Unwitting Exposure of the Therapist

Transferential and Countertransferential Dilemmas

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The unwitting exposure of the therapist's private life creates an unexpected rupture in the frame and puts both the therapist and the patient off balance. The exposure introduces into the therapy a moment of human sharing of vulnerability that has the potential to enrich the treatment. Clinical vignettes are presented to help therapists anticipate possible exposures and their consequences. The discussion encourages therapists to predict their reactions, obtain needed professional support, and make the most of opportunities for full exploration of patients' material.

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The unwitting exposure of the therapist's private life puts both the therapist and the patient off balance. Most clinicians are trained to follow a set of behavioral guidelines characterized by dependability, neutrality, and the maintenance of privacy regarding our personal lives. These guidelines are part of the therapeutic frame and are designed to create a sense of predictability for our patients and ourselves while we undertake the complex process of psychotherapy. When there is an unexpected rupture in the frame, both patient and therapist are affected.

Over time, personal privacy becomes a familiar part of the therapeutic stance for most therapists. This privacy allows them the necessary freedom to explore and understand their internal reactions to patients' material. Thus, therapists have very little preparation for the occasions when patients present material related to personal details about themselves. The frame is broken. The therapist may be stunned, shocked, and temporarily disorganized by her feelings of vulnerability and exposure. In other words, her customary internal sense of affective balance that allows her to maintain her therapeutic stance has been disrupted. She may have momentary difficulty in determining and carrying out the most therapeutic response. At the same time, the predictability of the frame is disrupted for the patient. He

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has been robbed of the right to "not know" whatever he is not ready to acknowledge about his therapist. He may experience a flood of chaotic affect and a loss of his sense of safety. Additionally, this uninvited disruption has the potential to damage the treatment by disturbing the transference fantasy. Both parties are in danger of feeling isolated and lost. The challenge is to find a way to exploit these disruptions in the service of the treatment.

In this article I explore the consequences of the unwitting exposure of details of a therapist's life and illustrate through clinical examples the ways in which therapy can be affected and, at times, thrown into turmoil. The immediate period of the exposure, when the patient and the therapist simultaneously experience a disruption in the frame and a loss of bearings, is a critical time for the therapy. The exposure introduces into the therapy a real moment of human sharing of vulnerability and helplessness that has the potential to bring the patient to a new level of feeling and enrich the treatment.

Over the course of a therapist's career, unwitting exposures are inevitable and may occur in a number of ways in clinical practice. The aim of this paper is to encourage therapists to anticipate possible exposures and the attendant intrapersonal and interpersonal effects of such exposures. Consideration of the real probability of unwitting exposure and its consequences is particularly important for training, to help prepare students and supervisors to think in advance and to "try on" various scenarios of possible exposure so they may anticipate their own and their patients' reactions. Although there is no way to rehearse and predict how any one clinician will react, it is useful to work through the denial of the real possibility that such exposures may happen. Discussion of clinical vignettes will explore the following examples of exposure: illness, pregnancy, miscarriage, public exposure of tragedy in therapist's family, public exposure of professional awards, public exposure of details of therapist's history, patient attending therapist's lecture, and patient discovering details of therapist's medical care.

LITERATURE REVIEW

The importance of setting and maintaining a clear frame for psychotherapy has been highlighted by authors since the early days of psychoanalysis.[1–3] Epstein[2] points out that particular aspects of the frame such as predictability, stability, and well-defined boundaries create a sense of trust and safety for both the patient and therapist. He notes that boundaries help to "define and protect the therapist's sense of integrity as a separate person from the patient" (p. 33). Violations of therapeutic boundaries may create confusion for the patient[3] and disrupt the therapist's coherent sense of self.[2]

Freud[1] sets forth a set of "rules" to be followed by analysts in beginning treatment, including a recommendation of anonymity for the analyst. He cautions that the revelation of personal details can strengthen the patient's resistances and interfere with the resolution of the transference. Current theorists[2,3] consider the therapist's anonymity to be a vital part of the frame for both therapist and patient. Epstein[2] maintains that knowledge of personal details about the therapist places a burden on the patient. According to Langs,[3] "self-revealing responses reflect difficulties in the therapist's ability to manage his own inner state" (p. 89).

