

Invitations to Dialogue

The Legacy of Sidney M. Jourard



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SELF-DISCLOSURE AND PSYCHOLOGICAL PRIVACY

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Love . . . consists in this
that two solitudes protect and border and salute each other.
R.M. Rilke (1954, p. 18)

At the turn of the nineteenth century, Jean-Martin Charcot (cited in Herman, 1992) was attracting worldwide attention for his use of hypnosis in treating the symptoms of hysteria (p. 10). His students, Pierre Janet and Sigmund Freud (working with Joseph Breuer), came to believe that hysteria was caused by psychological trauma, and found that the symptom could be alleviated when the traumatic memories accompanied by their dissociated affect were recovered and verbalized. Freud came to call this process psychoanalysis, and one of his patients, Anna O, referred to it as "the talking cure" (cited in Herman, 1992, p. 12). From this time there has been a generally accepted assumption in psychological theory that self-disclosure by the patient is a necessary curative element of psychotherapy.

Sid Jourard (Jourard & Lasakow, 1958; Jourard, 1959, 1966, 1968, 1971b, 1971c) has undoubtedly been the most well-known and prolific researcher in the area of self-disclosure. Jourard's advancement of what he termed "full self-disclosure" is reflected in the title of his work *The Transparent Self*. In this book, Jourard (1971c) wrote: "a person who displays many of the other characteristics that betoken healthy personality will also display the ability to make himself fully known to at least one other significant human being" (p. 32).

Jourard's work represented the cutting edge of a broader movement within Humanistic Psychology that challenged both the traditional role of therapeutic anonymity in the psychotherapy relationship and also what was perceived as a general climate of repression and secrecy in the culture at large. As has often been the case, much of the work that followed Jourard's distorted the original intent of his work by over-emphasizing the value of self-disclosure and minimizing the importance of psychological privacy. At times it seemed that the pendulum swung so strongly in the other direction as to create a climate demanding openness, full-disclosure, or transparency in Jourard's terms, regardless of the context or relationship involved. A 1967 article in the *American Psychologist* titled "What price privacy?" read in part:

The critical problem we face is not how to keep secrets from each other, but how to facilitate readiness to communicate. The overriding question is how to maintain an atmosphere of trust and confidence which will enable us to talk about personal affairs as freely as we talk about automobiles; to share experiences as we share the weather. (Bennett, 1967, p. 37)

Stein (1975) described her experience of individuals who seemingly had no need for privacy as follows:

I am embarrassed as they speak about the most deeply personal matters, and yet am also fascinated. Even as everything is "laid out on the table" with passion, I get the sense that nobody is really present. . . . As their gaze invites me to look through them and see that they are transparent, I find I do not know who is actually speaking. I find no solidity, no focus, but only flowing feeling and thought, tinged with desperation. . . . I finally see that this person's every word and gesture are expressing a terror of nonbeing and the desire to snatch my being from me (p. 74)

These issues have also been reflected in my clinical work, particularly in group settings. I have, on several occasions, worked with patients who were seemingly transparent. They often covered their anxiety about being known in a group by using indiscriminate self-disclosure to fill the empty spaces between themselves and others, creating a safe buffer zone. One individual described his experience as simply saying whatever came to his mind without censoring, and then leaving it to others to sort through and take what they wanted. Another described her experience as being like looking up to find herself in the deep end of the swimming pool, with the water way over her head. The rest of the group was still back in the shallow end of the pool looking at her. She was all alone without help or support. The others were scared by her plunge and it would be some time, if at all, before they worked their way to the deep end. Struggling to stay afloat, she decided to work her way back to the group and stand on solid ground.

Given the climate of the times, Jourard's seminal work on self-disclosure was innovative, courageous and profoundly influenced some of the most fundamental philosophical assumptions underlying psychotherapeutic practice. At the same time, Jourard clearly understood the essential dialectic between self-disclosure and psychological privacy. He wrote that people "need 'private places' if they are to maintain psychological, physical, and spiritual well-being" (Jourard, 1971c, p. 64). In speaking of the intimate encounter he wrote:

I may try to control and direct his behavior, his appearances, but his center always eludes me. If it does not, he ceases to be a person and becomes a machine or robot.

