

Practitioner self-disclosure in the counselling professions

**Good Practice in Action 117
Fact Sheet****Updated May 2024**

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Good Practice in Action 117 Fact Sheet: *Practitioner self-disclosure in the counselling professions* is published by the British Association for Counselling and Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB.

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Design by Steers McGillan Eves.

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Context

This resource is one of a suite prepared by BACP to enable members to engage with BACP's (2018) current *Ethical Framework for the Counselling Professions* in respect of practitioner self-disclosure.

Using Fact Sheet resources

The membership agreement with BACP establishes a contractual commitment by members to abide by the *Ethical Framework for the Counselling Professions*, which includes a responsibility for members to keep the skills and knowledge relevant to their work up to date.

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Practice issues and dilemmas are often complex, and may vary depending on clients, particular models of working, the context of the work and the therapeutic interventions provided. We therefore strongly recommend consulting your supervisor, and also, wherever necessary, a suitably qualified practitioner or lawyer. Some professional insurers will provide legal advice as part of their service.

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In this resource, the terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care. The terms 'therapist' or 'counsellor' are used to refer to those trained specifically as psychotherapists and counsellors.

Introduction

This Fact Sheet introduces the subject of practitioner self-disclosure and provides an overview and application in different contexts. As a general introduction, it can't be exhaustive in its coverage of the various subtleties of this complex topic.

Attitudes towards practitioner self-disclosure have broadly changed over time, although opinions still vary widely. Previously viewed negatively, research has highlighted that not only is self-disclosure unavoidable, it can also be a helpful therapeutic intervention. This shift is partly due to increasing evidence of the therapeutic relationship as the primary factor affecting therapeutic outcomes, and a move from looking at problems not only as intrapsychic (occurring within an individual) but intersubjective (occurring in the relational space between the individual and others) (Farber, 2006). See also GPaCP 004 *What works in counselling and psychotherapy relationships*.

Self-disclosure can strengthen the therapeutic alliance, normalise the client's experience, provide alternative models of thought/behaviour and encourage their disclosure (Farber, 2006; Knox & Hill, 2002).

However, disclosures, accidental or deliberate, can sometimes adversely impact the client's wellbeing and the therapeutic relationship. Careful consideration of this impact has implications for building appropriate relationships with clients, maintaining integrity, and demonstrating accountability and candour. All form a part of our commitment to 'putting clients first' (BACP 2018,1a). Client autonomy and the principles of beneficence, non-maleficence and trustworthiness require responsible use of self-disclosure only for the client's benefit and not to 'force' a particular perspective or behaviour on them. Therapists should always be mindful of the power and influence they have within any therapeutic relationship, as well as the potential impact of issues of identity and intersectionality, and consider the consequences when using self-disclosure, particularly with vulnerable clients. Care should be given to how its use affects therapeutic aims of supporting client autonomy, voice and empowerment.

As practitioner disclosure is a boundary issue, readers might consult Good Practice in Action 110 (BACP, 2019, updated 2023) and 111 (BACP, 2019, updated 2023).

Each situation will be different, so every instance of self-disclosure (whether planned or accidental) should be examined in its particular context, and dilemmas discussed with supervisors and colleagues.

1 Types of practitioner self-disclosure

Whilst self-disclosures have been described as 'therapist statements that reveal something personal about the therapist' (Hill & Knox, 2002, p.255) they can also include non-verbal communication (see 1.3). Disclosure can be categorised according to:

1.1 Content

Disclosures might include personal facts (for example relationship status, sexuality), past or present opinions, feelings or experiences, insights or coping strategies (Hill & O'Brien, 1999). Therapists are least likely to disclose their dreams, personal problems or physical attraction to clients (Lane, Farber & Geller, 2001, cited in Farber 2006, p.138).

Disclosures about something occurring within sessions are called 'immediacy' disclosures, such as a therapist sharing 'I felt a great deal of warmth when you talked about that'. Disclosures of facts about the therapist's life outside the session, such as knowing that their therapist plays the piano, are 'non-immediate' disclosures (Hill & Knox, 2002).