Freud also underscores the importance of the analyst's ability to maintain an internal sense of balance so that he can be receptive to the patient's unconscious. The therapist's self-esteem and sense of integrity depend on his maintaining a sense of composure and professional role.[2] The unwitting intrusion of personal details into the therapeutic relationship is a particular form of boundary violation that may disrupt the therapist's internal sense of balance and composure.

Authors approach this topic from several points of view. Some consider how their personal reactions to significant life events such as parenthood, miscarriage, illness, death, divorce, and malpractice suits have influenced their clinical work.[4–7] These discussions focus primarily on internal changes in the therapist's life and their effects on clinical work. The authors generally do not address their own sense of exposure or vulnerability with patients because patients were not told about many of these significant life events.

Basescu[8] describes the ways in which both the ongoing responsibilities and the periodic crises of parenthood have influenced her ability to be present for her patients. She writes of times when her anxiety over her children's health or child care crises interfered with this ability. She also reflects on her increased respect for the complex process of parenting and its positive effects on her ability to empathize with her patients' struggles as parents. Counselman and Alonso[9] point out that a therapist's illness may stir up feelings of vulnerability and

helplessness and threaten to disrupt her denial and fantasies of omnipotence. They encourage therapists to explore their conscious and unconscious conflicts regarding illness so they can help their patients freely explore related material from their own lives. Chasen[10] writes movingly of the impact of her son's death on her work as a therapist. She points out that her work with patients helped her to carry on when she wanted to die. Her paper provides a resource for therapists who have had such a major loss.

Others focus on the management of treatment when a major event has occurred in their lives. Schlachet[11] describes in detail how he managed his clinical practice while going through a difficult divorce. Gerson[12] writes of her efforts to provide continuity for her patients when she had a miscarriage. She underscores the complexity of the therapeutic work involved in analyzing her patients' reactions to her pregnancy and miscarriage as she was dealing with her own grief.

Several authors address the impact on the treatment, particularly on the transference, when details regarding the therapist's life have become known. Primarily, the examples are cases in which the therapist has been able to decide which details are revealed to the patient. Authors vary in the amount of personal information they choose to reveal to patients about a life event.

Schlachet[11] writes of his decision not to discuss the facts or acknowledge the reality of his divorce even when it appeared that several patients might have knowledge of the situation, and even when he was served with a subpoena during a group session. His article demonstrates how a therapist may acknowledge that something is happening in his life and explore the patient's reactions and fantasies about it without revealing the details. Abend[13] draws attention to the value of considering the unique needs of each patient when a therapist decides to bring personal material into treatment. When he became ill, the amount of information he gave to patients ranged from full disclosure to no information. Chasen[10] also writes of the variety of ways in which she talked to her patients of her son's death. Using rich clinical examples, she outlines her decision to speak openly to patients who learned of his death or who presented relevant material and to not discuss it with other patients. Grunebaum[14] describes a variety of ways in which therapists have managed psychotherapeutic treatment while ill. He favors taking a direct, honest approach while also considering each patient's needs. Friedman[15] reveals that as a result of her life-threatening illness, she altered her criteria for taking someone into treatment. She decided not to work with terminally ill individuals or with those who had lost family members to illnesses similar to hers.

TIMING AND ITS CONSEQUENCES

Using the more general perspective of these clinicians as a starting point, I will focus here much more specifically on the immediate time of exposure and its consequences. The examples vary in the degree of control the therapist has over the exposure of the personal details to the patient. The therapist's control is determined, in part, by the time she has to prepare for her discussion of the details with the patient and her ability to predict that the exposure will occur. For example, in the case of pregnancy, the therapist has a great deal of control over the exposure. She knows the discussion of her pregnancy will come up in the treatment at some point and thus has time to prepare. In the case of unexpected illness the therapist generally has some time to prepare her thoughts before the discussion of the details. On the other hand, when patients discover details about the therapist through public exposure, such as through the news media, the therapist's control is uncertain. The therapist may or may not know ahead of time that the information will appear in the media and may have little time to prepare for the discussion. When a patient learns details about the therapist through his own intrusive behavior, the therapist most likely will have the least control. The therapist will then have limited opportunity to predict the exposure and perhaps no time to prepare for the discussion.

