The Therapist’s Use of Self-Disclosure in a Relational Therapy Approach for Eating Disorders

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One of the critical aspects of Relational Therapy (RT) that distinguishes it from other treatments for eating disorders is the therapist’s use of self-disclosure. Self-disclosure is one way the therapist authentically represents her- or himself in the therapeutic relationship to foster relational movement and growth. This article makes use of an initial clinical vignette to compare and contrast the use of therapist self-disclosure within an RT approach with views of therapist self-disclosure from other psychotherapy traditions. Advantages are discussed for using therapist disclosure with eating disordered patients. Criteria are outlined to help the RT therapist decide when to disclose. Additional clinical vignettes show different types of therapist self-disclosure, their therapeutic purposes, and their relational impact. The article ends with implications for future research, training, and practice related to the use of self-disclosure in the treatment of eating disordered patients.

Self-revelation is not an option; it is an inevitability (Aron, 1991, p. 40).

CASE VIGNETTE

Cathy is a 45-year-old married woman and mother of two teenage sons. She has at least a 20-year history of anorexia nervosa. She received marital
counseling for several years but only six weeks of eating disorder treatment one year ago in a partial hospital setting. She states she went to the partial setting under duress in order to calm her husband and sons. She felt misunderstood and complained that she was the only one there who was over the age of 25. She learned some, but said she did not find it too helpful. Cathy comes to the interview today looking quite emaciated, weighing 84 pounds at 5'4". She is here because her husband has finally moved out, saying "he can't watch her kill herself," and her sons are angry and not talking with her. She says she really needs to do something about this illness now. She is losing everything she ever valued and loved. She needs a therapist who "can tell her the way it is and be honest with her."

Cathy then begins to ask me about "what weight I think she is supposed to be at." Before I have a chance to respond, she says she "doesn't want to hear how she is supposed to be within a range on some weight graph, like the other doctor and her family have told her." She emphasizes that she "is not a number and those charts don't take anything else into consideration." She has always been thin. She hasn't been over 95 pounds for years. She says she "doesn't look good over 100 pounds." I tell her, "I am not going to argue with you about what you are supposed to be because that will ultimately be up to you. I can't make you gain weight. Being in treatment and recovering will be up to you. I know it took great courage to just come to the appointment today. However, I feel like I am in a bind. I want to honor your request for me to be honest and "tell you the way it is," yet part of me is concerned that when I do, you will hear this as an invalidation of your experience. If you are asking me about the facts and about how I, as a therapist, think about treatment, then based on your age, height, weight history, and family history, your weight range would probably be around 113–118 pounds." I also told her, "I can understand why you feel differently, but want to be honest with you. We can agree to disagree."

Then the patient discussed how she has felt controlled by her mother in the past. Her mother had encouraged the patient to binge and diet with her. She is very angry with her mother because she feels her mother never listens to her or does what she asks, even when Cathy is direct. She wonders out loud if her rebelliousness with her mother has anything to do with her eating disorder. (She also was been fairly irreverent with me throughout the interview.) Then she quickly adds, "But today, I am here seeking treatment because I do want to get better. I am finally ready to be obedient." I looked at her feeling somewhat caught off guard by the quick transition from opposition to seeming compliance. I decided to respond with some humor and a bit of my own irreverence and made a disclosure that could simultaneously validate her opposition (her desire to be different and have a voice) and her motivation for change (willingness to take a risk, connect with me, and learn new ways of taking control and being herself). I said to her, "Obedience? I don't need you to be obedient. I have trouble being obedient. Personally,
I don't even know how to spell the word (smiling). I would have never made it in the nunnery, the priesthood, or the military. I would have quickly been tossed out. All I want for you is to be healthy. Health and obedience aren't necessarily the same thing. You'll have to explain to me a little more about what you mean by obedience." Cathy smiles back and says, "I just wanted you to know how much I want to change things."