Seven different categories of practitioner self-disclosure have been identified (Hill & Knox, 2002):

1. Biographical facts relating to life and training.
2. Feelings – including description of subjective experiences.
3. Insights showing what therapists have learnt about themselves.
4. Strategies found effective in dealing with specific issues.
5. Approval and legitimisation of the client in the specific therapeutic context.
6. Challenges to the client's thought process or behaviour via examples from the therapist's life.
7. Immediate thoughts or feelings toward the client, therapeutic relationship and process.

1.2 Intentionality

Deliberate self-disclosure involves therapists knowingly communicating something. Some disclosures are verbal, directly forming part of the therapeutic dialogue (such as when therapists share how they feel). Others might be subtle such as how the therapist dresses, visible tattoos and how the therapy space is decorated.

Accidental self-disclosure involves clients finding out something about their therapist by chance, such as seeing them in a supermarket, where something of the therapist's shopping habits is revealed.

Some self-disclosure is unavoidable (Zur, 2009) such as ethnicity, visible disability, or any unchangeable visible aspect of physical appearance. Therapists know that clients have access to this information and may derive subjective meaning from it. An example includes subtle reflexes in body language not fully in the practitioner's control, such as expressions of surprise.

1.3 Verbal or non-verbal

Verbal disclosures are those involving spoken, signed or written words such as 'I experienced anxiety when I was at University'. Non-verbal disclosures are all other pieces of information that the client picks up such as the fact that the therapist uses a walking aid. This distinction is important because therapists may not be as mindful of non-verbal disclosures.

1.4 Appropriateness

Self-disclosure may be appropriate (ethical), neutral or inappropriate (unethical). 'Putting clients first by: making them our primary concern' is a commitment we ascribe to (*Ethical Framework*, Commitment 1(a)). Ethical self-disclosure is always motivated by clinical-rationale and client welfare.

Disclosures relating to normal aspects of life, for example knowing that the therapist goes to the gym, may be avoidable/unavoidable, and may/may not have clinical significance.

Inappropriate self-disclosure is more beneficial to the therapist than the client, and counter-productive to the therapeutic aim of supporting the client within a trusting relationship. Examples may include disclosures of a sexual nature, including sexual attraction (especially towards clients). An exception is sexual orientation (see section 4).

1.5 Conscious and unconscious

While self-disclosure is often a conscious intervention, it may also be unconscious, being out of the awareness of both therapist and client. Bollas (1987, p.213) names this as the 'unthought known' and describes it as '... a form of knowledge that has not yet been mentally realised ... and yet it may permeate a person's being ...' so therapists may bear this possibility in mind.

The above categories are not mutually exclusive. For example, non-verbal disclosures, in the form of wearing religious jewellery or clothing, are also deliberate disclosures.

2 How self-disclosure affects the therapeutic work and relationship

Effects of self-disclosure are influenced by whether the therapeutic alliance is positive or negative (Myers & Hayes, 2006); highlighting the importance of ongoing assessment of that alliance. Disclosures that humanise the therapist, convey similarity to clients, and appreciate therapeutic progress can help reduce client distress (Levitt et al, 2016).

Research on client perceptions of self-disclosure suggests positive effects on therapeutic process (Danzon, 2018).

A consideration on how practitioner self-disclosure affects the therapeutic relationship is the 'human-expert' continuum (Danzon, 2018). Disclosures may humanise the therapist, which is positive, but for clients who need therapists to assume the role of 'expert/specialist' this might arouse mixed feelings. Being attuned to what the client needs from the relationship is important.

Self-disclosures hinder or enhance the therapeutic relationship, depending on the context, delivery and meaning for the client (Audet & Everall, 2003). However, research suggests that the most frequent outcome of disclosure was insight and improved client mental health (Hill et al, 2018).

