

# Opening up to disclosure

Anna Ruddle and Sarah Dilks consider whether therapists should talk about themselves in therapy

**As psychologists, we are increasingly encouraged to work as equal partners with people to overcome problems or facilitate recovery, as defined by the individual. There is an emphasis on the common human experience of all parties. So should we be behaving differently with clients, opening up more, sharing our own experiences of stress, anxiety and resilience? Or would this be considered unprofessional and even risky?**

## questions

What do different approaches say about self-disclosure?  
How is therapist self-disclosure experienced by clients?  
Can therapist self-disclosure improve therapy outcomes?

## resources

Goldfried, M., Burckell, L. & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behavior therapy. *Journal of Clinical Psychology*, 59(5), 555-568.  
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.

Psychologists from all corners of the discipline tend to work with people. We often hear about their lives, their hopes and fears, their highs and lows. But do they need to hear about ours?

As an example, consider working with people experiencing psychosis. Here, paranoia and social isolation often limit opportunities for ordinary interaction and impact on developing trusting relationships. The traditional stereotype of therapists as a silent 'blank screen' suggested it was unhelpful or even dangerous to share anything about ourselves with our clients. But recovery approaches to mental health problems (e.g. Department of Health, 2011; Slade, 2009) emphasise that the role of professionals is no longer to 'cure an illness' but instead to work with people towards what they consider a successful outcome.

We have explored therapist self-disclosure (TSD) in the literature and more anecdotally, and it is common practice. Everyone is doing it, but no one

is talking about it. It's time we started: we argue that a lack of systematic consideration of whether or how therapists should talk about themselves in therapy leaves us to grapple over what is 'unprofessional' and what is simply ordinary human interaction.

We are particularly interested in TSD as psychologists working with people who experience psychosis. We have noted the lack of attention to TSD in training and research within our field. This contrasts with discussions with our colleagues, which revealed the frequent and strategic use of TSD in therapy for psychosis. When someone is paranoid about your motives, it makes sense to explain your thinking and actions. Not answering questions about yourself ('I

wonder why you want to know that?') only raises suspicion. So we focus on the potential value of TSD, particularly with psychosis; the need for research to gain a deeper understanding of its use; and the scope for developing TSD practice guidelines.

## What is therapist self-disclosure?

Many mental health professionals presume TSD refers solely to the disclosure of mental health problems. The recovery literature perhaps compounds this view, through the value it places on the employment of staff with personal experience of mental health problems. Social media and anti-stigma campaigns like Time to Change add to the emphasis on promoting personal openness about mental health problems. Amongst others, political commentator Alistair Campbell recently blogged about his own



What is 'unprofessional' and what is simply ordinary human interaction?

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experience of alcoholism and depression in response to comedian Stephen Fry's declaration of a suicide attempt.

However, we take a much broader view of TSD than simply the disclosure of mental health problems. Consistent with the therapy literature (see e.g. Reynolds & Fischer, 1983), we see TSD as the sharing of any aspect of our personal experience with our clients, whether this is:

- | the therapist sharing their thoughts and feelings as they arise in therapy, e.g. 'I've noticed you seem uncomfortable when I ask how you feel', or their rationale for actions in therapy; or
- | disclosure of therapist experience or information outside of the therapy room, from simple biographical information such as 'I come from Nottingham' to stories from their personal life, successful and unsuccessful coping strategies or experiences of having been through adversity, including mental health problems.

Other distinctions between types of TSD that we have found helpful from reviewing the literature and/or our own practice include:

- | reactive (client asks) vs. voluntary (therapist initiates);
- | positive vs. negative (e.g. 'I've noticed you're very caring and loyal' vs. 'When your worries spiral in conversation, it's hard for me to get my opinions across');
- | degrees of intimacy (e.g. 'I really admire people who always keep going' vs. 'I really admire you – you always keep going');
- | degrees of personal information (e.g. 'My cat didn't come home once and I felt anxious' vs. 'I lost my partner in a car accident and will never truly get over it'); and
- | similar vs. dissimilar to client experience (e.g. 'I also felt anxious when I was unemployed' vs. 'I don't agree that you're weak – in fact, I'm

inspired by your resilience').

We believe that context is key to determining the rationale for and consequence of any TSD. The same utterance may carry a very different meaning and impact depending on the particular client, therapist and the specific moment in therapy.

