Transparency and Self-Disclosure[1] in Family Therapy: Dangers and Possibilities

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Therapy is a paid intimate relationship that thrusts clients and therapists into navigating personal and professional boundaries. When, where, why, and how is it appropriate and ethical for family therapists to be transparent, and when is it damaging? Theorists take varied stances from Haley's position of tight boundaries around therapist disclosure—whether in treatment or training—to the narrative viewpoint that therapists should be transparent about models of therapy, personal values, and life experiences that inform their practice and beliefs. However, these positions are not research based, and theorists who support disclosure offer few guidelines other than general statements. This article examines the history of ideas about disclosure in six major family therapy models, and the dangers and possibilities of transparency. It looks at the research on self-disclosure in individual therapy and whether and how it could apply to family therapy. Guidelines are proposed that take into account the multiple social identities of therapists and clients, and issues of safety and transparency.

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Sam and Mina[2] came alone to the fourth session. He had just received a diagnosis of prostate cancer, and they were struggling with how they were going to manage the

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[1]The terms self-disclosure, transparency, and disclosure have been used differently in varied disciplines. In this article, self-disclosure is defined as information that is shared by therapists that pertains to their personal lives. Transparency is when therapists are open about their methods of work, beliefs and values, and personal experiences that may inform the therapy. Clients may also be asked at times if they are willing to be transparent about their experiences with other clients and professionals. Disclosure is used as a term that encompasses both acts of self-disclosure and transparency. Self-disclosure has been further broken down into two categories by some theorists (Knox et al., 1997): self-revealing (personal information is revealed by the therapist) and self-involving (when therapists share with clients their reactions and responses to them). I have chosen not to make this distinction in this paper as transparency includes self-involving disclosures.

[2]In order to protect privacy and confidentiality, names and identifying information of clients, trainees, and colleagues have been changed, except for my own, or where the information exists in a public document.

upheaval that this illness had brought into their lives, and when, where, and how to tell their children. Unbeknownst to them, I grappled with my own questions: Would it be helpful or a hindrance to tell them of my own recent bout with cancer? To what end might I want to share that information? Was I in enough emotional control of my own experience that I could keep the focus on their story?

My most vivid memories from almost 30 years of work as a family therapist, educator, supervisor, and consultant are of times when I participated in and/or observed the intricate negotiations that occur between clients and therapists around their relationship boundaries. Possibilities might be opened up or dangers unleashed. Could I briefly present something about my illness experience to Sam and Mina, and fold the conversation back to their challenges? Would I be able to carefully attend to their reactions to see if sharing anything else about my time with cancer might be of support?

Given the numerous social identities we carry with us, I have become increasingly focused on how our perceived ''racial'' identity, sexual orientation, identity as a person with an illness, gender, cultural background, class, familial type, and so on, are or are not available as resources for relationship building and dilemma sharing in therapy. Crucial to this examination is looking at identities that have been marginalized or discriminated against, or identities that carry privilege. For example, if I were a therapist with AIDS and I was working with a client with AIDS in a scenario similar to the opening vignette, how would the questions I would ask myself about disclosure of my illness be similar or different?

Social identities shift, are visible and invisible, and are assumed correctly or incorrectly by others. Disclosures about who we are, both intentional and unintentional, are common in therapy. This has implications for trainees, supervisors, therapists, and clients. For instance, Patrice Wilson, a lesbian and trainee on a team on which I was the supervisor, said to me in private, ''I watch from behind the one-way mirror how other students talk about their relationships with their partners and their kids. I don't feel comfortable doing this with the rural families we work with. I take my ring off before I go into the therapy room because I don't know what I would say if a family member asked me if I was married. I feel like I don't have as many options as other students to join and connect with families.'' Because of possible prejudiced reactions, she felt that a resource that other people used in their work was not available to her. I asked Patrice, who was out to the team, if she felt comfortable sharing these thoughts with other team members. She decided to discuss it with them, and they asked her if she would like to do a role-play in which she was out to a family. They also asked if she could identify one couple or family with whom she was working to whom she could disclose more about her personal experiences. Thus, a process began in which Patrice gradually explored ways to tap into disclosure possibilities. Central to any steps like these is that therapists and trainees have control over how and what they disclose.

Clients also need protection from disclosures that may be unsafe. In a commonly used training video, the therapist works with three generations of an Anglo Mexican family. The 8-year-old daughter usually lives with her grandmother and her great-grandmother. The mother expresses sadness, guilt, and frustration that the daughter does not live with her much of the time. Financially she is struggling. The therapist states that the mother has to be like the chairman of the board, heading up parenting decisions for her daughter but always talking with the other board members (the grandmother and the great-grandmother) and making decisions together with them. Then he inappropriately shares a story from his own life. He says, ''My daughter lives

with my wife and me all the time so we can make the decisions for her.'' This disclosure highlights the differences in social class between the therapist and the mother. It holds a number of possibilities for the client to feel criticized and in a one-down position.

Little attention has been given in models of family therapy to guidelines about disclosure, or how social identities are intertwined with disclosure. Therapists, trainees, and supervisors have a responsibility to try to ensure that disclosures do not create a prejudicial experience for clients. What creates enough safety to share personal aspects of social identity? What constraints exist? Further, there has been minimal focus on what it means in teaching and supervision to intentionally crisscross private and public boundaries. In presenting seminars and workshops in the United States, Ecuador, Mexico, Russia, Colombia, England, and Spain, among other countries, I have been struck by how my disclosures about dilemmas I have faced often opens up possibilities for participants to take risks and expand their learning about family therapy concepts and therapeutic process. What can guide us in these practices? How can we assure that transparency is in the service of the work, and not serving a personal agenda? Stances taken within family therapy models about disclosure are foundational to this discussion.