Decisions about disclosure should consider what is disclosed, to whom, when, why and how (Henretty & Levitt, 2010 cited in Audet, 2019). Words chosen by a therapist depend on their unique style, therapy context, the relationship, use of voice tone and so on. Although responding to questions about the practitioner is addressed in section 8, here are some examples of helpful self-disclosure:

Client A: *"Why do I automatically think negatively?"*

Therapist: *"Negative automatic thoughts are quite common. I have them too. But we can learn how to respond to them"* (normalises and offers psychoeducation on nature of the mind, especially for the self-critical client).

and

Therapist: *"Something that works for many people, and I have used as a strategy, is to write my upsetting feelings and thoughts down"* (introduces a coping strategy, normalising its use).

Client B: (talking about an instance of racial abuse) *"I felt so angry...so small and helpless..."*

Therapist: (after a moment of silence) *"I don't know what words I can say that will help. I share your anger that this happened to you..."*

or

Client B later says: *"You don't know what it is like to be called that..."*

Therapist: *"You're right, I can't know what it is like... I am here to listen and try my best to understand"*

(intention is to be authentic and present with the client, attempt to 'join' with their emotions without taking over, and be transparent about the limits of knowledge or experience).

However, unhelpful disclosure can:

- burden the client with the practitioner's emotions or difficulties
- boost the practitioner's ego without benefit to the client
- leave clients confused, placing demands on them to work out the relevance of the disclosure to their concerns
- blur client-therapist boundaries, such as turning the therapeutic dialogue into casual conversation
- disrupt the session flow and take the focus away from or silence the client.

Examples of unhelpful self-disclosure include:

Client C: *"My father died three years ago. I should be OK now, but I'm not."*

Therapist: *"I lost my mother last year and it's still very hard"*

(rather than normalising and validating, the therapist expresses their unresolved grief, blurring the client-therapist roles, and placing a burden on the client to empathise with the therapist's statement).

A more helpful response might be:

Therapist: *"Many people feel that there is a point at which they 'should be OK'. But grief isn't like that. I lost someone close too and it still can hurt although some time has passed"*

(offers a general comment about grief, reflects sharing of a feeling that the therapist has accepted/made peace with their loss, in order to normalise the client's experiences and models the possibility of living alongside grief).

Additional examples of unhelpful self-disclosure:

Client B: (talking further about an instance of racial abuse directed at them) *"I felt so angry...so small and helpless..."*

Therapist: *"Racism makes me feel upset and angry too. My friend's son was recently stopped and searched by the police"*

(removes the focus from the client and their personal experience, putting the therapist's experience central. The client may be confused about how to respond to this).

Client D (opening the session): "How are you? Did you have a nice weekend?"

Therapist: *"Yes, I went to see some family, had a barbecue, ended up staying out late, and drank a lot"*

(client's greeting is met with unnecessary, revealing detail).

3 Self-disclosure in different therapeutic modalities

Modalities view practitioner self-disclosure differently. Contemporary psychoanalytic/psychodynamic practitioners are likely to view 'immediacy' or disclosures of countertransference as enhancing client awareness (Farber, 2006; Hill & Knox, 2002; Ziv-Beiman, 2013), whereas many traditional analysts regard it as unhelpful to the development of the primary therapeutic tool, transference (Forrest, 2010).

Viewing genuineness or authenticity as essential, humanistic-existential therapists are more likely to view disclosure favourably, helping spontaneity and relation to the client as a 'real person' (Jourard, 1964) and use self-disclosure to model how to resolve existential questions (Yalom, 2002).

CBT practitioners may use disclosure to strengthen the therapeutic bond, highlight the origin of psychological problems, help the client gain insight into their thinking style, demonstrate the effectiveness of strategies, motivate or encourage, normalise fears, and reinforce helpful behaviours (Danzer, 2018).

Feministic therapists may share their positions on social and political issues like gender, class, race and other societal power relations, reducing power imbalances, affirming shared experiences and even initially, helping clients make decisions about working with particular therapists (Danzer, 2018). Roberts, (2005), notes that some systemic or family therapists find self-disclosure encourages emotional expression but that dangers are also recognised. As a result, she suggests cautious use.

