

Marquette University

**e-Publications@Marquette**

---

College of Education Faculty Research and  
Publications

Education, College of

---

2002

## Self-Disclosure

Clara E. Hill

*University of Maryland - College Park*

Sarah Knox

*Marquette University, sarah.knox@marquette.edu*

Follow this and additional works at: [https://epublications.marquette.edu/edu\\_fac](https://epublications.marquette.edu/edu_fac)



Part of the [Education Commons](#)

---

### Recommended Citation

Hill, Clara E. and Knox, Sarah, "Self-Disclosure" (2002). *College of Education Faculty Research and Publications*. 168.

[https://epublications.marquette.edu/edu\\_fac/168](https://epublications.marquette.edu/edu_fac/168)

## Self-Disclosure

---

Clara E. Hill

Sarah Knox

Self-disclosure is one of the most controversial therapist interventions, with some theorists enthusiastically promoting it and others adamantly opposing its use in therapy. The purpose of this chapter is to review the empirical evidence about the effectiveness of therapist self-disclosure in individual therapy and propose guidelines for using it in practice. But first, we define therapist self-disclosure and discuss the theoretical positions about its use.

### DEFINITION

We define therapist self-disclosure as therapist statements that reveal something personal about the therapist. Note that this definition excludes disclosures that are nonverbal (that is, based on observations of dress, office decor, and surroundings) because these nonverbal disclosures are not voiced or offered discretely at one point in time and hence are qualitatively different from verbal disclosures. Most of the literature about therapist self-disclosure leaves the definition at this broad, inclusive level, although some have defined self-disclosure more narrowly. For example, McCarthy and Betz (1978) distinguished between self-disclosing disclosures (henceforth called just self-disclosures) and self-involving disclosures (which have also been called immediacy). Similarly, Hill and O'Brien (1999, p. 369) defined self-disclosure as a statement that "reveals something personal about the helper's nonimmediate experiences or feel-

ings," such as "When I'm not seeing clients, I like to fish." They defined immediacy as "immediate feelings about self in relation to the client, about the client, or about the therapeutic relationship" (p. 369), for example, "I'm feeling anxious right now with you."

Hill and O'Brien (1999) further recommended subdividing therapist self-disclosure into four subtypes: *disclosures of facts* ("I got my degree from Southern Illinois University"), *disclosures of feelings* ("When I have been in that situation, I felt angry"), *disclosures of insights* ("When I was in a similar situation adjusting to college, I realized that what made it so difficult was that I felt guilty leaving my mother all by herself"), or *disclosures of strategies* ("When I was in that situation, I forced myself to brush my teeth as soon as I finished lunch"). Therapists likely use each subtype for a different intention in the therapy process, and each probably also has a different outcome.

Another distinction in the literature is between positive or negative disclosures. This distinction has sometimes referred to positive or negative experiences or personal characteristics of the therapist (e.g., Hoffman-Graff, 1977) and at other times has referred to the therapist's positive or negative feelings or reactions to the client (Andersen & Anderson, 1985; Remer, Roffey, & Buckholtz, 1983; Reynolds & Fischer, 1983). Hill, Mahalik, and Thompson (1989) argued that the positive/negative dimension was too value-laden and suggested instead a reassuring/challenging dimension to capture the intent behind the

positive/negative distinction. For Hill and colleagues (1989), reassuring disclosures support, reinforce, or legitimize the client's perspective, way of thinking, feeling, or behaving; whereas challenging disclosures challenge the client's perspective, way of thinking, feeling, or behaving.

Furthermore, self-disclosures can be categorized in terms of whether or not the disclosure is reciprocal, that is, in response to a similar client disclosure (Barrett & Berman, *in press*). Finally, from the literature on client self-disclosure (see Cozby, 1973), we know that disclosures can be evaluated in terms of the breadth or amount of information disclosed, the depth or level of intimacy of information disclosed, and the duration or time spent in disclosure.

Therapist self-disclosure, then, has been defined variously in the literature, but one theme that unites these definitions is that therapist self-disclosure involves a therapist's personal self-revelatory statement. Hence, unless otherwise specified, the reader should assume that we are using this broad definition of self-disclosure in this chapter.

