Self-disclosure: the invaluable grey area.

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Abstract

Self-disclosure can be valuable in therapeutic relationships, though practitioners may feel apprehension around boundaries and worry what may be appropriate. This article asserts the importance of critical thinking around self-disclosure, emphasising that whilst there is no clear 'right and wrong', that what is necessary in professional practice is its carefully considered and purposeful use. Discussion using evidence and clinical examples is framed within a model which may be used to aid reflection on the use of self-disclosure within the therapeutic relationship. Self-disclosure is a grey area, though its use in mental health nursing can be invaluable.

Keywords

Self-disclosure, therapeutic use of self, therapeutic relationship, mental health nursing, reflection, clinical supervision

Key points

- Self-disclosure is an important practice in therapeutic relationships.
- There may be apprehension around the use of self-disclosure whilst maintaining boundaries.
- There is no clear 'do and don't' regarding self-disclosure, other than whatever is disclosed should be for the benefit of the patient.
- A model is introduced to aid reflection on the use of self-disclosure.

Reflective questions

- Identify times where you have used self-disclosure in your practice. What did you disclose and why? What was the benefit to the patient?
- Consider how a patient may feel if their nurse is not willing to share anything about themselves. How may this impact the therapeutic relationship?
- Consider the place in which you work. Is there a culture of openness or apprehension around self-disclosure? Does this culture have an impact on your practice?

Article

Boundaries in all interpersonal relationships are regulated by the control and adjustment of self-disclosure (Derlega and Chaikin 1977). However, this control and adjustment needs much more consideration in therapeutic as opposed to social relationships, where there is a professional role and responsibility. Professional self-disclosure has been defined as a comment by a practitioner which reveals something personal about themselves which would not otherwise be known by the patient, and may include feelings, similarities, insights or strategies (Hill, Knox and Pinto-Choleo 2018). It has been described as an important skill when initiating, developing, maintaining, and terminating therapeutic relationships

(Ashmore and Banks 2002), yet some professional textbooks indicate it is to be "generally discouraged" (Patel and Jakopac, 2012, p.89). It has been found to be common, yet its impact on patients is not well understood (Arrol and Allen, 2015). Unsurprisingly, it remains a grey area surrounded by apprehension and confusion.

Words like "professional" and "boundaries" can haunt the minds of practitioners who may fear becoming too close, leaving themselves vulnerable within the therapeutic relationship, or perhaps mindful of how colleagues may perceive their openness. Adding weight to the discouragement, even mental health nursing pioneer Hildegard Peplau argued that personal information about a nurse had no place in the therapeutic relationship, which she argued should maintain exclusive focus on the patient's interest (Peplau, 1969, 1997).

Carl Rogers held a counter view, that practitioners should not be limited to a professional role in such a way that prevented genuine and empathic connection (Rogers 1957, Rogers & Stevens, 1967). It could be strongly argued that some careful use of self-disclosure can be in a patients interest, and the debate over how much of the practitioners self should arise in a therapeutic relationship sets the scene for the coming discussion. The purpose of this article is not to provide one answer or a clearly defined threshold for boundaries and self-disclosure. Rather, it is to argue that what defines 'professional' is the careful consideration of what is shared and why it is shared, and provoke thinking in all helping professions. Two models are synthesised to frame this discussion.

Given that self-disclosure is such a unique intervention, using the distinct self as a tool, it should be carefully considered both in the moment then pursued into reflection and clinical supervision. Hawkins and Shohet's seven eyed supervisor model (2012) can be a useful guiding framework. This model includes two interlocking systems, the practitioner and patient matrix (eyes 1-4), and the practitioner and supervisor matrix (eyes 5-7). The first four eyes are most relevant to the interaction between practitioner and patient, focusing on; the patient, the intervention, the relationship and the practitioner. Eyes 5-7 focus on the supervisory relationship, supervisor's internal processes and the context in which the work happens. Further helpful points of consideration come through Elliot and Lui's (2010) rights of medication administration, adapted and applied to self-disclosure by Unhjeim et al (2018). The following eyes and rights synthesis focus on eyes 1-4 due to their role in the interpersonal interaction, and may prove a useful framework for deciding and reflecting on the use of self-disclosure (Table 1).