### Different perspectives

Psychoanalysis originally called for neutrality, allowing clients to express their unconscious feelings and desires, enabling the therapist to interpret their meaning and consequences (Freud, 1912/1958). However, Ziv-Beiman (2013) draws attention to more recent strands of psychodynamic psychotherapy that actually encourage some TSD. And a recent review of research into TSD suggests 90 per cent of therapists do self-disclose to their clients (Henretty & Levitt, 2010).

Some therapy approaches, like social constructionist family therapy, (e.g. Freedman & Combs, 1996) actively advocate TSD. For example, in 'reflecting teams' clinicians talk in front of families about what they have observed in a session. They are encouraged to put their comments in their personal context (e.g. 'As an Asian female, I can sympathise with the daughter struggling to get her voice heard'). Associated narrative approaches such as the Tree of Life (Ncube, 2006) radically challenge traditional views of TSD by encouraging therapists to share their personal life stories and values with their clients.

In contrast to psychoanalysis and family therapy, cognitive behaviour

## Why self-disclose?

(adapted from Henretty & Levitt, 2010)

- | To promote client disclosure
- | To foster the therapeutic relationship/alliance
- | To model for clients
- | To encourage clients' autonomy
- | To facilitate client self-exploration and self-revelation, especially around interpersonal patterns
- | To validate reality
- | To normalise and promote feelings of universality
- | To equalise power
- | To repair an impasse or alliance rupture
- | To correct misconceptions
- | To assist clients in identifying and labelling their emotions
- | To show similarities
- | To reassure
- | To build client self-esteem
- | To demystify therapy
- | To reinforce and/or shape for desirable client behaviour
- | To offer alternative ways to think or act
- | To help clients recognise boundaries between what they think and feel and what others think and feel
- | To provide clients with authentic human-to-human interaction

therapy (CBT) has little written about TSD. Some textbooks briefly reference its value in normalising a client's distress but only one article explores it in detail (Goldfried et al., 2003). Some recent 'third wave' cognitive approaches have given it slightly more attention, such as acceptance and commitment therapy (ACT). Harris (2009), for instance, advocates TSD 'if and when it's likely to be beneficial to the client in the service of normalization, validation, promoting self-acceptance, or enhancing the therapeutic relationship' (p.235).

### The rationale for self-disclosure

The literature cites a wide range of motives for TSD, predominantly gleaned

disclosure in cognitive-behavior therapy. *Journal of Clinical Psychology*, 59(5), 555–568.

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from surveys with therapists. Henretty and Levitt (2010: see box) summarise a number of these, stemming from their thorough review of quantitative research into TSD. Goldfried et al. (2003) also specifically outline the rationale for using TSD in CBT.

It seems particularly pertinent to use TSD to build a good working relationship and gain a client's trust early in therapy. TSD can also be used to model effective ways of coping (e.g. Dryden, 1990) and illustrate the commonality of unhelpful behaviours and thinking styles (e.g. 'I tend to be a bit of a perfectionist in my work and sometimes I find it exhausting too').

Note that disclosure might have a number of effects. It could help the client see the unhelpfulness of their current strategies; reduce distress by recognising we are all only human; or open up possibilities for new ways of thinking and acting. It may of course also induce anxiety – 'If she's a perfectionist, am I doing a good enough job in this therapy?! Clearly while a therapist may have a sound rationale for disclosing, the potential consequences need to be carefully considered.

As clinicians working with psychosis, we have noticed the particular value of TSD due to the specific difficulties in engaging people who are suspicious or socially isolated, and the stigma and social exclusion resulting from a diagnosis of psychosis. Individuals experiencing psychosis have often been marginalised by society. If we listen empathically to their unusual experiences, discuss ordinary reactions to suffering, but also look beyond these experiences and speak about 'normal' everyday things, this can be profoundly empowering and de-stigmatising ('she makes me feel like I'm someone special as well, that I'm worthy': client Tanya, quoted in Dilks et al., 2013, p.328). In this context, we think a number of reasons from Henretty and Levitt's (2010) list are especially pertinent: fostering the therapeutic relationship, correcting misconceptions, demystifying therapy, repairing an impasse in the alliance, validating a person's reality and normalising their experiences.