Stricker & Fisher (1990) suggest that it can also further the therapeutic alliance and assist modelling and can further the therapeutic alliance.

Disclosure in group therapy depends on modality. Existential-humanistic therapists believe it allows them to participate authentically, creating an atmosphere of sharing and interpersonal honesty (Yalom & Vinogradov, 1990).

Traditional psychoanalytic group therapy supports relatively detached, impartial leader stance (Dies, 2015). Educational/self-help or CBT-based group therapists may use self-disclosure to model and reinforce helpful strategies.

Montgomery (1997) claims that the main consideration in pastoral counselling services is how therapists navigate the potential dual-relationship scenario of working with a client with whom they share a religious or spiritual community.

4 The importance of context

Contexts in which practitioners disclose are important (Hill & Knox, 2002).

Race, ethnicity, class, socioeconomic status, language, education, immigration status and other privileges are distributed unevenly in society but intersect with each other. Traditional therapist neutrality may worsen longstanding trust barriers related to these privileges. For example, a client from a minority ethnic or religious group whose direct lived experience is of oppression may feel ignored, dismissed or rejected by a therapist belonging to a dominant social group who appears 'remote'. Practitioner self-disclosure can establish openness, sensitivity and a more equal, humanised relationship (Danzer, 2018). Burkard et al (2006) consider that:

- a. Discussing racial and cultural similarities and differences, gains trust, especially if practitioners are from dominant groups and clients from historically marginalised groups.
- b. Disclosure can convey sensitivity and understanding of clients' frustration with oppression.
- c. It can model appropriate help-seeking behaviours with clients unfamiliar with the therapeutic process, or who come from backgrounds where talking about emotional issues is stigmatised.

There are individual differences in how cultural values are expressed. To be helpful, disclosures should not be patronising, such as mentioning you 'have friends' belonging to the same perceived client group (Danzer, 2018). Disclosing a lack of awareness of the client's experiences, and a willingness to learn, may show greater empathy and honesty. Similarly, sharing in a client's outrage about their victimisation helps (Burkard et al 2006) although practitioners should take care not to let their feelings dominate. Disclosures should be brief, and always in the service of empowering client voice and narrative.

However, attempts at cultural closeness by self-disclosure can also result in misattunement, over-familiarity and unrealistic expectations.

Both client and therapist may make assumptions about their mutual understanding of intersectional issues. As Khan (2023 p.150) states: 'In being culturally close to your clients, it is important you don't focus solely on the closeness just to highlight and use it to show your understanding of the client. It is also important not to ignore any cultural distance between the two of you.'

Finally, therapists should work through the personal meaning that disclosing aspects of their personal and cultural identity has for them.

In a heteronormative society non-disclosure of sexual orientation means a likely presumption of heterosexuality. Awareness of this can sensitise all practitioners to the unique demand placed on LGBTQ+ clients and therapists to 'come out'. Information about sexuality (and asexuality) may be accidentally discovered (such as through participation in LGBTQ+ events). Some issues concerning self-disclosure of sexual orientation overlap with cross-cultural contexts, for example the willingness to acknowledge similarities/differences in experiences of marginalisation, such as if the client wishes to explore sexual identity. Danzer (2018) suggests that disclosures should be made on a case-by-case basis, considering client need, relevance to therapy, timing and delivery. Practitioners and clients should be sensitive to internalised or externalised homophobia.

Research supports the clinical use of disclosure when both client and therapist identify as LGBTQ+. Non-disclosure potentially harms trust, credibility and authenticity (Satterly, 2006 cited in Danzer, 2018 p.73). Communicating affirming attitudes is more important than being of the same sexual orientation. Heterosexual practitioners working with LGBTQ+ clients should be cautious about revealing their sexuality proactively. This may also be helpful when thinking about gender identity and other aspects of relationship and sexual diversity.

Practitioners working in remote geographical areas, specialising in work with particular communities or in situations of shared trauma, should consider how they might manage inevitable disclosures, discussing this possibility at the start of therapy and in supervision.