THERAPIST HAS TIME TO PREPARE

Pregnancy

Unlike many other exposures of the therapist's private life, pregnancy is a positive event that is shared by the therapist and patient. The gradual changes of pregnancy allow the therapist time to plan her strategy and come to the discussion of her pregnancy with a sense of balance. Nevertheless, at the moment of exposure the well-prepared therapist may be derailed by an unusual sense of vulnerability, which may impede her ability to help her patients freely explore their feelings about her pregnancy. Although the management of psychother-

apy during a therapist's pregnancy has been written about,[7] the following examples are included here because they specifically address the effect of the therapist's reaction to the exposure on the subsequent treatment.

The author had two cases in which her pregnancy altered her usual therapeutic stance with a patient.

In the first case, the patient was a relatively high-functioning, recently divorced professional woman of about the same age as the therapist. The patient's transference was characterized by identification with the therapist and a reluctance to bring into the therapeutic relationship feelings of dependency or anger. With the help of her supervisor, the therapist decided not to announce her pregnancy to this patient, but rather to wait for her to notice the physical changes. They felt that allowing the patient to acknowledge the pregnancy and experience the disruption in her identification with the therapist in her own time would be useful for the treatment.

At the seventh month, the patient still had not mentioned the changes in her appearance. As her pregnancy became more visible the therapist experienced a sense of exposure and vulnerability. The patient's denial caused a loss of equilibrium in the therapist. The physical changes were so marked she felt as if she were violating the patient's trust by not mentioning the pregnancy. Finally, the therapist told the patient of the pregnancy in the context of her announcement that she would be taking 8 weeks off for her maternity leave. The patient was shocked that she had not noticed the physical changes of the pregnancy. Because the therapist had been able to explore in supervision her sense of vulnerability, loss of balance, and exposure, she was able to help the patient explore her feelings about her need not to know about the pregnancy and her sadness that her current situation as a newly divorced woman in graduate school did not allow for her to become pregnant. Over the remaining few sessions, the patient was able to express her fear that she might never have the opportunity to have a child, her jealousy toward the therapist and the baby, and her sense of aloneness as the therapist left to have her baby.

During the same pregnancy, the author was treating a patient with Turner's syndrome: a genetic condition in which a woman is born with no ovaries and is infertile. When she learned of her diagnosis at the age of 25, she developed a psychotic depression. The patient entered treatment 1 month before her therapist became pregnant. Because of the fragility of the patient's mental state, the therapist announced her pregnancy in the third month, well before the patient might notice any physical changes. At this point, although the psychosis had resolved, the patient continued to express a profound sense of defectiveness, helplessness, and hopelessness. She had developed an idealized transference and held a fixed view of the therapist as all-knowing, perfect, and able to save her. The patient responded to the therapist's announcement of her pregnancy with surprise and quickly spoke of her admiration and joy for the therapist. In spite of the therapist's attempts to invite a range of feelings, this reaction formation remained fixed throughout the pregnancy. It may be that the therapist was unconsciously fearful of her patient's anger and may have colluded with the patient in denying her angry and murderous feelings. (Gerson[9] wrote of her difficulty in inviting patients' hostile feelings when pregnant.) Additionally, the therapist felt off-balance in the presence of the patient for the remainder of the pregnancy. She felt as if her obvious pregnancy contributed to the patient's unbearable despair.

When the therapist returned from her maternity leave with her sense of equilibrium restored, she felt able to invite negative feelings more fully. Nevertheless, this patient remained unable to express any negative feelings toward the therapist or the baby. She eventually left therapy several months after the therapist returned. The author might have been well advised not to accept this fragile infertile patient into treatment when she knew that she might become pregnant soon. It may be that the therapist's guilt regarding her pregnancy interfered with her ability to help this patient experience her feelings.

Pregnancy is a time of vulnerability and loss of balance for therapists. Ongoing consultation is valuable in helping the pregnant therapist to recognize her countertransference blind spots and to provide a "good enough" holding environment for the patient to fully explore his or her feelings about the pregnancy.

