., & Silverstein, L. B. (2003). *Qualitative data: An introduction to coding and analysis*. New York: New York University Press.
- Barak, A. (1999). Psychological applications on the internet: A discipline on the threshold of a new millennium. *Applied and Preventive Psychology*, 8(4), 231–245.
- Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, 69(4), 597–603.
- Bateson, G. (1972). *Steps to an Ecology of Mind*. New York: Ballantine.
- Beigler, J. S. (1975). A commentary on Freud's treatment of the rat man. *Journal of the American Psychoanalytic Association*, 2, 224–228.
- Bion, W. R. (1962). *Learning from experience*. Karnac Books.
- Bion, W. R. (1967). Notes on memory and desire. *The Psychoanalytic Forum*, 1(272-3), 279–80.
- Bion, W. R. (1990). *Brazilian Lectures*. London: Karnac Books.
- Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known*. New York: Columbia University Press.
- Bollas, C. (1989). *Forces of destiny: Psychoanalysis and human idiom*. Free Association Books.
- Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy: Theory, Research, Practice, Training*, 38(1), 21–30.
- Brottman M. (2012). Whereof one cannot speak: Conducting psychoanalysis online. *Psychoanalytic Review*, 99(1), 19–34.
- Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process*, 59(3), 974–988.
- Carlbring, P., Andersson, G., Cuijpers, P., Riper, H., & Hedman-Lagerlöf, E. (2018). Internet-

- based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: An updated systematic review and meta-analysis. *Cognitive Behaviour Therapy*, 47(1), 1-18.
- Chused, J. F. (1992). The patient's perception of the analyst: The hidden transference. *Psychoanalytic Quarterly*, 56(2), 161–184.
- Comer, J. S., Furr, J. M., Kerns, C. E., Miguel, E., Cox, S., Elkins, R. M., Carpenter, A. L., Cornacchio, D., Cooper-Vince, C. E., DeSerisy, M., Chou, T., Sanchez, A. L., Khanna, M., Franklin, M. E., Garcia, A. M., & Freeman, J. B. (2017). Internet-delivered, family-based treatment for early-onset OCD: A pilot randomized trial. *Journal of Consulting and Clinical Psychology*, 85(2), 178–186.
- Cooper, S. H. (1998). Countertransference disclosure and the conceptualization of analytic technique. *Psychoanalytic Quarterly*, 67(1), 128–156.
- Crastnopol, M. (1997) Incognito or not? The patient's subjective experience of the analyst's private life. *Psychoanalytic Dialogues*, 7(2), 257-280.
- Davies, J.M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues*, 4(2), 153–170.
- Davis, J. T. (2002). Countertransference temptation and the use of self-disclosure by psychotherapists in training: A discussion for beginning psychotherapists and their supervisors. *Psychoanalytic Psychology*, 19(3), 435–454.
- Dewald P. A. (1982). Serious illness in the analyst: Transference, countertransference, and reality responses. *Journal of the American Psychoanalytic Association*, 30(2), 347–363.
- Doss, B. D., Cicila, L. N., Georgia, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2016). A randomized controlled trial of the web-based OurRelationship

- program: Effects on relationship and individual functioning. *Journal of Consulting and Clinical Psychology*, 84(4), 285–296.
- Ehrenberg, D. B. (1992). *The intimate edge*. New York: Norton.
- Ehrenberg, D. B. (1995). Self-disclosure: Therapeutic tool or indulgence? *Contemporary Psychoanalysis*, 31(2), 213–228.
- Epstein, L. (1995). Self-disclosure and analytic space: Some issues raised by Jay Greenberg's paper on self-disclosure. *Contemporary Psychoanalysis*, 31(2), 229–236.
- Ferenczi, S. (1928). *The elasticity of psychoanalytic technique*. In *Final contributions to the problems and methods of psychoanalysis* (pp. 87–101). New York: Basic Books.
- Ferenczi, S. (1932). *The clinical diary of Sandor Ferenczi*, ed. J. Dupont (trans. M. Balint & N. Z. Jackson). Cambridge, MA: Harvard University Press, 1988.
- Ferenczi, S. (1933). *Confusion of tongues between adults and the child*. In *Final Contributions to the Problems and Methods of Psychoanalysis* (pp. 156–167). New York: Basic Books.
- Ferenczi, S. (1933/1949). Confusion of the tongues between the adults and the child—(The Language of Tenderness and of Passion). *International Journal of Psycho-Analysis*, 30, 225–230
- Freud, A. (1936). *The ego and the mechanisms of defense*. New York: International Universities Press.
- Freud, S. (1912). *Recommendations to physicians practicing psychoanalysis*. Standard Edition, 12, 109–120.
- Freud, S. (1915). *Observations on transference-love*. Standard Edition, 12, 159–171.
- Gabbard G. O. (2001). Cyberpassion: E-rotic transference on the Internet. *Psychoanalytic Quarterly*, 70(4), 719–737.

- Gabbard, G. O. (1998). Commentary on paper by Jody Messler Davies. *Psychoanalytic Dialogues*, 8(6), 781–789.
- Geller, J. D. (2003). Self-disclosure in psychoanalytic-existential therapy. *Journal of Clinical Psychology*, 59(5), 541–554.
- Geller, S. (2020). Cultivating online therapeutic presence: Strengthening therapeutic relationships in teletherapy sessions. *Counselling Psychology Quarterly*. Advance online publication. <https://doi.org/10.1080/09515070.2020.1787348>
- Ginot, E. (1997). The analyst's use of self, self-disclosure, and enhanced integration. *Psychoanalytic Psychology*, 14(3), 365–381.
- Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, 22(1), 417–433.
- Goldstein, E. G. (1997). To tell or not to tell: The disclosure of events in the therapist's life to the patient. *Clinical Social Work Journal*, 25(1), 41–58.
- Gorkin, M. (1987). *The uses of countertransference*. Northvale, NJ: Aronson.
- Gottlieb, L. (2020, April 30). *In psychotherapy, the toilet has become the new couch*. The New York Times. <https://www.nytimes.com/2020/04/30/opinion/psychotherapy-remote-covid.html>
- Greenberg, J. R. (1986). The problem of analytic neutrality. *Contemporary Psychoanalysis*, 22(1), 76–86.
- Greenberg, J. R. (1995). Self-disclosure: Is it psychoanalytic? *Contemporary Psychoanalysis*, 31(2), 193–205.
- Greenberg, J. R. , & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.

- Greenson, R. R. (1967). *The technique and practice of psychoanalysis*. New York: International Universities Press.
- Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstanding of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry*, 155(3), 409–414.
- Hanly, C. (1998). Reflections on the analyst's self-disclosure. *Psychoanalytic Inquiry*, 18(4), 550–565.
- Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling and Psychotherapy Research*, 5(2), 96–104.
- Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review*, 30(1), 63–77.
- Hill, C. E., & Knox, S. (2002). *Self-disclosure*. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 255–265). Oxford: Oxford University Press.
- Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: A 2013 review. *Telemedicine Journal and E-health*, 19(6), 444–454.
- Isay, R. A. (1991). The homosexual analyst: Clinical considerations. *Psychoanalytic Study of the Child*, 46(1), 199–216.
- Jacobs, T. J. (1995). Discussion of Jay Greenberg's paper. *Contemporary Psychoanalysis*, 31(2), 237–245.
- Jacobs, T. J. (1997). Some reflections on the question of self-disclosure. *Journal of Clinical Psychoanalysis*, 6(2), 161–173.
- Jacobs, T. J. (1999). On the question of self-disclosure by the analyst: Error or advance in

- technique? *Psychoanalytic Quarterly*, 68(2), 159–183.
- Jeffery, M. K., & Tweed, A. E. (2015). Clinician self-disclosure or clinician self-concealment? Lesbian, gay and bisexual mental health practitioners' experiences of disclosure in therapeutic relationships. *Counselling and Psychotherapy Research*, 15(1), 41–49.
- Johansson, R., Ekbladh, S., Hebert, A., Lindström, M., Möller, S., Petitt, E., Poysti, S., Larsson, M. H., Rousseau, A., Carlbring, P., Cuijpers, P., & Andersson, G. (2012). Psychodynamic guided self-help for adult depression through the internet: A randomised controlled trial. *PLoS ONE*, 7(5), e38021.
- Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. (2013). Guidelines for the practice of telepsychology. *American Psychologist*, 68(9), 791–800.
- Jones, E. (1995). *The Life and Work of Sigmund Freud*. Volume II. New York: Basic Books, Inc.
- Jourard, S. M. (1971). *Self-disclosure: An experimental analysis of the transparent self*. New York: Wiley-Interscience.
- Käll, A., Bäck, M., Welin, C., Åman, H., Bjerkander, R., Wänman, M., Lindegaard, T., Berg, M., Moche, H., Shafran, R., & Andersson, G. (2021). Therapist-guided Internet-based treatments for loneliness: A randomized controlled three-arm trial comparing cognitive behavioral therapy and interpersonal psychotherapy. *Psychotherapy and Psychosomatics*, 90(5), 351-358.
- Kanzer, M. (1980). Freud's human influence in the rat man. In M. Kanzer & J. Glenn, eds., *Freud and his patients*. New York: Jason Aronson.
- Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44(3), 274–283.

- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Leary, K. (1997). Race, self-disclosure, and “forbidden talk”: Race and ethnicity in contemporary clinical practice. *Psychoanalytic Quarterly*, 66(2), 163–189.
- Little, M. (1951). Counter-transference and the patient's response to it. *The International Journal of Psychoanalysis*, 32(1), 32–40.
- Machado, D. d. B., Laskoski, P. B., Severo, C. T., Bassols, A. M., Sfoggia, A., Kowacs, C., Krieger, D. V., Torres, M. B., Gastaud, M. B., Wellausen, R. S., Teche, S. P., & Eizirik, C. L. (2016). A psychodynamic perspective on a systematic review of online psychotherapy for adults. *British Journal of Psychotherapy*, 32(1), 79-108.
- Marcus, D. M. (1997). On knowing what one knows. *Psychoanalytic Quarterly*, 66(2), 219–241.
- Maroda, K. (1991). *The power of countertransference*. New York: Wiley.
- Mathews, B. (1988). The role of therapist self-disclosure in psychotherapy: A survey of therapists. *American Journal of Psychotherapy*, 42(4), 521–531.
- McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York; London: Guilford Press.
- Meissner, W. W. (2002). The problem of self-disclosure in psychoanalysis. *Journal of the American Psychoanalytic Association*, 50(3), 827–867.
- Migone, P. (2013). Psychoanalysis on the Internet: A discussion of its theoretical implications for both online and offline therapeutic technique. *Psychoanalytic Psychology*, 30(2), 281–299.
- Mitchell, S. (1995). Interaction in the Kleinian and interpersonal traditions. *Contemporary Psychoanalysis*, 31, 65-91.
- Miletic, M. J. (1998). Rethinking self-disclosure: An example of the clinical utility of the

- analyst's self-disclosing activities. *Psychoanalytic Inquiry*, 18(4), 580–600.
- Moore, B. E., & Fine, B. D. (eds). (1990). *Psychoanalytic terms and concepts*. New Haven: Yale University Press.
- Morgan, J. H. (2014). The Interpersonal psychotherapy of Harry Stack Sullivan: Remembering the legacy. *Journal of Psychology & Psychotherapy*, 4(6), 162.
- Paris, M., Silva, M., Añez-Nava, L., Jaramillo, Y., Kiluk, B. D., Gordon, M. A., Nich, C., Frankforter, T., Devore, T., Ball, S. A., & Carroll, K. M. (2018). Culturally adapted, web-based cognitive behavioral therapy for Spanish-speaking individuals with substance use disorders: A randomized clinical trial. *American Journal of Public Health*, 108(11), 1535–1542.
- Pergament D. (1998). Internet psychotherapy: Current status and future regulation. *Health Matrix*, 8(2), 233–279.
- Pinto-Coelho, K. G., Hill, C. E., & Kivlighan, D. M., Jr. (2016). Therapist self-disclosure in psychodynamic psychotherapy: A mixed methods investigation. *Counselling Psychology Quarterly*, 29(1), 29–52.
- Pizer B. (1997). When the analyst is ill: Dimensions of self-disclosure. *Psychoanalytic Quarterly*, 66(3), 450–469.
- Rachman, A. W. (1998). Judicious self-disclosure by the psychoanalyst. *International Forum of Psychoanalysis*, 7(4), 263–269.
- Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology: Research and Practice*, 36(6), 649–653.
- Renik, O. (1993). Technique in the light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, 62(4), 553–571.