So to be a person, the other must have a source, a center that he is privy to [from the Latin "privatus," meaning private] and I am not. (Jourard, 1971c, pp. 51-52)

Jourard (1971c) understood a private place as one in which a person need not feel "guilt for any discrepancy between the way he appears in public and the way he is in private" (p. 64). He believed that a sense of privacy was not only essential for meaningful interpersonal disclosure, but that it is essential for the knowledge of self required for individual growth. "One usually needs to *leave* other people in order to *take leave* of the way one has chronically been with them," he said (Jourard, 1971c, p. 68). Along these lines, he told the following story:

I was to conduct an informal seminar advertised, ambiguously enough, as "A Weekend with Sidney Jourard," to discuss *The Transparent Self* and anything else I was up to About 150 people jammed into the meeting room at the main lodge of Esalen, and I began to talk about self-disclosure, thinking that was appropriate. Every few

minutes someone would interrupt my brilliant oratory and say something like "But Dr. Jourard (or Sid), you've written *about* self-disclosure in *The Transparent Self* and you're not telling *us* anything about *you*. Disclose yourself to us!"

I ignored several of these comments, but one person (I forget whether man or woman) was persistent. I said "Damn it! You're not asking for self-disclosure, which I'm doing! You seem to want a strip tease! Would you like me to undress?" I continued, "Look, if you want to sit with me, and really talk, I'm ready. But I'm a private person. Respect this much as I respect your right to disclose or withhold. (Jourard, 1971a, p. 108)

This dialectic can be better understood by sharpening our understandings of the meaning of the experience of psychological privacy, and clarifying the relationship between privacy and self-disclosure. As this chapter unfolds, I will first consider the experience of privacy and then go on to consider the role of privacy in intimate relationships, in general, and in the psychotherapeutic relationship in particular.

Privacy

The psychological literature has tended to emphasize the aspects of privacy having to do with seclusion and withdrawal (Auslander, 1978; Bates, 1964) and the idea of interpersonal control (Westin, 1967; Ittelson, Proshansky, Rivlin & Winkel, 1974). Margulis (1977) in a review of the literature concluded that "Privacy as a whole or in part, represents the control of transactions between person(s) and other(s), the ultimate aim of which is to enhance autonomy and/or to minimize vulnerability" (p. 10).

These definitions are limited in their adherence to a paradigm that emphasizes the objective and behavioral aspects of a phenomenon, in this case what we understand privacy to be from *observing* the *behavior* of others. These definitions might more accurately be understood as what we observe others doing in order to safeguard their privacy, rather than the experience of privacy itself. The experience of privacy does not require physical isolation, nor is its presence guaranteed by solitude. The natural science perspective's dualistic emphasis on the person as separate from his or her world lends itself to a conception of privacy as a separation or isolation from the world. The experience of privacy itself does not involve a separation from the world or a guarded anticipation of disruption.

Fischer (1971), utilizing a phenomenological methodology designed to gain an understanding of the lived experience of privacy rather than its behavioral correlates, concluded that privacy involves the diminishing of an observer stance to the world and the emergence of an intense and open focus on, and relationship with, the object of attention that is almost a full merging. The *experience* of privacy involves an open and unifying relation with aspects of the world, in contrast to the previously described conception of privacy as isolation and distance. The experience of privacy could not, by definition, include a focus on boundary control because in privacy such boundaries are not in conscious awareness.

Perhaps because such a distinction is not generally made, privacy has been confused with concepts such as secrecy, isolation and silence. Bok's (1982) explanation of the confusion between privacy and secrecy is that the private is such a central part of what secrecy is designed to protect that the two can be mistaken as identical. In secrecy the withholding of disclosure is primarily intended to conceal aspects of the self that are experienced as shameful or unacceptable. In privacy, the withholding of self-disclosure is instead a part of a general attempt to be authentically in relationship. A part of being authentic in relationship is to modulate the ways in which one is made known to the other so as to genuinely reflect one's readiness to be known.

In secrecy the focus is on the horizon of an anticipated disruption of privacy, and not the experience of privacy itself (Masek, 1983). In disrupted privacy, the focus shifts between "the intruder, self as caught by the intruder, and the peripheral world, as well as the lost object" (Fischer, 1971, p. 157). The affective experience shifts to uneasiness, embarrassment or shame. Nietzsche (cited in Schneider, 1977) believed the function of shame was to safeguard the private sphere, and his description of shame closely matches the structure of disrupted privacy. Sartre (1953) agrees that shame is a response to the intrusion of the other and the need to conceal oneself. Thus, behavioral definitions of privacy with their emphasis on protection and control of barriers between self and world are closer to the experience of secrecy or the disruption of privacy than to privacy itself. One of the implicit rules in a pathological family that makes it so destructive is that the child is forbidden to tell anyone outside the family what is going on. In such a family, secrecy is a part of what makes the experience pathological, and privacy is what allows the child the inner sanctum to survive the pathology of the family.