## THEORETICAL POSITIONS ON THERAPIST SELF-DISCLOSURE

### Psychoanalytic/Psychodynamic Theories

Although Freud is reputed to have used self-disclosure with his patients, including showing them pictures of himself and discussing personal activities and interests (Cornett, 1991), his writings warn other analysts against such practices. Following Freud's directives, psychoanalytic therapists have been trained to be neutral, anonymous, abstinent, and non-self-disclosing in therapy. Such a neutral approach is deemed necessary for uncovering, interpreting, and resolving client transference, which psychoanalysts assert must remain unhampered by information about the therapist as a real person (Goldstein, 1997). As Jackson stated, "The point of the therapist's revealing little . . . is so that the patient may reveal more" (1990, p. 94). In fact, psychoanalytic therapists have asserted an inverse relationship between a client's knowledge of a therapist's per-

sonal life, thoughts, and feelings, and a client's capacity to develop transference to the therapist (Freud, 1958). Psychoanalysts generally acknowledge, however, that total anonymity on the part of therapists is impossible. Nevertheless, many assert that therapists should strive for relative anonymity, confining self-disclosure to information implicit in the therapy setting, such as revelations inherent in therapists' offices and appearances (Lane & Hull, 1990).

Many psychodynamic therapists, though clearly rooted in the psychoanalytic tradition, have tempered their view of therapist self-disclosure. For example, Lane and Hull (1990) stated that clients may become more aware of the effects of their behaviors on others when therapists disclose their reactions to clients. Likewise, Goldstein (1997) and Palombo (1987) argued that thoughtful use of therapist self-disclosure can reinforce the empathic attunement and responsiveness necessary for successful engagement and treatment of some clients.

### Humanistic Theories

Humanistic theorists more openly embrace therapist self-disclosure, asserting that such interventions demonstrate therapists' genuineness and positive regard for clients (Robitschek & McCarthy, 1991) and demystify the therapeutic process (Kaslow, Cooper, & Linsenberg, 1979). Proponents of this approach advocate therapist authenticity, realness, and mutuality (Goldstein, 1997), regarding these as necessary prerequisites for client openness, trust, intimacy, gains in self-understanding, and change (Rogers, 1951; Truax & Carkhuff, 1967). Therapist transparency is believed to make the therapist more humane, to bind therapist and client together, to enable therapists to serve as models of personal growth for clients (Lane & Hull, 1990), and to equalize the control over the therapy relationship while simultaneously correcting client transference misconceptions (Jourard, 1971). In addition, therapist self-disclosure is believed to help clients feel less alone with their painful experiences and emotions, thereby confirming the essential humanness and universality of clients' experiences (Cornett, 1991).

### Behavioral/Cognitive/ Cognitive-Behavioral Theories

It is likely that therapists with behavioral and cognitive orientations would view therapist self-disclosures positively, especially when these interventions are intended to serve as a model for client self-disclosure. We found nothing in the literature, however, that describes how therapist self-disclosure is viewed by these orientations.

### Feminist Theories

Feminist therapists have supported the appropriate use of therapist self-disclosure (Mahalik, VanOrmer, & Simi, 2000), believing that this intervention can serve several therapeutic goals. Therapist self-disclosure may, for example, serve as a vehicle for transmitting feminist values, equalize power in the therapy relationship, facilitate client growth, foster a sense of solidarity between therapist and client, help clients view their own situations with less shame, encourage clients' feelings of liberation, and acknowledge the importance of the real relationship between therapist and client. In addition, feminist therapists believe that therapist revelation can enable clients to make informed decisions about whether or not they choose to work with a therapist. For clients to make such decisions, appropriate content for therapist self-disclosure includes therapists' beliefs and lifestyle, religious and class background, sexual orientation, political views, and feelings toward clients.

### Multicultural Theories

Multicultural theories, which are now considered the fourth force in psychotherapy, also advocate using self-disclosure, particularly with clients from different sociocultural backgrounds and alternative lifestyles (Goldstein, 1994; Jenkins, 1990; Sue & Sue, 1999). Because mental health services often occur within a biased historical and social context (Jenkins, 1990), therapists working with clients who are culturally different from themselves may need to self-disclose to prove themselves worthy of trust (Sue & Sue, 1999). The client stance of "Prove that you can be trusted" or

"Before I open up to you, I want to know where you are coming from" is nevertheless difficult for therapists because of the implied demand for self-disclosure, an intervention many are still trained to avoid. Some clients, however, may not open up until the therapist first discloses.

### CLINICAL EXAMPLES

The following two clinical examples are taken from a qualitative study (Knox, Hess, Petersen, & Hill, 1997) in which clients were interviewed about their experiences of therapist self-disclosure and its effects. These examples were selected because they were clear illustrations of therapist self-disclosure (as opposed to immediacy) and because they had a positive impact on the clients.

"Ann," a 35-year-old White woman who sought therapy for depression and an eating disorder, had been in therapy with "Dr. S," a 45-year-old White male therapist, for almost 7 years. A helpful self-disclosure that Ann vividly remembered was when Dr. S revealed that he spent his childhood summers at the beach. This disclosure made Ann feel that Dr. S could understand her because she, too, had spent summers at the shore. She also viewed Dr. S's disclosure as evidence that he trusted her, which increased Ann's self-esteem, comfort, and sense of importance. As a result of the ensuing discussions of days spent at the shore, Ann was able to recall the good times of her childhood and see her parents as not entirely evil, but as ill. This realization allowed Ann to forgive her parents before they died and also helped her feel less guilty about her own children. Furthermore, the disclosure equalized the therapy relationship and enabled Ann to see Dr. S as a real person. Ann credited Dr. S's disclosure with having allowed her to feel more comfortable and open with him and with fostering her trust in him.

