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Counselor Self-Disclosure: The Impact of Disclosing Mental Health Clients

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Counselor Self-Disclosure: The Impact of Disclosing Mental Health to Clients

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Abstract

Counselors may often hear during the course of their education, or continuing education, to use clinical judgement when determining whether or not to utilize self-disclosure with clients. It may be challenging, especially for counseling students and new counselors, to determine when and how to use self-disclosure without further direction and limited clinical experience. This paper will present a literature review of recent counselor self-disclosure research attempting to measure the skill's impact upon clients and the counseling relationship. Special attention will be given to studies which focus upon a counselor's disclosure of their own experiences with mental health. Counselor self-disclosure of mental health includes, but is not limited to, experience receiving mental health services and diagnosis of a mental health disorder. Final thoughts from the writer will be presented to summarize conclusions drawn from the current literature.

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The client's best interest. This broad and general statement is perhaps used most when teaching critical thinking skills to human service providers. Counselors are often instructed to consider the client's best interest when determining the next steps in the therapeutic process. What does client's best interest truly mean? There isn't usually a clear definition provided to counselors during instruction, so counselors may often find themselves confused or seeking additional resources to determine their next move (Miller & McNaught, 2018).

A clinical scenario in which counselors may be most puzzled in determining the client's best interest is whether or not to utilize counselor self-disclosure (CSD) in session. Multiple variables affect this dilemma such as theoretical orientation, client view of self-disclosure, ethical & cultural considerations, strength of the therapeutic relationship, and the type of disclosure being considered (Knox & Hill, 2016). The ability to consider many factors and determine the most clinically appropriate time for CSD can be very challenging, especially for a novice counselor.

CSD research has gifted counselors with findings to provide counselors with suggestions for creating clinical judgements. However, very few research studies have been conducted in the clinical setting and findings sometimes show less than significant results (Elkins, Swift, & Campbell, 2017). The lack of research with clear and significant findings can create confusion in the counseling field regarding when and how to use CSD appropriately.

Research is even scarcer when seeking information about specific types of CSD. Depending on the type, an information-seeker may find very few studies examining the effects of CSD upon clients and counselors. CSD of a counselor's mental health is one such type of CSD

with limited research available to aid counselors in determining if CSD is in the client's best interest (Somers, Pomerantz, Meeks, & Pawlow, 2014). A review of current CSD and CSD of counselor's mental health literature can provide some direction for clinical practice.

Review of Literature

Despite a small body of clinical research focusing upon CSD, a body of literature exists providing information and considerations in regards to the topic. CSD is an umbrella term for many specific types of CSD. To address this, an overview of types, teachings, and ethical considerations is reviewed. CSD of a counselor's mental health is a distinct subtype of CSD and to determine whether or not a counselor should disclosure their mental health status, research and literature is available to assist in a counselor's decision-making process. CSD research and literature reviewed can be applied in the clinical setting to support both counselor and client in establishing and maintaining a therapeutic relationship.

Introduction to CSD

Self-disclosure, in a therapeutic setting, can be defined as a counselor verbally revealing something personal about themselves (Knox & Hill, 2016). For each counselor, self-disclosure can have a unique meaning because CSD exists on a continuum. On one end of the continuum, a counselor reveals nothing to a client about their thoughts and feelings; on the other end, the counselor is totally open with the client revealing all. Along this continuum, there are also different types of CSD a counselor can actively choose to utilize in therapy.

Current literature often focuses on two different types of CSD, immediate and non-immediate (Ziv-Beiman & Shahar, 2016). Immediate disclosure occurs when a therapist reveals their thoughts, feelings, and opinions in relation to the client and/or the counseling process. Non-immediate disclosure is the sharing of a therapist's personal experience outside of session

(i.e. biographical information, hobbies, coping skills). Research has sought to determine the effects of immediate and non-immediate CSD on both counselors and clients.

In general, research findings regarding the effectiveness of utilizing CSD in session has been mixed (Ziv-Beiman, 2013). Some research results indicate that after CSD clients' feel more humanized, trusting of their counselor, and hope (Audet, 2011; Yeh & Hayes, 2011). CSD can have a negative effect on clients such as questioning of a counselors competence and professionalism, transference, and feeling responsible for the counselor's well-being (Audet, 2011; Miller & McNaught, 2018). Despite a concern for the possible negative effects CSD could have upon clients, surveys of counseling practices estimate approximately 90% of practicing therapists use CSD (Yeh & Hayes, 2011). Overall, it appears the type and frequency of CSD used may have the greatest impact upon clients.