Renik, O. (1995). The ideal of the anonymous analyst and the problem of self-disclosure.

Psychoanalytic Quarterly, 64(3), 466–495.

Renik, O. (1996). The perils of neutrality. *Psychoanalytic Quarterly*, 65(3), 495–517.

Renik, O. (1999). Playing one's cards face up in analysis: An approach to the problem of self-disclosure. *Psychoanalytic Quarterly*, 68(4), 521–539.

Richardson, L. K., Frueh, B. C., Grubaugh, A. L., Egede, L., & Elhai, J. D. (2009). Current directions in videoconferencing tele-mental health research. *Clinical Psychology*, 16(3), 323–338.

Roddy, M. K., Rhoades, G. K. & Doss, B. D. (2020). Effects of ePREP and OurRelationship on low-income couples' mental health and health behaviors: A randomized controlled trial. *Prevention Science*, 21(1), 861–871.

Rothstein, A. (1997). Introduction to symposium on aspects of self-revelation and disclosure: Analyst to patient. *Journal of Clinical Psychoanalysis*, 6(2), 141-144.

Safran, J. D. (2012). *Psychoanalysis and psychoanalytic therapies*. American Psychological Association.

Sapru, I., Khalid-Khan, S., Choi, E., Alavi, N., Patel, A., Sutton, C., Odejayi, G. & Calancie, O. (2018). Effectiveness of online versus live multi-family psychoeducation group therapy for children and adolescents with mood or anxiety disorders: A pilot study. *International Journal of Adolescent Medicine and Health*, 30(4), 20160069.

Scharff J. S. (2012). Clinical issues in analyses over the telephone and the Internet. *The International Journal of Psycho-analysis*, 93(1), 81–95.

Schwaber, E. A. (1998). “Traveling affectively alone”: A personal derailment in analytic listening. *Journal of the American Psychoanalytic Association*, 46(4), 1044–1065.

- Searles, H. F. (1959). *Oedipal love in the countertransference*. In: *Collected papers on schizophrenia and related subjects*. New York: International Universities Press, 1965, pp. 284-303.
- Searles, H. F. (1975). *The patient as therapist to his analyst*. In *Tactics and techniques in psychoanalytic theory*. P. Giovacchini, ed. New York: Jason Aronson, Inc.
- Searles, H. F. (1986). *My work with borderline patients*. New York: Jason Aronson.
- Sfoggia, A., Kowacs, C., Gastaud, M. B., Laskoski, P. B., Bassols, A. M., Severo, C. T., Machado, D., Krieger, D. V., Torres, M. B., Teche, S. P., Wellausen, R. S., & Eizirik, C. L. (2014). Therapeutic relationship on the web: To face or not to face? *Trends in Psychiatry and Psychotherapy*, 36(1), 3–10.
- Shill, M. A. (2004). Analytic neutrality, anonymity, abstinence, and elective self-disclosure. *Journal of the American Psychoanalytic Association*, 52(1), 151–187.
- Singer, E. (1977). *The fiction of analytic anonymity*. In: *The human dimension in psychoanalytic practice*. ed. K. Frank (pp. 181-192). New York: Grune & Stratton.
- Solomonov, N., & Barber, J. P. (2018). Patients' perspectives on political self-disclosure, the therapeutic alliance, and the infiltration of politics into the therapy room in the Trump era. *Journal of Clinical Psychology*, 74(5), 779–787.
- Suler, J. (2004). The online disinhibition effect. *Cyberpsychology and Behavior*, 7(3), 321-326.
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: W.W. Norton.
- Tauber, E. S. (1954). Exploring the therapeutic use of countertransference data. *Psychiatry: Journal for the Study of Interpersonal Processes*, 17(4), 331–336.
- Thompson, C. (1956). The role of the analyst's personality in therapy. *American Journal of Psychotherapy*, 10(2), 347-67.

- Tillman, J. G. (1998). Psychodynamic psychotherapy, religious beliefs, and self-disclosure. *Journal of Psychotherapy*, 52(3), 273–286.
- Wachtel, P. L. (1993). *Therapeutic Communication: Principles and Effective Practice*. New York: Guilford.
- Watzlawick, P., Bavelas, J. B., & Jackson, D. D. (1967). *Pragmatics of Communication*. New York: Norton.
- Winnicott, D. W. (1949). Hate in the counter-transference. *The International Journal of Psychoanalysis*, 30(1), 69–74.
- Winnicott, D. W. (1953). Transitional objects and transitional phenomena. *The International Journal of Psycho-Analysis*, 34(1), 89–97.
- Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. New York: International Universities Press.
- Wolson, P. (2021). Some pros and cons of psychoanalytic teletherapy. *Psychoanalytic Psychology*, 38(2), 109–110.
- Yalom, I. D. (1999). *Momma and the meaning of life*. New York: Basic Books.
- Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York: Harper Collins.
- Yellowlees, P. M., Shore, J., & Roberts, L. (2010). Practice guidelines for videoconferencing-based telemental health. American Telemedicine Association. *Telemedicine Journal and e-Health*, 16(10), 1074–1089.
- Ziv-Beiman, S., & Shahar, G. (2016). Therapeutic self-disclosure in integrative psychotherapy: When is this a clinical error? *Psychotherapy*, 53(3), 273–277.
- Ziv-Beiman, S., Keinan, G., Livneh, E., Malone, P. S., & Shahar, G. (2017). Immediate therapist

self-disclosure bolsters the effect of brief integrative psychotherapy on psychiatric symptoms and the perceptions of therapists: A randomized clinical trial. *Psychotherapy Research*, 27(5), 558–570.

Zur, O. (2007). *Self-disclosure*. In O. Zur *Boundaries in psychotherapy: Ethical and clinical explorations* (pp. 149-165). Washington, DC: American Psychological Association.

Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the Internet age. *Professional Psychology: Research and Practice*, 40(1), 22–30.

Appendix A – Recruitment Flyer

IRB Protocol #: 21/11-160
Approval: January 27, 2022
LIU Sponsored Projects

Therapist Self-Disclosure Over Telehealth**Description of the Research:**

The purpose of this study is to explore therapists' use of self-disclosure over telehealth platforms. The time commitment for participating in this study will be approximately 1 hour through a semi-structured interview and a brief questionnaire. Interviews will take place over Zoom or a similar platform.

Inclusion Criteria:

- Doctoral level psychologist
- Currently licensed and practicing
- Psychodynamically or psychoanalytically trained
- At least 5 years licensed clinical experience
- At least 1 year experience providing psychotherapy over telehealth

Exclusion Criteria:

- Integrative theoretical orientations (e.g., integrating psychodynamic treatment with CBT, DBT, ACT, etc.)
- Telehealth experience limited to telephone sessions
- Clinicians who primarily treat children

Compensation:

As an incentive for participation, you will be offered a \$20 gift card (Starbucks or Amazon.com) upon completion of your interview.

Contact:

If you have any questions, please contact nathan.fordsham@my.liu.edu

If you would like to participate in this study, please complete the attached screener/demographic questionnaire. If you are eligible, you will be contacted to schedule an interview: <https://tinyurl.com/therapist-self-disclosure>

Thank you for your time,

Nathan Fordsham, M.S.
Clinical Psychology Doctoral Candidate
Long Island University Post



Appendix B – Participant Screener

Thank you for your interest in this study! Below are 5 screener questions that will determine your eligibility for participation. If you are eligible you will be forwarded to an informed consent form following this screener.

Q2 What is your Professional Degree?

- ☐ Ph.D. (1)
- ☐ Psy.D. (2)
- ☐ M.S./M.A. or other master's level degree (3)

Q3 Are you currently licensed and practicing as a doctoral level psychologist?

- ☐ Yes (1)
- ☐ No (2)

Q4 How many years of licensed clinical experience to you have working in-person?

- ☐ 1-2 (1)
- ☐ 3-4 (2)
- ☐ 5+ (3)

Q5 How many years of licensed clinical experience to you have working over telehealth (video platform)?

- ☐ less than 1 (1)
- ☐ 1+ (2)

Q6 Please select the orientation that best describes your primary theoretical: orientation:

- ☐ Cognitive, Behavioral, or Cognitive-Behavioral (1)
- ☐ Psychodynamic or Psychoanalytic (2)
- ☐ Third Wave (e.g., DBT, ACT, etc.) (3)
- ☐ Integrative or Other (briefly describe) (4)

Disqualification Page

Q14 Thank you for completing the screener. Based on your responses, you are not eligible to continue as a participant in this study. I appreciate your time and interest.

Sincerely,

Nathan Fordsham

Q7 Thank you for completing the screener! To continue, please click the arrow below and you will be taken to an informed consent form with further information.

Appendix C – Demographic and Clinical Questionnaire

Q8 What is your age?

- ☐ 18 - 24 years old (1)
- ☐ 25 - 34 years old (2)
- ☐ 35 - 44 years old (3)
- ☐ 45 - 54 years old (4)
- ☐ 55 - 64 years old (5)
- ☐ 65+ years old (6)
- ☐ Prefer not to say (7)

Q9 What gender do you identify with?

- ☐ Male (1)
- ☐ Female (2)
- ☐ Non-binary / third gender (3)
- ☐ Prefer not to say (4)

Q10 Please specify your ethnicity:

- ☐ White / Caucasian (1)
- ☐ Hispanic / Latino (2)
- ☐ Black / African American (3)
- ☐ Asian (4)
- ☐ Native American / American Indian (5)
- ☐ Pacific Islander (6)
- ☐ Other (7) _____
- ☐ Prefer not to say (8)

Q11 Where did you complete your doctoral degree? (Name of University)

Q12 Briefly describe the clinical setting and population you are currently work with:

Q13 Please indicate your (psychodynamic/analytic) clinical orientation from the following options:

- ☐ Contemporary Freudian (1)
- ☐ Ego Psychology (2)
- ☐ Self Psychology (3)
- ☐ Interpersonal (4)
- ☐ Relational (5)
- ☐ Object Relational (6)
- ☐ Intersubjective (7)
- ☐ Other (8) _____

Appendix D – Informed Consent Form**LONG ISLAND UNIVERSITY – C. W. POST****Institutional Review Board (IRB)**

IRB Protocol #: 21/11-160

Approval: January 27, 2022

RESEARCH PARTICIPANT INFORMED CONSENT FORM Study Title: Shared Screens:
A Qualitative Study of Therapist Self-Disclosure Over Telehealth**Faculty Investigator:** Danielle Knafo, Ph.D., Professor of Psychology, Clinical Psychology
Doctoral Program, danielle.knafo@liu.edu, (516) 299-3893.**Student Investigator:** Nathan Fordsham, M.S., Clinical Psychology Doctoral Program,
nathan.fordsham@my.liu.edu, (732) 895-8967.

You are being asked to join a research study. Participation in this study is voluntary. Even if you decide to join now, you can change your mind later.

1. Why is this research being done?

This research is being done to explore therapists' use of self-disclosure over telehealth. The study population will be doctoral level licensed psychologists with psychodynamic or psychoanalytic training. Other inclusion criteria include having at least 5 years of licensed clinical experience, and at least 1 year of clinical experience over telehealth. Exclusion criteria include clinicians with integrative theoretical orientations, telehealth experience limited to telephone sessions, and clinicians who primarily work with children.

2. What will happen if you join this study?

If you agree to be in this study, we will ask you to do the following things:

- Complete an online screener and demographic questionnaire
- Provide some information about your clinical training and experience
- Participate in a 1-hour interview with the researcher. Interviews will take place over Zoom.

