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Abstract: *A review of the analogue literature about therapist self-disclosure suggests that nonclients generally have positive perceptions of therapist self-disclosures. A review of the naturalistic psychotherapy literature indicates that therapist self-disclosure occurs infrequently, is used more often by humanistic-experiential than psychoanalytic therapists, is most often about professional background than about intimate personal details, is used for many different reasons, is used cautiously by therapists, and is helpful in the immediate process of therapy. Effects of therapist self-disclosure on the ultimate outcome of therapy are less clear. Limitations of the research (poor and inconsistent definitions and lack of a clinically appropriate methodology for studying self-disclosure) and guidelines for therapeutic practice are presented.*

Therapist self-disclosure can be broadly defined as statements that reveal something personal about therapists. Although most of the literature has used this broad definition, it is important to distinguish self-disclosures (which reveal nonimmediate personal information) from immediacy statements (which reveal immediate feelings about the client or the therapeutic relationship). Therapist self-disclosure is one of the most controversial therapist interventions, with some theorists enthusiastically promoting it and others adamantly opposing

its use ([Hill & Knox, 2002](#)). The purpose of this article is to review the empirical evidence about the effectiveness of therapist self-disclosure in individual therapy and propose guidelines for its use in practice.

Perceptions of Therapist Self-Disclosure by Nonclients

Most of the existing research on therapist self-disclosure has been analogue in design, that is, involving simulations of therapy rather than actual therapy. In these analogue studies, participants (usually undergraduate psychology students participating for course credit) have been presented with a disclosure stimulus embedded in a written transcript, audiotape, or videotape of a hypothetical therapy session, after which they rate their perceptions of the disclosure or of the therapist. Of 18 analogue 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 & Friedlander, 1987](#); [Simonson, 1976](#); [Simonson & Bahr, 1974](#); [VandeCreek & Angstadt, 1985](#); [Watkins & Schneider, 1989](#); [Wetzel & Wright-Buckley, 1988](#)), 3 reported negative perceptions ([Carter & Motta, 1988](#); [Cherbosque, 1987](#); [Curtis, 1982](#)), and 1 reported mixed findings ([Goodyear & Shumate, 1996](#)). In his review of this analogue literature, [Watkins \(1990\)](#) concluded that therapists who self-disclosed in a moderate or nonintimate way have been viewed more favorably and have elicited more client self-disclosure than therapists who did not disclose at all, who disclosed a lot, or who disclosed very intimate material. Hence, we can conclude that nonclients typically perceive therapist self-disclosure positively.

Use of Therapist Self-Disclosure in Psychotherapy

How often do therapists disclose? Across several studies in which judges coded therapist verbal behavior from transcripts of therapy sessions, 1 to 13% (mean 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 et al., 1988](#); [Hill, Thames, & Rardin, 1979](#); [Stiles, Shapiro, & Firth-Cozens,](#)

[1988](#)). Hence, it appears that therapist disclosure occurs infrequently in therapy.

What is the focus of therapist self-disclosure? 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](#)). Hence, disclosures are not typically about personal, intimate topics.

What types of therapists disclose? 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](#)). 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](#)). Hence, theoretical orientation appears to be a better predictor of therapist self-disclosure than demographic variables.

Why do therapists disclose? When reviewing videotapes of their sessions, therapists indicated that they disclosed to give information and to resolve their own needs ([Hill et al., 1988](#)). In surveys ([Edwards & Murdock, 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 of thinking and acting, and to satisfy clients who wanted therapist disclosure. Similarly, when asked why they thought their therapists disclosed, clients indicated that therapists disclosed to normalize their experiences, reassure them, and help them make constructive changes ([Knox, Hess, Petersen, & Hill, 1997](#)). Hence, therapists disclose for a variety of reasons, all of which reflect immediate goals for therapy process rather than longer-term goals for therapy outcome.

When would therapists not disclose? Therapists indicated that they generally avoided self-disclosure when the disclosure was for their own needs or when the disclosure would move the focus from the client to the therapist, would interfere with the client's flow of material, would burden or confuse the client, would be intrusive for the client, would blur the boundaries between the therapist and client, would overstimulate the client, or would contaminate the transference ([Edwards & Murdock, 1994](#); [Geller & Farber, 1997](#); [Simon, 1990](#)). Hence, therapists are cautious about disclosing in many situations, suggesting that disclosure can be a risky intervention.