"Susan," a 44-year-old White woman with dissociative identity disorder, had been seeing "Dr. A," a 58-year-old White male therapist, for almost four years. She described their early relationship as uncomfortable and distrusting, "rocky" enough that she used his comments and reactions as reasons to consider leaving therapy. Dr. A's

consistency and persistence, however, allowed Susan to feel more safe and open to revealing her feelings, and so she stayed in therapy. Susan, who was interested in AIDS research, brought in a song about a young man dying of AIDS and gave it to Dr. A. When Dr. A returned the tape, he disclosed that one of his family members had died of AIDS. Susan was initially surprised by the personal nature of his disclosure and then felt sympathy for Dr. A. She said that this disclosure enabled her to be more open, more present, and less protective in therapy. She viewed the disclosure as a gift, which made her feel safer, closer, and special that someone like Dr. A would share such a personal and emotional experience with her. The disclosure validated her feelings about the trauma of loss, which she could connect to recent losses in her own family. Dr. A's disclosure also changed how Susan saw him: It made him easier for her to talk to, equalized their relationship, and helped her feel better outside of therapy.

## RESEARCH REVIEW

### Perceptions of Therapist Self-Disclosure by Nonclients

The existing research on how therapist self-disclosure is experienced has been primarily analogue in design (that is, involving simulations of therapy rather than actual therapy). Subjects (usually undergraduate psychology students participating for course credit) are typically presented with a stimulus of a disclosure embedded in a written transcript, audiotape, or videotape of a hypothetical therapy session. After reading, listening to, or watching the stimulus, participants rate their perceptions of the disclosure and/or of the therapist.

Generally, these studies have shown that nonclients perceived both therapist self-disclosing and self-involving disclosures favorably. Of 18 studies of therapist self-disclosure in individual therapy, 14 reported positive perceptions of therapist self-disclosure (Bundza & Simonson, 1973; Doster & Brooks, 1974; Dowd & Boroto, 1982; Feigenbaum, 1977; Fox, Strum, & Walters, 1984; Hoffman-Graff, 1977; Myrick, 1969; Nilsson, Strassberg, & Bannon, 1979; Peca-Baker & Fried-

lander, 1987; Simonson, 1976; Simonson & Bahr, 1974; VandeCreek & Angstadt, 1985; Watkins & Schneider, 1989; Wetzel & Wright-Buckley, 1988), three reported negative perceptions (Carter & Motta, 1988; Cherbosque, 1987; Curtis, 1982), and one reported mixed findings (Goodyear & Shumate, 1996). Of seven studies investigating therapist self-involving statements in individual therapy, six reported positive perceptions (Andersen & Anderson, 1985; Dowd & Boroto, 1982; McCarthy & Betz, 1978; Remer, Roffey, & Buckholtz, 1983; Reynolds & Fischer, 1983; Watkins & Schneider, 1989), whereas one reported negative perceptions (Cherbosque, 1987).

In his review of this analogue literature on therapist self-disclosure, Watkins (1990) concluded that therapists who self-disclosed in a moderate or nonintimate way have been viewed more favorably and elicited more client self-disclosure than therapists who did not disclose at all, who disclosed a lot, or who disclosed personal and intimate material. This analogue research provides some useful information, suggesting that therapist self-disclosure is experienced positively by nonclients who read it, listened to it, or observed it. Because of their analogue design, however, the findings may not be generalizable to real clients in real therapy relationships. Only one of the analogue studies, for example, investigated the effects of therapist self-disclosure with current therapy clients rather than nonclients (Curtis, 1982). Similarly, we are limited in our understanding of how these results may apply to non-majority populations, for only Cherbosque (1987) specifically targeted such participants.