SIMULTANEOUS EXPOSURE

Unexpected Illness

A therapist's unexpected illness provides many opportunities for exposure of personal details that may put both the therapist and the patient off balance. Therapists who have enjoyed a sense of omnipotence in the therapist role may experience a disruption in the way they relate to themselves and their patients when they suddenly become ill. Serious, life-threatening illness destabilizes us all. The patient also loses the sense of predictability that he has come to rely on. The patient may be notified of the therapist's illness by a stranger and may not be given a date when the therapist will return, intensifying the patient's sense of loss. Some patients experience a sense of abandonment and disorganization of their psychological world. Although the therapist has no control over the timing of the illness and often little control over what is said to the patient, he gener-

ally has some time to prepare for the discussion of the details of his illness when he resumes therapy with the patient.

A colleague experienced an unexpected serious heart attack followed by open heart surgery. Several colleagues informed his patients that their therapist was seriously ill and would be away from work for an indeterminate time. They were told he would notify them later when he was ready to return.

As would be expected, the heart attack, surgery, and recovery aroused a sense of mortality and feelings of fear and uncertainty about the future that were unfamiliar to the therapist. To help him work through this disruption in his sense of himself, the therapist reentered psychotherapy. Additionally, he discussed with his supervision group his sense of vulnerability and of loss of control. At one point he wondered whether it was appropriate for him to continue as a therapist with his current patients given the disruption of the frame, his own loss of usual defenses, and the patients' loss of transference idealization. With the help of his colleagues, he decided it would, in fact, be more destructive for his patients if he did not return than if he returned and worked through the shared losses and disruption.

Upon his return to work the therapist still felt as if he had lost his sense of equilibrium. Nevertheless, he found himself helping his patients explore their fear of his death while he was simultaneously processing his own feelings about his newly experienced sense of mortality. The therapist found that containing his own fears as he was helping his patients explore their fears was one of the biggest professional challenges he had faced. He continued to use his supervision group and his individual psychotherapy to help him with his intense new feelings. Although several patients needed extra support from colleagues over the course of the therapist's illness and recovery, no patients seriously regressed or terminated therapy.

It took several years for the therapist to integrate his newly found feelings of vulnerability and mortality into his sense of self. As time went on, he became more comfortable with experiencing his anxiety about his future while at the same time encouraging his patients to explore their feelings about his health. Together, the therapist and the patients fashioned a new frame, with adjusted expectations of trust and predictability, built on their shared experience with mortality.

Miscarriage

A therapist's miscarriage is another example of unwitting exposure caused by unexpected changes in health. A miscarriage is an unexpected traumatic event that disrupts a woman's sense of stability. The therapist has very little ability to predict the exposure of her loss to her patients and very little time to prepare for her discussion of this loss with her patients.

A colleague had a miscarriage in her fifth month of pregnancy after a long period of infertility. She was grief-stricken and experienced a sudden jolt in her sense of herself as she was forced to shift her identity from that of a pregnant woman to that of a nonpregnant woman. The pregnancy had just recently become noticeable, and the therapist had begun to tell patients she was pregnant. When she miscarried, she missed a few days of work with no advance notice. She was forced to deal with patients' reactions to the rupture in the frame, disruption of the transference, and her loss. At the same time, she was feeling angry, sad, shocked, and vulnerable.

The therapist had a particularly difficult time helping several of her patients deal with her loss. These were single women in their late 30s who had been dealing with uncertainty and sadness as to whether they would ever have children. Because of their infertility, she had told these patients about her pregnancy before she told other patients and before it was visible—about 4 weeks before the miscarriage. Their initial reactions had been characterized by jealousy, anger, and a sense of abandonment. When they learned of the therapist's miscarriage they felt stunned, were unable to experience any feelings, and became depressed.

The therapist found that discussing her uncharacteristic anger, emotional lability, and grief with colleagues and her supervisor helped her to regain her familiar sense of herself as a therapist. She then was able to understand that these women unconsciously believed that their previous expressions of anger and jealousy were responsible for the miscarriage. They were unable to experience their anger at the sudden rupture of the frame, turned their aggression inward, and became depressed. With her increased sense of equilibrium and insight in hand, the therapist was able to encourage her patients to express their feelings of jealousy, grief, and fear aroused by her fragility. In this instance the loss of equilibrium created by her miscarriage became an opportunity for deeper exploration of both her own and her patients' competitive and aggressive feelings.