TRACKING THE HISTORY

A brief overview follows presenting how various theorists in family therapy have dealt with the topic of disclosure.[3] Relevant terms such as *use of self*, *joining*, *mutuality*, and *decentering practices* are tracked because the shifts and changes in terminology provide information about the changing attitudes toward disclosure by therapists. In addition, observing how people grapple with language and attempt to capture what happens as therapists disclose or fail to disclose information highlights the intricacies of this aspect of therapy. What is indisputable is that both therapists and clients struggle to traverse the unique relationship possibilities that therapy offers. In a survey of 282 therapists and interviews with 60 of them about self-disclosure in therapy, one of Mathews's (1988) main conclusions was that as therapists thought through whether to disclose, they were saying that ''yes, the therapeutic relationship is different (from other relationships) . . . but not always . . . and we are not always sure when it is different or in what ways'' (p. 530). Clients contend with defining the relationship as well. Victor, a Mexican American father, challenged his therapist, ''asking her why and how she expected them to disclose so much personal information when she was unwilling to reveal anything about herself'' (Falicov, 1998, p. 22). Or, as Azar, a client who has had a crush on an old lover for months, put it, ''I liked my therapist a lot better after she told me recently that she was obsessed with someone for 10 years.''

[3] I invite readers to think about how theories you have been trained in have affected your perspectives on disclosure in therapy, and your social identities and background. For example, I come to these themes as a heterosexual middle-class woman of Irish, Anglo, and Welsh background trained in structural, strategic, Bowen, Milan, feminist, and narrative models. I have also been strongly influenced by familial experiences; my father was hospitalized in a state mental institution in the 1950s and given electro-shock treatment for suicidal depression. There was nothing transparent about these events and his subsequent psychiatric care in our family of six. Rather, they grew unspoken in our family life like the pale green algae that fills New England ponds in summer heat.

Proponents of two of the early models of family therapy, structural and strategic, eschewed many traditional stances about therapy (Haley, 1976; Minuchin, 1974). However, they stayed close to psychodynamic ideas about keeping tight boundaries between therapists and clients with regard to disclosure on the part of the therapists. This was mirrored in stances on training where the supervisors or teachers did not look at their own values, beliefs, and families of origin[4] as part of understanding what they brought to the therapeutic process. For example, Haley (1976) described a bill of rights for clinical students that ''includes an item that says no teacher may inquire into the personal life of a therapy student, no matter how benevolently, unless: (1) he [sic] can justify how this information is relevant to the immediate therapy task in a case, and (2) he can state specifically how this inquiry will change the therapist's behavior in the way desired'' (pp. 176–177).

The use of self was proposed but only to facilitate joining.

> As an instrument of change, the use of self should not be confused with self-disclosure of the therapist's personal experiences, which the structural model discourages because it attracts attention to the therapist and distracts from family process. In the structural model, stories from the therapist's own life are only justified as instruments of joining (''I have two sons of the same ages.'') (Colapinto, 1991, p. 436)

Disclosure is used as a limited technique connected to joining. In addition, the self of the therapist is presented more generically, not as a person with varied social identities that one might call upon to use in joining.

There is also an emphasis on having just one person in the treatment room. Other team members are seen as ''introducing an element of distraction in the joining of therapist and family'' (Colapinto, 1991, p. 435), and they dilute the power of the therapist to use oneself to enter into the family system. Themes of hierarchy, boundaries, and therapists retaining control over what is said and done are at the core of strategic and structural work. To the extent that relational aspects are emphasized, they are in the service of the therapist keeping a position of power and greater responsibility than that of clients.

In contrast with strategic and structural work, in the symbolic experiential model (a model that commonly used cotherapists), Carl Whitaker proposed a high degree of self-disclosure (Roberto, 1991). This included disclosure to the family and to a cotherapist in front of the family.

> The purpose of using personal communication is partly to provide a model for the family of intermittent separating and joining, a problem of boundaries. Second, self-disclosure accentuates therapeutic observations by adding affect. . . . Finally, by thinking intimately and subjectively at times, the therapists induce family members to allow their own subjectivity (even irrationality) to emerge for examination. (Roberto, 1991, p. 460)

In watching videotapes of Whitaker's work and reading transcripts, his disclosures appear to be idiosyncratic and provocative. He does not offer guidelines, nor does he articulate a process by which therapists might decide how, where, and when to use different aspects of personal experience or theoretical beliefs.

[4] I prefer the term family that you grew up in (FTYGUI instead of FOO). It is cumbersome, but as a student who was adopted pointed out, your family of origin is not necessarily the family in which you are raised.

In the Bowen family therapy model, self-disclosure, although first done anonymously,[5] was presented as an essential part of training and supervision. Kerr (1981) later wrote that people learning Bowen's theories needed to experience emotional explorations of concepts in order to adequately understand them. Yet, it was not until the feminist interpretations of this work that much was mentioned in the literature about therapist self-disclosure. As theoreticians like Betty Carter and Monica McGoldrick (1989, 1999) looked at life cycle theory in relationship to Bowen's ideas, they addressed the impact of the therapist's developmental stage on the overall shape of the therapy.