Early research by Jourard and others focused on the positive relationship between self-disclosure and mental health. Several studies reported a positive relationship between scores on Jourard's Self-Disclosure scale (JSDQ) and psychological adjustment scores as measured by the MMPI (Himelstein & Lubin, 1965; Jourard, 1971; Taylor, Altman & Frankfort, 1968). The correlations in these studies have been quite low, however, ranging from .18 to .34 with even lower coefficients reported in replication attempts (Cozby, 1973). In addition, other studies have reported a negative relationship between the JSDQ and questionnaire measurement of adjustment (Mayo, 1968; Stanley & Bownes, 1966).

Jourard (1971b) eventually suggested a "curvilinear relationship" between self-disclosure and mental health (p. 49). Later studies tended to confirm that moderate levels of self-disclosure are correlated with mental health and that either high or low levels of self-disclosure are correlated with psychopathology (Derlega & Chaikin, 1975). Cozby (1973) found that mental health is positively correlated with high disclosure to a limited number of people, and psychopathology is related to either high or low disclosure to almost anyone. In fact, individuals who reveal intimate information to casual acquaintances are rated as maladjusted by observers, while those who reveal intimate information to close friends are rated as well adjusted (Chaikin & Derlega, 1974).

Other research (Truax, Altmann & Wittmer, 1973) indicates that the relationship between self-disclosure and mental health may be more complex. This work suggests that the relationship

between the person disclosing and the person he or she is disclosing to is one of the variables that influences the correlation between disclosure and psychological adjustment. In addition, studies with psychologically disturbed individuals seem to reveal a different relationship. One study with prison inmates reported that the greater the psychopathology as measured by the MMPI, the higher the disclosure in an interview (Persons & Marks, 1970). Another study with a group of hospitalized schizophrenic patients found that the most seriously disturbed patients were more disclosing in group therapy sessions than those who were less disturbed (Persons & Marks, 1970).

We are drawn to the private not only by a desire to withdraw from certain aspects of the world, but also to indwell other aspects, often dimensions of ourselves not otherwise accessible. What is lost in privacy is the world outside of that focal object. An extreme example is the patient with a schizophrenic style of relating whose world is limited to a narrowly confined, self-contained set of parameters and who is unresponsive to the possibilities and contingencies of the world at large.

We are drawn to disclosure by a desire for unencumbered closeness and a return to the primal state of oneness (Nouwen, 1975). This may be advantageous in drawing us into deeper contact with the world around us, but it can come at the cost of our own awareness and growth.

Abandoning this dialectic has its consequences. Heidegger (1962) believed that to live authentically in-the-world required an integration of one's actual limitations with an openness to possibilities. He saw the abandonment of the tension of this ambiguity and a clinging to either end of the duality as inauthentic. A denial of one's need for privacy is a denial of one's limits as a human being, a denial of one's earth-boundedness as another animal and, ultimately, a denial of one's finiteness and eventual death (Becker, 1973). For example, the New Age movement espouses both a striving for self-disclosure and intimacy that denies the need for the private, and a striving for health that denies the inevitability of illness and death (Weiss, 1987).

Not only does a denial of the private cut us off from the full range of our authentic humanness, it specifically blocks us from some of the most treasured and genuine aspects of ourselves. Early in life it becomes clear that who we simply *are* will often not be accepted. In our striving for intimacy and acceptance, the self is split into a "good" self projected at the presentational level, and a true self consisting of good, bad and a myriad of other arbitrary distinctions.

Some readers may consider such a conceptualization of the private as an endorsement of duality. They may further question how intimacy is possible in the face of such dishonesty. Privacy and disclosure are both authentic responses to an imperfect world, however. We learn to protect this true self from the disapproving world that would change or violate us (Brown, 1983; Fischer, 1980). Object-relations theorists are quick to point out that splitting is an inevitable response to an unreliable environment (Guntrip, 1969). These hidden aspects can be most true of our selves precisely because they have been guarded from external pressure to be other than authentic. This freedom from the concrete demands of others is what opens the doors to the creativity possible within the safe confines of privacy (Fischer, 1980).

Just as there is value in the authentic indwelling of the private, there is danger in denying its value. The myth of Pandora is one of many dealing with the fate that befalls those who expose that which was meant to be concealed (Bok, 1982). However we may value disclosure in ourselves or others, it is clear that there are aspects of the world that make exposure risky. In some instances it may actually be physically dangerous to have one's privacy penetrated. While most children are not exposed to such overt danger, they have experienced aspects of the world that convince them to disguise or hide parts of themselves. The threat to survival may be partial or symbolic, but it is usually sufficiently covert as to be discovered only in later years, if at all, and with much resistance (Kempler, 1987).