PATIENT LEARNS DETAILS ON HIS OWN

At times a patient may learn personal details about the therapist on his own. The patient may experience a disruption of the therapeutic frame before the therapist knows of the exposure. The therapist may experience a shift in her relationship with this patient and not know why. In the following cases, when such an exposure was discovered the therapists felt surprised, confused, and angry. They had no time to prepare for the discussion of these personal details with the patients, although they

might have predicted that one of their patients would be exposed to these details.

Patient Reads Therapist's Medical Record

The first case example involves a treatment conducted by a colleague who experienced a serious heart attack that required immediate surgery and a prolonged absence from his patients.

The therapist received his medical care at the institution in which his patient worked. When the therapist returned from his medical leave, he was physically well enough to work but, as would be expected, still felt vulnerable and mildly disorganized because of his lost sense of omnipotence and his concern for his future. Before returning to work, he thought about and reviewed with colleagues a carefully prepared approach to the exploration of patients' feelings about his illness. He paid particular attention to his countertransference feelings that might inhibit the full exploration of his patients' fantasies and feelings. He felt he was ready for most questions about his illness and recovery.

Several weeks after his return, he realized that one patient who worked at the institution in which he had received his care knew much more about his illness than he had disclosed. Upon exploration, the patient revealed that she had read his chart and knew details about the therapist's medical status that he had decided to keep private, such as details of his family history and his idiosyncratic reactions to medication. The therapist was flooded with an unexpected sense of exposure, vulnerability, and rage that inhibited him momentarily from exploring with the patient both her reactions to the illness and her inappropriate intrusion into his private life. The therapist felt unsteady in sessions with this patient for some time. This very experienced therapist decided that until he was able to reestablish a sense of balance about his own feelings he would protect the therapy by becoming less active. He believed that this temporary decrease in activity was preferable to expressing feelings that he did not yet fully understand. With the aid of supervision, the therapist was able to regain his sense of internal balance and adopt his usual even manner to discuss with the patient his sense of violation. Additionally, he told the patient that such an intrusion into his private life was unacceptable and could not be repeated. The patient and the therapist spent months exploring the patient's discomfort in expressing her rage and fear about the therapist's abrupt departure and the feelings of both parties regarding the patient's intrusion. They then were able to examine this uncharacteristic behavior in the context of the patient's history.

Although there was no way to anticipate the specifics of this incident, any therapist who receives medical care at an institution in which his patient works would be wise to prepare himself for the possibility that some of his personal medical information might become exposed to this patient. The therapist might have predicted such a possibility and used the support of colleagues to prepare himself for managing his feelings of violation. Additionally, all therapists who have an ongoing medical condition would be well served to think ahead and discuss with supervisors and colleagues what they might tell their patients if their illness becomes more obvious, interferes with their work, or increases in severity.

This intrusion into the therapist's personal life constituted a serious violation of the therapeutic boundaries. In this particular case, the patient was able to listen to the therapist's reaction, and together they were able to work with their feelings about the illness and the violation and come to some understanding of the meaning of this behavior in the light of the ongoing therapy. However, such intrusive behavior on the part of a patient represents potential danger for the therapist and the patient. The therapist must acknowledge that such snooping on the part of the patient is a danger to himself and the patient and must set limits immediately. Such serious breaches of the frame could lead to stalking of the therapist.

Patient Is Told of Therapist's Illness

The second case example demonstrates the destabilizing effect that the exposure of details of a therapist's serious illness can have on both therapist and patient. As in previous cases, the therapist had no time to prepare for the discussion, but might have predicted that this information would be exposed to one of his patients.

A male colleague received an unexpected diagnosis of malignant melanoma. This diagnosis stirred up intense feelings of disbelief, fear, panic, and an unbearable sense of vulnerability in the therapist. The actual surgical removal of the mole was minimally invasive, and the therapist missed no work. Therefore, in contrast to the intense inner turmoil the therapist experienced, his patients experienced no obvious interruption in treatment. Because of a disruption in his sense of himself, the therapist contemplated a possible short leave from work.