Lerner (1999) described ways for trainees to be attentive to the interaction of stages between therapists and clients. He presented a case example where he worked with a family intermittently over a period of years. He wrote movingly of his decision to share with this family that he was diagnosed with cancer. He lived and worked in the same small town and did not want them to hear it from someone else. Several years later, when the father was diagnosed with cancer, he asked for information from Lerner about his illness experience, and found him an important resource. Lerner believes that his self-disclosure both deepened his relationship with the family and contributed to a close working relationship through difficult times, including the subsequent death of the father.

Feminist therapists advocate directly for self-disclosure (Brown, 1994; Mahalik, van Ormer, & Simi, 2000). This is in keeping with their high value on demystifying any types of therapy, increasing collaboration, decreasing hierarchy, affirming shared and diverse experiences of women, and acknowledging power differentials.

> The term self-disclosure has so many different meanings that there is no consensus on its appropriate use. However, because self-disclosure may be ill advised, it must be both value and theory driven and always in the client's best interest. As a result, therapists must develop methods of continually monitoring their levels of self-awareness. The Feminist Training Institute's Code of Ethics states that the therapist is responsible for the use of self-disclosure in a purposive and discretionary manner and always in the best interest of the client (Lerman & Porter, 1990, cited in Wyche & Rice, 1997).

Descriptions of how mutuality and empathy are supported with self-disclosure are common in feminist therapy literature. However, no real guidelines are given about how to address the hazards.

Around the same time that feminist ideas were being integrated into family therapy, Tom Anderson (1987, 1990) elaborated his reflecting team model. He also strived for a more collaborative framework for treatment. In Anderson's work, team members, rather than conveying their messages to the family via phone-ins or private discussion with the therapist behind the one-way mirror, entered the room and talked in the presence of the family. At times, they also shared personal stories about their experiences that might have relevance to the dilemmas that the families were facing. Family members were invited to comment on what they had heard, and to ask for more information (if they wanted to) from particular team members or the therapist about any personal information that had been disclosed.

Roberts (Roberts, ''Alexandra,'' and ''Julius,'' 1988), in writing up a case with clients as coauthors, extended these ideas by demonstrating the importance of

[5] See, for example, Bowen's article (Anonymous, 1972) about his family of origin.

disclosing to clients what is written in case notes and treatment plans. If therapists and trainees do not share the report-writing process with clients, mistakes and inaccuracies cannot be corrected, nor do clients have ownership over records that others read and use to make decisions about them; their story is coopted.

This continues to be an arena in which therapists are reluctant to relinquish their power and are probably the least transparent, yet it is one that has extensive implications. As one client said after he moved cross country and requested records from a previous therapist, ''When I read what he wrote about me, I thought I was the scum of the earth. I thought we had worked well together and he liked me. It took me a long time to recover from reading his report.''

The narrative work of Michael White and others introduced the ideas of transparency[6] and decentering practices into family therapy. With transparency, therapists make the origins of their ideas clear to clients. They may come from their own life experiences, conceptual models, or from their experiences in talking and working with families (White, 1995a). Use of the term ''transparent'' more clearly broadens the practices beyond self-disclosure by including disclosure about theoretical stances and therapeutic work with other clients. Later, in writing about decentering, White moved deliberately into shifting power dynamics in therapy. He views clients as experts who have much to share with other clients through advice that they pass on to one another, support groups that they form, or stories that they share of their own experiences (White, 1997). Team members ask questions of each other in front of clients; this emphasizes what team members are learning from them (Lax, 1995; White, 1995b). However, much is left out with regard to the interplay of the social identities described earlier that clients and therapists bring to therapy, along with issues of visible and invisible social identities, safety, and power.

Within the narrative framework, one of the most detailed explications of the day-to-day logistics of transparency and therapy comes from Jonathan Diamond (2000), an addictions specialist. Given the AA group model and the openness in the substance abuse field to therapists with firsthand experience of conquering addiction, clients sometimes encounter their therapists outside of therapy in places like AA meetings. Diamond wrote eloquently about what can happen when therapists relapse and clients know about it, or when therapists share personal stories at AA meetings and their clients are there. He highlights the importance of therapists carefully acknowledging the different planes of relationship that they have with each client (e.g., as members on a first-name basis only in AA; as therapist and client; as people who live in the same town). Examples are given of questions to raise in therapy to clarify what it might mean to the client, the therapist, and their working relationship when these planes intersect.

In the family therapy literature with regard to disclosure, several points stand out. First, even though there are a wide variety of positions, each is based on anecdotal clinical experience, not on research studies about the efficacy of transparency, or in-depth family and therapist reflections about therapeutic process and disclosure. Second, many theorists support or are against disclosure without looking at the ways in which disclosure may be both helpful and hazardous simultaneously, or how nondisclosure may be detrimental (Hanson, 2004). Third, they do not often unpack the ways

[6] Sidney Jourard introduced transparency into therapy. See his book, *The Transparent Self* (1964).