Even in a benign world, violations of privacy can be unhealthy or detrimental. Just as our experience with others in the world is in a constant process of development and change, so too is our inner private experience. The experience of sharing something private early on in its development does not have the same meaning or structure as it does later in its development (Kempler, 1987; Schneider, 1977). Our inner experience is as vulnerable to the input of others as infants are to the world around them. Once we have let something go from inside of us, it can never be fully ours again in quite the same way. The brilliant idea shared prematurely with a colleague seems to lose some of its attraction as it never quite develops the way it might have in the reflective calm of privacy.

Privacy and Intimacy

It is my contention that psychological privacy is a part of the essential foundation upon which genuine intimacy may be built. Intimacy is, in part, interpersonal privacy, the coming together of two or more people each with a secure sense of personal privacy. Without access to a mature sense of individual privacy, only pseudo-intimacy is possible (Weiss, 1987). Fischer's (1971) research confirms the structure of intimacy is a variation of that privacy; "Intimacy necessarily occurs within privacy, although privacy is not necessarily intimate" (p. 154).

The relationship between privacy and intimacy can be illustrated with the following analogy. When a chorus sings in harmony or a symphony plays together, each player is attuned to his or her own music and yet each also hears the symphony and how he or she fits with that whole. If the individual were not to attend to his or her own music, then the symphony would never rise above the level of mediocrity. If the individual did not attend to his or her relationship to the whole, he or she could not make music.

Most of us fear drawing genuine boundaries may mean the end of our intimate relationships, tapping into one of our greatest fears, that of abandonment. In effect, we may feel forced to choose between the threat of abandonment, and the loss of a sense of genuine self (Weiss, 1987). Rollo May (1964) wrote that:

Castration is no longer the dominant fear of men and women in our day, but ostracism. Patient after patient I've seen . . . chooses to be castrated, that is, to give up his power, in order not to be ostracized. In this over-participation, one's own consistency becomes inconsistent because it fits someone else's. One's own meaning becomes meaningless because it is borrowed from somebody else's meaning. (p. 31)

For this reason many patients fear exploration of their experience in psychotherapy, believing this may threaten their intimate relationships, and in one sense they are correct in that their individual growth may threaten pathological collusions in other relationships (Felder, 1984).

Rather than risk abandonment, we often choose to placate our partners by denying the importance of our own private places. In a quest for genuine intimacy we may attempt to eliminate loneliness by allowing our boundaries to be violated. Following the "urge to merge," the unfortunate result may be a false, dissatisfying sense of pseudo-intimacy. We may drive ourselves into dissatisfying relations in an attempt to meet hopes for unity and wholeness which cannot be met in this way (Nouwen, 1975). As theologian Henry Nouwen (1975) puts it, "Many people find it hard to appreciate a certain closeness in a marriage and do not know how to create the boundaries that allow intimacy to become an always new and surprising discovery of each other" (p. 21).

We often look to others for answers when we have lost contact with an inner sense of our private selves. Or we lack the faith in what we will find, which is required for exploration of the depths of loneliness. Thoreau (1950) said:

When our life ceases to be inward and private, conversation degenerates into mere gossip . . . In proportion as our inward life fails, we go more constantly and desperately to the post office. You may depend on it, that the poor fellow who walks away with the greatest number of letters . . . has not heard from himself this long while. (p. 72)

In psychotherapy, as our patients reach out to us to fill their existential void, we turn them back towards their sense of privacy wherein we believe their answers lie. Psychotherapy provides the sanctuary of solitude, or privacy, in which personal growth is truly nurtured (Weiss, 1987). It is just as crucial to have a relationship in which one need say nothing, as to have one wherein one may say anything (Kempler, 1987).

Without a sense of boundaries, or privacy, our experience is not grounded in the world, not interactional. There is no response required from the other, or even called forth, just self-expression for its own sake. It is the sense of privacy, of limits, that makes contact interactional and allows intimacy (Weiss, 1987).