### Frequency of Therapist Self-Disclosure in Psychotherapy

According to a number of different sources (judges, clients, and therapists), therapist self-disclosure is a low-frequency intervention in therapy. For example, across several studies where judges coded therapist behavior in transcripts of therapy sessions, 1 to 13% (with an average of 3.5% across studies) of all therapist interventions in individual therapy were self-disclosures (Barkham & Shapiro, 1986; Elliott et al., 1987; Hill, 1978; Hill, Thames, & Rardin, 1979; Hill et al., 1988; Stiles, Shapiro, & Firth-Cozens, 1988). In a study con-

ducted by Ramsdell and Ramsdell (1993) of former clients (surveyed up to 14 years after therapy ended) who had been seen at least six times by therapists from a wide variety of orientations, 58% said that their therapist had self-disclosed at least once. Specifically, 9% said their therapist had disclosed once, 34% indicated 3–4 times, 9% indicated 4–9 times, and 6% said their therapist had disclosed 10 or more times. Given that Ramsdell and Ramsdell assessed clients' memories of how much therapists had disclosed rather than having judges code disclosure behavior in sessions, this study probably captured more of clients' perceptions of memorable self-disclosures or their overall sense of the therapists' disclosing style. Finally, in a survey of therapists from a wide range of orientations (Edwards & Murdock, 1994), therapists reported that they generally disclosed a moderate amount (3 on a 5-point scale), with only 6% indicating that they never disclosed.

A few studies have examined how often different types of therapist self-disclosures have been used. Therapists reported that they disclosed most often about their professional background (e.g., therapy style and training) and rarely about sexual practices and beliefs (Edwards & Murdock, 1994; Geller & Farber, 1997; Robitschek & McCarthy, 1991). Clients reported more helpful than unhelpful therapist disclosures in a study of individual therapy (Knox et al., 1997).

Furthermore, humanistic/experiential therapists reported disclosing more often than did psychoanalytic therapists (Edwards & Murdock, 1994; Simon, 1990) and were also judged by experienced clinical psychologist raters as having a more disclosing style than analytic therapists (Beutler & Mitchell, 1981), which fits with their stated theoretical orientations. No differences in disclosure were reported, however, between male and female therapists (Edwards & Murdock, 1994; Robitschek & McCarthy, 1991), nor among therapists of different racial/ethnic origins (Edwards & Murdock, 1994).

### Why Do Therapists Disclose?

On the basis of reviewing videotapes of their sessions, therapists indicated that they had disclosed to give information and to resolve their own needs (Hill et al., 1988). In surveys (Edwards & Mur-

dock, 1994; Geller & Farber, 1997; Simon, 1990), therapists indicated that they most often disclosed to increase perceived similarity between themselves and their clients, to model appropriate behavior for clients, to foster the therapeutic alliance, to validate reality or normalize client experiences, to offer alternative ways to think and act, and because clients wanted therapist disclosure. Similarly, when clients were asked why they thought their therapists disclosed, they indicated that they believed therapists disclosed to normalize their experiences, reassure them, and help them make constructive changes (Knox et al., 1997). Hence, there is some overlap between therapist and client perceptions of why therapists disclose (to normalize experiences, reassure clients, and help clients change).

Therapists indicated on surveys that they generally *avoided* self-disclosure when the disclosure would fulfil their own needs, move the focus from the client to the therapist, interfere with the client's flow of material, burden or confuse the client, be intrusive for the client, blur the boundaries between the therapist and client, overstimulate the client, or contaminate the transference (Edwards & Murdock, 1994; Geller & Farber, 1997; Simon, 1990). These results suggest that therapists are very aware about possible negative consequences on outcome of disclosing in therapy.

### The Effects of Therapist Self-Disclosure

The effects of therapist self-disclosure have been investigated both in terms of immediate outcome in the session (for example, what happens in the session right after a therapist self-discloses) and in terms of distal outcome (for example, changes after treatment).

#### *Immediate Outcome*

Given that the frequent reasons for using therapist self-disclosures are immediate goals for the therapy process rather than long-term goals for symptom change, it makes sense to examine immediate rather than ultimate outcome. Indeed, the studies (three studies on two data sets) that have examined the immediate outcome of therapist self-disclosures on clients have found positive

effects. Hill and colleagues (1988) found that clients gave the highest ratings of helpfulness and had the highest subsequent experiencing levels (such as involvement with their feelings) in response to therapist self-disclosures. In contrast, therapists gave the lowest ratings of helpfulness to self-disclosures, which Hill and colleagues speculated may have been because disclosures made therapists feel vulnerable. In a further analysis of the same data, Hill, Mahalik, and Thompson (1989) found that reassuring disclosures were viewed as more helpful than challenging disclosures in terms of both client and therapist helpfulness ratings and subsequent client experiencing levels.

In a qualitative study of helpful therapist self-disclosures (Knox et al., 1997), clients noted several major impacts of helpful therapist self-disclosures (not including immediacy statements). Knox and colleagues (1997) noted that therapist self-disclosures led to client insight and made the therapist seem more real and human. Feeling that the therapist was more real and human in turn improved the therapeutic relationship and helped clients feel reassured and normal. The improved therapeutic relationship and feeling reassured and normal in turn made clients feel better and served as a model for positive changes and for being open and honest in therapy. It is interesting to note here that the effects of therapist self-disclosure were part of a complicated sequence of events combining both immediate and distal outcome.