TABLE 1

Positions of Different Models on Self-Disclosure and Transparency

Structural/ Strategic	Symbolic Experiential	Bowen	Feminist	Reflecting Team	Narrative
Trainees, supervisors, teachers not asked to examine and/or disclose their values and beliefs as part of learning process. Therapist self-disclosure as a limited technique in the service of promoting joining.	High levels of self-disclosure in both treatment and training, including between cotherapists, as a way to mold shifting boundaries, help subjectivity to emerge, and add affect.	Self-awareness and disclosure emphasized in training and supervision. Important to be cognizant of therapists' experiences and life cycle stage, and its interface with life cycle stages of clients.	Advocate for self-disclosure, especially in the service of demystifying therapy, increasing collaboration, decreasing hierarchy, affirming shared and diverse experiences, and acknowledging power differentials.	Team members encouraged to self-disclose in training, and in front of family members during team reflections. Clients encouraged to ask questions about and comment on reflections.	In training and therapy, encouraged to be transparent about life experiences, conceptual models, and personal values. As part of decentering process, clients are asked about disclosure to others.

in which their approach lends itself to certain types of disclosure and shuts down others. Fourth, theorists in the late 1980s and early 1990s were clearly looking at disclosure in a broader way to include aspects of therapy such as supervisory or reflecting team relationships with clients, written reports, and transparency about theoretical beliefs and therapists' values. However, this is not done in a manner in which the varied social identities of clients and therapists are seen as interfacing with what is shared when, how, and in what form. Finally, few guidelines exist, and those that have been given are quite general (Cole, Demerritt, Shatz, & Sapoznik, 2001; Roberts, 1997; White, 1995b).

Thus, in the rest of this article, disclosure and transparency are discussed in a both/and frame. Descriptive guidelines are proposed and illustrated with case vignettes. How social identities may influence safe disclosure is described. Research done on self-disclosure in individual therapy is examined for hypotheses about disclosure in family therapy, and ideas are proposed for further studies.

DANGERS AND/OR POSSIBILITIES OF TRANSPARENCY

Dangers and possibilities are written about in tandem because disclosure on the part of the therapist may be experienced simultaneously by a client as helpful and unhelpful. A colleague, Ava Lin, worked with a woman, Karen, who had been sexually abused by her father. After almost a year of sessions, Karen was still blaming herself and did not feel comfortable going to a support group to talk with others who had been abused. In addition, she was unable to disclose what her father had done to her to her husband, with whom she experienced difficulties with sexuality and intimacy. Ava, the therapist, made a decision to share with her that she too had been sexually abused by her father, and this was part of the reason that she had developed a specialty in this area of psychology. In doing so, Ava described how she had found it difficult to move from a place of shame and sense of responsibility for the abuse.

Karen seemed surprised, relieved, and a little disquieted to hear this from Ava. She asked Ava a number of questions about how she worked through the shame and guilt, and conversations ensued that helped Karen shed some of these emotions and share more with her husband. However, in response to Ava asking her how it affected her to have this information about her therapist, Karen said, ''It makes me feel protective of you and worried about if I will say things that will be hard for you to hear, or give you flashbacks. Now I'm watching you to see if you are OK.'' Ava worked with Karen to reassure her that she did not need to ''take care of her therapist.'' Ava also carefully monitored her affect as she shared anything in therapy about her abuse experiences, and checked in with Karen each time to see if she was feeling that she had to be concerned about her therapist.

Within a family or couple, one person might experience the disclosure as helpful, and another as a boundary violation. For example, a colleague, Tom Olinsky, worked with a family in which the daughter, Loung, was very upset because she did not get into the college she had applied to for early admission. Tom shared the story of how he was admitted to his first-choice school, but that ultimately he did not think that it served him well and that he should have gone to a less competitive college. Loung's mother responded to the story with many thoughts about varied options and how in life, one door closing means lots of others opening. Tom's disclosure wasn't well received by Loung. She felt that he did not understand the importance to her of this

decision, and how could he? He got into the college to which he had applied. Therapists need to evaluate both the risks and possibilities of a disclosure. What points of view are embedded within their disclosure? How might different clients respond in varied ways? Are multiple perspectives available to clients within what the therapist shares?

''Danger'' is inscribed first in the heading for this section in keeping with a strong focus on power differentials in therapy. Across many models, one constant is the recommendation that any disclosures affirm and support the centrality of clients' concerns. Because the therapist has more power, he or she always has the possibility of infringing upon, overtaking, and/or overwhelming client stories. This may happen in an inadvertent way. Allen, a single-parent father with many questions about his parenting, worked with a colleague of mine, Patrick Quillen. Patrick, in trying to join with him, often shared stories about the ups and downs of parenting his three sons. At the end of treatment, when Patrick asked Allen what was least helpful in their time together, he was surprised when the father said, ''It was hard to hear those stories about your sons. I felt like there was no way I could ever do as good a job as you. It became like a competition. I guess you were trying to let me know we were in this together as parents. But I started feeling like an even lousier father. Who could keep up with you and your kids?''

Another danger is that client's and therapist's stories become so intertwined, it is hard to assess whose agenda is being addressed (Roberts, 1994). I supervised a therapist who was working with a young man, Raul, whose siblings did not approve of the methods he used to become sober. The therapist, a woman in recovery herself, told him that she had a similar experience with her brothers and sisters. In subsequent work, she overfocused on the ways that Raul's siblings did not understand him, to the point that she seemed to be located more in some of her own familial dynamics. There was little exploration or emphasis on ways that Raul's siblings did understand and were connected to him.

A therapist might share something personal that he thinks will lessen the power differential between him and a family, whereas the family might experience it as a deflection of interest. Yoel Goldstein, a therapist in his 60s with a wise and impish demeanor, told his clients, a couple, that ''it is not what I am saying about relationships has come easily to me. I am, after all, on my fourth marriage.'' Nancy, one of the partners in the couple, said, ''I think he told us that in good faith, but I really didn't want to hear about him, we had so many things we needed to talk about.''

I have watched family members' eyes glaze over as reflecting teams, enamored of their intricate understandings of familial dynamics, go on too long with their observations. Therapists can be prone to showing their erudition in ways that highlight that they have access to education, and thus power.