A relational therapy (RT) approach to the treatment of eating disorders (Tantillo, 2000; Tantillo, Nappa Bitter, & Adams, 2001; Tantillo & Sanftner, 2003) proposes that an individual is able to let go of eating disorder symptoms as she is able to (a) identify the connections between her relationships with food and her relationships with the self and others, and (b) develop mutually empathic and empowering relationships with others inside and outside the therapy office. One of the critical aspects of RT that distinguishes it from other treatments for eating disorders is the therapist's use of self-disclosure in the therapeutic relationship. While the therapist reveals her- or himself to patients in many different ways (nonverbal communication, style of dress, office surroundings, ground rules regarding time and money, etc.), self-disclosure is defined here as judicious, intentional verbal communication by the therapist, about the therapist, used for therapeutic purposes. An example of the kind of disclosure a therapist would make within a RT approach is seen in the above vignette. In this paper, I describe what distinguishes therapist self-disclosure in an RT approach from other therapy approaches. I address why therapist self-disclosure is helpful when working with patients with eating disorders, especially within the context of an RT approach. I also discuss the criteria the RT therapist can use when deciding whether to offer disclosure, as well as strategies for how to offer it. One way to understand what distinguishes the use of self-disclosure within an RT approach from its use in other therapy approaches is to begin with an examination of the above vignette from the perspective of various psychotherapy traditions.

DIFFERENT THEORETICAL PERSPECTIVES ON THERAPIST SELF-DISCLOSURE

A Traditional Psychoanalytic/Psychodynamic View

Each type of psychotherapy is based on a certain conceptualization of what fosters psychological growth, change, and healing. These conceptualizations also define the role of the therapist as healer and alter how she or he responds to the patient in a given therapeutic interaction (e.g., making a choice to self-disclose or not). A therapist working within a traditional psychoanalytic/psychodynamic framework is acting as a mirror of patient projections (Freud, 1912; Lane & Hull, 1990; Langs, 1982). She or he promotes neutrality through abstinence and anonymity (very little or no therapist
self-disclosure) in order to help the transference unfold “unimpeded and uncontaminated” (Jackson, 1990, p. 101). The therapist working within this framework might not respond at all at the points that I did in the above vignette or might have simply asked the patient to say more about the meanings related to her target weight and to the term “obedience.” It is very unlikely that the therapist would have self-disclosed to the patient that she or he felt “in a bind” in response to the patient’s contradictory request for an honest therapist and a therapist who will only do as she says in regards to her weight. The therapist also would not have revealed her or his own experience or attitudes in regards to the issue of obedience.

In a traditional psychoanalytic/psychodynamic framework, psychological healing and personality change occur via uncovering the unconscious, free association, analysis of dreams and fantasies, and analysis of the transference (Menaker, 1990). Therapist interpretation of patient material leads to increased patient insight regarding unconscious drives and defenses and their impact on present functioning. The hallmark of psychological growth and maturation is independence and autonomy from the object (e.g., the therapist in this case). The therapist is viewed as an outside observer, not as a participant in the relationship. She or he is the object of the patient’s drives and tries not to use self-disclosure, which would gratify these drives. Therapist self-disclosure is seen as a sign of countertransference difficulties.

A Self-Psychology Therapy View

In a self-psychology framework, the therapist views the occasional and judicious use of therapist self-disclosure as a “form of empathic attunement and self-object responsiveness” that can promote a sense of validation, deepen affect in patients, increase patient self-disclosure, increase a patient’s ability to reconnect with walled off parts of their experience, and allow the development of a self-object transference (Goldstein, 1994). The goal of self-psychology is to help the patient develop a new self-structure and a greater degree of self-cohesion. The therapist’s role as healer is to promote the self-object transferences (re-experiencing of the patient’s frustrated or unmet early self-object needs, mirroring, idealization, etc.), provide a second chance for patients to complete their development, and work through any disruptions in treatment due to therapist empathic failures (Menaker, 1990).