Where practitioners and clients share a traumatic experience, such as living in a conflict zone, it can be useful to name this explicitly and subsequently use self-disclosure when clinically relevant and beneficial to the client. Alongside supervision, personal therapy can be helpful for those living in small communities.

Some practitioners choose to disclose current or historic physical or mental health problems.

Such disclosures can be useful because current, ongoing health problems may impact a practitioner's fitness to practise, and the client then has the right to know (although what details are told must be carefully decided upon, probably with supervisory support). When used responsibly, disclosures about resolved historic difficulties can facilitate joining with the client, de-stigmatise illness, model resilience, or give rise to benefits discussed earlier.

Therapists sometimes find themselves in an emergency situation such as ill-health or bereavement in which they may have to weigh up the dilemma of how little or how much to disclose. It is possible that the client, without sufficient information, may develop fantasies about the situation, but equally the therapist has a right to personal confidentiality and privacy. If possible, supervision is a place in which to discuss the options in this dilemma. GPiA 132 *Breaks and endings* (BACP 2023) may also be relevant.

Supervision can help reflect on the meaning of self-disclosures with particular clients, so that they will not adversely affect therapeutic aims. For example, when working with clients who have suffered interpersonal traumas and who habitually attempt to push boundaries, practitioner disclosure may be harmful as clients may misinterpret communications resulting in a misplaced sense of similarity and familiarity. Danzer (2018) offers more on practitioner self-disclosure in the context of specific mental health problems (eating disorders, personality difficulties or chronic trauma).

Use of self-disclosure may be impacted by the particular work setting. This includes any organisational rules/policies as well as the practitioner's own assessment of the appropriateness of self-disclosure in that environment. Genuineness and relational authenticity remain important wherever but, in some settings, (such as prisons), practitioners may not wish to disclose certain information about themselves for various reasons including safety.

5 Self-disclosure in training and supervision

Therapists may have dilemmas about making disclosures, and both training and supervision are useful for trainees to explore their position (Bottrill et al, 2010). Practitioner self-disclosure should be covered in training so that this common clinical issue isn't overlooked (Danzer, 2018). A skill developed with experience, trainees on placements or newly qualified therapists may typically use self-disclosure sparingly. Experiential aspects of training, such as process groups or role-play, offer opportunities to try out self-disclosure and reflect on personal boundaries and how trainees wish to grow this skill.

Supervisors and trainers will inevitably reveal parts of themselves, and skilful use can help build trust with supervisees/trainees, modelling skills and sharing insights (Farber 2006). Disclosures that normalise feelings of vulnerability when working with clients are useful to supervisees/trainees (Ladany & Lehrman-Waterman, 1999 cited in Farber, 2006). Too much disclosure by supervisors/trainers or if supervisees/trainees perceive a disclosure as the 'correct' way to practise, may inhibit new practitioners from developing individual therapeutic styles.

Whether a supervisor's disclosure has positive or negative consequences depends on the nature of the supervisory relationship, clarity of their intentions, and whether they understand a supervisee's need in clinically complex situations (Knox et al, 2011).

6 Self-disclosure when working with children and young people (CYP)

Research by Capobianco and Farber (2005), finds that: '... children almost never solicit personal disclosures from their therapists ...' However, Farber also states the potential benefits of self-disclosure with CYP are almost identical to adult therapy, namely strengthening the alliance, facilitating engagement, and encouraging client disclosure (Farber, 2006).

BACP's competence framework for counselling CYP advises the use of authentic self-disclosure to 'maintain a spontaneous presence for the client' (BACP 2019 updated 2022 p.25). When using play therapy techniques with young children, practitioners may display more aspects of their personality than when using verbal therapy elsewhere.

Adolescent clients may require therapists to be proactively more authentic and transparent in order to establish a rapport, especially if they have been 'sent' to therapy by an adult or face other barriers such as those linked to disadvantage or exclusion.

Commonly, therapists are asked about their parental status, marital status, adolescent experiences, pets and hobbies.