Yet many possibilities can be opened with transparency. In supervising a team of therapists over several years, I asked them to gather from their clients at the end of treatment what they found was most helpful, and invariably they referred to instances when either their therapist or a reflecting team member had shared something about his or her personal struggles. Clients said things like, ''Those stories helped me to see that we're all human and I wasn't a bad person,'' ''I didn't feel put down coming to get help,'' ''I felt less alone,'' and ''I learned how we all are vulnerable.'' Maria, a client who had recently moved out of the family home, said, ''After I heard Sara's (a reflecting team member) story about how she felt and her experiences when she separated from her husband, I didn't feel crazy any more. I wasn't 'sick,' I was a person with understandable

emotions and feelings, similar to what Sara went through.'' Maria went on to describe herself as more able to cope with her emotional ups and downs because they were ''normal . . . Sara had them too.'' Disclosures by therapists can enhance connection in therapy, removing clients from a one-down position to one in which both are on an emotional sojourn together, with therapist's hints along the way.

It is crucial that therapists work with the effects of their transparency on various client family members. Therapists need to be aware and willing to read feedback carefully. This entails focused attention on clients' nonverbal and verbal reactions as stories are being shared, rather than getting caught up in the emotions of one's own experience. A single disclosure to a client can have elements within it that both support the therapy and are potentially detrimental to it. Likewise, because the therapeutic relationship accounts for 9%–30% of the variability when therapeutic outcome is measured (Beutler, 2002; Horvath & Symonds, 1991), therapists need to be attuned to how disclosure might impact their alliance with each member of a couple or family.

GUIDELINES AND CONTEXT: THE INTERPLAY

These are descriptive guidelines in the spirit of dialogue: thoughts to reflect upon when deciding whether, when, where, and how to be transparent in the therapy process. Although these guidelines are discussed each in turn, they interface with one another, and must be considered in light of the context of the treatment environment and social identities of clients and therapists.

The use of self in therapy may be constrained by how the therapist or trainee sees the larger society responding to different social identities. Sylvia, a therapist who speaks with a slight accent, spoke about how clients often asked her where she was from. ''When I tell them I am from Colombia, I often get such a negative reaction, like I'm coming from a terrorist country, that mostly now I just say I am from Latin America. Meanwhile, other Latino/a therapists at my agency criticize me because they say I'm not proud of my heritage.'' Sylvia is not able to draw upon and use certain aspects of her social identity because she wants to keep the focus on treatment and not on misconceptions that people have.

Cecelia Gomez struggled with this regarding her racial and ethnic identity. ''Being able to pass as White had given me 'White privilege.' I had a choice to make: keep my pseudo-White privilege or acknowledge my Mexican ethnicity and face the negative assumptions that some clients made about Mexicans. I must admit, it was a difficult decision, because all I wanted to do when I was in the therapy room was to do therapy, not to address negative racial stereotypes'' (McDowell et al., 2003, p. 183). However, because Cecilia wanted to integrate her ethnic and racial identity into her therapist identity, she began, when appropriate, to disclose it to clients and use it as a resource. She presented a powerful interchange that occurred with a White man who was pursuing a cross-racial relationship.

Cecelia: So Mexican conjures up bad things for you.

Client: They are a different class of people.

Cecelia: So for you when you think of Mexican, the terms that come up for you are not as good as White.

Client: Yeah, mm hmm.

Cecelia: So now that you know I am Mexican (Cecelia used this term purposefully to challenge the client's view of Mexicans), what does that mean to you?

Client: No matter what race anyone is, it doesn't bother me. I'm not racist; the only thing that bothers me is when someone can't speak English. I think they are ignorant. I can't help it . . .

Cecelia: This is very interesting. What is it like for you to be talking about race like this?

Client: I like it, I guess I'm not racist but maybe I have a lot of misconceptions. I don't want that. My parents were very prejudiced. (McDowell et al., 2003, p. 189–190)

In this example, Cecelia used self-disclosure to enrich and push the level of discussion in treatment about race and ethnicity.

Invitational Inquiry

First, throughout the therapy, invite clients to ask you about what informs your treatment approaches. In initial sessions, a framework can be presented of a two-way interview. Remark that you are sure that they will have questions for you as well. Give brief overviews of some of your stances about change and healing in a way that lets clients know that you welcome discussion about your ideas and the format of treatment. Provide opportunities in subsequent sessions for comments from clients regarding what is efficacious and what is not in your time together. Encourage clients to ask questions that will help them to decide if you and they make a good team. For example, one family with young children decided that they did not want to work with a therapist because he had never had children and had not gone through the kinds of challenges they experienced in juggling work and family life.

Tentative Transparency

A second guideline is to present a small piece of information about your experience, and then observe if the clients think it would be helpful for you to share more. I worked with a family with three teenagers in which the presenting dilemma was conflict between the mother and oldest daughter. For the fourth session, as described in the opening vignette to this article, just the parents, Sam and Mina, appeared at my office, obviously distraught. The first thing I thought was that something had happened between the mother and daughter. ''No,'' they said, ''things have continued to remain calm between them. But two days ago Sam was diagnosed with prostate cancer. There are still a lot of unknowns about his prognosis and treatment, and we are struggling with what to tell our children, and how to tell them.'' Six months before I began working with this family, I had finished a year-long bout with breast cancer. They didn't know that I had direct experience living with the ambiguity that cancer brings as it crashes into your life. Nor did they know I'd thought long and hard about how to talk with my teenager about it. As Sam and Mina shared their questions and disclosed that Sam's mother had already adamantly stated that they should never say the C-word (cancer) to the children, I wrestled with whether it would be useful to share any of my illness experience with them.