In our experience of working with paranoia, the early stages of therapy are critical in fostering the relationship and gaining someone's trust. Clients may misinterpret a benign comment in a

negative way or incorporate the therapist into their belief that there is a government conspiracy against them. Offering clients transparency about your motives and actions can reduce this suspicion (e.g. explaining 'I'm asking you lots of questions because I want to understand properly, but you don't have to tell me if you don't want to').

TSD can be used in these early stages of therapy to show you are an honest, warm person with no ill intentions. You might choose to use TSD via general 'small talk', referring to an episode of *EastEnders* or a recent football match. This builds a sense of alliance but also provides clients with genuine, authentic human-to-human interaction, demystifying therapy.



TSD can also be effective when used to validate a person's reality, even if this is seen as unusual or different to what others believe. This does not mean we have to agree with or endorse particular beliefs (so we might explicitly say 'I haven't personally experienced my neighbours trying to hurt me'). But as therapists, we can use our psychological understanding to offer a genuine empathic response (e.g. saying 'If I was thinking my neighbours wanted to kill me I would feel terrified'). Or we can show our understanding that specific beliefs make sense in the context of a person's life: 'If I had experienced all the abuse and violence you did growing up, I might also be on the lookout for people out to get me.'

The therapist sharing their own 'odd' experiences (Nelson, 1997, p.85), including hearing voices or feeling they've been followed, can be very helpful in illustrating the universality of certain types of human experience. Simply

providing information on the prevalence of experiences clients erroneously believe to be 'mad' or uncommon can also be a relief – for instance, see Ellett and Wildschut's (2014) recent article in *The Psychologist* on the commonality of paranoia.

Chadwick (2006), an experienced clinician in the field of psychosis, summarises his position as coming from a commitment to openness and mindful acceptance, which in his view necessitates TSD: 'Therapists need to be open and consistent... If I make a mistake, I apologise; if I am stuck, I say so; if clients ask me a personal question, I take the question at face value and answer directly... If the question is too personal, I would say this...' (p.75).

### What's the impact of disclosure?

Henretty and Levitt (2010) comprehensively reviewed the quantitative research into TSD, demonstrating there are not enough studies to reach many conclusions. Their review suggested TSD enhanced clients' ratings of therapist warmth but did not have any reliable impact on other qualities traditionally deemed important to therapy outcomes, such as trustworthiness and empathy. TSD also appeared to induce more self-disclosure by clients if used infrequently and at a low to moderate intimacy level, compared to not disclosing or disclosing frequently. However, varying definitions make it difficult to generalise in this area, and there are other methodological flaws, including the use of analogue methodology (asking non-clinical samples to imagine a therapy situation) and surveys of therapists rather than direct analyses of 'live' therapy sessions.

To our knowledge, there are very few high-calibre qualitative studies exploring the experience of TSD, with the exception of two frequently cited studies: Knox et al. (1997), and Audet and Everall (2010). The latter phenomenological study of clients' experiences identified three types of effects of TSD: (a) 'forming a connection' early in therapy, (b) 'conveying presence' through being attentive and responsive and (c) 'engaging the client in a meaningful working relationship' (p.338). These authors exemplified how TSD could either facilitate or hinder these processes depending on how the disclosure was done and how it was received by clients. For instance, they quote: 'there was this feeling of relief and this person isn't going to think I'm a weirdo or I'm a screw up because they have this relevant

experience of their own' (p.335), in contrast to 'It's kind of like my therapist has a broken finger and my whole arm is broken, and she says, "But you know, we're the same"' (p.336).

### Practice implications

We believe psychological therapists, especially those working with psychosis, are in need of more systematic guidance on the use of TSD. We feel the issue warrants more attention in training, both in teaching and placements. We hope this would encourage more open discussion and reflection in supervision. We also wonder about practice implications for other applied psychologists. How much should educational psychologists share of themselves when working with children? Or occupational psychologists with their clients?