When examining the above vignette from the standpoint of self-psychology (Kohut, 1971, 1977, 1984), the therapist would tend to respond in a way that would meet Cathy’s self-object needs in the moment in order to promote the experience of empathy. She or he may have told Cathy that she or he could understand why Cathy is so concerned about her target weight, given how much others, like her
mother, have not listened to her. The therapist might have gone on to ask if there was something specific that had transpired in the interaction with the therapist that might have contributed to her irritation regarding a target weight. The therapist might have paused then to allow Cathy to respond to the therapist's attempt at validating her experience. However, the self-psychologist may still tend to value interpretation over the use of therapist self-disclosure, and probably would not reveal as much about her own experience in regards to the target weight and the issue of obedience, as I did in the above vignette. She or he would be more interested in clarifying and affirming the patient's experience related to this issue.

Since Kohutian self-psychology can be viewed as a one-person psychology with an emphasis on allowing the patient's self-object transferences to unfold without contamination from the therapist, this can limit the therapist's use of self-disclosure. Additionally, self-psychology maintains a classical view that who the therapist is as a unique individual is irrelevant to the process of therapy. Kohut stated that the patient's transferences develop before treatment in the context of internal factors in the patient's personality structure. Making accurate interpretations on the basis of empathy is what is central to the work of therapy (Aron, 1991).

A HUMANISTIC VIEW

Therapists who employ a humanistic approach to treatment (e.g., Rogerian, existential, gestalt, some varieties of interpersonal, cognitive-affective therapy, systemic, and family therapy) value the therapist's use of self-disclosure as a therapeutic tool (Weiner, 1983). Humanistic therapies emphasize genuineness and openness on the part of the therapist, therefore, they would support the more open and transparent responses that were made to Cathy in the vignette in regards to her target weight and her emphasis on obedience in the treatment. Humanists view authenticity in the therapeutic relationship as a necessary ingredient for patient self-disclosure, trust, self-knowledge, increased intimacy, healing, and psychological change (Goldstein, 1994; Jourard, 1971; Rogers, 1951). Therapist self-disclosure is an interpersonal process that promotes the authentic therapeutic relationship and increased inter- and intrapersonal change (Jourard, 1971; Mowrer, 1964; Rachman, 1990; Rogers, 1961).

Humanistic therapy's emphasis on using the real relationship with the patient in order to not repeat an earlier experience of invalidation and trauma can be traced to Ferenczi (1933/1955). He advocated that during a therapeutic impasse the therapist needs to be aware that the patient is communicating two levels of trauma. That is, the patient is expressing something regarding the original trauma with family members and regarding trauma she may be experiencing in the here-and-now in regards to a
perceived empathic failure on the part of the therapist. This is seen in my disclosing to Cathy the bind I feel as I begin to understand how out of control Cathy has felt in relationships to others. I try to respond to her in a way that validates her need for control regarding her target weight and simultaneously expresses my desire to be honest and open with her (her request) about my treatment approach and beliefs. Therapist self-disclosure can be critical at these times, as it can convey empathy about the dual nature of the patient’s trauma, acknowledge the reality of the patient’s pain and any way the therapist contributed to this, provide a corrective experience, strengthen the therapeutic relationship, and maintain forward movement in treatment.

While Humanistic therapies are similar to RT in their emphasis on therapist openness, genuineness, authenticity, and use of the real relationship, this emphasis is not specifically informed by a psychology of women or feminist principles and practice. In RT the therapist makes disclosures to advance movement in the relationship because the therapist believes that women’s psychological growth and change occurs specifically within the context of mutual connection. Also, while Humanistic therapies encourage self-disclosure to foster a general sense of patient liberation and validation, these disclosures, for example, are not aimed at creating a more egalitarian relationship because of societal forms of oppression experienced and internalized by women on a daily basis. In contrast to Humanistic therapies, therapist disclosures in RT may link the personal and the political. For example, in response to the patient’s glorification of thinness, the therapist may disclose her or his own negative feelings regarding the societal value placed on thinness and how the value is oppressive because it preys on women’s vulnerabilities in our society and contributes to negative body image and eating disorders.