3. Photographs/Video recordings:

As part of this research, we are requesting your permission to create and use audio recordings of the interview. Any audio recording will not be used for advertising or non-study related purposes.

You should know that:

- You may request that the audio recording be stopped at any time.
- If you agree to allow the audio recording and then change your mind, you may ask us to destroy that recording. If the recording has had all identifiers removed, we may not be able to do this.
- We will only use these audio recordings for the purposes of this research.

- The audio recording will be transcribed by Nathan Fordsham who will keep all data confidential.

Q18 Please indicate your decision below by checking the appropriate statement:

- ☐ I agree to allow the study team to make and use audio recordings of me for the purpose of this study. (1)
- ☐ I do not agree to allow the study team to make and use audio recordings of me for the purpose of this study. (2)

4. What are the risks or discomforts of the study?

You may get tired or bored when we are asking you questions or you are completing questionnaires. You do not have to answer any question you do not want to answer. Although your IP Address will not be stored in the survey results, there is always the possibility of tampering from an outside source when using the Internet for collecting information. While the confidentiality of your responses will be protected once the data is downloaded from the Internet, there is always the possibility of hacking or other security breaches that could threaten the confidentiality of your responses.

5. Are there benefits to being in the study?

It is expected that the results of this study may provide information of value to the field of psychology, and to the expansion of research on therapist self-disclosure in particular.

6. What are your options if you do not want to be in the study?

Your participation in this study is entirely voluntary. You choose whether to participate. Withdrawal from the study will not result in any penalty but will incur a loss of benefits.

7. Will you be paid if you join this study?

In compensation for your time, you will receive a \$20 gift card to either Starbucks or Amazon.com.

8. Can you leave the study early?

- You can agree to be in the study now and change your mind later, without any penalty.
- If you want to withdraw from the study, please contact Nathan Fordsham immediately at nathan.fordsham@my.liu.edu

9. How will the confidentiality of your data be protected?

Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Long Island University Institutional Review Board and officials from government agencies such as the National Institutes of Health and the Office for Human Research Protections. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

10. What other things should you know about this research study?**What is the Institutional Review Board (IRB) and how does it protect you?**

This study has been reviewed by an Institutional Review Board (IRB), a group of people that reviews human research studies. The IRB can help you if you have questions about your rights as a research participant or if you have other questions, concerns or complaints about this research study. You may contact the IRB at 516-299-3591 or Michael.Marino@liu.edu.

What should you do if you have questions about the study?

Contact the student investigator (Nathan Fordsham at nathan.fordsham@my.liu.edu / (732) 895-8967) or the faculty investigator (Danielle Knafo, Ph.D. at danielle.knafo@liu.edu / (516) 299-3893). If you cannot reach the investigators or wish to talk to someone else, call the IRB office at 516-299-3591.

You can ask questions about this research study now or at any time during the study.

If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Institutional Review Board at Long Island University at (516) 299-3591.

Q24 Here is a link to a printable copy of the Informed Consent Form for your records.

11. What does your agreement on this consent form mean?

By marking the “Agree to Participate” box below, you are indicating that you have fully read the above text and have had the opportunity to print the consent form (or ask for a printed copy) and ask questions about the purposes and procedures of this study. If you choose not to participate, please choose the “Decline to Participate” box below.

☐ Agree to Participate (Date) (1) _____

☐ Decline to Participate (2)

Q20 Please enter and sign your name below: _____

Q19 (you can sign using your mousepad by clicking and dragging the cursor...)

Q25 Lastly, what is the best way to contact you? (Email address and/or telephone) _____

Appendix E – Hierarchical Data Organization**HIERARCHICAL DATA ORGANIZATION****I. DETERMINANTS OF SELF-DISCLOSURE****A. Self-Disclosure is Determined by Both Patient and Analyst Factors (81.82%)****1. *It depends on the patient* (P1, P2, P5, P7, P9, P11)**

- It is very much dependent on the patient. (T1, P1)
- And that's determined by the patient. (T5, P1)
- It depends how healthy and functional they are; how fragile they are. (T22, P1)
- The two patients Monday morning are both high functioning people and I just said, "Look, I'm driving down from the country, I should be there on time, but if there's a crash on some hill, or something happens, I'll be late. I'll let you know. (T23, P1)
- It depends on the person that I'm working with. (T6, P2)
- It depends on how far along we are. (T7, P2)
- It depends on my sense of what it will or will not do for the process. (T8, P2)
- With some people with whom I've been working for a while and it's not "analysis," it feels freer to do it. (T11, P2)
- I don't think it impacted the relationship much because this relationship has existed now for probably three years. And I don't disclose much in that relationship. It feels comfortable. (T23, P2)
- It depends on the relationship. It depends on the person you are working with. (T41, P2)
- It comes up a lot as a choice and I think it depends on how comfortable you are in self disclosure in general, and on the kind of relationship that you have established with a person. (T48, P2)
- It might come with particular patients. (T4, P5)
- It kind of just depends on the patient. (T15, P5)
- There are times and with certain patients that I just think that rather than being just sort of neutral... (T2, P7)
- It's very much a case by case. (T3, P7)
- It varies so much with the person. (T18, P7)
- Let's say someone who is kind of in analysis or let's say a fairly high frequency analytic therapy. I think that awareness of boundaries is much more, almost automatically, maintained. (T21, P7)
- I have a couple of people, older people, where I feel very much it's supportive. That's what they are there for. (T22, P7)
- With self-disclosure, I would say that I look at it and use it on a very individual basis. (T1, P9)
- It really depends on the level of functioning of the patient that I'm working with and how I think it might help the treatment or help them. (T2, P9)
- I might disclose one thing to one patient but not another. (T3, P9)
- It depends on which patient I'm thinking about at the time. (T21, P11)

2. *Some patients don't even notice* (P1, P7, P8, P11)

- I might say "do you want to know?" Some people don't want to know, really. (T19, P1)
- Sometimes patients don't even pick up on things that I think they would. (T44, P1)

- I thought it was really interesting that he was like, “Oh, I don't remember that.” (T47, P1)
 - People vary so much in terms of what they feel comfortable asking or what they're curious about. (T31, P7)
 - This painting used to be something else (points to painting in the background) at one point, and I changed it at one point, and I thought it was interesting that some people had a real reaction to it and knew that something was different, or they knew right away that the picture was different. And other people either didn't notice it, didn't say anything, or weren't sure, where they knew something was different but didn't know what it was. (T15, P8)
 - Some patients don't notice at all. (T36, P11)
3. *Taking theoretical and conceptual rules of the game a little less seriously* (P2, P4, P5, P7, P9, P10)
- I'm not as avoidant of it, I'm not as fearful of it, as some theoretical approaches warn you about. (T1, P2)
 - Since my orientation is more interpersonal, self-disclosure is inevitable and not always undesirable. (T3, P2)
 - Why did I choose to disclose it? Partly because with this particular person, I have a more open relationship. It's not bound by “rules” as much. (T21, P2)
 - These days I would be less anxious about it because I became more relaxed about it. (T35, P2)
 - Taking theoretical and conceptual rules of the game a little less seriously. Relaxing the frame if you will. (T37, P2)
 - I'm less concerned that making a wrong move, or a little extra self-disclosure, or not wearing a tie, or whatever, is going to be a dramatic event in the treatment. (T38, P2)
 - With time I came to trust that I can maintain the essence of the work without worrying about doing this right, doing that right, exactly this way that way. (T39, P2)
 - Not being orthodox about them. (T40, P2)
 - When I was in graduate school, and in a formal analysis, my analyst who was an eminent psychiatrist of the old school, totally believed in self disclosure. That wasn't common then. But he used it very well. And because of that, I've always sort of self-disclosed. (T1, P4)
 - I'll tell you a wonderful story my therapist told me, which was self-disclosure. I've always remembered that. (T42, P4)
 - I roughly consider myself a contemporary Freudian analyst. And so, with the accent on the contemporary, there's a little more leeway. (T1, P5)
 - My training was Contemporary Freudian, and so while it's not classical, I think generally the thrust is not much or very little self-disclosure, but over many years, my own development, I think I'd become much more selective. (T1, P7)
 - For some of them, self-disclosure is far more desirable, recommended, considered very useful. (T44, P7)
 - I'm open to doing it. I'm not a classicist in that way. I'm more of a totalist. (T5, P9)
 - It's very relational. (T48, P10)
4. *Self-disclosure over telehealth is determined by the analyst's personal life* (P2, P5)
- Probably somewhat determined by my own unconscious. (T9, P2)

- I think a lot might also depend on what is going on in the analyst's or therapist's life during the pandemic. (T49, P2)
- I'm able to work from home, life has not been disrupted all that much in terms of ability to make a living, ability to kind of maintain a structured life. But I know of a lot of therapists who are single, left alone, had COVID, were isolated, became depressed. I would suspect that for them, it would have been much harder not to be self-disclosing, not to share it, when you're sick, alone. And at the beginning of the pandemic when you couldn't visit anybody, nobody could visit you, you were alone 24/7. (T50, P2)
- Self-disclosure has something to do with who are you, like as the analyst or therapist, who are you? Where are you located? Where are you located in space and time? Where are you located historically? Like so many levels. (T24, P5)

B. Forms of Self-Disclosure (100%)

5. *Analyst generally avoids self-disclosure, but there are exceptions* (P1, P3, P4, P5, P6, P11)

- "Oh! Well, my partner works at that company too!" I don't ever do that oh-my-partner-works-at-that-company-too kind of self-disclosure. (T4, P1)
- If it's not relevant, I don't bring it up. (T10, P1)
- I don't say "God, it's making me think about my own mother's death, that makes me sad." I don't use that kind of self-disclosure because that's more personal. (T11, P1)
- I would not tell stories about myself, share stories about myself in therapy, which I know some people do, for example, if they feel the patient is talking about something and they have done something or experienced something similar, I certainly would not do anything like that. (T1, P3)
- I don't usually reveal things about my personal life to my patients. It's not super strict, but it's also not open, I would say. (T5, P3)
- In general self-disclosure would be an exception, but not an unacceptable one or an unheard of one, but something really called for in the situation. (T2, P5)
- I wouldn't say I have a hard and fast rule against or for doing it, though I would say generally, I don't talk about how I'm feeling. (T8, P5)
- Though, maybe if the tensions are really high because let's say something traumatic happens to the patient where there's a conflict in the room between us and automatically the temperature is up, and different in the room. I mean, I think I do at least acknowledge that my feelings are expressed, you know. I think I do probably disclose a feeling. (T9, P5)
- It's pretty rare that I would bring in something about my outside life, or a book I'm reading, or my kid. (T10, P5)
- I mean, it's not like it hasn't happened... (T11, P5)
- I definitely don't reveal my feelings towards a patient, if something irritates me. I don't think it's therapeutic. (T2, P6)
- I'm much more inclined to think, it's very strange that I'm getting irritated, or if I'm tired, I think all of that is something going on in the process. And I don't find that anything about my affects is a good thing to reveal. (T3, P6)
- About family members, I very rarely reveal anything like that. Whether I have children... (T4, P6)