Theoretical influence upon CSD.

The type and frequency of CSD used by a counselor is often influenced by their personality, theoretical orientation, and clinical experience (Audet, 2011). A counselor's personality usually influences their theoretical orientation and each theoretical orientation often teaches the use of CSD in a distinctive way (Knox & Hill, 2016). Psychodynamic and psychoanalytic, humanistic, cognitive-behavioral, & multicultural and feminist theories' CSD stances will be highlighted.

Psychodynamic and psychoanalytic therapies have traditionally discouraged all types of CSD due to concern about disclosures leading to an inability for the counselor to be unbiased. However, as the theoretical orientation has evolved, counselors identifying with the theories have begun to embrace CSD to a limited extent. Currently, most psychodynamic/psychoanalytic

counselors practice CSD when they have determined that doing so will model an emotional release and strengthen the therapeutic relationship (Audet, 2011; Knox & Hill, 2016).

Humanistic counselors often fully embrace the use of CSD in session. Proponents of this orientation assert that disclosures show genuineness and openness. Additionally, CSD can demystify the counseling process, increase a client's feelings of trust, and assist in balancing the client-counselor power dynamic. The counselor's humanness can also be revealed through CSD and facilitate a catalyst for change in the client (Audet, 2011; Knox & Hill, 2016).

Audet (2011) and Knox & Hill (2016) both agree CSD isn't often discussed in cognitive-behavioral theory. However, counselors who utilize cognitive-behavioral practices with clients tend to practice CSD to strengthen the client-counselor relationship. CSD in cognitive-behavioral theory can also allow the counselor to model and reinforce clients' thoughts and behaviors.

Mutlicultural and feminist theories embrace CSD in the clinical setting. The theories propose CSD helps to balance the power differential inherent to the counseling relationship and empower the client (Audet, 2011). Mutlicultural and feminist theories also practice disclosure to grow a feeling of solidarity between the counselor and client, facilitate a catalyst for change, reduce shame within the client regarding help-seeking behaviors, and provide the client with more information to make an informed decision about seeking/continuing services (Knox & Hill, 2016).

Regardless of one's theoretical orientation, a counselor's clinical experiences can help to determine the type and frequency of CSD used in session. Research focusing on CSD decision making has revealed there may be a pattern in the clinical decision making process (Miller & McNaught, 2018). To decide if CSD is in the client's best interest counselors evaluate if CSD

will be used as a tool for change or to build the relationship. Once the purpose is determined, counselors consider if the disclosure is a good match for the client's personality, goals, and values and also consider if boundaries can be maintained after the disclosure. If the counselor has determined CSD is indeed for the client's best interest, the counselor should evaluate post-disclosure the effectiveness of the intervention.

Novice counselors may struggle to determine if and when to practice CSD without much clinical experience to reflect on. In fact, many counselors are trained to not practice disclosure in their program of choice and thus may experience an increase in anxious feelings regarding CSD (Knox & Hill, 2016). Counselors with limited client experience, therefore, tend to practice CSD sparingly and rely upon ethical standards to determine when to utilize CSD in their practice.

Ethical considerations.

A common concern for practicing counselors contemplating the use of CSD in the clinical setting is violating their code of ethics. Within one's code of ethics lies the responsibility to establish and maintain boundaries with clients. The improper use of CSD, such as disclosing information that is irrelevant to the client's presenting concerns, could lead to clinical issues such as facilitating a feeling of friendliness with the client, shifting the focus from the client to the counselor, and creating a feeling of responsibility within the client to care for the counselor (Audet, 2011). It is important to note, however, the act of CSD is not considered unethical by most professional ethical standards. A counselor must instead evaluate whether or not their disclosure's intent is meant to be therapeutic.