### *Treatment (Distal) Outcome*

The results of studies of the effects of therapist self-disclosure on ultimate outcome have been mixed. Of studies using a correlational method, no relationship was found between the frequency of therapist self-disclosures and client, therapist, and/or observer judgments of treatment outcome in six studies (Beutler & Mitchell, 1981; Braswell, Kendall, Braith, Carey, & Vye, 1985; Coady, 1991; Hill et al., 1988; Kushner, Bordin, & Ryan, 1979; Williams & Chambless, 1990), and a negative relationship was found between frequency of therapist self-disclosure and therapists' ratings of client improvement in another study (Braswell et al., 1985). We should note, however, that the

definitions of and ways of assessing self-disclosure in these studies were vague and inconsistent.

In contrast to the previous neutral or negative results, two other studies using other methodologies found positive effects of therapist self-disclosure on treatment outcome. A survey of former clients who had received at least six sessions of treatment found that clients rated therapists' sharing personal information as having a beneficial effect on therapy (Ramsdell & Ramsdell, 1993). Another study found that clients who received more *reciprocal* therapist self-disclosures (that is, self-disclosures in response to similar client self-disclosures) liked their therapists more and had less symptom distress after treatment, although they did not increase in the number or intimacy of their own self-disclosures (Barrett & Berman, 2001).

The Barrett and Berman study involved an experimental manipulation such that graduate-student therapists increased the number of reciprocal self-disclosures in brief therapy with one client and refrained from using them with another client. Importantly, therapists gave only about five disclosures per session in the high-disclosure condition, suggesting that disclosures were still infrequent.

### Summary of Empirical Research

So what do we know? A summary of the analogue literature suggests that nonclients generally have positive perceptions of therapist self-disclosure. They liked therapists who moderately disclosed personal information about themselves. A summary of the literature about actual therapy indicates that humanistic/experiential therapists disclosed more than psychoanalytic therapists, therapists disclosed infrequently in therapy, and therapists disclosed mostly about professional background and rarely about sexual practices and beliefs. Furthermore, in actual therapy, disclosures were perceived as helpful rather than unhelpful in terms of immediate outcome, although the effects on the ultimate outcome of therapy remain unclear. Finally, therapists had many therapeutic reasons for disclosing (to give information, to normalize client's experiences), as well as several indications of when they would avoid



disclosing (to meet their own needs, to move the focus from client to therapist).

## LIMITATIONS OF THE RESEARCH

Although the research evidence on therapist self-disclosure is provocative and interesting, it must be viewed with caution. Studies have rarely used similar definitions or methods to study self-disclosure, and results have not been replicated across studies in actual therapy. In what follows, we briefly identify several problems in hopes of improving future research.

### Definitional Issues

Many different definitions of therapist self-disclosure have been used in the empirical literature, making it difficult to compare results across studies. For example, is "willingness to be known" the same as "revealing something personal about oneself"? Clearly, a therapist disclosure of a superficial past positive experience in response to a similar client disclosure (such as, "I also felt anxious when I took tests in college") would be viewed very differently from a deep therapist disclosure of immediate feelings in the therapeutic relationship ("I am feeling angry at you right now because it feels like you're belittling me"). Hence, we stress that researchers must clearly define what they mean by therapist self-disclosure. Preferably researchers should use definitions consistent with those used by other researchers so that results can be compared across studies. Furthermore, we strongly encourage researchers to differentiate between self-disclosures and immediacy, and to differentiate subtypes of disclosures (of facts, of feelings, of insight, and of strategies) given that different types of disclosures probably have different effects on therapy.

### Focus on Frequency

Much of the research investigating the effects of therapist self-disclosure in actual therapy has correlated the frequency of self-disclosures with treatment outcome. Clearly, there is no compelling reason to believe that more disclosures should

lead to better outcome. It may even be that therapist self-disclosure yields its positive effects because it typically occurs so infrequently. In fact, therapists may disclose more in particularly difficult cases where the client has trouble making a connection with the therapist. Such cases may have worse outcomes not because of the greater number of therapist self-disclosures, but because of the clients' initial disturbance level. Similarly, Stiles, Honos-Webb, and Surko (1998) identified a problem in the entire process-outcome literature that they called "responsiveness." They noted that therapists give clients what they perceive they need at a particular time. If therapists are indeed responsive to client needs, it is unlikely that there would be a relationship between therapist self-disclosure and outcome; one client might need one disclosure, whereas another might need ten. Hence, frequency is not the right thing to be examining; rather, researchers should be examining types of disclosures, timing of disclosures, quality of disclosures, and client readiness for disclosures. Furthermore, it strains the imagination to think that any single self-disclosure would lead to client change at the end of treatment. Rather, it makes sense that self-disclosures influence the immediate process, which then indirectly influences treatment outcome.