I have learned for myself how difficult it is to feel in genuine contact with someone who is indiscriminately self-disclosing to the point of seeming to be transparent, seeming to have no boundaries, no private places. I feel distrustful, anxious and wary. The moments of greatest intimacy and genuine contact for me are when I meet another's boundaries and they feel substantive and alive. This is where we meet each other in intimate contact, in the cherishing of our mutual boundaries and the valuing and respecting of our privacy. (Weiss, 1987, p. 124)

Privacy and Psychotherapy

As discussed earlier in this chapter, Western assumptions about the relationship between self-disclosure and mental health can be traced to Freud and Janet's discovery that the symptoms of hysterical conversion could be successfully treated by talking alone (Breuer & Freud, 1961). Freud (1900) stressed the importance of uncensored disclosure by the patient in psychotherapy and understood the patient's silence as a breakdown of free association and a manifestation of transference difficulties (Loomie, 1961). In 1913, Freud described "the fundamental rule of analysis: for the analysand" as "whatever comes into one's head must be reported without criticizing it" (p. 107), and recommended that analysts instruct their patients: "finally, never forget that you have promised to be absolutely honest, and never leave anything out because for some reason or other, it is unpleasant to tell it" (p. 135).

The analytic position stresses the awareness of intrapsychic dynamics as foundational for the psychological health of a person, and concludes that the blunting of awareness through a denial or distortion of the "objective" world is the primary symptom of a neurotic conflict. Therefore, the intent of psychotherapy is to bring repressed material, along with its accompanying distortions, into conscious awareness. Any action, conscious or unconscious, on the part of the patient that is counterproductive to this intent is defined as resistance. Among the examples of resistance given by Singer (1970) are "selective omissions, or conscious censoring in reporting fantasy material, dreams, or recent events" (p. 223). Patient silences are understood as anal-retentive defenses against the conflicted feelings that might be evoked in disclosure (Loomie, 1961; Meerlo, 1952; Zeligs, 1961). Silence may also be understood as repressed aggression in response to a perceived intrusion by the therapist.

An implicit assumption in the analytic position is that the therapist is the one who is responsible for the direction and progress of the psychotherapy, and the patient is somehow less suited for that task. Freud believed that the objective presence of an analyst who would discover and interpret the unconscious material was necessary for the success of the analysis. (It is interesting to note in this regard that Freud's own analysis was conducted by himself, however, without the benefit of another, "objective," analyst.) More specifically, the analytic position is that the analyst is the only one who has the access necessary to interpret the latent meanings of the patient's silences (Bok, 1982; Meerlo, 1952). Freud (1953) wrote that "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret . . . the task of making conscious the most hidden recesses of the mind is one which is quite possible to accomplish" (p. 89). These formulations are based on an understanding of the unconscious as a primitive, regressive force which if left alone would lead to self-destructive actions, thereby justifying the interventions of others.

Humanistic psychology developed as a response to such pathological understandings of the nature of human consciousness and proposed an alternative conceptualization of the unconscious as a healthy and adaptive part of the personality (Felder & Weiss, 1991; Whitaker & Malone, 1953/1981). Rogers (1946) became the most well-known advocate of an approach to psychotherapy that emphasized the client's capabilities and responsibility for his or her own growth. Rogers (1946) understood the intent of therapy as "trying to understand the client as the

client sees himself' [or herself] (p. 420). He viewed the client's silence as simply another mode of expression and respected the client's choice to use the therapeutic hour in whatever manner he or she chose. He recommended the following stance for the therapist in response to silences on the part of the patient:

While he does not really know what is going on in client silences, he does allow them because he is convinced that self-exploration continues in them. He trusts in the purposiveness of the client's behavior and intentions. And so waits until the client is ready to speak again. This belief and trust in the purposive orientation of the client is often rewarded when the client, emerging out of the *privacy of his silence* [emphasis added], reveals the contents of the silent experience, shares with the therapist what he was absorbed in while not speaking. (Cited in Maes, 1978, p. 118)

A review of the relevant psychological literature revealed that while there have been extensive studies done in the area of self-disclosure, there is only one study on the topic of privacy in psychotherapy (Weiss, 1986). Research has been limited by two complementary assumptions about psychotherapy; that non-disclosure is pathogenic and that full disclosure is therapeutic (Bok, 1982). Several authors have suggested a linear relationship between full disclosure by the patient and the successful outcome of the psychotherapy (Jourard, 1968 ; Mowrer, 1964; Rogers, 1961). As a result, research on self-disclosure and psychotherapy typically considers only strategies to increase patient disclosure and has consistently ignored both the factors which might reasonably and healthfully inhibit self-disclosure and honor the value of privacy (Cozby, 1973; Hoyt, 1978).

This author undertook a phenomenological study of the patient's experience of privacy in psychotherapy. Patients currently in psychotherapy for two years or longer were interviewed in-depth about their experiences of privacy over the course of their treatment. The interviews were analyzed using a phenomenological methodology, resulting in a general structure of the patient's experience of privacy in psychotherapy (Weiss, 1986).