It can be challenging to determine the types and frequencies of CSDs which are ethical in practice since the research regarding the therapeutic value of the intervention is mixed. The lack of a clear direction regarding the use of CSD may be due to the many variables which contribute

to the impact CSD has upon clients. Variables include the client's perception of the counselor's expertise, the content of the disclosure, the technique used to disclose, and the client's culture (Elkins et al., 2017). What appears to be clear though, in accordance to current research, is the complete absence of CSD can be detrimental to the therapeutic process (Audet, 2011).

If never disclosing is harmful to the client and therapeutic environment, then one may consider professional suggestions regarding CSD to comply with ethical standards. Ethicists hold varying positions regarding CSD, so professionals often seek the ethical opinion of those who align with their theoretical orientation. Ethicists who identify with a risk-management view encourage practitioners to restrict their practice of CSD to protect the professional boundaries of the client-counselor relationship. In contrast, humanistic, multicultural, and feminists ethicists maintain the practice of CSD is ethical because holding boundaries which are too rigid harm the facilitation process of the therapeutic relationship (Audet, 2011).

Cultural considerations.

Counselors are ethically bound to provide culturally-sensitive services to their clients. A multicultural lens is to be used with all clients to prevent harmful or ineffective counseling interventions. A counselor must possess awareness of their own culture, knowledge of other cultures, and skills which are rooted in cultural humility. Most research supports broaching, or openly confronting, cultural differences with clients is best practice (Poston & And Others, 1991). A limitation to current research is the lack of culturally-specific study designs; most research draws conclusions from a study sample of various ethnicities, with the majority of the sample being comprised of European Americans (Kim et al., 2003). Despite the limitations, CSD cultural considerations for Native Americans, African Americans, Asian Americans,

LGBTQI+, and counselors who identify with a marginalized culture will be outlined to provide broad and general considerations.

Native Americans, like most marginalized cultures, tend to prefer a counselor who identifies with their culture especially if the client strongly identifies with their Native American group. However, Native American counselors may not always be available to provide counseling services, or if there is culturally similar counselor there is great diversity among tribal values. CSD can assist a counselor in building a relationship with a Native American client. Native Americans tend to prefer a counselor who practices disclosure over a counselor who does not. The act of CSD appears to communicate to the client that the counselor is both trustworthy & credible; additionally, CSD models for the Native American client the disclosure the counselor is asking the client to provide (Lokken & Twohey, 2004).

African American clients tend to mistrust counselors who do not identify with their culture. If a counselor is culturally different from an African American client, CSD can be an intervention used to increase rapport, credibility, and trust with a client. CSD of cultural differences and a willingness to explore this potential barrier has been found to improve the counseling relationship; CSD of this nature is perceived by the client to communicate an understanding of the oppression experienced by many African Americans and an openness to hearing the client's experience of oppression (Poston & And Others, 1991).

Asian American clients may also experience benefits when CSD is practiced in session. Asian Americans tend to view a counselor as an expert authority figure and the intervention of self-disclosure can be an effective modeling tool for clients. Additionally, counselors disclosing their approval of the client and offering disclosures of personal thoughts regarding a solution to a counseling issue are valued among Asian American clients. CSD appears to be valued by Asian

American clients because of the common belief that the counselor is the expert and the client is seeking a solution to a specific issue; CSD as an intervention, therefore, may increase the client's trust in the counselor as a credible, professional helper (Kim et al., 2003).

Individuals who identify as LGBTQI+ tend to seek counseling intervention at a higher rate than peers who identify as heterosexual. Due to the prevalence of LGBTQI+ persons seeking counseling, it may be especially important for counselors to consider if CSD is an effective intervention for the group. Like other marginalized populations, individuals who identify as LGBTQI+ tend to prefer counselors who also identify with their group; clients often rate their counselor most positively if the counselor and client are culturally similar. If a counselor is culturally different, current literature reveals LGBTQI+ clients still tend to rate counselors who practice CSD as an intervention as more trustworthy and perceived as possessing counseling expertise (Borden, Lopresto, Sherman & Lyons, 2010).

CSD of a counselor's own identification with a marginalized population appears to be well received by clients, as supported by current research. Recent literature suggests that a counselor who practices the disclosure of their identification with a marginalized population (i.e. individuals with a disability, individuals whose first language is not English, persons of color, etc.) positively impact their client. Clients who receive this type of CSD tend to report they view their counselor as cognitively flexible, open to experiences, and self-aware (Choi, Mallinckrodt, & Richardson, 2015). However, exceptions to the general finding exist if a counselor discloses an identity which greatly challenges a client's own beliefs (ex. LGBTQI+ counselor disclosing their sexual identity to a conservative client), so counselors should also consider their client's culture before practicing CSD (Jeffery & Tweed, 2015).