In the same week, the one patient who worked at the institution in which he received his medical care appeared at the ER displaying much affective lability, experiencing thoughts of suicide, and describing flashbacks to his mother's death when the patient was quite young. After an extended interview, the patient told the ER doctor that the

day before a co-worker told him that his therapist was dying of cancer. The patient's affective lability decreased, he was judged safe to go home, and the therapist was called.

During the patient's regular appointment the next day, the therapist, still shocked by his diagnosis, felt mildly disorganized by the loss of the frame. He was faced with the task of conducting a psychotherapy hour with this patient without the benefit of his customary sense of balance, predictability, and privacy. In the hour the patient expressed much distress and described his certain belief that the therapist would die of his cancer and leave him. He asked for a referral because he felt he could not explore his fears with the therapist. The patient's terror and his certainty of the therapist's imminent death stimulated the therapist's own fears and panic regarding his future. The therapist experienced great difficulty in maintaining his professional demeanor and agreed that they needed additional support to help the treatment survive. The therapist enlisted the help of the ER psychiatrist, who agreed to see the patient several times a week for at least 2 months. Because of the traumatic rupture of the frame and the patient's intense fears, the therapist continued to see him weekly to provide reassurance and reestablish the frame.

The ER physician and the therapist together were able to provide a good enough holding environment for the patient to process his intense feelings and continue to function at work and in his daily life. After 2 months, the patient was able to stop seeing the ER physician. Meanwhile, the therapist sought out personal psychotherapy to deal with the threat of a terminal illness. The task of sitting with this patient and discussing the possibility of his imminent death when he had not yet processed it himself proved to be a very great challenge.

Although there was no way to foresee such an occurrence, the therapist might have anticipated that at some point personal medical information might become available to this patient. His decision to use the help of both a supervisor and colleagues to provide a safe place for himself to explore his intense feelings allowed him to recover relatively quickly his familiar sense of balance as a therapist. In turn, he was able to provide the containment necessary for his patient to deal with the turmoil caused by the disruption to the frame.

PUBLIC EXPOSURE

The following case examples illustrate several ways in which public exposure of personal details about the therapist may rupture the therapeutic frame and cause a sense of loss of balance in the therapist. In such cases the therapist might predict that one of her patients could learn details about her through the public exposure and might prepare in a general way to discuss them.

Therapist's Lecture

Patients' attendance at lectures given by their therapists is a common but nonetheless unsettling experience for a therapist. The author has had instances in which she knew ahead of time a patient would be present at her lecture and instances, as in the following case, in which she did not.

The patient told her several weeks beforehand that she had received an invitation to the meeting at which the therapist was giving a lecture to the public and was planning to attend and bring her daughters. The daughters did not know the patient was in psychotherapy. The therapist explored with the patient her expectations and the meaning of her decision to attend. Because she had an opportunity to prepare for this exposure of herself in an anxiety-producing role as lecturer, the therapist approached the event with a sense of balance. However, to her surprise she found that once she faced the audience, looked at her patient, and started her lecture, she was more tense, more constricted, and less spontaneous than usual. One member of the audience asked a particularly difficult question that caught the therapist off guard. The therapist had faced such questions before. However, with her patient present she felt more self-conscious and less able to manage the challenge gracefully and flexibly.

In some instances the therapist might decide that a patient's attendance at the lecture posed too serious a risk to the treatment frame and would advise the patient not to attend the lecture. However, this therapist did not choose to do so. Although she underestimated the personal impact on her of the patient's presence, the lecture was well received. Additionally, the therapist felt it was a positive step for this woman, who had experienced such shame and maternal deprivation and who had such a hard time taking care of herself, to come to the lecture with her daughters.

All therapists would be well served to anticipate that there may be a patient present at any lecture they give in either public and professional settings and to use the help of colleagues ahead of time to explore what it means to the therapist to be observed in a different role. Later exploration of the impact on the patient of such observation of the therapist is essential and can deepen the treatment.

Therapist Receives an Award

A colleague was presented with an award at a large professional meeting. Several weeks later, as he led a group psy-

chotherapy session, a patient told the group that she had been present when the leader had received an award and that she had heard the group therapist's excellent lecture. The group members immediately congratulated the therapist. Several of the patients questioned the therapist about the circumstances of his award. The therapist found himself at the center of attention in the group in a new way. He had to discuss with this patients the experience of receiving the award and talk of his pleasure. He felt out of role and awkward. For several weeks after his exposure, the patient who told of the award was silent in group. The therapist called the group's attention to the shift in the patient's behavior and pointed out the possibility it was related to the patient's negative feelings about the award. The patient was then able to discuss her sense of inferiority in the face of the therapist's competency.