After about 10 minutes, I made a tentative foray out. I calmly told them that when I had had breast cancer, I too reeled at first from losing so much ''control'' of my life. And yet, I found that when I talked with my l3-year-old daughter about my diagnosis, we were able sometimes to communicate about things that were very ambiguous.

I explained my efforts to model for her some kind of ''relationship'' with the unknowns that came with the illness—that and nothing more. I waited to see what questions they might have, to see how my crossing that boundary and making my illness story public was meaningful or not to their own struggles.

They asked me why I decided to talk with my daughter openly about my cancer, and how I handled it when I did not have clear answers to her questions. They spoke about what might be the hardest parts of talking with the children when the prognosis was ambiguous. Later, the father inquired about how I kept the uncertainties and the patient identity of cancer from taking over my life. Each time I responded briefly and in a manner that pivoted the conversation back to their concerns. My experience gave me credibility with this couple, and a set of stories that all of us could partake of as they shaped their own narrative about cancer.

Emotional Response

The next guideline is to be cognizant of where the disclosure might take you emotionally so that you can stay emotionally present and focused on the feelings and thoughts of the clients. I struggled with this before deciding to say something to Sam and Mina. I had no previous experience disclosing anything about my cancer experience to new clients. This disclosure was about events in my life that were very close in time. By not sharing many particulars, I was able to give information and impart the essence of the story. I tried to stay observant of any surges of emotion that I felt, and used them as barometers of whether and when to further disclose. The emotional valence of a session should not be tipped away from the clients.

Reactions

Another guideline is that the therapist should be open to a wide array of potential reactions. Refrain from communicating (by your pauses, facial expression, tone of voice) that you need a certain kind of response from clients. This is tricky because the affect you often need to express in self-disclosure is about your own humanity and/or capacity to move somewhat inside their emotional space because you have been emotionally touched by a similar experience. Anything shared should be in the service of sustaining them. This is a different kind of interchange than with family and friends, when a more mutual type of support is likely and expected. Because you are with and stand aside from your experience with a careful curiosity, you can model for family members ways that they might gain distance and reflect on events in their lives.

Dilemmas, not Solutions

The fifth guideline is that the therapist more typically presents dilemmas from her life and what it was like to grapple with them, rather than solutions. This can be an easy line to trip over. Stuart and Peliwe originally came to see me for couples' issues. In one session, they wanted to sort out what to do after their teenage son had stolen liquor from them and taken it to a friend's party where the parents let the teens drink. Rather than asking them questions about their policy on keeping liquor in the house at this life stage, or inquiring what they thought about the friend's parents' decision to let the teens drink there ''because it was safer than if they were doing it off in the woods,'' I began to tell them how when my daughter was a teenager, I kept no alcohol in the home. Then I launched into how I thought it was such a mixed message for

adults to let teens outside of their family drink at their house when all knew it was against the law. This was clearly something I had strong feelings about. I was emotionally deregulated and hadn't considered the potential negative impact of my personal judgments. The couple reacted with surprise and my response took us off track from a focus on their decision-making. It would have been much better if I had said something like, ''When my daughter was a teen, I was unsure about whether to keep liquor in the house,'' and then turned the discussion back to their concerns.

How Disclosures Might Affect Joining, Alliances, and Coalitions

In thinking about a deliberate self-disclosure, it can be important to scan and identify why you think it might be useful to share that story. Will it provide new information for clients? Might it shift your relationship to them? Could it open the therapy and contribute to a healthy sense of shared vulnerability? Will who you are as a therapist and a person perhaps be more available to family members? As Roget Lockard said, ''You (the client) and I have a certain formal relationship that positions me in relation to you as an ally, hopefully a capable ally. But the bottom line, and the centerpiece of the relationship, is that we're both human beings'' (Diamond, 2000, p. 267).

However, there may be times when a therapist's story is too close to a client's story, or a therapist does not have enough distance from an experience in her or his life. For example, a trainee was working with Zahir, a man with four children from a previous relationship and who had recently married Amina. Zahir did not want more children, but Amina, who had no biological children, did. There was a lot of tension between Amina and Zahir's children, and couple arguments about whether it was fair to ''deprive'' Amina of giving birth. When this couple was first dating, Amina had become pregnant and had an abortion.

The trainee, Theresa Brown, had some similar experiences in her own life and still had regrets about not having children. She reflected on whether she had stories that she could share about her own experience being married to a man who had children from a first marriage, and later, her decision to have an abortion. But as she considered, Theresa thought, ''My history is just too similar to Amina's. If I tell pieces of any of my stories, it might create more of an alliance with her. How would this affect my connection with Zahir? And some of the stories in my own life still feel pretty raw.'' For these reasons, Theresa ultimately decided not to talk about any of her experiences.

The Treatment Environment

The context in which therapy occurs also has implications for disclosure. A community clinic has a different ambiance than a hospital or school, or doing therapy in a client's home or one's home office. In varied institutions, there will be different expectations about boundary crossings, both spoken and unspoken.

Nara Zimmer works as a therapist in a school and in a mental health clinic. When working with several families at the clinic who had children with learning disabilities, she felt quite comfortable, when it was appropriate, sharing some of her own experiences as a person who also has a learning disability. The clinic was several towns over from the town where she lived, and the atmosphere of the workplace was, overall, respectful of boundaries and information discussed in sessions.