### Lack of Theoretical Basis for Research

Another important issue to note is that despite the rich theoretical literature on therapist self-disclosure, most of the research has been atheoretical. Hence, we do not know if therapist self-disclosure contaminates the transference as asserted by psychoanalytic theorists, or whether it is particularly appropriate with culturally different clients as asserted by multicultural theorists. Given the provocative and widely divergent claims by the different theoretical orientations, research is needed to determine to test these propositions.

### Methodology and Analysis

The analogue design of many of the studies presents limitations because they are not realistic and have limited applicability to real clients, real therapists, and real therapy, where the evolving con-



text and relationship are crucial. In addition, most of the participants in the analogue studies were undergraduates participating for research credit, and these students may differ in meaningful ways from actual therapy clients. Furthermore, the therapist self-disclosure stimulus used in these studies was often provided with minimal context, instead of emerging out of an ongoing interaction between therapist and client. In fact, a study that compared therapists' responses to filmed clients (an analogue) with their actual behavior in intake sessions with real clients found that therapists did not disclose the same amount in the analogue situation as they did in real intake sessions (Kushner et al., 1979).

In addition, the most typical methods for analyzing the effects of therapist self-disclosures in ongoing therapy have been the correlational method mentioned above (in which the frequency of therapist self-disclosures is related to session or treatment outcome), sequential analyses (in which the effects of self-disclosure are tested in terms of the immediate client behavior), surveys (in which therapists and clients are asked about their experiences of giving or receiving therapist self-disclosures), and qualitative methods (in which participants are interviewed and data are coded using words rather than numbers). Each method for studying self-disclosure has its advantages and disadvantages (see Hill & Lambert, in press), and none is ideal for studying therapist self-disclosure. We suggest that new models need to be built that combine sequential analyses of immediate outcome with analyses of longer-term outcome, incorporating mediating variables such as how the client thought about and acted upon the disclosures outside of therapy.

Thus, particular types of disclosures (for example, reassuring and reciprocal) done at the optimal time in therapy might help to build the therapeutic alliance, which in turn might allow clients to benefit further from other interventions and feel confident to explore themselves more thoroughly and make changes, which in turn may lead them to disclose more to significant others outside therapy and receive positive feedback, which in turn might lead to better treatment outcome. This more complicated pathway of influence needs to be investigated using new methodologies designed specifically for this purpose.

## THERAPEUTIC PRACTICES

In crossing the threshold of anonymity, therapists may powerfully affect their clients with self-disclosures. It is incumbent upon therapists, then, to understand the potential impact of their disclosures and to use this intervention appropriately. On the basis of the empirical literature, we suggest several practice guidelines (note that these guidelines are for self-disclosure and not for immediacy).

1. *Therapists should generally disclose infrequently.* A number of studies show that therapists disclose only infrequently. It may be that self-disclosure is helpful because it occurs so infrequently.

2. *The most appropriate topic for therapist self-disclosure involves professional background, whereas the least appropriate topics include sexual practices and beliefs.* Disclosing about professional background seems particularly important so that therapists can inform clients about their credentials and build trust. Such disclosures are also relatively benign and not deeply intimate. Disclosing about sexual practices and beliefs, in contrast, is not typically necessary for therapy and may be much too intimate for the therapeutic setting. Research has indicated that therapists who disclosed nonintimate material were viewed more favorably than those who disclosed intimate material.

3. *Therapists should generally use disclosures to validate reality, normalize, model, strengthen the alliance, or offer alternative ways to think or act.* These reasons for disclosing appear to be helpful in therapy and to enhance the therapeutic relationship.

4. *Therapists should generally avoid using disclosures that are for their own needs, remove the focus from the client, interfere with the flow of the session, burden or confuse the client, are intrusive, blur the boundaries between the therapist and client, overstimulate the client, or contaminate the transference.* Disclosures used for each of these reasons can have a deleterious effect on the therapy relationship and process. In addition, disclosures used for these reasons may signal that the therapist is struggling with unresolved conflicts, which should be addressed in supervision and/or personal therapy.

5. *Therapist self-disclosure might be particularly effective when it is in response to similar client self-disclosure.* Therapist self-disclosure used in response to similar client self-disclosure may be effective because it helps clients feel normal and reassured.

6. *Therapists should observe carefully how clients respond to their disclosures, ask the clients about their reactions, and use that information to conceptualize their clients and decide how to intervene next.* Therapist self-disclosure is a provocative and potentially powerful intervention, so therapists need to monitor how clients react to it (how they feel when they hear it, whether it influences their view of the therapist, and whether it affects the therapy relationship).

7. *It may be especially important for therapists to disclose with some clients more than others.* Therapists may need to use self-disclosure in some cases to build trust. Without therapist self-disclosure, some clients might not persist in therapy.