The results indicate that the patient's experience of privacy consists of four constituents: awareness of self, validation or empowerment of self, acceptance and integration of self, and modulation of the ways in which self is made known to other. The patient's experience of privacy is always set against the ground of his or her expectations about self-disclosure in psychotherapy. All of the participants interviewed believed that substantial self-disclosure was necessary for effective psychotherapy. Patients believed they had to be sufficiently self-disclosing for their therapists to be able to understand aspects of their experience that they themselves were not yet aware of. Several participants believed that withholding any information at all would be detrimental. Some patients felt compelled to be fully disclosing in order to meet what they understood to be their therapists' expectations of them. Several believed that their decisions to withhold disclosure would be understood as resistance by therapists. And they believed this to be true despite the fact that only one of the therapists explicitly stated any expectations of

uncensored self-disclosure by the patient, and several stated either explicitly or implicitly that they held no expectations about their patient's self-disclosure.

Awareness of Self

The first constituent in the experience of privacy is an awareness of self apart from the actual or imagined perceptions of self by others. All of the participants described having to somehow bracket their therapists' perceptions of them in order to become more aware of their own immediate experience. Patients are often absolute in their non-disclosure of an experience at this time in order to gain greater awareness of their own experience without having to bracket what they believe to be their therapist's expectations of them in regard to self-disclosure (see above).

Validation and Empowerment of Self

The second constituent of the patient's experience of privacy is a validation and empowerment of self. The awareness of self apart from others' perceptions of self is a necessary precondition for, but not in itself sufficient for the experience of empowerment. The experience of the validation and empowerment of self is often played out in the patient's struggle to be responsible for defining what will be the agenda for the psychotherapy, which aspects of his or her experiences will be understood as problematic and as potential agendas in psychotherapy. In a sense, patient and therapist are trying to work out whose experience will be honored in the therapeutic relationship.

The Acceptance of Self

The third constituent of the patient's experience of privacy is the experience of acceptance of self and a sense of ownership. This is the pivotal constituent in the experience of privacy. The sense of conflict that was predominant in the second constituent is less present here as the focus shifts from conflict with the therapist to an acceptance of self. Prior to this experience of acceptance of self the focus is on guarding or protecting aspects of oneself which are experienced as problematic, or "bad." As long as one understands aspects of one's experience as "bad" then decisions to withhold disclosure of that experience are perhaps best conceptualized as secrecy rather than privacy. When acceptance of self occurs, patients are able to come to terms with aspects of themselves that they have considered to be unacceptable, and to integrate these aspects of their experience into a comprehensive understanding of themselves.

From acceptance of self often follows the protection provided by withholding disclosure. In other words, privacy is often nurtured and developed in the safety of non-disclosure. People often feel that if they disclose an experience before having achieved this sense of acceptance of self that they will literally lose an aspect of themselves. With the acceptance of self comes a sense of "ownership" of an experience as a part of one's being-in-the-world.

Modulation of the Ways Self Is Made Known

The final constituent of the patient's experience of privacy is a modulation of the ways in which one makes oneself known to the therapist, primarily via self-disclosure, so that they authentically reflect one's readiness to be known. The experience of privacy becomes related not to the amount of self-disclosure but to the meaning of that self-disclosure. Privacy may thus result in almost any level of self-disclosure, from absolute non-disclosure, to partial non-disclosure, to an attempt to be as fully self-disclosing as possible.

After the experience of acceptance of self, the modulating of self-disclosure may take on an entirely different character. The first constituent of privacy involved an awareness of authentic self, the second a validation and empowerment of authentic self, and the third an acceptance and sense of ownership of authentic self. The final constituent involves *being* one's authentic self.

In most cases, when the patient is able to stay with the natural process of development of his or her experience up through the experience of privacy, there is then a new depth of self-disclosure without a fear of loss of self, and a greater sense of intimacy between the patient and the therapist.

Transcendental Privacy

There also appears to be a subtype of the patient's experience of privacy in psychotherapy that a small number of patients reported. This experience of transcendental privacy consists of all of the constituents described in the general structure of privacy as well as other unique dimensions.

Transcendental privacy is the experience of indwelling one's own immediate experience while also being deeply in relationship with another. The experience of indwelling involves a bracketing of everyday realities and an intense focus on and being with one's own in-the-moment experience. There is no longer any sense of being in an other-centered relationship, or an awareness of self as seen by an Other. There is also no sense of being guarded, or the experience of secrecy.