A Feminist View

Feminist therapists see self-disclosure as a critical ingredient for therapeutic change (Mahalik, Van Ormer, & Simi, 2000; Simi & Mahalik, 1997). In a feminist orientation the goal is to empower patients and help them heal from their wounds. The therapist helps the patient to identify the roots and effects of oppression in her life and facilitates a corrective experience by aiding the patient in expanding her vision of alternatives, so she can make informed choices instead of nonconsciously responding to the norms of sexual stereotypes (Brown & Walker, 1990). A feminist therapist would support therapist statements that decrease a sense of patient oppression and increase her choices, her voice, and an experience of empowerment (e.g., letting Cathy know she did not need to be “obedient” and that “obedience and health are not necessarily the same”). Also, feminist therapists suggest that therapist self-disclosure of lifestyle, back-
ground, and beliefs, such as theoretical orientation, political and religious beliefs, sexual orientation, socioeconomic background, and other values is important for patients to make informed choices regarding therapist selection (Mahalik, Van Ormer, & Simi, 2000). The feminist therapist's assumptions regarding psychological healing and growth and the interventions used to promote them, depend upon the other theories she or he adopts in terms of practice (e.g., psychoanalytic/psychodynamic, self-psychology, Rogerian, relational, etc.).

In feminist therapy practices, the clinician functions as a role model and uses self-disclosure to create an atmosphere of shared value and expertise. The therapist represents her- or himself as someone who also has vulnerabilities, may have experienced challenges similar to the patient, and developed solutions (e.g., the therapist’s responses to Cathy about her own experience of obedience). She or he validates and normalizes the patient’s struggles and her ability to make changes according to her own experience and needs. The real self of the therapist is always incorporated into the symbolic representations of the therapist (Brown & Walker, 1990). Self-disclosure is seen as one technique in a feminist practitioner’s approach, but one that is powerful because it promotes core feminist principles of egalitarianism and a feminist consciousness.

While the use of therapist self-disclosure in RT is based on the feminist principles and practices described above, it is offered in a context that distinguishes it from its primarily politicized use during the first generation of feminist therapies. Therapist self-disclosure was originally used to promote a “consciousness-raising group of two” (Brown & Walker, 1990, p. 136) that would examine the roots and impact of women’s oppression and the link between the personal and the political. Therapist self-disclosure in RT may involve disclosure regarding power inequities or criticism of current cultural values that oppress women, but it is specifically offered within the context of individual patient needs and with the therapeutic aim of fostering mutual connection and the growth of the self in the relationship. It is also offered with the transferential or symbolic aspects of the therapy process in mind (Brown & Walker, 1990).

A Relational Therapy View

RT is based upon the feminist orientation described above and on the belief that women psychologically grow, heal, and recover through mutual connections with others. RT espouses that development proceeds through “relational differentiation (Surrey, 1984) and elaboration rather than through disengagement and separation” (Jordan, 1986, p. 5). A person’s experience of mutuality in relationships involves having an impact on the other and allowing oneself to be open to the influence of others. Perceived mutuality involves a bidirectional movement of thoughts, feelings, and actions (Genero,
Miller, Surrey, & Baldwin, 1992). It involves an attunement and responsiveness to the subjective experience of the other on a cognitive and affective level and an acceptance of the wholeness of another person, including her or his similarities and differences. The RT approach is based on a model of mutual intersubjectivity in which patient and therapist are each responding in the above fashion. There is an understanding that each person can grow through the interaction (Jordan, 1986).