## REFERENCES

- Andersen, B., & Anderson, W. (1985). Client perceptions of counselors using positive and negative self-involving statements. *Journal of Counseling Psychology*, 32, 462-465.
- Barkham, M., & Shapiro, D. A. (1986). Counselor verbal response modes and experienced empathy. *Journal of Counseling Psychology*, 33, 3-10.
- Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, 69, 597-603.
- Beutler, L. E., & Mitchell, R. (1981). Psychotherapy outcome in depressed and impulsive patients as a function of analytic and experiential treatment procedures. *Psychiatry*, 44, 297-306.
- Braswell, L., Kendall, P. C., Braith, J., Carey, M. P., & Vye, C. S. (1985). "Involvement" in cognitive-behavioral therapy with children: Process and its relationship to outcome. *Cognitive Therapy and Research*, 9, 611-630.
- Bundza, K. A., & Simonson, N. R. (1973). Therapist self-disclosure: Its effect on impressions of therapist and willingness to disclose. *Psychotherapy: Theory, Research, and Practice*, 10, 215-217.
- Carter, R. I., & Motta, R. W. (1988). Effects of intimacy of therapist's self-disclosure and formality on perceptions of credibility in an initial interview. *Perceptual and Motor Skills*, 66, 167-173.
- Cherbosque, J. (1987). Differential effects of counselor self-disclosure statements on perception of the counselor and willingness to disclose: A cross-cultural study. *Psychotherapy*, 24, 434-437.
- Coady, N. F. (1991). The association between complex types of therapist interventions and outcomes in psychodynamic psychotherapy. *Research on Social Work Practice*, 1, 122-138.
- Cornett, C. (1991). The "risky" intervention: Twinship self-object impasses and therapist self-disclosure in psychodynamic psychotherapy. *Clinical Social Work Journal*, 19, 49-61.
- Cozby, P. C. (1973). Self-disclosure: A literature review. *Psychological Bulletin*, 79, 73-91.
- Curtis, J. M. (1982). The effect of therapist self-disclosure on patients' perceptions of empathy, competence and trust in an analogue psychotherapeutic interaction. *Psychotherapy: Theory, Research, and Practice*, 19, 54-62.
- Doster, J. A., & Brooks, S. J. (1974). Interviewer disclosure modeling, information revealed, and interviewee verbal behavior. *Journal of Consulting and Clinical Psychology*, 42, 420-426.
- Dowd, E. T., & Boroto, D. R. (1982). Differential effects of counselor self-disclosure, self-involving statements, and interpretation. *Journal of Counseling Psychology*, 29, 8-13.
- Edwards, C. E., & Murdock, N. L. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling and Development*, 72, 384-389.
- Elliott, R., Hill, C. E., Stiles, W. B., Friedlander, M. L., Mahrer, A. R., & Margison, F. R. (1987). Primary therapist response modes: Comparison of six rating systems. *Journal of Consulting and Clinical Psychology*, 55, 218-223.
- Feigenbaum, W. M. (1977). Reciprocity in self-disclosure within the psychological interview. *Psychological Reports*, 40, 15-26.
- Fox, S. G., Strum, C., & Walters, H. A. (1984). Perceptions of therapist disclosure of previous experience as a client. *Journal of Clinical Psychology*, 40, 496-498.
- Freud, S. (1958). *The dynamics of the transference*. In J. Strachey (Ed.), *The standard edition of the complete works of Sigmund Freud* (Vol. 12, pp. 97-109). London: Hogarth. (Originally published in 1912)