Sharing interests appropriate to the client's age such as a film or TV show, can help establish rapport. Young clients may also be interested in discussing topical social or political issues and news. Disclosures of immediacy may be more common than factual disclosures and may be non-verbal due to the greater use of playfulness and spontaneity in therapy with children.

7 Self-disclosure, the internet and working online

Over the last decade or so, the clear lines between professional and personal domains have blurred (Zur et al, 2009). Clients now have access to a wide variety of information about therapists, ranging from professional websites to social media accounts. Increasingly, as practitioners work virtually via video-conferencing, clients see into their 'space'. Thus, when working online, it is important to be aware of unintentional 'background' disclosures such as objects, photos, pets, children and background household noise just as when working in person in private practice in the therapist's home.

Self-disclosures online can be intentional or unintentional, covering a range of areas such as personal information about practitioners or various opinions expressed. Even internet content that we 'like' or 're-tweet' reveals information. Some clients may attempt to subscribe to or befriend therapists on social media (see Good Practice in Action 040, 047 and at: www.bacp.co.uk/membership/membership-policies/social-media).

Practitioners should assume that anything they have posted online may be read by potential, current or ex-clients, and photos or other content posted on private social media accounts, circulated without their knowledge.

All may affect the client's perceptions of the therapist and the therapeutic relationship, even if it doesn't explicitly present within a session. Direct questions about the practitioner's online 'presence' should be dealt with by balancing the need for transparency with boundaries.

A further phenomenon of working online is that both practitioner and client can exhibit disinhibition meaning that either may say things they wouldn't if working face to face (Suler, 2004).

8 Handling direct questions

Clients commonly ask therapists direct questions such as 'Are you married?', 'Do you have children?', 'What is your sexuality?' and 'Are you religious?'. There may be more subtle requests for information such as 'Lovely shirt. Where did you get it?' Practitioners may experience a range of reactions including a pressure to answer or feel intrusion. Refusal to answer, perhaps even by deflecting or changing the topic, may come across as unfriendly.

Practitioners can explore their attitudes to self-disclosure through questions like:

- 'What am I prepared to share about myself?'
- 'How do I feel about clients knowing this fact about me?'
- 'What are things I wish to keep private?'

Depending on the question, client, therapist's personality, therapeutic style, modality and context, it may be appropriate to provide an honest, short reply and thereafter, if clinically relevant, invite the client to explore why this question was important to them. An alternative approach is to try to uncover meaning by saying something like 'I can see it's important for you to know this. I am wondering if it would help if we explored that a little before I answer your question?'. Some clients may find this question 'stereotypical', and as always, rather than sticking rigidly to a particular response, practitioners should remain open and flexible to how clients perceive the dialogue.

As ever, the intimacy of the question, the client's manner and tone (for example, whether they seem angry, upset or curious), the client demographic, type and stage of therapy, and nature of the therapeutic relationship, may all influence meaning. Brodley (1995) offers a helpful checklist of things to consider when responding to clients' questions or requests.

Sometimes, questions catch us by surprise either because of their timing, for example, at the door, or because of their content, for example 'Do you think I am attractive?'.

Some questions can feel intrusive. Helpful responses might include:

'I can see you are interested to know this, but I wonder how relevant it is for our work together' or 'It would be inappropriate for me to discuss my personal life here, which is a space where we focus on helping you' (afterwards, inviting the client to share how they feel about the response). The 'inequality of sharing' between client and therapist might also be acknowledged through a statement like 'It can feel unequal that I know more about you than you do about me. We can talk more about that if you wish'.

Some direct questions may affect the therapist's comfort level, including impacting their sense of safety (see section 10).