A balance must be found for each clinician utilizing CSD between too much and the absence of disclosure. Support in determining one's CSD practice can be found through self-reflection, clinical experience, ethical standards, peer consults, and supervision. Although there is a bouquet of research regarding general practices for CSD and suggestions for steps to take to determine when to practice CSD, there are many gaps in the research. For the purposes of this paper, a gap of particular focus is the practice of counselor's disclosing their own mental health to clients.

CSD of Mental Health

We all have mental health, and counselors are no different. Many counseling programs encourage their counseling students to seek individual counseling both during and after the program; some programs require their students to receive counseling for a duration of time to meet graduation requirements (Elkins et al., 2017). Despite the prevalence of mental health challenges experienced by those working in the counseling field, counselors are often not given direction as to if and how their mental health should be disclose to their clients. Counselors must then determine if CSD of mental health is appropriate based upon current research, their own values & beliefs, and their client's views of mental health.

Research findings.

Very few quantitative studies designed to measure client response to CSD of mental health have been conducted. In an original study, Fox, Strum, and Walters (1984) measured the impact upon clients after reading a vignette. Participants were assigned to read a vignette describing either CSD of past experience as a client or non-disclosure. Results suggested clients rate therapists more positively after CSD when compared to individuals who read non-CSD vignettes.

Somers et al. (2014) replicated the study by measuring college students' responses to counseling vignettes of providers disclosing mental health status. Results suggested clients rate providers more positively when mental health is disclosed versus when it is not. Both studies, original and replicated, measured client response to CSD using an author developed Likert scale.

The limited quantitative research using a valid and reliable assessment leaves more to be desired in regard to scientific research of CSD of mental health. Additionally, research is lacking which addresses the multicultural elements of CSD of mental health. Overall, most literature supports that CSD of mental health most likely does not significantly impact the counseling relationship (Elkins et al., 2017). Beyond scientific research, current literature exists to supplement the decision-making process for counselors determining when and if to disclose their mental health.

Perspective of the counselor.

Surveys and studies of counseling professionals imply many counselors seek mental health services. It is estimated that between two-thirds and three-fourths of therapists have been a client of mental health services (Armour, 2007). Counseling programs may influence the prevalence of treatment; dependent upon a program's accreditation and ethical standards, students may be required to attend personal therapy to graduate (Elkins et al., 2017). It is estimated that approximately one-third of counselors first experienced personal therapy in graduate school (Armour, 2007), perhaps because of schools sometimes requiring participation in mental health services.

Most counseling professionals report positive experiences from personal therapy. Commonly cited reasons for seeking mental health services are concerns about depression, motivation to address anxiety surrounding their counseling practice, personal issues, and desire

to be a better counselor (Armour, 2007). Reported benefits include decreased stress, increased awareness of possible countertransference issues, increased empathy for clients, and personal growth (Elkins et al., 2017).

When calculating if and when a disclosure is in the client's best interest, counselors may experience a more positive, or at least neutral, response from a client if they disclose a resolved mental health experience (Elkins et al., 2017; Miller& McNaught, 2018). Possible benefits of disclosing one's mental health to a client may include inducing a feeling of universality, balancing the client-counselor power dynamic, and providing hope by sharing their positive experiences with counseling (Yeh & Hayes, 2011). Despite the many possible benefits of CSD of mental health from the counselor's perspective, scholarly literature supports the client's attitudes may have a stronger influence upon a successful CSD experience.

Perspective of the client.

A client's attitudes towards the counseling process, counselor, and mental health concerns can be influenced by a number of factors. Of particular concern is society's perception of both mental health and seeking help for challenges. Strong messaging received from the media can greatly influence an individual's understanding of the counseling process and the effectiveness of seeking help (Armour, 2007). Individuals may also identify with the messaging received from society about mental health, and feel stigmatized for either experiencing mental health challenges or seeking help to address their concerns.