Effects of Therapist Self-Disclosure

In the previous section, we noted that the more typical reasons for using therapist self-disclosures are immediate goals for the therapy process rather than long-term goals for symptom change. Therefore, 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 et al. \(1988\)](#) found that clients gave the highest ratings of helpfulness and had the highest subsequent experiencing levels (i.e., involvement with their feelings) to therapist self-disclosures. Interestingly, therapists gave the lowest ratings of helpfulness to self-disclosures, perhaps because disclosure made them 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 ([Knox et al., 1997](#)), clients noted several major impacts of helpful therapist self-disclosures. [Knox et al. \(1997\)](#) 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.

The results of studies of the effects of therapist self-disclosure on distal or 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, 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 self-disclosures were vague, and the methods of assessing self-disclosure were 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 of personal information as having a beneficial effect on therapy ([Ramsdell & Ramsdell, 1993](#)). Another study found that clients who received more reciprocal therapist self-disclosures (i.e., 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.

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 review of the literature about actual therapy indicates that humanistic—experiential therapists disclosed more than psychoanalytic therapists, that

therapists disclosed infrequently in therapy, and that therapists disclosed mostly about professional background and rarely about sexual practices and beliefs. Therapists had many therapeutic reasons for disclosing (e.g., to give information, to normalize client's experiences), as well as several indications of when they would avoid disclosing (e.g., to meet their own needs, to move the focus from client to therapist). Finally, disclosures were perceived as helpful rather than unhelpful in terms of the immediate outcome of therapy, but the effects on the ultimate outcome of therapy remain unclear.

Limitations of the Empirical Research

Although the evidence about the effects on therapist self-disclosure is provocative and interesting, it must be viewed with caution. We identify several methodological problems in hopes of improving future research.

First, many different definitions of therapist self-disclosure have been used in the empirical literature, making it difficult to compare results across studies (e.g., "willingness to be known" may not be the same thing as "revealing something personal about oneself"). Clearly, a therapist disclosure of a superficial past experience in response to a similar client disclosure (e.g., "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, researchers must clearly define what they mean by therapist self-disclosure, preferably using definitions consistent with those used by previous researchers so that results can be compared across investigations. We also 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).

A second problem is that the analogue design used in many of the studies is not realistic and yields limited applicability to real clients, real therapists, and real therapy, where the evolving context and relationship are crucial. 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](#)).

Third, much of the naturalistic research on therapist self-disclosure has correlated the frequency of self-disclosures with treatment outcome. 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 occurs so infrequently. In fact, therapists may disclose more in particularly difficult cases where the client has trouble making a connection with the therapist. Hence, rather than examining the frequency of self-disclosures, researchers should examine types of disclosures, timing of disclosures, quality of disclosures, and client readiness for disclosures.

In addition to correlational, analogue, and survey methods, sequential analyses (in which the effects of self-disclosure are tested in terms of the immediate client behavior) and qualitative methods (in which participants are interviewed and data are coded using words rather than numbers) have also been used to study the effects of therapist self-disclosure. Each method has advantages and disadvantages; and none is ideal for studying therapist self-disclosure. 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 (e.g., 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. This 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. On the basis of the empirical literature on self-disclosure, we suggest several therapeutic practice guidelines:

1. Therapists should generally disclose infrequently.
2. The most appropriate topic for therapist self-disclosure involves professional background, whereas the least appropriate topics include sexual practices and beliefs.
3. Therapists should generally use disclosures to validate reality, normalize, model, strengthen the alliance, or offer alternative ways to think or act.
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, or overstimulate the client.
5. Therapist self-disclosure in response to similar client self-disclosure seems to be particularly effective in eliciting client disclosure.
6. Therapists should observe carefully how clients respond to their disclosures, ask about client reactions, and use the information to conceptualize the clients and decide how to intervene next.
7. It may be especially important for therapists to disclose with clients who have difficulty forming relationships in the therapeutic setting.

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Notes

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