- In general, if it's nothing I'm doing, I'm just the same as I normally am, I'm not leaving, I'm not pregnant... I tend not to disclose. (T12, P6)
 - I mean there are definitely things that I hide. I don't tell them every mood or everything. (T27, P6)
 - I don't generally self-disclose, unless I think it would really help the patient understand something that they're talking about. (T1, P11)
 - I try not to self-disclose, unless I really feel like it would be beneficial. (T2, P11)
6. *Analyst will disclose countertransference in the moment, to facilitate insight and explore transference* (P1, P8, P9, P10)
- There are two different self-disclosures: one is the facts of your life and the other is your experience in the moment. (T2, P1)
 - Disclosing "what you're telling me is making me feel sad" is one form of self-disclosure. (T3, P1)
 - I'm pretty free with it (countertransference). (T9, P1)
 - I have no hesitation to say, "That would make me really angry... it's making me feel angry for you right now." (T12, P1)
 - My ideal work is, in terms of self-disclosure, using it not to talk about any kind of facts about my life, or about me necessarily, but about an experience that I'm having with the patient and an experience of them that helps facilitate their understanding of themselves and interaction between us in the transference. (T1, P8)
 - Talking about how I might feel in the moment in a particular situation, during a session, disclosing that I'm feeling a certain way, just for exploration with the patient to see what they think about that. (T2, P8)
 - Whether that's something that they think is relevant for their relationships, and how they make people feel, or if it's more about what I bring to it, versus just them. (T3, P8)
 - I do work a lot with countertransference, so I do most frequently share my reactions, my internal reactions, not all the time and not with everyone, but in terms of the content of the types of things I share, that's probably the one that I share most frequently, as opposed to just general information about myself. (T6, P9)
 - The fact that I connected it, that my countertransference went there, suggested to me that there was a common experience. So I looked at the experience, I said does that seem to fit where the patient is that she's feeling criticized... and yes, she's feeling criticized. So I was trying to offer her another way of understanding her partner's behavior. (T27, P10)
7. *Judicious self-disclosure is used spontaneously or intuitively, rather than strategically* (P1, P2, P5, P9)
- There's a balance that you have to find. (T51, P1)
 - You have to find that balance. (T58, P1)
 - You have to use it judiciously. (T2, P2)
 - You have to be careful, but not to be too fearful of it. (T4, P2)
 - There are no clear criteria. (T5, P2)
 - It's somewhat intuitive really. (T9, P2)
 - It's not really a strategy. It's not kind of like "okay, now I'm going to be self-disclosing." (T10, P2)

- It was not so much planned, but when it occurred, it felt okay. It felt legitimate. (T19, P2)
 - I don't think it was a self-disclosure that had a purpose other than it was a spontaneous reaction to something that I picked up. (T26, P2)
 - But it wasn't intentional. It wasn't like he was *in need* of that disclosure. (T28, P2)
 - Use self-disclosure, I meant intuitively, but it really is based on your understanding of how it will be received and what it will or will not do. (T45, P2)
 - Obviously, I can't go crazy with this. (T46, P2)
 - When it has happened, I think it's a good thing, as long as it isn't uncontrolled, an enactment. (T38, P5)
 - In the moment, it felt like the natural thing to do, and I was trying to be helpful. (T26, P9)
8. *Analysts are receptive to self-disclosures around race, culture, demographics* (P5, P7)
- There are other elements of self-disclosure like race, or culture, which are obvious and are in the room. And that might come up in the very beginning of treatment. (T3, P5)
 - It's important to be able to talk about these things, so I might say something or call attention to it at the beginning of treatment, to make an opportunity for it to be talked about. (T5, P5)
 - If I get questions about those demographic type things, I don't want to say I automatically answer them, but I'm sort of more receptive to answering. (T6, P5)
 - I take off for all the Jewish holidays and over the years, I say that I'm taking off because of the Jewish holiday. I just feel much more comfortable doing that, than just saying, "Well, next Tuesday and Wednesday I won't be in." (T6, P7)
 - Yes, it does give information if they didn't know before, that I'm Jewish, or that I'm observant. (T7, P7)
9. *If they say, "Where are you going?" I find it weird to say, "Well what are your fantasies?"* (P1, P2, P6, P7, P10)
- When I was first trained you didn't tell your patient where you're going on vacation, and now it's like I don't even think twice about it, you know, like "yeah I'm going to this place." (T18, P1)
 - I disclosed to a person who was about to adopt a cat that was abandoned. And it reminded me of how I got a cat some 25 years ago. And the circumstances were very similar, and I chose to disclose it. (T20, P2)
 - It seemed comfortable at the moment, especially since, again because the cat has walked across the screen at some point in the past. So it felt not too much out of the scope of the relationship. (T22, P2)
 - If they say, "where are you going?" I find it weird to say "well what are your fantasies?" (T9, P6)
 - ...unless someone directly asks about things that I think are really kind of superficial, like movies or TV. (T12, P6)
 - If I'm on vacation, if they want to know... If people have asked, I've told them (T29, P6)
 - I don't volunteer it necessarily, but if someone asks me "where will you be going," I say. (T8, P7)
 - I often talk about my dogs. I have some pictures in my office. (T6, P10)

- I also may disclose something about exercise because I'm a big, big believer in exercise. (T8, P10)
- Occasionally people do ask me where I'm going. I'm gonna tell them. (T44, P10)

10. *Self-disclosure about health, sickness, and death* (P2, P6)

- Do you disclose when you have an illness? Do you disclose when there is a death in the family? Do you disclose meaningful things in your life? And usually in the context of you cancel a session. Do you tell the person why? Those kinds of things. It comes up a lot, self-disclosure comes up whether we like it or not. (T47, P2)
- I didn't get COVID, but I think that if I had gotten it that I would have told them. Even if I had a mild case, I probably would have told them, because, you know, they're worried about it, they talk about it. (T23, P6)
- I revealed to patients that my mother died because I had canceled a number of sessions and I canceled them quickly. I didn't want patients to think that I had a heart attack or something that would feel very, very frightening. (T31, P6)
- I have worked with dying analysts and I feel very strongly that they should talk to their patients about the reality of their cancer and stuff like that. (T40, P6)
- It's not that I don't feel one should never talk about sickness or anything like that, but that really, really impinges on the patient. (T41, P6)

11. *Disclosing pregnancy is a unique form of self-disclosure since it is initiated by the analyst* (P6, P11)

- I had two pregnancies, so obviously, with those patients, I felt strongly that I should tell them what sex the child was. I felt that I had intruded on their space. (T5, P6)
- With my pregnancies, I feel like that was a big intrusion on their space. And not to tell them that I had a boy or a girl, if they wanted to know. It's not like I sent them a birth announcement (laughter). But I felt that if they asked, they were entitled (to know) because I had done this to them. (T8, P6)
- When I had to inform patients about my maternity leave, I had to share that I'm going on maternity leave, which meant that I was having a child and they would have not known that otherwise. (T6, P11)
- Because I knew I had to say it, it wasn't a choice, but I wouldn't say I felt comfortable with that. (T18, P11)
- I definitely was concerned about how she (the patient) would respond, especially because she wasn't seeing me. So, it was sort of an abrupt topic. Meaning, she wasn't seeing my belly expand, there was no sign other than me telling her this information, so it was sort of out of the blue in her mind. (T19, P11)
- It's one of the first times I initiated saying something about myself, or something that I need. Like, I need to go on maternity leave, she doesn't need that. But I do. So that felt uncomfortable, too, because the dynamic is different with that. (T20, P11)

C. Motivations for Self-Disclosure Over Telehealth (54.55%)

12. *She could kind of picture me there and get back to herself, as opposed to this preoccupation that I wasn't available* (P1, P5)

- I think the hug comment was really effective. I think it put words on something, not that she needed to be reminded that I care about her, but in some way it reminded her of our physical presence or something together, that I am still there for her. (T28, P1)
- It made it as real as it could that I am still there for her, even though I'm on the phone. (T29, P1)

- Some people needed to know to be able to picture you there to know you're still alive and still you know existing somewhere. (T66, P1)
- Eventually what I started doing, at first an intuition and then I realized it was helpful to do, was to describe where I was, what the room was like, sometimes, or just where I was... (T14, P5)
- I don't know the exact sequence, but what I did say was, "No, no, I'm in a room that's all my own, and I can close the door." And I described it as a room with a door that can lock and it has windows... It was like the door and the windows... the separateness. It's more about that it was separated. (T19, P5)
- She was relieved and then she could kind of picture me there. And she could get back to herself, as opposed to this preoccupation that I wasn't available. (T20, P5)
- I felt good about it in the sense of getting to what was needed... that insight or intuition. (T21, P5)
- The connection with the patient. (T22, P5)
- The resuming of her free association, her ability to communicate, felt very good (T23, P5)

13. *Analyst is willing to self-disclose about location or in response to breach in the frame* (P1, P6, P7, P10)

- I might say, "Well, I have to share space differently today" (T7, P1)
- I've definitely told my patients when I went upstate to my house in the Catskills. (T18, P6)
- Almost every one of them asked, "Where exactly is it?" And I told them. (T19, P6)
- I've definitely revealed about my country house which I didn't before. (T21, P6)
- I revealed when I came back from the country house that I was working in my office, but by myself. (T22, P6)
- Often people would because it was clearly so different. Like in a way, like if I painted my office radically, one color to another, most people would be aware of that and make some comment. (T33, P7)
- There are times when I have to say "I apologize. Give me two seconds. I'm just gonna shut an extra door." I'll say, "There are a lot of dogs here today," something like that. (T13, P10)
- Except to explain the kind of breach in the frame based on what's going on in the environment, I wouldn't say it changed. (T14, P10)
- If I'm waiting for an important phone call, I will say to them I may have to take a call during today's session. I apologize. It's an important call. And so, I apologize, I'm going to have to check my phone when it rings. That's a self-disclosure that's unavoidable. (T38, P10)

14. *If I feel I'm intruding on their space, I'm willing to reveal things* (P6, P11)

- In general, if I feel I'm intruding on their space, I'm willing to reveal things. (T7, P6)
- That's the same thing about vacations. I'm doing something to them by going away. (T9, P6)
- I really have a separate category of things that I've caused. (T10, P6)
- I have a certain feeling of containment and I really don't feel that I want to be deceptive in some way that if they found out later that they would feel that there's something I wanted to hide. (T26, P6)

- Since they're not in my office, and if they're picturing my office and I'm not there, I feel it's deceptive. (T28, P6)
- They knew where I was, so that was honest, that part of the treatment was what I believe in (T64, P6)
- If I'm working from home, sometimes my child will cry in the next room. And if a patient hears that and they ask about it, I have to be honest and say that that's my child or something along those lines. At some point, you have to be transparent. (T3, P11)

15. *Is self-disclosure for the patient or for the analyst?* (P6, P10)

- I do think it's a fine line. I do think sometimes, in a more interactive treatment, telling the patient too much, I just think it gets into a slippery slope where you don't know what's what. Who is causing what. (T66, P6)
- I ask myself, am I disclosing this for my patient or myself? (T2, P10)
- I want to make sure that my motivation for doing it is for the patient and the treatments betterment. (T5, P10)
- Do they need to be gratified? Is it a need to gratify them? Maybe. (T46, P10)

II. TELEHEALTH AND SELF-DISCLOSURE

D. Self-Disclosure Over Telehealth is Inevitable (100%)

16. *Pet intrusions: "When my cat walks across the screen"* (P2, P3, P9, P10)

- When my cat walks across the screen, for example. (T14, P2)
- One of the things that they do see, which maybe I could have been stricter about, is that I have a dog. When I'm in person, the dog doesn't come anywhere near the office space, it's closed off. Since I've been doing telehealth, I tend to leave the door open and the dog tends to walk in and out of the office, and sometimes she'll make herself comfortable on the couch behind me. Patients see that. (T8, P3)
- I have two dogs and very frequently they jump up on my lap so patients can see my dogs. (T10, P9)
- Sometimes the dogs are barking. (T11, P9)
- The only way that it's changed is that a lot of times I do telehealth from home and occasionally there is a lot of barking. I have three dogs. (T12, P10)

17. *Every once in a while, I might get a delivery in the middle of the session* (P3, P4, P9)

- Every once in a while, I might get a delivery in the middle of the session. It's conceivable that this could have happened when I was in person, but probably less so and I think that reflects more the comfort of just kind of being around all the time. (T15, P3)
- Having more deliveries, or food deliveries, or something like that. (T16, P3)
- An unintentional disclosure might be the intercom rings, I have to let a delivery person in. And then I have to leave the screen to go to the door. Sometimes, if my headphones are still in, they could overhear me opening the door, accepting the delivery, etc. (T17, P3)
- If, for example, a workman had to come in to do some work somewhere else in the space... Maybe the patient overhearing... That would be sort of an unintentional disclosure. (T18, P3)
- If you need a plumber... (laughter). (T19, P3)