In the experience of transcendental privacy the patient makes every effort to communicate at least a portion of his or her experience to the therapist, but is unable to do so fully. The experience is an ineffable one. Paradoxically, this intense, nonverbal, indwelling of one's own in-the-moment experience can facilitate an increased sense of intimacy and understanding between patient and therapist, privacy and intimacy.

Our understandings of the dialectic between psychological privacy and self-disclosure in psychotherapy have been limited by attempts to understand privacy from an individualistic perspective, outside of its lived context of relationship. From an individual perspective, privacy is cast in an adversarial light, pitting the patient's perspective against the therapist's. Seen in this light, the patient is understood as struggling to validate and hold onto his or her own perspective in the face of the discrepant and persuasive perspective of his or her therapist. An oppositional

rather than complementary relationship between world views is posited, as if either patient or therapist alone had access to the sole correct interpretation.

From a more collaborative perspective, the reality of the patient's experience is defined in the context of the relationship. There are aspects of my experience that are known only by me and that others are not aware of. There are also aspects of myself that I am not aware of, and become aware of only through the perspective of others. A full understanding of my experience is gained only in dialogue encompassing all perspectives. The experience of privacy in psychotherapy seems to begin as a conflict-laden experience as the patient struggles to first separate and then empower his or her self in relationship with the therapist. As the experience of acceptance of self develops, however, the patient has less need to define self in opposition to other, and is more open to understandings of self in relation to other.

From an individualistic perspective, privacy is understood as resistance, meaning any action, conscious or unconscious, which interferes with the movement of unconscious material and the accompanying defenses into conscious awareness. Adler (cited in Weiss, 1986) understood that if the therapist was considered to be the ultimate arbitrator of the patient's psychic reality, resistance actually constituted a disagreement between the patient and therapist about the nature of the patient's experience. He further believed that it was healthy for the patient to "resist" the therapist if he or she believed the therapist was imposing a perspective that didn't fit with his or her experience (cited in Weiss, 1986).

From a relational perspective, privacy involves an awareness and validation of one's own subjective experience while also acknowledging that there are aspects of the self that can only be known in relationship with another. In such a perspective, "resistance" lies in the therapist and not the patient (Felder & Weiss, 1991). As long as the therapist's interventions are based on a priori theoretical understandings they will generate "resistance" in the patient in the sense that Adler understood it, because they pathologically challenge the patient to dispute his or her own experience.

From an individual perspective privacy is understood as an obstacle to intimacy. Privacy, equated with selfishness, is seen as precluding contact with others. I have argued above and elsewhere, however, that choosing to focus on one's own experience not only does not interfere with interpersonal intimacy but leaves one more available to be intimate with another (Weiss, 1986). Thus it is not the patient's sense of privacy that impedes the development of intimacy in the therapeutic relationship. Instead, the problem lies with the therapist's reluctance to accept the patient's developing sense of privacy. Privacy is what allows relationship without an accompanying sense of loss of self. It is the absence of privacy in relationships that makes intimacy threatening.

Therapist Expectations

The split between the objective theoretical understandings of privacy found in the psychological literature and the subjective experience of privacy reported by patients is also lived out in the relationship between patient and therapist. In some cases there is an overt conflict between the therapist's objective understanding of the patient's experience, and the patient's

subjective understanding of his or her experience. More often than not, the conflict is an internal one between the patient's subjective experience and what he or she imagines to be the therapist's perspective.

It seems that we as psychotherapists have a contradictory set of expectations for our patients, and our patients end up living out that split in their efforts to develop a healthy sense of privacy. On the one hand, few psychotherapists would ascribe to a model of mental health in which the person depended largely on others as the ultimate arbiters of his or her own psychic reality. In general, we encourage patients to become more aware of their own subjective experience and to make life decisions on the basis of this rather than the expectations of others. Perhaps the modal question in psychotherapy is: "how are you *feeling*?" Many therapists now encourage patients to attend specifically to their bodies as infallible indicators of how they *really* feel beneath all the cognitive defenses and denial. At the same time, many psychotherapists adhere to theoretical frameworks that prioritize the therapist's perspective of the patient's experience. In such models the therapist is seen as the ultimate arbitrator of the patient's reality because he or she is believed to have privileged access to objective truths.