In contrast, in the school setting, Nara often heard information disclosed inappropriately (e.g., teachers gossiping about families in the staff lunchroom) and attended educational planning meetings where students were talked about disrespectfully. Nara also had a niece and nephew who went to that school. Given that the boundaries were more diffuse, Nara decided that she did not feel comfortable disclosing information about her learning disability in that environment. What she did do, which is a common strategy, is talk about her ''cousin'' with whom she was close who had a learning disability. She then shared her stories as if it were her ''cousin's'' experience.[7] This is not transparency per se, but it is a way to draw upon personal experiences and feelings with clients.

After Dana Boynton went into semiretirement, he no longer rented office space downtown and worked only out of his house. ''I found that I was both more open and more cautious about what I disclosed. Lots of things in the home office, like the orchids I grow and family pictures, prompt clients to ask me questions. At the same time, because they were coming to my house and community, which tells a lot more about me than an office in a professional building, I found myself sharing less about my life. It's funny; I realized, too, that years ago when I did in therapy in clients' homes, I tended to share more about my life. Maybe it was a way to acknowledge that clients were opening up their lives to me in a different way by inviting me into their home.''

Before being transparent, multiple issues need to be considered by therapists. They must probe their reasons for sharing personal stories and the emotions that surround them. Therapists need to scan and make sure that varied points of view are included with disclosures, and what information about social identities might be brought to the surface. How disclosure might affect current connections and alliances (or lack thereof) with clients also needs to be considered. Finally, the milieu in which therapy is taking place will have implications for what is appropriate to disclose.

RESEARCH

Transparency and disclosures by therapists need to be researched in family therapy. There is an existing body of research on self-disclosure by therapists working with individuals (Fox, Strum, & Walters, 1984; Mahrer, Fellers, Durak, Gervaize, & Brown, 1981; Mathews, 1988; Nilsson, Strassberg, & Bannon, 1979; Robitschek & McCarthy, 1991; Rosie, 1980). Unfortunately, most of this research has used nonclient volunteers, many of them White college students, in single contrived therapy sessions (Knox et al., 1997; Watkins, 1990). Therefore, the findings are limited with regard to the impact of therapist self-disclosure in the actual overall process of therapy. These studies do not provide information about the varied clients with whom family therapists work, nor the potentially different reactions to therapist transparency that family members may have; neither are these studies multidimensional. They do not look at situational variables, such as treatment setting, time in therapy, social identities of clients and therapists, or interactive effects of disclosure.

However, there are a few studies that have been done with individuals in brief therapy that can provide hypotheses about how self-disclosure might be viewed by clients in family therapy, and ideas on how to research it. Hill and colleagues (1988) found that therapist self-disclosures received the highest client helpfulness ratings

[7] Although this could technically be considered a lie, I see this as a form of protecting confidentiality in the same way that we change identifying information of clients.

TABLE 2

Guidelines and Questions to Ask Oneself

1. Check to make sure that your desire to share theoretical beliefs and values that you have is likely to be of interest, support, and use to your clients.
Am I talking about my theoretical stance out of my interest, or to show off to clients what I know? Have I scanned to make sure that there are not biases in models (e.g., against single-parent mothers) that undermine or are prejudicial to key social identities of clients? Am I using language about change that is respectful of the clients and connects to their language? How might this information be of use to them?
2. Be transparent tentatively and briefly, and look for feedback from clients.
How can I disclose something succinctly yet meaningfully, and then read cues from clients, particularly cues that what I have said is not helpful?
3. After any type of disclosure, keep turning the conversation back to clients' concerns and their story.
What links can I make to what clients have already talked about?
4. Scan and make sure that you are in emotional control of what you are going to share.
Where am I emotionally with what I wish to talk about? Am I still too close to the experience? Have I reflected enough on it to understand and present it from different angles?
5. Make sure that you are not expecting a particular reaction from clients after you disclose something.
Will I be upset if I don't get validation (e.g., an idea) or a certain emotional response from clients? Will I be surprised if they react differently from I expected? What am I conveying with how I present something with regard to what kind of reaction I am expecting?
6. Offer information in a framework that emphasizes challenges you have faced and issues in process, rather than what the outcome was.
Is this information about dilemmas I have faced, rather than solutions? Is this information likely to be of use to the clients' process?
7. Be cognizant of what level of disclosure is comfortable for you.
What is pulling me toward wanting to share this particular information? What is its meaning in my day-to-day life at this point in time? Are there any aspects of feeling unsafe, especially around my social identities, that are brought to the fore by sharing this information?
8. Think about how presenting information from your life or about your theoretical beliefs or values will affect joining, alliances, and coalitions.
With whom do I seem to be most and least allied right now? In what ways are clients taking different sides with regard to different dilemmas? How do these positions relate to stances I have taken, or shared social identities, that I have with clients? How might what I disclose affect therapeutic alliances or familial dynamics?
9. Be attentive to what transparency can mean in your particular work setting.
What are the spoken and unspoken rules in the work milieu with regard to disclosure? What is already being communicated about your beliefs and life experience in the setting? How might your comfort level shift in different work contexts?
10. Create, share, and write treatment plans and case reports with clients.
What are easy ways to ask for client input? How can you ensure that the ultimate ownership of the telling of their story is in the hands of clients?
11. Overall, keep thinking about your intent whenever you disclose.
What is the purpose of sharing this information at this time in treatment—within the framework of conceptual models being used—when we are talking about this particular content?

in a study in which 127 sessions were videotaped. Immediately after each session, a session evaluation questionnaire was completed by each of the 8 female clients, and 8 male and female therapists. Then, clients and therapists separately reviewed the video of the session. Clients were asked to rate their emotional reactions to therapist interventions. Therapists were asked to describe their intentions with regard to interventions. Clients also filled out treatment outcome measures.