The media's portrayal of counseling may raise concern in a number of individuals about the process and the professionalism of counselors. Depending upon the media's representation, mental health professionals may be unflatteringly represented as cartoonish, villainous, or unethical (Armour, 2007). Now that media is more accessible than ever to folks, counselors

must consider how, if at all, the representation of their profession influences clients walking into their office. Negative perceptions of counselors, held by clients, may include a lack of ability to respect boundaries (especially sexual), inability to empathize with others, and a predisposition to label clients as "crazy". Despite the often negative depiction of counselors presented, most clients report they support counselors receiving psychotherapy, but may not want to have the counselor's treatment disclosed to them in session (Elkins et al., 2017).

Recent CSD of mental health literature has investigated if clients' attributes, such as identification with the stigma of mental health and culture, contribute to their perception of CSD of mental health. The stigma of challenges with mental health often influences an individual's willingness to seek and continue to receive treatment (Armour, 2007). Current publications reveal if a client identifies with the stigmatization of mental health, the client would not respond well to a counselor's disclosure of their own mental health challenges (Elkins et al., 2017). A client who feels the stigma of their mental health treatment may react to CSD of mental health by questioning the counselor's competence and professionalism. However, if the client feels acceptance around their own mental health challenges and supports others seeking help when needed, the client may respond neutrally or positively to CSD of mental health (Audet, 2011; Elkins, et al., 2017). These clients tend to respond favorably to CSD of mental health when a counselor discloses their experience with a similar mental health disorder and/or symptom (Levitt et al., 2016).

One may assume the influences listed above, such as media portrayal of mental health services and the stigma of mental health, impact the people who seek counseling services. Data collections consistently find many people in the United States experience mental illness, but often do not seek treatment at the onset of symptoms (Armour, 2007). Approximately 1 in 5

people experience mental illness each year. In the United States, 43.3% of individuals sought mental health treatment in 2018, and the average person postponed seeking treatment until 11 months after first experiencing symptoms (National Institute of Mental Health, 2019). It is essential that mental health professionals consider their client's culture and perception of mental health & services when considering CSD of mental health due to the factors which may influence the client's reaction.

Applications to Clinical Mental Health Counseling

Research and literature focusing on CSD can provide guidance to counselors and counselors-in-training. Through integrating one's educational and clinical experiences, and current literature direction can be provided as to better clarifying when CSD is in the client's best interest. It is of the utmost importance this information be applied to the clinical setting to best support clients in their journey towards well-being.

Current literature suggests the use of CSD, appropriately, improves the client-counselor relationship in clinical settings through influencing specific relationship factors. Clients who experience CSD in a clinical setting may feel more humanized, trust for their counselors, and hopeful about the counseling process (Audet, 2011; Yeh & Hayes, 2011). Positive effects such as these appear to have the strongest influence when CSD is used sparingly and the disclosure is of an immediate and resolved topic (Ziv-Beiman & Shahar, 2016); not practicing in this manner could have negative ethical consequences. Some research has found CSD to have either no effect or a negative effect on the client, so in the clinical setting the counselor must also consider the client's perspective to determine best-practice of CSD.

Individuals who do choose to seek help from a clinical mental health counselor bring in their own unique culture. Dependent upon culture, a client may value CSD for reasons such as

increasing trust in their provider and decreasing anxiety about seeking help. The client's culture may also dictate the stigma they feel about experiencing mental health challenges (Armour, 2007). Literature suggests clinical mental health counselors would do best to consider their client's perspective to determine if CSD is a good fit, rather than counselors taking a "one size fits all" approach to CSD.

A special consideration, when discussing CSD, is the disclosure of a clinical mental health counselor's own mental health. Due to the popularity of counselors seeking and receiving mental health services at some time during their life, it may be beneficial for educators and supervisors to regularly broach this specific CSD topic with their students and supervisees. Conversations around CSD of mental health may better prepare clinical mental health counselors for client interactions which may warrant disclosure.

Literature encourages clinical mental health counselors to consider many different aspects and prior experiences with CSD to determine whether or not CSD could be an effective intervention with their clients (Miller & McNaught, 2018). Although novice counselors often do not have a depth of clinical experience to reflect upon, they can consult with other peers, review academic literature, and take the time to learn about what value, if any, their client places upon CSD. CSD research and literature is important to the clinical mental health counseling field because the information gained from publications assists counselors in improving the services they provide to clients.