RT espouses the development of mutual empathy and empowerment in the therapeutic relationship through a focus on patient and therapist authenticity, the use of the real relationship (along with attention to the transferential relationship), and the use of judicious self-disclosure (Jordan, 1986; Miller, Jordan, Stiver, Walker, Surrey, Eldridge, 1999; Miller & Stiver, 1997). It is important to note that in an RT approach, therapist authenticity does not equal self-disclosure. One can be authentic, that is, trying to represent oneself more fully in the relationship (Miller et al., 1999), without self-disclosing. For example, authenticity can occur through verbal means (e.g., validation and reflection), and through non-verbal means (e.g., being attentive and emotionally present in the moment to moment interplay of therapy). Also, when self-disclosure is used, it does not equal full therapist self-revelation, and it is used in the best interest of the patient. It is used to help the patient recognize that the therapist has been moved in response to his or her experience or behavior and to promote the experience of mutuality. This process also leads to increased self-empathy as the patient realizes that her thoughts, feelings, needs, and behaviors do matter to someone and can be part of the relationship (Miller et al., 1999).

An RT approach supports my self-disclosures with Cathy in the above vignette because these disclosures were based on feminist and relational motivations to demystify my role (e.g., reveal my humanness and struggles with obedience); demystify the process of therapy (e.g., letting Cathy in on my “bind” as I tried to validate her struggles related to control and respond to her contradictory requests—wanting total control over her weight and an honest therapist); and decrease the power differential between Cathy and me (“I can’t make you gain weight. Being in treatment and recovering will be up to you…We can agree to disagree.”). Following the self-disclosing statements, I asked for clarification to increase dialogue between us about my self-disclosures and her response (e.g., “You’ll have to explain to me a little more about what you mean by obedience.”).

In an RT approach to eating disorders, therapist self-disclosure helps normalize and validate the patient’s struggles and symptoms (versus seeing them as “pathological”) and decreases the patient’s sense of shame, oppression, and isolation in the world. Therapist self-disclosure frees the patient to develop healthy resistances (e.g., more positive images of oneself in relationships with others, identification of one’s strengths, the use of healthier coping strategies, and the ability to challenge unrealistic images of
women and men in the media) as opposed to psychological resistances (e.g., eating disorders and other mental health problems) (Gilligan, 1991; Miller, 1986; Miller & Stiver, 1997; Reed & Garvin, 1996, Tantillo, 2000).

My self-disclosures in the above vignette were aimed at helping Cathy begin to recognize that her eating disorder behaviors are adaptations that have allowed her to survive in difficult life circumstances. Cathy’s starvation and its emotionally numbing effects disconnected her from the painful bind she felt in relationship to her mother while also allowing her to maintain the relationship with her mother, exert control, and voice difference in the relationship. However, these symptoms also kept her disconnected from her genuine needs, thoughts, and feelings and distracted her from doing the emotional work required to increase mutuality with others and to establish a clearer sense of herself in the relationship. By disclosing the “bind” (relational dilemma) I felt in talking with her about her target weight, I also verbalized for her the bind she has experienced in her relationships with mother and others (wanting to be authentic without losing the connection and wanting the same in return). I conveyed validation of Cathy’s experiences by acknowledging her need for control and a voice in decision-making, as well as her need for an honest therapist. I followed up my self-disclosure with validating statements about her attempts to take control in healthier ways. I said, “I know it took great courage to just come to the appointment today.” I acknowledged that although we have a therapeutic connection, we are different people with different ideas and experiences and that I understand why she would feel differently about the weight issue. This allows her to value her experience and see that I also understand and value it, but may not agree with it.