As with any therapy skill, guidelines on TSD would need to be used flexibly. Use of TSD is likely to vary according to the therapeutic approach, stage of therapy, therapist's professional experience, personal preference, therapy process issues and the interaction between all these factors. While some guidance about staff self-disclosure exists in the recovery literature (e.g. Scottish Recovery Network, 2007) and some NHS Trusts are developing guidance (e.g. Dorset Wellbeing and Recovery Partnership, 2013), we are not aware of any specific to therapy. Henretty and Levitt (2010) do provide some detail in their helpful recommendations about 'what', 'when', 'why' and 'how' to self-disclose in therapy, based on their literature review. For example, they recommend that therapists 'self-disclose infrequently' and 'take into account the client's possible reactions' (p.73). However, their recommendations make clear there are no hard-and-fast rules for TSD. Rather, TSD requires careful consideration in relation to each specific client and their individual context. We would therefore encourage therapists to bear these what, when, why and how questions in mind whenever considering the use of TSD.

In addition it is also worth thinking about when *not* to self-disclose as a therapist (e.g. when a negative consequence is possible or likely).

For instance, when the TSD may:

- I invoke envy in a client (e.g. 'I'm off to the Bahamas');
- I involve a personal experience the therapist has not overcome sufficiently to remain objective;
- I open up areas of questioning the therapist is not comfortable with;
- I inappropriately shift the focus of

therapy to the therapist (as one client put it, 'It almost felt like a parent-child relationship... like I was the therapist and she was the patient getting everything off her chest': Audet & Everall, 2010, p.335); or

- I encourage confusion about the nature of the relationship (e.g. TSD for some may imply that a more intimate personal relationship is possible).

With regard to 'how' to disclose, the therapist could consider informing a client that they might occasionally do this, or could seek permission in advance of a disclosure they think may have particular impact. They may also want to ask the client what their experience was of the TSD and possibly return to it later in therapy. Finally, therapists might consider rehearsing a warm but clear way of saying they are not comfortable continuing with a particular topic.

### Research recommendations

Research is needed to develop clearer definitions of TSD and a greater understanding of its use and consequences. Although we have a particular interest in TSD in working with psychosis, we believe this applies to therapy more generally. Research would inform the theoretical underpinnings of TSD, allowing it to be incorporated more explicitly within therapy models. For example, research could be developed to test Ziv-Beiman's (2013) model of TSD as a pan-therapy 'integrative intervention'. She argues TSD has a dual effect by enhancing non-specific relationship factors and working as an active technique in its own right (e.g. encouraging insight, cognitive change or change in the experience of self and others). In relation to psychosis, research could examine how TSD might contribute to the key therapist activities identified in Dilks et al.'s (2013) grounded theory model of therapy processes in psychosis.

More systematic research is especially needed into the use and impact of TSD in real-life therapeutic encounters. For instance, while Goldfried et al. (2003) make reasonable speculations that TSD might impact on clients' engagement in therapy or have a micro-impact within certain CBT techniques (e.g. helping to elicit thoughts or reflect on experiments to test out beliefs), these hypotheses have yet to be tested.

We believe the most promising research will come from studying actual interactions within therapist-client pairs. This work would benefit from lessons learnt in therapy process research,

accommodating the complexities of investigating the impact of therapist-client interactions that are mutually influential (Stiles, 2013).

In this vein, Henretty and Levitt (2010) recommend 'future researchers... take into account multiple factors of therapist disclosure, such as intimacy/depth, duration/breadth, timing, quality, client readiness and content' (p.70). They also suggest considering whether the TSD was 'of positive versus negative information... before or after a client disclosure... volunteered or as a result of a client question, and the client's expectations and preferences' (p.70). Measuring these multiple factors would help capture the complexities of the therapeutic interaction.

### Changing the narrative

In our experience, therapist self-disclosure is regularly practised yet rarely discussed. Its neglect within training, theory and research perhaps stems from a longstanding narrative that TSD may be unhelpful or even dangerous. Yet a review of the literature and an informal survey of expert psychologists working in psychosis revealed TSD is much more prevalent than one might think. Indeed, it seems therapists are actively engaging in TSD as a therapeutic technique in itself.

Of course, many clinicians may want to hold their own position on TSD, and some may be uncomfortable with the idea of training or guidelines. Yet mental health services are moving towards a more recovery-focused, anti-stigma, partnership model of working. Are we therefore approaching a position of expecting some therapist self-disclosure? If so, we need to build more systematic support, guidance and research around its use. This would help ensure we practise both ethically and effectively but also, importantly, that we look after ourselves.



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