Conclusion

"Client's best interest" is sometimes left undefined when teaching counselors when and how to appropriately utilize CSD in practice. Due to the vague guidance sometimes provided, novice counselors may under- or over-utilize CSD in their practice until they have clinical

experience to incorporate into their decision-making process. Unfortunately, clients could experience adverse effects of an unbalanced CSD practice as the counselor learns how CSD fits into their personal practice.

Current research and literature may provide individuals in the counseling field with direction not currently being received in educational settings. Although there is not an all-encompassing, single suggestion for when and how to use CSD, academic publications provide additional guidance to define "client's best interest." Counselors may experience the best response from clients if they practice disclosing immediate and resolved topics at a moderate frequency (Ziv-Beiman & Shahar, 2016). Counselors must also consider their client's culture and identification with the stigma of mental health to determine if CSD is a good-fit for the client as an intervention (Armour, 2007; Knox & Hill, 2016).

Identification with society's stigma of mental health challenges appears to be one of the most important factors for counselors to consider if they would like to use CSD of mental health as an intervention (Elkins et al., 2011). Counselors may experience the most success if they practice CSD of mental health with clients who accept mental health challenges and seeking support for mental health as "normal". As with general CSD, CSD of mental health should only be disclosed if the counselor is discussing an immediate and resolved issue that relates to the client's presenting concerns.

Despite the common ethical concerns with self-disclosure, such as blurring boundaries, research and literature supports the use of CSD is helpful when done correctly. Counselors would do well to educate themselves further on when and how to practice CSD because the effects of the interventions use can be very positive for clients. Increasing conversations and

education on the topic of CSD could create a greater acceptance of CSD as a clinical intervention, and therefore benefit clients receiving services.

Limitations

Limitations to the topics of CSD and CSD of mental health exist. Due to the limited body of current, scientific research on these topics, it is challenging to compare research results to draw conclusions about the effects of CSD. Additionally, many CSD studies are not conducted in the clinical setting with randomly assigned test-subjects; therefore, the research results may not be valid when applied to a clinical practice. Finally, many types of CSD exist and current research has not focused on all types which counselors may experience in their practice; without existing research we are unsure if general CSD conclusions are applicable to each sub-type. These limitations are concerning because they present a challenge to counselors who are trying to decide if the research results are applicable to their practice.

Future Research

Future research focusing on addressing the gaps and limitations of current research is needed. Scientific, quantitative studies utilizing valid and reliable testing instruments would add a beneficial element to the current body of research. Also, research conducted in the clinical setting, as opposed to surveys, could help the field better generalize results to counseling practices. Adding to the existing body of literature in this way may improve the counseling services being provided to clients and support counselors in utilizing CSD appropriately.

Author's Note

The thought of self-disclosing to my clients used to be something that terrified me. As a relatively reserved person, I sometimes struggle to share about myself and would much rather listen to another person's story. In a clinical setting, I was also very concerned about blurring

boundaries with clients and moving the focus of the session away from them. My assumptions were put to the test when I began practicing counseling skills in the "real world" as a counseling intern.

As I began to build a client caseload, I started to notice all the instances during which I was compelled to self-disclose. There were times when I wanted to intervene with statements like "I think you're worth it" or "I too have experienced (insert experience)". The feeling of wanting to self-disclose in an immediate manner made me curious about the topic of self-disclosure and wondering if all self-disclosures were "bad." To challenge my initial assumptions about CSD, I wanted to research the topic more and develop this capstone project.

I learned a great deal reading current research and literature about CSD and as I dove further, my curiosity also expanded to CSD of mental health. Knowing myself and other counselors have been faced with mental health challenges, I thought this was an interesting sub-type of CSD which I could also learn from. Incorporating what I learned from my research has helped me to better consider if CSD of mental health is something that fits into my counseling style.

Overall, the information and personal growth I have gained through the capstone project process has allowed me to become a more flexible counselor. My assumptions and biases about CSD were challenged and I've been able to better integrate research findings with my personal style. I am very much looking forward to using what I've learned to better serve the folks I counsel in the future.

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