Out of some 32 different types of therapist response modes, self-disclosures on the part of the therapist received the highest client helpfulness ratings. In a fascinating contrast, the 8 therapists ranged widely in how they rated the helpfulness of their disclosures. Three therapists rated them as the most helpful, and the others rated them as one of the least helpful. The researchers hypothesized that this may have been because the ''therapists may have felt more vulnerable when disclosing their own reactions, or may have felt uncomfortable with the shift in power dynamics'' (Hill et al., 1998, p. 229).

Knox et al. (1997) interviewed 13 clients, balancing as much as possible ''across client and therapist gender, therapist theoretical orientation, and when [in the therapy process] the interview was conducted'' (p. 277). Clients were asked about the frequency of self-disclosure and its impact, and to give an example of a helpful and unhelpful therapist self-disclosure. All 13 clients described a helpful therapist self-disclosure. This was mostly personal information from the past. Clients described these interactions as helping them to gain other perspectives and see themselves as ''normal,'' and they reported that they used these interaction models for what the therapists said to give them ideas about ways to make positive changes and/or disclose more about themselves. Negative effects are not described in detail in the article, but the authors talked briefly about concerns that clients had about the closeness that seemed to arise with the disclosure that did not always feel comfortable.

In a recent study by Hanson (2004), 18 clients, primarily women who described themselves as White or Caucasian Canadian, recounted the effects of disclosures and nondisclosures in therapy. A total of 131 incidents of helpful and unhelpful disclosures were audiotaped and coded, along with 26 incidents of nondisclosure. The participants were two times more likely to find disclosures to be helpful (with the greatest effect on strengthening the therapeutic alliance), and twice as likely to experience nondisclosures as unhelpful. This research raises thoughtful questions about when failure to disclose may be detrimental to clients.

Implications and Ideas for Research in Family Therapy

This is a topic area that lends itself to getting clinicians and clients involved in research, and helping to bridge the gap between clinicians and researchers. The research designs described above that involved individuals who were actually in therapy could be extended to research with couples and families. The definition used would need to be broadened from self-disclosure to transparency to be of most use in family therapy. Existing videotapes of sessions could be reviewed for examples of transparency. Therapists could be interviewed about their decision-making process as they chose to be transparent, and whether later they considered it successful or appropriate. Clients and therapists could watch videotapes together of instances in therapy where disclosures occurred, and be interviewed about it both separately and together, including questions about nondisclosure.

A checklist could be developed with clients and clinicians that highlight different types of disclosures to gather more information on frequency and types. This could be extended by having clients and therapists, after sessions, denote on a sheet which of these disclosures were helpful. (The checklist would ask for contextual information such as social identities of clients and therapists; work context; content being discussed; and time in therapy.) Questions about any longer lasting effects of transparency could also be followed up posttreatment.

The role that disclosure and nondisclosure play in the therapeutic alliance with clients of different ages would be intriguing to know, too. We need to explore the whys, whens, wheres, and hows of transparency before we can go on to compare it with other aspects of therapy.

CHALLENGES FOR NEW THERAPISTS AND TRAINEES

Young therapists may need support to see their experiences as a resource. As Clarissa, age 25, said, ''Many of my clients are a lot older than me, who am I to share things about my life?'' Training that emphasizes detailed observation of students' multigenerational history can provide them with a sense that they have a rich and informative database. In addition, as they work closely with other trainees and their familial history, transparency skills can be practiced.

Another challenge for new therapists is learning how to move in and out of different levels of awareness so that there is continual monitoring of disclosures. Watching others work with this process as a cotherapist—as an in-the-room reflecting team member, or behind a one-way mirror—is key to learning about this. Time for post-session analysis is essential so that therapists who have disclosed or chosen not to disclose can articulate their thinking. Questions can be raised from the perspective of how nondisclosures might affect the work.

Where there is little access to ''live'' work, training videos can be edited so that clips of varied therapists making disclosures can be compared and contrasted. Trainees can be asked to look for instances in the videos when they themselves might have disclosed, and talk that through in relationship to the guidelines.

In role-plays, trainees who act out being clients can be asked to reflect in depth upon how various disclosures or nondisclosures affected them. Variables such as different work contexts or approaching the session from another theoretical stance can be changed. It can be helpful for therapists to know their basic attitudes and proclivities about disclosure. Supervisors and teachers need to bring into the discussion more of a focus about how not disclosing might be damaging to therapeutic process.

ENDING REFLECTIONS

> . . . the world is a dialogue between degrees of transparency—globes of the grapes, the wine in the glass equally penetrated by light but ever so slightly less clear than the vessel itself, degrees of reflectivity.
>
> Mark Doty, writing about a painting in *Still Life with Oysters and Lemon* (p. 5).

Clients and therapists are in an intimate paid relationship, not a personal relationship, but nevertheless, one with many personal aspects. Safeguards come with this contract, along with limitations. Therapists and clients together have to create in each therapy a comfort with the personal within the professional relationship.

Therapy is a ''dialogue between degrees of transparency . . . and reflectivity.'' The focus of the conversation, the ''light'' referred to by poet Mark Doty in the epigraph above, remains on clients' stories. And each of the life journeys of a client and a therapist—their ''vessel''—is illuminated in quite different ways. But the core of the therapeutic work is the human connection that comes with the reflective possibilities between lives.

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