Therapist's Relative Writes Memoir

A colleague experienced an unsettling exposure of personal details to a patient early in his career. A female patient who had an eroticized transference to this young and inexperienced male therapist came across the memoirs of the therapist's father in a bookstore. In his memoirs the father mentioned his son's adolescent promiscuity. The patient told the therapist that she had read the book and "now she knew so much about him." The therapist felt an immediate loss of equilibrium and an impulse to burst out laughing, which he did not do. Because of the intense erotic transference, this was a very uncomfortable therapy for this inexperienced therapist anyway, and this exposure threatened to make the treatment unbearable for the therapist—hence the urge to laugh. The therapist said nothing at the time of the exposure. For the remainder of the course of therapy, the patient referred to the therapist's family members by name, an action that increased the therapist's sense of exposure and vulnerability. With the aid of regular supervision with a senior clinician, the therapist set limits on the extensive discussion of the erotic transference and did not process the discovery of the personal details in the memoirs. The therapist maintained clear, firm boundaries for several more years, during which time the erotic transference decreased and the patient left treatment. This example points to the critical role excellent supervision can play for an inexperienced therapist.

Tragedy in Therapist's Family

Another colleague experienced public exposure of his life when several members of his family were murdered. Because of the unusual nature of the murders, media coverage of the crimes and the trial of the accused murderer was extensive. Not only did patients learn of the murders on the TV news, many of them came to the visiting hours at the funeral home and to the funeral.

Such a profound loss caused the therapist to lose his sense of balance for some time. He asked colleagues to meet with his groups for several weeks until he felt able to function as a therapist. Before he returned to work, the therapist's main concern was whether he would be able to know where he was affectively in each therapy session. He wondered if he could trust his internal experiences during sessions to inform him of his patient's needs. He decided the best way to deal with this exposure and his unbearable loss was to address it directly. He resumed his groups first and told each group that being there and working helped him. He encouraged the patients to tell him if they felt his loss got in the way and he promised he would let them know if he felt his feelings interfered with his ability to act as a therapist. In one training group he wept in response to a group member's very specific question about the murders. The group wept with him.

At the time of the first anniversary of the murders, group members expressed anger and fear when one member became angry with the therapist. They felt anger was dangerous to him. The therapist realized that the group had become stuck because of their concern about his fragility. He decided that in order for the group go on with their work he had to be open about his own anger. He thus told them of his anger at the murderer. In spite of weeping and discussing his own personal anger, the therapist felt he never left his role as therapist.

In the face of this unspeakable tragedy, the opportunities for the therapist to feel exposed and off balance continue. Several years after the murders, a new individual patient told the therapist in the second session, "I know who you are. I want you to know I know." In spite of all he had been through, the therapist was shocked and felt a loss of equilibrium. He continues to deal with the feelings of being off balance by giving patients the information they ask for and encouraging them to let him know if they feel his loss gets in the way. He has found it necessary to be prepared for patients to avoid talking of his loss in order to protect him. His solution has been to have his antennae up and to vigorously explore whatever comes up.

CONCLUSION

This paper adds to the current discourse in the psychotherapy literature on the exposure of personal details about the therapist in therapy. Recognizing that there are no clear answers, nonetheless it is important to broaden the awareness of clinicians to better prepare them for the probability that they will be faced with unexpected exposure of personal details and simultaneously experience a sense of disruption in their sense of themselves as therapists. The discussion raises therapists' consciousness so that they will be aware of the

impact on themselves of exposure of personal material, obtain needed professional support and supervision, and make the most of opportunities for full exploration of patients' material directly or indirectly related to the discovered knowledge. In such cases the treatment may be positively affected by the unwitting exposure. The therapist's obvious vulnerability may help patients to experience a sense of commonality with the therapist and feel less alone and pathological, while at the same time providing an opportunity for patients to empathize with another human being.

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