- I was home, I was still wearing a nightgown. The doorbell rings. It's a new referral. That's the problem with working at home. (T30, P4)
 - Sometimes the other phone rings and they'll hear it. (T13, P9)
18. *Child intrusions: There's a big sign right in front of my office saying, "Dear Mom, I hate you."* (P2, P4, P8)
- When I had little kids and I used to have my office in the basement of my home, I was much more aware of noises that the kids made upstairs, the dog was barking. There were a lot more distractions and I was much more aware of them, and I would kind of get almost anxious that shouldn't be part of the scene. (T34, P2)
 - I worked at home since I had a child. The patient walks out of the office, and there's a big sign right in front of my office saying "Dear Mom, I hate you. Love, (daughter's name)." Both of us laughed. It was a sophisticated patient, but it was sort of adorable. (T29, P4)
 - There have been situations where patients could hear my kids. That was earlier on, before I had my system figured out really, my situation figured out. (T18, P8)
 - There were mistakes that would happen. or accidents where somebody would knock on the door, or they would hear somebody yelling. That was not something I could control. (T19, P8)
19. *Obviously in person I wouldn't be wearing a nightgown. It's a telehealth problem* (P1, P3, P4, P8)
- Hearing footsteps... (T21, P1)
 - When it's a phone call, as opposed to telehealth (video), and so nobody is seeing the other person, there is the possibility of kind of doing something else during the call, whether it's just rustling a paper or something like that... and I have a couple of patients who are highly reactive to that. They're like, "what's going on in the background? I hear something banging, or papers, or something like that." (T22, P3)
 - Clearly you cannot be doing stuff. Whereas again when you're on the phone, you can be moving a paper or doing something else with your hands (T24, P3)
 - Obviously in person I wouldn't be wearing a nightgown. It's a telehealth problem. (T35, P4)
 - Those really didn't happen in person. Even if I was late in person, I still wouldn't do that. (T38, P8)
 - That wouldn't happen in person because I wasn't in my home. I was already at work. (T41, P8)
20. *Use of self assumes inevitable self-disclosure; some amount of your realness is a good thing* (P1, P5, P6, P11)
- Like I'll betray a knowledge of something... (T44, P1)
 - You wouldn't know that if you weren't a cyclist. (T45, P1)
 - If I have a patient who works in a field close to what my husband does, and so I'll know certain languages and I'll understand things. I can ask things about what they're doing, and I'm thinking, "I shouldn't really know this," but then they don't seem to notice. (T48, P1)
 - If one is listening using oneself, one's own feelings, one's own body, as through listening to material and processing it, using these levels of experience and giving something back to the patient. Even if I'm not saying "I thought this, I felt this..."

- there is something disclosed, even if it isn't overt. that is happening all the time. (T7, P5)
- In the movement from a state of omnipotence to the depressive position, which we are all in and out of and we're all moving, hopefully towards, is a kind of a tolerance and an awareness of the subjectivity of the other. And in a way we want as the end, as a sign of health, for the patient to be able to take in more of us as a real person, which may or may not come with actual self-disclosures, but some amount of your realness that's needed, wanted, called for, is a good thing. (T36, P5)
 - As analysts part of our role is to not, for good reason, to not disclose and yet, it's this fine line between one, just being seen more fully and then having there be room to show something of ourselves. (T37, P5)
 - I'm much more disclosing about politics. Not intentionally. (T13, P6)
 - There is no doubt my patients know that I'm liberal, and I'm involved with politics. Probably, more than they should in a way, because I'm very emotional about it and if they are on the same page it's very difficult for me to just sit there. (T15, P6)
 - I have strong feelings about things and I'm not going to keep my mouth shut. (T47, P6)
 - You self-disclose so much and whatever room you're in you are disclosing, what you're wearing, you're disclosing, what you respond to, or, you know, everything is a is some kind of disclosure. (T28, P11)
 - What patients know about me from all the unspoken stuff too. (T29, P11)
 - Everything is... you disclose something. Like, I wouldn't choose a painting that I didn't like, so obviously, he knows I like it. (T37, P11)
21. *I don't think you're blank by being withholding, defended, or guarded* (P1, P4, P6, P7, P10)
- I think that no self-disclosure is frustrating and can be mystifying and distancing. It's distancing. (T51, P1)
 - With no self-disclosure from me it's much harder for patients to tell me if they're angry at me. Or if they're frustrated, or they want me to do something different (T54, P1)
 - She had gone to a very classical analyst and she felt very sort of deprived. He was absolutely neutral, blank slate, gave her nothing of himself and she really did not like that. (T57, P1)
 - I don't keep a blank screen. I don't know that therapists do anymore. (T13, P4)
 - Little things, but trivial, unless you want total anonymity. (T31, P4)
 - Not revealing *certain* things to a patient, like if they ask you if you've seen a movie or they ask you where you're going on vacation, or things like that, I feel it's insulting to the patient not to disclose things like that. (T1, P6)
 - I think I've gotten looser about that, because some things I feel strongly about, and I feel like for me to just stay like a blank screen when I feel so strongly about certain things that I think are wrong... my patients wind up knowing a lot more. (T49, P6)
 - I feel strongly that not answering anything, it's really like a dead treatment, (T60, P6)
 - Knowing of people who've had treatments like that, they really wonder how they survived. They idealized it for a long time. It was classical and wonderful. But it really didn't touch a lot of deeper issues. (T61, P6)

- Let's say somebody would ask me, "are you married?" or "do you have children?", it would not be my style to say "why do you ask?" as the go to. (T4, P7)
- Where it's not such a big deal, and I think a few of the people who ask can feel sort of rejected or not such pleasant feelings. (T9, P7)
- I don't believe in it. I don't aspire to it. (T28, P10)
- I work very hard at not being judgmental. But neutrality doesn't exist. I mean, you want neutrality, then you do therapy with a robot. (T29, P10)
- The need to project and that the development of transference is so robust that people will turn me into whatever they need to turn me into. And that's great. (T30, P10)
- The need for relationship and the need for connection, because I think that change in healing happens within the relationship, requires that one not be neutral. (T31, P10)
- To me it's silliness. (T35, P10)
- I don't think you're blank by being withholding. (T41, P10)
- You're withholding. You're defended. You're guarded. (T42, P10)

E. Increased Self-Disclosure Over Telehealth (100%)

22. *Telehealth pulls for more sharing, to stay related, in spite of the distance of the screen* (P1, P2, P3, P4, P7, P8, P9, P10)

- It slipped out of my mouth (T46, P1)
- There was a kind of a bit of reassurance, a bit of sharing, a bit of maybe implying that I understand his dilemma. (T27, P2)
- Something about telehealth that does pull for, I think, more sharing because there is this, at least for me, more of a pull to stay related, in spite of the distance of the screen. I think there's a pull to kind of be in the same room, so to speak. (T30, P2)
- People want to talk. People want to relate. They don't want to break off or have too many interruptions in ongoing relationships. (T51, P2)
- I also see myself being a little bit more open in a certain way. It may be related to connecting... via this telehealth. (T10, P3)
- When a person is in your office, in person, there is that kind of sensing of where they may be emotionally, you are relating to your own experience, minute to minute or second to second... and sometimes you are feeling a little bit of that being lacking on telehealth. There may be a way in which I become even more personable, more open... It's a way of countering the experience of the distance. (T11, P3)
- I'm trying to overcome whatever sense of distance one might experience on the screen versus the person physically being in your office. (T12, P3)
- Online I think it's more objective. It's somewhat more depersonalized. (T18, P4)
- Telehealth and self-disclosure. Well, it's an interesting question to me, because I recently caught myself in response to what he was talking about, a childhood trauma, his own childhood trauma, I gave an example from my own life and as I heard myself saying it, I felt, now where am I coming from? (T10, P7)
- I did wonder to myself, would I have done that if we were sitting face to face? (T12, P7)
- Is there's some greater need to make a connection, you know, virtually, that I would feel more relaxed about because there are many more cues and many more things to read. (T13, P7)

- That relationship pulled more for... and at times, I think I also felt a little uncomfortable about that. And then with other people, it remained not very different from what it would be in the office. (T20, P7)
 - I felt like at the time I over shared, and then I caught myself. (T23, P7)
 - Somebody told me about her cancer. It was a new person, and I volunteered that I had had similar experience. Now, would I have done that if she was in my office? I tend to think not. (T24, P7)
 - It's both virtual, it was also the times we were living in, I think, where like the need to connect felt more imperative. (T25, P7)
 - There were so many different needs that came to the surface during this pandemic... I'm thinking of one person in particular who lives an extraordinarily isolated life, has no living relatives, has really no friends. Now, her constant pattern is to check in with me, "have you had that experience?" and "what would you think and what you do?" So let's say my feeling is I engage with that because that's what she's looking for. It's supportive, right? That's the kind of connection that I think is important to her, to get more information from me also, or to connect in some way. (T34, P7)
 - There are a number of people where I felt like as I was saying something, I felt now why am I doing this? (T35, P7)
 - I sometimes find myself more emotionally reactive than I would be in my office. (T39, P7)
 - I believe that in certain ways, intentional self-disclosures have increased. (T20, P8)
 - Especially because people are feeling more disconnected because of increased isolation and restricted mobility and less contact with other people that it probably compensates to some degree to feel like I'm not just their therapist and a clinician but I'm a person. (T33, P9)
 - I think overall, it's helpful for people and maybe helps them feel more connected and more satisfied that there's a kind of... it's more of a full meal, the session... (T34, P9)
 - I would say there have been no changes in what I share. That's not to say there wasn't a change in my urge to share. (T17, P10)
 - Particularly during the first year of the pandemic there was an isolation factor, which I think increased an urge to share, to connect more, because you're just not connecting with that many people. (T18, P10)
 - I just remember feeling like very disconnected and somewhat isolated. (T21, P10)
 - There just was more of a general wish to relate more. (T22, P10)
23. *In-person, that would have been just in the room, without my having to say it* (P1, P4, P5)
- I said to her, "If we were in the room, you could feel my pull to hug you. I wouldn't. But you'd be able to feel my body wanting to go hug you right now. And you can't feel that on the phone." (T15, P1)
 - In-person, that would have been just in the room, without my having to say it. (T16, P1)
 - I've had to put more words to things, sometimes. (T17, P1)
 - "I hate this! I miss being in the room with you!" (T26, P1)
 - A patient with an eating disorder... "It makes me really nervous not to be able to see your body." (T27, P1)
 - I really missed feeling, there's so much body energy, there's so much work that happens nonverbally. (T60, P1)

- We've gotten better at it now maybe because we are more comfortable this way... knowing that each other is there. But I think we don't even realize anymore what we're missing maybe. (T62, P1)
- Part of what's going on between us is so much my pleasure in her, and my support of her, my reactions... I'm almost cheering! You can't cheer the same way, virtually. (T12, P4)
- It's happening all the time when we see patients in the office, because you're literally there, in space and time. Sometimes, the literal facts of what is happening in the room, two bodies in the room, becomes a point of focus. (T25, P5)
- I think it's happening all the time, anyway, but probably in nonverbal ways. The breach and the trauma of the pandemic, and the change, meant you have to highlight it more. (T26, P5)

24. *A sort of loosening of some of my therapeutic vigilance over telehealth* (P2, P3, P7, P8, P9)

- I'm not wearing a tie... I usually am. (T15, P2)
- Possibly more openness in that way. (T6, P3)
- Certainly, during the height of the pandemic, where there was so much anxiety, everybody was caught in this. Maybe I just found myself being more personal or more chatty than my usual style. (T14, P7)
- It's not self-disclosure, like in "CAPS," but let's say my feeling during COVID, if I think about it truthfully, that probably came out of the isolation we were all feeling, and some – until I caught myself - a sort of loosening of some of my therapeutic vigilance or behavior. (T15, P7)
- More normally or regularly there would be just less chitchat, I'd be very conscious of the task at hand, what we're here for. (T16, P7)
- I feel there was something about telehealth, where this might have been part of the pandemic happening, where I felt like it gave me an excuse. (T39, P8)
- I think it's gotten more frequent. (T7, P9)
- I do feel like there's a sort of loosening of the boundaries a bit, with telehealth. (T8, P9)
- Yeah, it's probably also a bit more frequent. (T15, P9)