It is my recommendation that practicing psychotherapists approach this issue by first critically examining their own assumptions, particularly their beliefs about disclosure and non-disclosure in psychotherapy and their understanding of how the reality of a patient's experience is defined. What evidence is there that the experience of privacy is a valuable experience for the patient, or one that should be facilitated by a therapist? Patients report that the experience of privacy can be an essential part of their growth in psychotherapy. Once they develop a sense of privacy, they report being better able to bracket the needs and expectations of others in order to become more aware of their own immediate subjective experience. They report being better able to make decisions based on their own experience and needs, rather than trying to meet only the expectations of others. Patients report being able to come to terms with and integrate aspects of themselves that they have previously considered to be shameful or unacceptable. They also report being more authentically available or intimate in relationships with others without a corresponding fear of loss of self.

We know that when patients disclose to their therapists before they are ready, without the development of a sense of privacy, that they often feel as if they have literally lost a part of themselves. Self-disclosure in the context of a sense of privacy can be an integrative, growth-enhancing experience that leaves persons feeling more intimately in relationship with others. Self-disclosure without privacy can be a self-destructive experience that leaves a person feeling more alone and less ready to be in relationship. Given that self-disclosure is so much of a focus in psychotherapy, the experience of privacy can make the difference between an integrative rather than a self-destructive experience for the patient.

If a therapist comes to understand and value the patient's experience of privacy, how might he or she best facilitate the development of that experience? The most readily apparent first step for a therapist is to communicate to the patient his or her support for and understanding of the experience of privacy. The question remains whether to communicate this at the beginning of

psychotherapy, or to wait until the issue comes up. The advantage of waiting until privacy becomes an issue is that the therapist's statements about privacy will be immediately relevant. The disadvantage is that the therapist may very well not know when a patient is struggling with issues of privacy. B. Kempler (personal communication, 1985) suggests telling new patients that they may reach a point in their psychotherapy where they struggle with whether or not to disclose a particular issue. He tells patients in advance that it is fine to be private during their therapy, and that the process of decision-making regarding disclosure is generally more important than the specific content or outcome involved. The disadvantage of raising the issue at the beginning of therapy is that it may not be as meaningful out of context, and may not be as convincing to the patient.

R. Felder (personal communication, 1988) describes a specific technique for dealing with patients who infrequently attend to their own sense of privacy. He will tell such patients in advance not to respond to what he is about to say, but instead, to just listen and attend to their own experience. In a similar vein, C. Whitaker (personal communication, 1986) frequently instructed patients not to discuss their sessions with anybody at all for a period of twenty-four hours.

Some might argue that the best way for a therapist to facilitate a patient's experience of privacy is to intrude as little as possible in the patient's ongoing experience; to attempt to achieve therapeutic anonymity. From this perspective every question might even be seen as a violation of the patient's privacy because each represents an attempt to control the agenda, to prioritize the information that the therapist understands as important. This is essentially the position taken by psychoanalytic psychotherapists. The patient is instructed to attend exclusively to his or her own ongoing experience while the analyst listens attentively in order to carry out the responsibility for interpretation of the patient's experience. While such a structure does encourage an unimpeded awareness of self, the patient is also required to abstract his or her ongoing experience in order to report it to the analyst. Not only does this abstraction of ongoing experience detract from the patient's capacity to fully indwell that experience, it also may impede the experience of the validation or empowerment of self. In addition, although the analytic approach of therapeutic anonymity is designed to minimize contamination of the patient's ongoing experience, this position rests on an understanding of patient and therapist as fundamentally separate from each other.

From a relational perspective, patient and therapist are seen as inexorably interconnected such that the experience of one cannot be adequately understood outside the context of the relationship. Therefore, for the therapist to be actively involved in relationship with the patient is not an intrusion into the patient's private experience, but an acknowledgment of the relational nature of experience. Patients do not report that it is their therapist's interventions that are experienced as a detriment to their experience of privacy. What does hinder the patient's sense of privacy, however, is the feeling of not being understood, the sense that a therapist is committed to an a priori agenda that curtails his or her ability to be with the patient. It is not the therapist's being with the patient that interferes with privacy, but the therapist's failure to be with the patient that is problematic. It is countertransference that most effectively blocks the development of the

patient's experience of privacy; the therapist's failure to bracket his or her own agenda in order to be with the patient as he or she is, and not as the therapist expects him or her to be.

The most powerful way for a therapist to facilitate a patient's experience of privacy has less to do with anything the therapist says or does, but stems more from a sense of presence or a way of being. Perhaps Jourard (1968) said it best when he wrote: "Psychotherapy is not so much a science or technique as it is a way of being with another person . . . the embodiment of an *intention*—the wish that the one who is Other for the therapist should experience his freedom, should be and become himself" (p. 57).

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