- Geller, J. D., & Farber, B. A. (1997, August). *Why therapists do and don't disclose*. Paper presented at the annual meeting of the American Psychological Association, Chicago, IL.
- Goldstein, E. G., (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, 22, 417-433.
- Goldstein, E. G. (1997). To tell or not to tell: The disclosure of events in the therapist's life to the patient. *Clinical Social Work Journal*, 25, 41-58.
- Goodyear, R. K., & Shumate, J. L. (1996). Perceived effects of therapist self-disclosure of attraction to clients. *Professional Psychology: Research and Practice*, 27, 613-616.
- Hill, C. E. (1978). Development of a counselor verbal response category system. *Journal of Counseling Psychology*, 25, 461-468.
- Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988). The effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology*, 35, 222-233.
- Hill, C. E., & Lambert, M. J. (in press). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.
- Hill, C. E., Mahalik, J. R., & Thompson, B. J. (1989). Therapist self-disclosure. *Psychotherapy*, 26, 290-295.
- Hill, C. E., & O'Brien, K. (1999). *Helping skills: Facilitating exploration, insight, and action*. Washington, DC: American Psychological Association.
- Hill, C. E., Thames, T. B., & Rardin, D. (1979). A comparison of Rogers, Perls, and Ellis on The Hill Counselor Verbal Response Category System. *Journal of Counseling Psychology*, 26, 198-203.
- Hoffman-Graff, M. A. (1977). Interviewer use of positive and negative self-disclosure and interviewer-subject sex pairing. *Journal of Counseling Psychology*, 24, 184-190.
- Jackson, J. M. (1990). The role of implicit communication in therapist self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 93-102). New York: Plenum.
- Jenkins, A. H. (1990). Self-disclosure and the non-white ethnic minority patient. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 117-134). New York: Plenum.
- Jourard, S. M. (1971). *The transparent self*. New York: Van Nostrand Reinhold.
- Kaslow, F., Cooper, B., & Linsenberg, M. (1979). Family therapist authenticity as a key factor in outcome. *International Journal of Family Therapy*, 1, 194-199.
- Knox, S., Hess, S., Petersen, D., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44, 274-283.
- Kushner, K., Bordin, E. S., & Ryan, E. (1979). Comparison of Strupp and Jenkins' audiovisual psychotherapy analogues and real psychotherapy interviews. *Journal of Consulting and Clinical Psychology*, 47, 765-767.
- Lane, R. C., & Hull, J. W. (1990). Self-disclosure and classical psychoanalysis. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 31-46). New York: Plenum.
- Mahalik, J. R., VanOrmer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 189-201). Washington, DC: American Psychological Association.
- McCarthy, P. R., & Betz, N. E. (1978). Differential effects of self-disclosing versus self-involving counselor statements. *Journal of Counseling Psychology*, 25, 251-256.
- Myrick, R. D. (1969). Effect of a model on verbal behavior in counseling. *Journal of Counseling Psychology*, 16, 185-190.
- Nilsson, D. E., Strassberg, D. S., & Bannon, J. (1979). Perceptions of counselor self-disclosure: An analogue study. *Journal of Counseling Psychology*, 26, 399-404.
- Palombo, J. (1987). Spontaneous self-disclosures in psychotherapy. *Clinical Social Work Journal*, 15, 107-120.
- Peca-Baker, T. A., & Friedlander, M. L. (1987). Effects of role expectations on clients' perceptions of disclosing and nondisclosing counselors. *Journal of Counseling and Development*, 66, 78-81.
- Ramsdell, P. S., & Ramsdell, E. R. (1993). Dual relationships: Client perceptions of the effect of client-counselor relationship on the therapeutic process. *Clinical Social Work Journal*, 21, 195-212.
- Remer, P., Roffey, B. H., & Buckholtz, A. (1983). Differential effects of positive versus negative self-involving counselor responses. *Journal of Counseling Psychology*, 30, 121-125.
- Reynolds, C. L., & Fischer, C. H. (1983). Personal

- versus professional evaluations of self-disclosing and self-involving counselors. *Journal of Counseling Psychology*, 30, 451-454.
- Robitschek, C. G., & McCarthy, P. R. (1991). Prevalence of counselor self-reference in the therapeutic dyad. *Journal of Counseling and Development*, 69, 218-221.
- Rogers, C. (1951). *On becoming a person*. Boston: Houghton Mifflin.
- Simon, J. C. (1990). Criteria for therapist self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 207-225). New York: Plenum.
- Simonson, N. R. (1976). The impact of therapist disclosure on patient disclosure. *Journal of Counseling Psychology*, 23, 3-6.
- Simonson, N. R., & Bahr, S. (1974). Self-disclosure by the professional and paraprofessional therapist. *Journal of Consulting and Clinical Psychology*, 42, 359-363.
- Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, 5, 439-458.
- Stiles, W. B., Shapiro, D. A., & Firth-Cozens, J. A. (1988). Do sessions of different treatments have different impacts? *Journal of Counseling Psychology*, 35, 391-396.
- Sue, D. W. & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: Wiley.
- Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy*. Chicago: Aldine.
- VandeCreek, L., & Angstadt, L. (1985). Client preferences and anticipations about counselor self-disclosure. *Journal of Counseling Psychology*, 32, 206-214.
- Watkins, C. E., Jr. (1990). The effects of counselor self-disclosure: A research review. *The Counseling Psychologist*, 18, 477-500.
- Watkins, C. E., Jr., & Schneider, L. J. (1989). Self-involving versus self-disclosing counselor statements during an initial interview. *Journal of Counseling and Development*, 67, 345-349.
- Wetzel, C. G., & Wright-Buckley, C. (1988). Reciprocity of self-disclosure: Breakdowns of trust in cross-racial dyads. *Basic and Applied Social Psychology*, 9, 277-288.
- Williams, K. E., & Chambless, D. L. (1990). The relationship between therapist characteristics and outcome of in vivo exposure treatment for agoraphobia. *Behavior Therapy*, 21, 111-116.