25. *Increased self-disclosure related to COVID anxiety* (P2, P6, P7, P10, P11)

- Especially at the beginning of COVID when the anxiety was so palpable, and everybody was looking for "how are we going to survive this," I think there was more self-disclosure, more sharing of anxiety. (T18, P2)
- They've asked, do you go to restaurants indoors. Do you do this, do that? And I said no. (T20, P6)
- I told them when I got my vaccine. A number of them wanted to know. Sometimes they look to me for guidance. "Are you getting the booster yet?" (T24, P6)
- That's the kind of thing I feel comfortable talking about in terms of health. And where I am. (T25, P6)
- I remember with one or two people, saying something about or even sharing my own feelings about the idiosyncrasies of how people responded to the pandemic, and maybe occasionally putting in my own attitude. (T17, P7)

- Over time, there has been more sharing about COVID. And what steps you're taking, what steps you're not taking. People ask a lot, "are you going out to eat" that kind of thing. (T20, P10)
- I would run a psychodynamic process group, talking about the fears of the pandemic, the unknown for everybody. Like, it's not just a patient thing. It's an everybody thing. That helped open discussion up, that we are going through this together. (T24, P11)
- But this (wearing a mask) was like an equalizer. And it was also disclosing that there are these fears and unknowns for me too. And we don't know. But it will be. And how can we talk about this? (T25, P11)

26. *Patients can pick up on analyst's countertransference over telehealth* (P7, P8, P9)

- I have one patient who for her own reasons wasn't getting vaccinated. And I increasingly felt I had a lot of reactions to this. First of all, I didn't like it. But I also felt it was in some ways, compromising the treatment. I think she very much picked up my irritation. (T41, P7)
- I did acknowledge, I said I had thought about it a lot myself, and that it was very much coming out of really my own growing intolerance of so much remote work. I would say that was very useful to her. (T43, P7)
- Just telling them what I think, and how I am reacting, is a different type of self-disclosure than would happen, I think, in my office where it's my setup. (T29, P8)
- I'm working with a patient who really pushes my buttons and can be kind of annoying. And I became very real in a moment where my annoyance became apparent to him. (T24, P9)
- It was easy for him to see that I was kind of feeling impatient with them. I didn't say it in a very extreme way, but he's very sensitive, and it bothered him. (T25, P9)

27. *Changes to physical location present an opportunity for increased self-disclosure* (P1, P2, P6, P7)

- For the entire pandemic I have been living in what used to be a weekend house, no longer just weekends, and some of my patients know that, and know where I am and will say "what's happening with the weather up there... do you have good snow up there..." but others have no idea that I'm not in the city. (T5, P1)
- When I'm in the city, I'm in my apartment, and there's bicycles. (T6, P1)
- They don't know that I'm at a house. (T8, P1)
- Patients who came the days I did laps in the park would see my bike in my office. But now people who see me in this house see a bike stand with two bikes behind me... (T21, P1)
- When I'm in the city, there's a lot of construction going on outside my apartment, so somebody else will say, "I can tell you're in the city. It's really noisy." (T34, P1)
- Apparently, it was raining really hard in the city and I didn't know and she made a comment. I was like, What? (laughter...). (T41, P1)
- There were more outside noises (at work) than there are here (at home) (T32, P2)
- Definitely, it's changed in terms of my whereabouts. (T17, P6)
- A number of times, I was – certainly closer to the summer – I was in a different place. I was in Long Island, and then a number of people would see the green or somebody might say, I see you're not in the city again. (T32, P7)

28. *Creating and curating a background over telehealth includes contextual self-disclosure* (P2, P3, P4, P5, P8, P9, P11)

- Some people ask me about the picture behind me (T16, P2)
- The setup that I have is a kind of office suite that is part of my living space. Most patients don't recognize that, or don't question it, but some do. (T2, P3)
- I always make sure that the screen behind my computer is professional looking. (T34, P4)
- With telehealth... it's a different visual landscape for the patient. If they commented I might respond to something. (T16, P5)
- When it comes to working remotely or doing virtual therapy, there are the contextual self-disclosures that aren't overt or direct or anything you're choosing to disclose but things that are just there. (T4, P8)
- What the office looks like and what my background looks like, my literal background behind me, and what I choose to include as the space between these four walls of the frame. (T5, P8)
- Other people have different types of backgrounds, some people put pictures on their background, some people have a green screen, people do all sorts of different things with their zoom setup, and their waiting room and stuff. (T11, P8)
- I'm not sure exactly what it discloses about myself, but that's sort of like an artifact, I guess. (T12, P8)
- There's something important to me about having books behind me. (T13, P8)
- I don't have Zoom or FaceTime reception in my home office downstairs, so I see people in my living room when I'm using the computer. (T9, P9)
- If I work from home and they see the background, they'll make certain comments about the window, or what they hear, not knowing where I am, because it's different than what they're used to seeing. (T32, P11)

III. THE FRAME

F. Telehealth Has Changed the Frame of Therapy (81.82%)

29. *There are some things about people being invited into my own office or home* (P1, P2, P3)
- Personal life self-disclosure has changed because it's had to. (T13, P1)
 - That kind of stuff is just happening. It's going to happen. (T21, P1)
 - Clearly people see your home now and they see that kind of stuff. (T49, P1)
 - Conditions also have had an influence. Working on Zoom created a somewhat different frame. (T12, P2)
 - It has... I think inevitably it has changed. (T13, P2)
 - There are some things about people being invited into my own office or home. (T17, P2)
 - It's kind of automatically not 100% a neutral space that somebody might have if they were just in an office suite or something like that. (T3, P3)
 - They're obviously seeing more of my personal life than they might have otherwise. (T9, P3)
30. *People are not going to walk into my office in their underwear, but they might show up for a Zoom session in their boxers* (P2, P3, P8, P9)
- He is home, showing up in his t-shirts, yawning since it's the first thing in the morning. So, there is an informality to that relationship. (T24, P2)

- There is something about... just that I see more of my patients, physical space, and sometimes even their family space, because sometimes there'll be a situation where somebody in their family will walk into the screen. (T7, P3)
 - We were having a session, and something happened, actually off screen, between her and her mother. She came back onto screen. And then the mother came into the screen and actually gave my patient a hug. All of this happening on screen ... That's the kind of thing that at least my experience with the patient has been... very different. (T13, P3)
 - They (patients) disclose a lot, similarly, with what goes on behind them in the frame. (T17, P8)
 - When they're in my space, in my office in person, everything is kind of controlled for. They can choose a seat, or they could choose to lay down or sit, but beyond that, there's not as much. (T22, P8)
 - I've come to find that there is so much more, when they're in their own space, for me to react to and for me to sort of disclose my feelings about. (T23, P8)
 - One patient was talking to me about their spouse for almost a whole session, and then I all of a sudden heard their spouse saying something, and I was like totally (stammering) what, what, where are you?? she was in the same room as her spouse and just talking about him as if he wasn't there in a pretty derogatory way. (T24, P8)
 - People are not going to walk into my office in their underwear, but they might show up for a Zoom session and halfway through say, could you hold on a sec, I have to go to the bathroom and then stand up and they're in their boxers. (T27, P8)
 - Some people need to get dressed up to be on Zoom. Other people are okay just being in bed in their PJs. (T28, P8)
 - I felt almost like I didn't have any control over... It wasn't like I could say can you please leave now? I'm just sitting there, just watching this conflict escalate. (T31, P8)
 - I'm definitely more exposed to things that I wouldn't necessarily be if I was in my office. (T12, P9)
 - I think I'm being exposed much more to other parts of my patients lives and vice versa, compared to if they just saw me in my office. (T14, P9)
31. *It's really hard to sit together in silence and stare at each other on a computer screen* (P1, P3)
- The hardest thing for me was that it became much more content based. It's all verbal. It's really hard to sit together in silence and stare at each other on a computer screen. That's what I missed the most, just feeling each other's presence without having to speak. Can't do that. That's gone. (T61, P1)
 - Listening in a slightly different way... Maybe a little bit more with the "suspended attention" in person. (T25, P3)
 - One patient has a lot of silences, which we talk about. And it makes a big difference when she's in the office and when she's on screen. Whereas there are other patients where I don't really notice that much of a difference. (T26, P3)
32. *There is a greater strain to connect with patients over telehealth* (P7, P9)
- I feel it, like to work extra hard. I don't love it. (T26, P7)
 - I still have a collection of people who will never now come in person, and I don't love it. I like it so much better in person. (T27, P7)

- I feel a strain. The naturalness of it, that you don't even have the optimal distance. It's not natural to talk to someone, you know, a number of inches away. (T28, P7)
- Definitely. Certainly, when I'm meeting somebody for the first time, meeting them via telehealth, because that's my feeling that I'm working harder. It seems less relaxed. How do you connect? (T29, P7)
- There's a kind of strain and I'm doing something more. It's more difficult. I don't know. Maybe there's self-modulation (T40, P7)
- It might be more likely that I would feel more patient with him in person, that there might be more of a feeling of rapport. (T27, P9)
- Certain patients. Patients who I think struggle interpersonally, it's harder. Others, it's very easy. (T28, P9)

33. *There was this alienation, disconnection from one's place in space and time* (P1, P3, P5, P6, P8)

- At first it was hard, but look, it's been two years, right. I think the whole first year it was hard and now we are all used to it. (T59, P1)
- I do wonder about the difference in the beginning and ending of sessions too, that in a way I guess there's more self-disclosure (T63, P1)
- If they're waiting for you to enter your (Zoom) room, they don't know and you don't tell them and then you just say sorry I was running late. Little things like that, or you know "oh wait, I want to get a glass of water" like you'll say that to your patient in person. But (over telehealth) they're just mysteriously waiting for you. (T64, P1)
- At the end of the session too, it's like this very abrupt, it's a horrible ending, still, even after two years, I feel like they're just gone. you both know that that person is now in their own space. It's different than when they leave your office and they know you're still in the office space... and it's a transition for both. So that transition, it's a different kind of self-disclosure on both ends. (T65, P1)
- I'm sitting the opposite way that I sit when somebody is in person in the office. They are on the couch and I'm facing them and they're actually seeing what's going on, on this side of the room. So that sometimes seems a little unusual to me. (T27, P3)
- One patient I have been seeing for a number of years in analysis... the switch of her knowing I was no longer in my office and that was somewhere else was very disorienting. (T12, P5)
- There were feelings of alienation, and a sense of being sort of lost... dissociated. (T13, P5)
- If you use your self, there was this alienation, disconnection from one's place in space and time. (T17, P5)
- Before (telehealth) if I was seeing them in person and I was five minutes late, I'm more likely to say, "I'm sorry, it was an important call." (T11, P6)
- I think the fact that we were on the computer, I think it gave me more excuses to be late, or if I needed to, rationalize it to myself to give myself a few extra minutes that I needed, and then make up an excuse that I really didn't need to do. (T40, P8)

34. *Self-disclosure has decreased over telehealth due to less intimacy in therapy situation* (P4, P8)

- I think it has, moving to less, because it feels like a more objectified experience or putting it the other way, a less intimate experience. (T11, P4)

- That's so much better in person because she sees my body reactions. She sees my smile and my pleasure in her. (T15, P4)
- Those kinds of things take place much better in the office. I think there's more natural intimacy, and therefore more self-disclosure. (T17, P4)
- It would never be the same as if we were two people in person because we never could connect personally, even if there's personal things I say. (T19, P4)
- There's less of a texture, and I don't reveal as much, not because I made a decision but because the situation doesn't call for it. (T20, P4)
- In other ways certain types of intentional self-disclosures have decreased. (T20, P8)

G. Replicating and Protecting the Frame Over Telehealth (54.55%)

35. *Instead of four walls of a room, you have four sides of a frame* (P2, P5, P6, P8)