Table 1: Use of Self-Disclosure - Eyes and Rights Synthesis

Eyes (Hawkins and Shohet 2012)	Practitioner and Patient Matrix			
	Eye 1 The patient	Eye 2 The Intervention	Eye 3 The Relationship	Eye 4 The Practitioner

Rights (Unhjem et al 2018, adapted from Elliot and Liu 2010)	Right patient: Identifying the patient need	Right action: Reasons for self-disclosure are justified Right intervention: Content of self-disclosure appropriate to patient need Right time and dose: Stage in relationship or treatment Situation and context appropriate	Right response: Monitoring the impact on the relationship	Right dose: Self-disclosure comfortable for the practitioner

Given the dynamics and subjectivity of self-disclosure, which involves unique practitioners and unique patients, this model is intended to promote critical thinking rather than be a robust guide. It could be argued that due to the variables involved in human interactions, a definitive rule to self-disclosure is impossible. Whilst this may aid personal reflection and critical thinking, clinical supervision would be strongly encouraged alongside, where this model may guide discussion.

Eye 1 - Focus on the patient is essential, and can lead to increased empathy and understanding. This may identify a sense of isolation, alienation and loss of connection with common human experience, and could justify the use of self-disclosure to address this need. In depth consideration of the current situation and mental state of a patient is necessary, as appropriate interventions cannot be selected without insight into the needs it may address. The 'right patient' is the one whom would benefit from practitioner self-disclosure. Further to identification of the patient need, eye 1 overlaps with further eyes and rights, as the intended benefit to the patient is the constant of all consideration.

Eye 2 – Self-disclosure is an intervention in of itself, and much consideration is needed here. This eye begins with a focus on therapeutic justification, then moves to review the content of disclosure and the context in which it takes place. Therapeutic justification is required for it to be the 'right action', in that the reasons for self-disclosure are conscious, for a specific reason, and justified in terms of therapeutic benefit. This eye may challenge ritualistic practice, and scrutinise any intervention which is not purposeful or useful. Self-disclosure should be

considered, purposeful and with a specific need in mind; a need which may simply be the strengthening of the relationship. What self-disclosure should not be is accidental, wayward and without purpose.

There are a huge variety of things which may be disclosed (See Box 1).

Content of self-disclosures (Yalom 2002, Knox and Hill 2003, Knight 2012, Roberts 2012, Murphy and Ord 2013, Arroll and Allen 2015, Hill, Knox and Pinto-Choleo 2018 Unhjem et al 2018)
Appearance Behaviour Beliefs Attitudes Values Thoughts Feelings Life experiences Similarities Family Interests Activities Identity Insights Dilemmas Personal strategies Dilemmas Motives

Whilst a minimum dose of self-disclosure is unavoidable in what we communicate through appearance and behaviour (Murphy and Ord 2013), the content of intentional self-disclosure can be conceptualised in three categories; 'mechanisms', 'here and now' and 'there and then' (Yalom 2002, Knox and Hill 2003, Knight 2012). The 'mechanisms' are simply a disclosure of what the practitioner is doing, and why they are doing it. Whether this be task based, such as taking a blood pressure, or more psychologically based in terms of asking about thoughts and feelings, patients must be kept informed of the practitioner's motives and intentions. This transparency is unlikely to cause much debate, and should be recognised as a key aspect of good practice through its impact on building and maintaining trust.

'Here and now', defined as 'immediacy' by Hill, Knox and Pinto-Cohelo (2018), is more complex and therefore requires more careful consideration. This refers to the communication of thoughts and feelings within the immediate context of the relationship with the patient. Contemplation of the dynamics within therapeutic relationships may be an opportunity to reflect on similarities in patterns of relationships in previous or current experience outside it. This may be described as "mentalizing the relationship", as alternative perspectives may be gained from focusing the patients mind on to the mind of the practitioner (Bateman and Fonagy, 2016, p.276). Practitioner thoughts, feelings and observations

are therefore valuable insights and opportunities for learning. The consideration of this must always pass one test; is disclosure in the best interests of the patient (Yalom 2002). If the disclosure may allow a patient to learn something new which could prove useful in their day to day life, failure to do so might be described as a missed opportunity. Any work, though in particular that which may explore a patients emotional problems, should require a practitioners willingness to be open about their own emotional state. Studies have indicated a "definite, solid relation" between therapist emotional expression and psychotherapy outcome (Peluso and Freund 2018, p.469).