9 Practice points to consider

Working responsibly with practitioner self-disclosure requires practitioners to educate themselves and work reflexively. It is important to:

- Work through the meaning of disclosing aspects of personal and cultural identity as well as other issues of context and intersectionality.
- Ensure disclosures are used mindfully, with full attention, not casually or habitually.
- Remember that something known about you, cannot be unknown.
- Be attentive to the client's response (immediate or delayed) and any consequences (helpful or unhelpful).
- Remember that practitioners can disclose in many ways, not just with body language and words. For example, what might appearance, dress and accessories, website, therapeutic setting (for example therapy room decoration or online background) say about you?
- Ask yourself: 'For whose benefit am I sharing this?' and keep disclosures brief.
- Bring the focus back to the client following a self-disclosure, perhaps explicitly. For example, 'Within what I just shared with you, was there anything that you could relate to? Did it help or move you away from where you wanted to be?'
- Consider (at the appropriate time), discussing self-disclosures transparently with clients. For example, 'Sometimes therapists share things about themselves to help move the therapy forward. If I share something with you, perhaps you could tell me how it makes you feel, including if it made you feel uncomfortable?'
- Only make disclosures involving a high level of intimacy after a therapeutic relationship has been established, and about resolved issues. This prevents a blurring of boundaries and the likelihood that clients feel a pressure to provide support.
- Consider how you might respond to direct requests for information (deciding where your personal and professional boundaries are). Preparing for this, and for situations where therapeutic ruptures might result can help.
- Make regular and effective use of clinical supervision to discuss any dilemmas or instances of self-disclosure that feel uncomfortable. This will enable you to reflect on your motivations thereby ensuring that disclosures are appropriate, clinically relevant and not motivated primarily by personal need.
- Remember self-care and personal safety (see section 10).

10 What if things go wrong?

When contracting with clients, it is important to encourage them to raise any issues with us as they occur and to inform them where they can make a complaint or discuss concerns with a third-party. Despite best efforts, situations can arise where self-disclosures lead to actual or perceived harm that cannot be worked through.

Adverse effects that self-disclosures might have on clients can be lessened by:

- Recognising the potential for harm (even when acting with good intentions).
- Being attuned to any communication (verbal or non-verbal) from the client about the disclosure, and how it affected them.
- Creating an atmosphere of openness where clients can tell practitioners how they feel about the disclosure (including explicitly inviting their views on it).
- Reflecting (with the client and in supervision) on what element of the self-disclosure had the adverse impact, for example timing, content or its interpretation? Perhaps the intended meaning and relevance were unclear to the client?
- Being aware of therapeutic ruptures and willing to confront and work through them with the client and in supervision.

Transparency and candour are both part of BACP's *Ethical Framework*, which means that we need to take responsibility for our actions within the therapy and aim to do our best to right any situation in which the client or the therapeutic work has been negatively impacted (see also Good Practice in Action 073 and 113). Supervision here is vital as quite often self-disclosures are discussed retrospectively.

Sometimes, making self-disclosures can have an undesirable effect on the practitioner. When disclosing aspects of identity that have historically been the basis for discrimination or violence (such as race, disability, sexual or gender identity), it is important to consider how to respond if the client reacts unfavourably.

This may range from not wishing to work with you to overt racism, homophobia, or other types of discrimination and psychological harm. This poses challenges for how a practitioner's right to safety and dignity is balanced with the ethical duty to put clients first. Practitioners should think how they might work through such a scenario with the client (where feasible) or assert their own boundaries regarding managing challenging behaviours. Such situations can have major and lasting effects on the practitioner's personal and professional wellbeing if left unprocessed. A mix of supervision, line-managerial support (if appropriate), peer support and personal therapy (if required), are important.

Practitioner disclosure can also impact on personal safety. Clients may subtly try to draw out information about where practitioners live, their family or daily routines, leading to client behaviours that can be unsafe or threaten a practitioner's psychological or physical safety (see Good Practice in Action 106: *Safe working*. Other relevant resources include Good Practice in Action: 040, 047, 078 and 088).

Conclusion

Practitioner self-disclosure can be a powerful tool that creates an authentic therapeutic relationship and aids therapeutic work. However, it can go wrong and is a complex subject influenced as much by the personality and therapeutic style of the practitioner as by client-related and contextual factors. Mostly, there are not many clear indicators of when and how much practitioners should self-disclose.

This resource offers some ways of thinking about making disclosures responsibly. Like any skill, it is refined through learning and experience, and modifying your practice depending on what clients need at any given moment.

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