- This space is mine, the screen is set, pretty much always the same way. (T31, P2)
- The nature of the trauma is like time and space become disoriented or collapsed. And realizing that meant finding the markers of the new space and time. (T18, P5)
- The ones on the phone, because they're on the couch normally, it didn't seem right to be doing face to face and they didn't want it either. (T16, P6)
- Instead of four walls of a room, you have four sides of a frame. (T6, P8)
- Wanting to have everything be kind of consistent in my office, not too much change happening. (T7, P8)
- I don't necessarily know if that is right or wrong. But because you could also use it – to use the reactions to a different background, to talk about that. I guess I'm finding myself wanting that frame. (T9, P8)
- I'm needing more of a frame or more of a consistency in some way, like there's something familiar about coming to an office and being in the waiting room with everything about it and I want to try to replicate that as much as possible. But it discloses something about myself. (T10, P8)
- In the beginning I tried to hold on to it a piece of what it was like, the experience in my office in person. (T14, P8)
- There is something that I need, I feel like a certain sense of control over the background that makes me feel like there's that frame, in terms of my side of it... (T16, P8)
- There are more opportunities to talk about a patient's boundaries as a result of how they interact with me through Zoom. (T21, P8)
- Letting her know that I wasn't comfortable not knowing who was in the room, and why I value the idea of having a space that is private. (T25, P8)
- There's so much communication in that, but also there is so much about boundaries. I have to kind of disclose my feelings about why a frame is necessary for therapy to work. Because I'm basically in their space and I'm seeing things that I don't really have control over. (T26, P8)
- I felt it was important to protect the frame and to demonstrate the importance of having a frame going forward. (T30, P8)
- I think it was important for me to say that I felt uncomfortable with not knowing who was in the room and what was happening. (T32, P8)
- I felt like that was protective of the treatment. (T33, P8)

36. *When the frame remains the same, self-disclosure has remained consistent between in-person and telehealth* (P1, P2, P11)

- My experience, countertransference, reactions to patients, that kind of self-disclosure, I don't think has changed. (T14, P1)
- I probably would have told him the story anyway. (T29, P2)
- I often will go to my office and do remote therapy from there. (T5, P11)
- No, I actually think it's pretty much the same, especially because I've kept my office so patients will see me if it's on Zoom in my office (T7, P11)
- In terms of the frame of the office, whether it's zoom or in person, I feel like self-disclosure has stayed the same. (T8, P11)
- I haven't disclosed more, doing teletherapy, or felt like I needed to. (T9, P11)
- He would come in person when he could, pre pandemic, and he would comment on this painting that he doesn't like in my office, then when we switch to Zoom, he said, "Oh, you still have that painting," it didn't really change (laughter), and he feels comfortable enough to say it. (T31, P11)

IV. THE IMACT OF SELF-DISCLOSURE

H. The Benefits of Self-Disclosure (63.64%)

37. *I think it strengthens the relationship, when done judiciously* (P1, P4, P7, P9, P10)

- It's just a shared experience. We both wish we could be in the room together. (T30, P1)
- In general, it brings you closer, I think it increases trust. (T50, P1)
- I think it's been very helpful to people. (T3, P4)
- It can serve any number of functions. (T4, P4)
- It was a very useful therapeutic moment. (T42, P7)
- Try to only do it if I think it'll help them in some way; help them think about their own situation in a new way or help with our bond and the therapeutic alliance. (T4, P9)
- I wanted her to feel like she's normal and she's not alone and that there is a reality to what she's going through, that it's a tough place to work for some people depending on what their job is there. (T20, P9)
- Self-disclosure is a useful tool. (T1, P10)
- There are times when it normalizes something for a patient, (T3, P10)
- There are times when it accentuates the bond or helps develop the bond. (T4, P10)
- I often disclose things around anger because I feel like anger is kind of a card-carrying member of the emotional register that most people don't want to play nicely with. So sometimes I will disclose something about an experience of anger that I had or ways that I demonstrate it, to normalize it and model. (T7, P10)
- A lot of times people will say, it felt really good, it felt like you trusted me with something (T10, P10)
- I think it's a point of bonding in a sense, you know, they like to know something about you that they can refer to and think about and kind of hold (T40, P10)
- I think it strengthens the relationship, when done judiciously. (T49, P10)

38. *When we're two humans, I think they feel freer to do that as well* (P1, P4, P6, P10, P11)

- I prefer to be a human being in a room with my patients, and I think it humanizes me. (T52, P1)
- It allows my patient to tell me how they feel. (T53, P1)
- When we're two humans, I think they feel freer to do that as well. (T54, P1)

- It's important to use humor to be able to play together and laugh together. (T55, P1)
 - Oftentimes patients will say you know, "I don't know anything about you, and I have to tell you everything about me," and I'll say "What are you talking about you don't know anything about me? You know what makes me laugh. You know, the kind of humor I come back with. You know, what makes me sad. You've seen me get frustrated. You know a whole lot about me..." (T56, P1)
 - I'll talk in general, philosophically about living a life. (T9, P4)
 - The idea of being the dork at that moment, was allowing her to be able to stumble and to be able to not find her way. (T22, P4)
 - We're allowed to stumble and be awkward and we still can do what we need to do. (T26, P4)
 - I hope at my best, I do those kinds of self-disclosures or making a point about who you are as a human being, how you function as it relates to how we all function. (T43, P4)
 - Most of the time, when it's about books and TV programs and stuff like that, I think it only impacts to make it more of a human relationship. (T59, P6)
 - It made me feel like I got to know the real you a little better. (T11, P10)
 - It's also a need, I think, for them to be able to feel like they know me a little bit so that they can connect, something to kind of hold on to. (T47, P10)
 - It was showing the human. (T26, P11)
 - More patients have said that in my practice, that since they've known about me having a child, I feel more human to them. (T27, P11)
39. *It's a different level of communication than exploration and analysis* (P1, P4)
- There are things that seem sort of extra-therapeutic... I mean, it's still a way of bonding, relationship building in that way, that adult-adult meeting of the minds. I think that matters also. But it's not intentional. It just happens. (T35, P1)
 - It's sort of a very non regressed way of somebody who's being more of their social self, but genuine and spontaneous, more of their adult self, and I'm being not in a caretaking role, particularly. (T36, P1)
 - It's a different level of communication than exploration and analysis. (T10, P4)
 - For her to have a cheerleader is one of the things that are therapeutic for her. (T14, P4)
 - There's a difference between doing therapy and being therapeutic. That's not called therapy, but that is being therapeutic. (T16, P4)
40. *Benign personal self-disclosure can be used to break the tension or provide perspective* (P4, P9)
- Sometimes, I'll tell a story about myself, that is benign, that's superficially relevant, just to break the tension, for her sake, as well as mine (T5, P4)
 - Sometimes it's a ridiculous story and sometimes it really is comic relief. If she said, "why did you just do that?" I said, "because I think we were where we needed a break." (T6, P4)
 - I laughed and said, "I don't see what's so bad about being a dork?" Personally, everybody I know including me are dorks. Why would we be the kind of professionals we are unless we're dorks?" Then I laughed and said, "The dorks succeed." And she was giggling... which is part of what I want to do with her because it's not only comic relief, it's just *relief*. (T21, P4)

- I gave an example that isn't self-denigrating. (T23, P4)
- It was not so deeply personal that I felt I was revealing myself. (T25, P4)
- At the very least, comic relief but for people who are isolated (T38, P4)
- It oftentimes is enormously therapeutic and it alleviates some kind of stress. (T41, P4)
- I shared with her that I went to (name/location of university) and I have a wonderful career, and I do things that are fun. I go skiing, I travel. So, I wanted her to know that information so she could see a live person who went to a "good" school, but it's certainly not Yale or Vassar. So that's an example of a deliberate disclosure. (T16, P9)
- I felt confident that it was important information that could be helpful to her. (T18, P9)
- I see a doctor and she's under a lot of stress. She feels overworked. There's a lot of dysfunctional communication in her department and she feels like there's something wrong with her that she's having a negative reaction to her experience there. I disclosed to her that I work with other patients who either are currently working, or who have worked there, who have had similar complaints. (T19, P9)

41. *Profound personal disclosures: "I was saying to her, I know it's true because I lived it"* (P4, P6)

- Another is being able to identify with someone when you feel alone in the world (T7, P4)
- It's a great story to tell people who are fumbling or shy or feeling awkward... that is really much more profound than comic relief. (T8, P4)
- People who haven't had the experience of growing up which I have had now (T39, P4)
- Examples that fit their experience when they can't get it elsewhere. (T40, P4)
- Then I said, I adopted a traumatized child, and we are having the same experience. That's a lot of self-disclosure. (T44, P4)
- It was *so* personal. But I was saying to her, I know it's true because I lived it. (T47, P4)
- Some of them dealt with it fine, and it actually brought up a lot of crying about when their father died, someone they had never mourned. It just broke through a huge defense. (T33, P6)

I. The Intrusion of Self-Disclosure (81.82%)

42. *Self-disclosure is unhelpful when it causes the patient to become concerned about caring for the analyst* (P6, P8)

- The one place I didn't tell people was when I went to Antarctica. I just thought that they'd be terrified. They would be so worried (laughter), because it's not the easiest trip in the whole world. (T30, P6)
- That was not actually a great thing for some of my patients. (T32, P6)
- For others, they were really overly concerned about me. (T34, P6)
- Some patients were overwhelmed at the thought of me dying. Their mother figure. (T35, P6)
- It was not helpful. They just kept talking about it... Are you okay? (T36, P6)
- Something that would bring them right into my life, and worrying about me in some way... (T39, P6)

- I find it counterproductive if a patient needs to take care of me or feels that they need to take care of me or protect me from my own... because I'm expressing some sort of guilt or feeling apologetic about something, (T45, P8)
- Really apologetic about being late, for example. And they're saying, oh, no, no, no, trying to say like, it's not a problem at all. (T46, P8)
- Sometimes I feel that that's not helpful because then if I am keeping them waiting and they're getting annoyed, I don't think it's helpful to them, to not be able to articulate it (T47, P8)

43. *You become the needy, self-involved, impinging mother when it's done to meet your own needs* (P4, P8, P10)

- When I feel it becomes about me more than about what's right for them. I get into a story and all of a sudden, I'm too deep into my experience, and I've lost sight of them. (T28, P4)
- I don't think it's ever been destructive. It's just been too self-absorbed. (T36, P4)
- there were times where I disclosed about something that was happening in my life, in order to explain some way that I felt I was being not as good as, for lack of a better word, not as up to my standards, my typical standards for myself as a therapist, like being excessively late. (T35, P8)
- Just seeming more tired or even maybe missing a session where then I would disclose something where I afterwards thought I was just doing it to unburden myself of my own guilt or whatever I was feeling about having... disappointing them I guess. (T36, P8)
- Trying to explain myself, and I generally don't feel like that's the best move, especially when it's for my own benefit. (T37, P8)
- I was tempted to share the example. But I chose not to because it felt it deflected too much of the patient's experience at that juncture. (T26, P10)
- I think you become the needy, self-involved, impinging mother when it's done to meet your own needs. (T50, P10)

44. *Self-disclosure and transference: "It really flustered her image of me"* (P5, P6, P11)

- She shut down because I was in my home and she felt that she was an intrusion, and that I preferred to be with my family. She had a fantasy... with a lot of destruction and loss... her vulnerability and mine kind of getting mixed together. (T19, P5)
- A long-term analytic patient had a lot of fantasies about my personal life, and assumed a lot of sameness. I never questioned it, I let her have her fantasies, and she never asked... So then my husband came into the apartment, and it was loud outside the glass door, and I don't know what he said, but she took that sound to be the sound of a young child who is calling me. And the patient felt so heartbroken by this, that I have this other life, that all the possibilities were collapsed. (T29, P5)
- She asked, "I hear you have a child" and I just agreed. I mean, I wasn't going to deny it, even though that's not what it was. (T30, P5)
- And then she did ask if I had a partner. And I said I have a husband. it would have just felt like a lie to sort of keep it vague when she did have this kind of concrete experience. (T31, P5)
- Even though she misinterpreted it, she was so distraught, and I felt she needed some reality. I didn't clarify the whole story, or who was who, and I let her think it was a young child. (T32, P5)