Completing the tripartite are 'there and then' disclosures which refer to the practitioners personal life outside of the therapeutic relationship (Knight 2012). This was likely Peplau's biggest area of concern. Unhjem et al (2018) found that disclosures have been around immediate family, interests and activities, life experiences and identity. Sharing personal life has been perceived as humanizing the relationship and improving rapport (Steuber and Pollard 2018). Practitioners always have control over what they choose to share, and minor details which demonstrate a life beyond the professional role can break down perceived 'us and them' barriers.

The sharing of life experiences is where there can be further common ground, yet as with all therapeutic interventions, this should 'resist the righting reflex' (Miller and Rollnick 2012). While self-disclosure may be of personal strategies (Hill, Knox and Pinto-Choleo 2018), this should not aim to give advice, solutions or solve a person's problems, e.g. "This is what I went through, and this is what I did". Rather, as Roberts (2012) suggests, this should present dilemmas from the practitioner's life, and the experience of grappling with them. This is likely to develop a shared understanding of human experience, opposed to a power dynamic of 'expert' and 'pupil'.

Both 'right time' and 'right dose' may consider the context, including the patient and their stage in the therapeutic relationship or treatment. Whilst self-disclosure can be used in developing, maintaining or ending relationships, the correct dose may differ at any of these times. Considering Peplau's (1952) phases of nurse patient relationship would be valuable. Whether in the orientation, identification, exploitation or resolution phase, self-disclosure may be used with different purpose which all intend to benefit the relationship. Orientation, the first phase, may see self- disclosure used to establish trust. It is often used in rapport building (Arroll and Allen, 2015), and it has been suggested that it may be hard to form any relationship without early self-disclosures (Derlega et al 1993). Therapists own feelings have also been described as an important bridge into enabling patients to engage in intimate discussions when ending relationships (Shaharabani Saidon, Shafran and Rafaeli 2018). As stated, the justification for any right time and right dose rests with the practitioner. The time and dose may also be different depending on the context, and any influences of wider context on practitioners choices (see eye 7).

Eye 3 – The relationship between patient and practitioner should be taken into account, both in terms of using or withholding self-disclosure. Each professional and therapeutic relationship is unique with a multitude of variables, and constant reflection is needed to ensure this develops in a way which is therapeutic. This may lead to more self-disclosure to increase trust and show humanity, and some nurses have perceived disclosure as invaluable in making the nurse-patient relationship more "open, honest, close, reciprocal and equal" (Unhjeiim et al 2018, p.803). However, the content and intensity of disclosure can influence relationships greatly, and this may not always be beneficial.

Disclosures of practitioners own illnesses for example, can have a distorting effect on the relationship and have been described as stealing the patient focus (Arroll and Allen 2015). Roberts (2012) gives the example of a therapist consciously disclosing her own childhood sexual abuse to a patient with similar experiences. Whilst this was conscious and purposeful, one implication was a role reversal as the patient then became protective of their therapist, mindful of upsetting them and their attention shifted to the therapists mental state rather than their own. This extreme example of self-disclosure is not poor practice, although an absence of consideration and reflection on it would be. This 'there and then' disclosure may require thorough exploration through 'here and now' and 'mechanism' disclosures. Something which impacts on the therapeutic relationship may need to be discussed within the therapeutic relationship, to save it becoming a barrier to patient progress.

Given that disclosing may have negative implications, it is perhaps not unreasonable to see why practitioners may be apprehensive about using it at all. However, the withholding of basic information when asked by a patient has been described as undermining the therapeutic relationship (Knight 2012), and a common sense human experience could appreciate why this would be the case. Patients share so much. Whilst the focus should never drift away from the patient, it can surely be permitted to drift enough to show practitioners as more than robots, and demonstrate the reciprocal trust needed for therapeutic connection. What is disclosed needs to be carefully considered in terms of the impact on the relationship, but disclosing nothing could potentially be more damaging. Yalom (2002) insists that the question should be 'why not self-disclose?', and total restriction of self-disclosure has been described as impracticable (Carew 2009).