- Some patients have an idealization, you must have had a wonderful childhood. You must have had a wonderful mother. It's not for them to know whether I did or I didn't, you know, in terms of the transference. (T38, P6)
 - The most negative things are the interpersonal when they feel that I am very close to somebody and I'm not that close to them... patient will say, "Well, I knew you would support her. I knew you would speak up because you think she's the greatest. A lot of that is transference. But, there is a little bit of a feeling of exposure because they're not 100% wrong (T50, P6)
 - We haven't seen each other since pre-COVID. And when I told her about me going on maternity leave, it really flustered her image of me. (T10, P11)
 - She wondered whether I had a partner or whether... there were all these other questions she kind of didn't let herself think about because she just was pretty set on who she thought I was. (T11, P11)
45. *"But now I know you have somebody, and I didn't want to ever know that."* (P1, P7, P9)
- I would not say that to a very fragile patient. (T24, P1)
 - Patients whose primary issue is being really lonely and feeling that they have no life or a very limited life. It's sort of flaunting that I have one. And it sets up a distance and the envy that's already there, it sort of solidifies it in a way that I think would be really hurtful to them. (T25, P1)
 - "But now I know you have somebody, and I didn't want to ever know that." (T32, P1)
 - She is extremely fragile, extremely traumatized, has been sexually abused which means any intrusion, any unwanted intrusion, is a trigger. (T37, P1)
 - It just feels like an unwanted intrusion, something out of her control. (T38, P1)
 - I think it was very much a trauma reaction to being intruded on. (T40, P1)
 - There was something like she just didn't want to know that much about my personal life. (T43, P1)
 - ...and for some that is because of envy, for some that's because they don't want to know that much about my personal life for different reasons. (T67, P1)
 - In fact, it did bother this person. (T11, P7)
 - There were instances where the example definitely bothered the person... (T37, P7)
 - The person didn't bring it up because they might be too uncomfortable... (T38, P7)
 - With the dogs, one patient of mine got annoyed at the interruption (T29, P9)
46. *One could question accidental, right?* (P10, P11)
- One could question accidental, right? (T32, P10)
 - I have a number of rooms in my house, so really, I could make sure they're not there. But I like them there. (T33, P10)
 - I really could do whatever is necessary. But I like having them there and it's just occasionally that they're a real pain in the ass. So, I run that risk. I don't really see that as accidental (T34, P10)
 - It is an intrusion that I worked very hard to have not happen. Anybody coming in my house. (T36, P10)
 - I don't answer the door. I don't answer the phone. I feel very strongly about that. (T37, P10)
 - My bar is pretty high for when I'll do that. (T39, P10)

- I actually think everything's a choice. Like, what I put in my office is a choice. Things are curated to a certain degree. If I work from home, I'm putting the camera at a certain angle, so I know what the patient's seeing. (T30, P11)
- If I'm in a different room, I have to be okay to talk about the different rooms, because it's something I would notice too. (T33, P11)
- I even think it is a personal thing, like how one dresses is personal, how one makes their office or presents their office is personal to a degree, and if I decide to work from home. (T34, P11)
- It is a choice in terms of why am I working from home that day versus not? (T35, P11)

J. The Neutral Impact of Self-Disclosure (54.55%)

47. *It's not like that disclosure was particularly meaningful* (P2, P4, P9)

- I don't think that the self-disclosure was a kind of a marker in the relationship like that he'll remember it as like, oh, things changed or things were particularly meaningful. (T25, P2)
- It's not like that disclosure was particularly meaningful. (T28, P2)
- I think at times, probably, I do too much, because we all have areas where we cross lines. I don't think it's been destructive. I think it may not have been necessary. (T2, P4)
- But that disclosure may or may not have been helpful to him. (T26, P9)

48. *Self-disclosure can change the direction of analysis and beget further disclosure* (P5, P6, P11)

- Now that has kind of entered the treatment. It's opened up more about her own needs in a relationship, her own desires around having a child or not having a child. (T33, P5)
- I felt almost pushed to disclose something about my relationship with my mother, which I didn't. (T37, P6)
- That really opened up more and more questions for her. Still, that's the only thing she really knows about me. And now she wants to know more. (T12, P11)
- She has a hard time permitting herself to do certain things that she wants in her life. And knowing that I had a child has led her to think more about feeling permitted herself to do things that she wants to do. (T22, P11)
- Not even just related to having a child, but in so many different things that she wants in her life, permitting herself to go for it. A lot of that has happened post my maternity leave. (T23, P11)

V. RESPONSES TO SELF-DISCLOSURE

K. Watching for patient reactions to self-disclosure (63.64%)

49. *Gauging patients' reactions to analyst self-disclosure* (P2, P4, P9)

- You learn fairly quickly with whom you can be a little more self-disclosing and with whom you shouldn't. And you learn that by seeing how the person reacts to it. (T42, P2)
- I'm thinking of one particular person who I learned fairly quickly is not very interested in hearing any kind of self-references. She wants to talk; she doesn't necessarily want me to say very much. And when I tried at times to say something

- that may be a little more in reference to what she was saying, kind of trying to create, to let her see a different angle on things, it was just washed over. (T43, P2)
- You learn quickly that okay, this is not the style that will work with this person. With other people it works much better. (T44, P2)
 - I watch for people's reaction. (T24, P4)
 - I watched for her reaction; she got the point. (T26, P4)
 - There was my feedback. (T45, P4)
 - I felt good about it. She liked the information, so I felt even better after I saw her reaction. (T17, P9)
 - I'm apologetic, but I could tell by the patient's body language that they were kind of irritated and had a very serious intense look on their face. (T29, P9)
50. *Negative Reactions: "I was up in my country house, and they were in the middle of people dying. I think it was painful for them"* (P1, P6)
- That patient I was just talking about who's very alone... she heard my husband's footsteps one day, and she freaked out and now she knows I have a partner, and she doesn't. That's going to happen. (T20, P1)
 - Hearing footsteps, one has been this person completely freaking out, "There's somebody there, there's somebody there." Me saying, "I promise you can't hear anything, just you can hear footsteps even going past a closed door. (T31, P1)
 - It also meant that she knows now that I have a partner that I don't have a limited life... which she sort of would have suspected but she never wanted to know for sure that I don't have the lonely, limited life she has. I'm one of those people out there in the world that she envies. (T39, P1)
 - Then she discovered I wasn't in the city and then she was upset. (T42, P1)
 - Some of the people that don't have a country house, I think it has brought up a class difference almost. (T62, P6)
 - I think it's brought up envy – you could get away. Definitely, when all the sirens were going on in the beginning of Covid. I was up in my country house and they were in the middle of people dying. I think it was painful for them. (T63, P6)
 - The fact that I have a country house, the fact that I could get away, you know, some of them are stuck in smaller spaces, don't have choices. (T64, P6)
 - The economic, or sociological part is there anyway for some of them, but it's not so apparent when everything is geared to what is going on with them and they don't have to think about me *that* much. (T65, P6)
51. *Positive reactions: "This was the best session we've ever had"* (P4, P9, P10)
- I think it's been very helpful to people. (T3, P4)
 - On the whole it's absolutely positive. (T37, P4)
 - She said "this was the best session we've ever had (T45, P4)
 - She felt relieved. (T21, P9)
 - Most of them really like it. A lot of them have dogs themselves. (T30, P9)
 - She has a very strong positive reaction. (T31, P9)
 - In general, I think they've been more positive. (T32, P9)
 - So, the only responses I've gotten are positive. (T40, P10)
52. *Patients can be forgiving of too much self-disclosure* (P1, P3, P4)
- "Yes. I'm sorry. Somebody is just walking by outside in the hall." "Oh, okay, yeah that happens." (T33, P1)

- I think my patients are very kind. And generally forgiving, so I don't notice. (T20, P3)
- Now sometimes I think I go too far, but my patients know me. They don't care. (T27, P4)

L. Processing and Reflecting on Self-Disclosure (90.91%)

53. Processing and exploring self-disclosure with patients models accountability and therapeutic communication (P1, P4, P6, P7, P8, P10, P11)

- I tried to get him to talk about his reaction to the self-disclosures, the unintentional self-disclosures. (T47, P1)
- I was certainly willing to ask, was this hard for you to hear? Was this helpful? (T46, P4)
- If they have any reaction that I spoke up against this or for this, then I bring it up, or I try to get them to bring up if they're uncomfortable with something. (T48, P6)
- My tendency would be to respond, and then maybe to wonder why they're asking. (T5, P7)
- when I process a self-disclosure with a patient and where I am understanding their experience of it, and how it impacts them, and I'm helping them understand the reason for it, then I think that has a positive effect for a patient (T42, P8)
- It demonstrates or models a certain type of accountability and type of communication that often people don't, you know, it's more of a therapeutic relationship type of communication for many People, or something that they don't commonly engage in, the type of dialogue that they don't commonly engage in about what's happening in the relationship. So that's positive. (T44, P8)
- I try to explore it with them, if it's possible. (T47, P8)
- I have on occasion said later on, what was it like for you when I shared that? (T9, P10)
- At the end of the first session, I always ask, "What questions do you have for me?" And a lot of times people will have a question, they'll want to know something. (T43, P10)
- Sometimes if they ask me a question, I'll say I absolutely will answer that, but I want to explore it a little first. Often, I'll answer it and then I'll explore it. (T45, P10)
- We talk about it in terms of what thoughts they have, what questions they may have, that way we can understand more about their mind by what questions they're asking. (T4, P11)
- I asked her what questions she has and why she thinks about *those* types of questions. (T13, P11)
- She wants to know my real thoughts about it. (T14, P11)
- She wonders whether she'd feel a sense of relief, or similarity, or difference. (T15, P11)
- The way I handle self-disclosure is the way I handle everything, what's really being said, and what's behind what's being said, and why is that being said, and is there any transference going on? It's no different than any other topic. (T16, P11)
- What do they really want to know? (T17, P11)

54. Analyst reactions: "I almost feel like I'm caught" (P3, P5, P9, P10)

- I'm not casual about it, but I don't feel like I have to act like that's not the case. (T4, P3)

- These are kind of embarrassing because I feel like it reflects that I'm not conscientious enough... (T14, P3)
- Maybe one as I say that I could be more cognizant of and not have happened but then again... (T18, P3)
- If anything, the residual for me is just this bit of self-judgment of "I should be less casual" (T21, P3)
- I almost feel like I'm caught. And then I just stop doing whatever it is that I might have been doing. So that is an unintentional revealing of something... (T22, P3)
- I say this thing and it's so... I always regret it. I say, "I know if I don't get it, it will just keep ringing and no one else is going to get it." And I don't think that ever lead to anything, but every time I say it, I know it will take care of the anxiety of having to pause, but I don't feel good about it, but I keep doing it anyway. (T28, P5)
- When I'm at home, the nature is that the bell is always ringing. It's really aggravating. (T27, P5)
- That made me feel tense and self-conscious and protective of the session. (T29, P9)
- It's a necessary evil. I find it annoying. I prefer working in my office. (T15, P10)

55. *Analyst reactions: "I felt a little mixed, not as confident"* (P8, P9)

- There are other times where I don't feel confident that I made the right decision in disclosing something, either about something that was happening in my life. (T34, P8)
- and I... How did I feel about it? I felt a little mixed, not as confident (T21, P9)
- I wondered how she felt about my sharing that information? And if she wondered, you know, would I talk about her? Not that I would ever mention names to anybody. (T22, P9)
- I also didn't want her to feel like I was minimizing what she was feeling. I wanted to validate her but also, you know, not make her feel like just because I know these other people going through it, it doesn't mean that her situation isn't crummy. (T23, P9)

56. *I was aware of that, so I didn't act on it* (P5, P7, P10)

- The more self-reflection the analyst or therapist has, it usually doesn't go poorly. (T39, P5)
- I would often be aware of it, would check in myself, probably with a little more of like a red flag. (T19, P7)
- I would hopefully try to take a lesson for the next time to move more in the direction of making myself unobtrusive. (T36, P7)
- I tried to really be cognizant of that urge. (T19, P10)
- But I was aware of that, so I didn't act on it. (T23, P10)