Eye 4 – Finally, practitioner's need to be self-aware of their own feelings and how they are affected through interactions. Whilst self-disclosure may be a useful tool, it should not be to the detriment of the practitioner. People should only share what they are comfortable sharing, as whilst practitioners are bound by confidentiality, patients are not (Yalom 2002). Sharing any sensitive information could cause considerable discomfort and anxiety, and practitioners have acknowledged feeling vulnerable following self-disclosure (Carew 2009). Furthermore, consideration should be given to risk and safety concerns. Some patients may present risks to others at times, and self-disclosures should not aggravate this risk in any way. However, if self-disclosure is avoided entirely it may be detrimental to the

therapeutic relationship. In these cases, consideration should be given to the purpose of the relationship, and whether it is indeed a therapeutic relationship, or a custodial one.

Eyes 5 and 6

Eyes 5 and 6 relate to the supervisory relationship, and the supervisors internal processes. Whilst these exist independent of the interaction between practitioner and patient, the supervisor may be an additional source of information. Supervisors may note their relationship with supervisee, considering whether it may parallel the supervisee's relationship with their patient (Searles 1955, Mattinson 1975). Furthermore, the supervisors internal processes, namely thoughts and feelings arising from the supervision, may give additional insight to supervisee, and considerations of things which would not be known otherwise. The eyes and rights synthesis may be of value to the practitioner, though additional value could be gained from a supervisors perspective on all points.

Eye 7

The act of self-disclosure also prompts consideration of eye 7, the wider context in which the work takes place. The decision to self-disclose has been influenced by context, for example whether based in inpatient or outpatient settings (Steuber and Pollard 2018). Much research and literature around self-disclosure centres on individual therapy sessions (Unhjem 2018), and Roberts (2005, p.57) stated that different institutions and cultures would have "different expectations about boundary crossings, both spoken and unspoken". The norms within cultures and sub-cultures of practice are likely an area which require more research, as there are no doubts that individual values may sometimes be compromised for fear of breaking ranks with colleagues. It would be important that these expectations could be challenged and flexible according to patient's needs, rather than adherence to an unhelpful ritualistic approach. All individuals should reflect on how much of their self-disclosure practice is influenced by how they may be perceived by others.

Conclusion

A recent qualitative meta-analysis of 21 papers showed that self-disclosure was most often followed by positive comments from patients, indicating positive thoughts, feelings or understandings (Hill, Knox and Pinto-Coheleo 2018). However, this study proved no clear causal relationship, unsurprising given the number of variables present in human relationships. Self-disclosure thus remains a grey area, but still arguably one of any practitioners most useful tools. Perhaps given the potential benefits, it should no longer be 'generally discouraged', yet always be carefully considered.

The eyes and rights synthesis may prove useful, as it is the act of thinking through these points before and after any self-disclosure rather than any arbitrary line in the sand, that should constitute our definitions of professional. Moreover, this synthesis may be of similar value to other grey areas such as the use of humour, touch and spirituality. Competency is demonstrated when we can justify our conscious and purposeful use of

therapeutic skills and techniques for the benefit of the person we are working with, and the crucial humanising impact of self-disclosure is to be celebrated. Roberts (2012) cites some examples of patient feedback, such as ''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". This final point, that we are all vulnerable, is the very thing that connects us as humans. Yalom (2002, p.8) writes that we should think of ourselves and patients as "fellow travellers", "a term that abolishes distinctions between "them" (the afflicted) and "us" (the healers)". Empathising with patients involves seeing the world as they see it (Wiseman 1996), and through the process of entering another's experience we should each recognise the humanity in the other. Mutual trust and a decrease in role-distancing can come from self-disclosure (Ashmore and Banks 2002), without which there is potential for othering rather than connection.

Reflection

I often do a thought experiment with students, where I ask them to consider society starting afresh (using the contemporary graphic novel and TV show 'The Walking Dead' as a frame of reference). So, we have no law, no professional regulation, and no accountability other than to our own humanity and core values. In this instance I ask, would we still have the same apprehension about sharing some of ourselves? My opinion is a resolute 'no', and my belief is that the formalisation and professionalization of human relationships can create a distance which may be unhelpful.

The importance of self-disclosure cannot be overstated, and was evidenced to me as I ended my therapeutic relationship with a fellow traveller, and asked, "what was the most beneficial thing you gained from our time together?". He replied, "I think it was just hearing you saying that you'd had some similar experiences, and you'd felt the same". So, regardless of the mechanisms of therapy and the model I used, the most important thing was that I'd shared some of myself. In this case, therapeutic use of self and self-disclosure wasn't just part of therapy, it was the therapy.

3039 words

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