While therapist self-disclosure in the RT approach is aimed at fostering a sense of mutual connection, it also needs to convey to the patient that the therapist understands and accepts the patient’s tendency to fear mutual connection (the relational paradox) (Miller & Stiver, 1997). The therapist helps move the relationship from connection through disconnection and to a new, more mutual connection. Each dynamic in the therapeutic relationship is understood as an effort to create or maintain connection or to move out of connection. This parallels the patient’s attempts to differentiate within the connection and to deepen the connection. For example, I stated to Cathy that I wanted to honor her request for me to be honest (and connect with her in our work) but also worried she would feel invalidated if I was honest because of her need for control related to her weight (her need for differentiation in the relationship). Therapist self-disclosure can hold out the reality of these two simultaneous forces and convey an acceptance of patient strategies for disconnection (e.g., binging, purging, and food restriction). These strategies distract and disconnect the patient from her authentic experiences in order to maintain available connections with others (e.g., avoid conflict or rejection) (Tantillo, 2000). I convey an acceptance of Cathy’s
strategies for disconnection in an indirect way through my self-disclosure regarding obedience. For example, my self-disclosure subtly expresses how I can tolerate “disobedience” (a possible strategy of disconnection). This approach may weaken the patient’s connection with food (her use of eating disorder behaviors) because she begins to experience increased safety and authenticity in the therapeutic relationship and the assurance that the therapist is open to addressing and working through disconnections. Therapist self-disclosure during times of disconnection can be quite powerful and healing, as the patient has often experienced numerous disconnections that offered her no opportunity to experience an authentic and empathic response on the part of the other person.

WHY USE THERAPIST SELF-DISCLOSURE WITH EATING DISORDERED PATIENTS?

A number of other biopsychosocial factors support the idea that the therapist should use self-disclosure with eating disordered patients. For example, starvation, with its many physiological and psychological sequelae, mitigates against patients accurately perceiving what is transpiring during the therapy hour (Garner, 1997; Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950). Even when the acute symptoms of starvation have abated and the patient’s intake and weight are more stabilized, patients still tend to experience numerous cognitive distortions because of biogenetic factors such as underlying serotonergic disturbance (Kaye & Strober, 1999) and a history of nonresponsiveness from others, invalidation, and other disconnections in relationships (Bruch, 1982; Garner, Vitousek, & Pike, 1997; Tantillo, 2000, 2001; Tantillo & Sanftner, 2003; Vitousek & Hollon, 1990; Wolff & Serpell, 1998; Wonderlich, Mitchell, Peterson, & Crow, 2001). The patient’s pervasive sense of ineffectiveness, difficulties accessing, identifying, trusting or regulating her own feelings, and the patient’s confusion in understanding the behavior of others (Bruch, 1982) support the use of the real relationship and therapist self-disclosure. Letting patients know how the therapist has been moved by their experience allows them to feel more confident that this experience originated within them and that it evoked a validating response from the therapist. The black and white thinking and various other reasoning errors and irrational beliefs on the part of the patient also improve with more, not less, activity on the part of the therapist and more, not less, self-disclosure.

From a developmental perspective, therapist self-disclosure is important in the work with eating disordered patients because many of them are adolescents. These patients are busy trying to define who they are in relationships with others. They respond to a therapist who can be a role model and who lets them know that she or he has been moved by their experiences and
behaviors. Adolescents often push for genuineness and self-disclosure on the part of the therapist (Rachman & Ceccoli, 1996). Therapist self-disclosure promotes a sense of mutuality and helps the adolescent begin to value and practice being vulnerable and open with others, differentiate within the connections with others, know others have had similar struggles with differentiation, accept responsibility for their behaviors, and also know that adults must accept responsibility for their behaviors.

Eating disordered patients with characterological impairment, especially within Cluster B, also tend to benefit from an increased level of judicious therapist self-disclosure, so they know that the therapist is emotionally present. Otherwise, they may drop out of therapy or (usually unconsciously) increase the volume of their pain until the therapist provides a level of emotional responsiveness that ensures that the therapist has clearly seen, heard, and felt the patient's pain (Dennis & Sansone, 1997; Ferenczi, 1928/1994, 1933/1955; Greenberg, 1986; Linehan, 1993; Rachman, 1990; Wilkinson & Gabbard, 1993; Wonderlich, Mitchell, Peterson, & Crow, 2001).

Since these patients have usually suffered from a pervasive lack of perceived mutuality in relationships, they experience a painful relational paradox—a simultaneous intense hunger for and fear of mutual connection with others. They feel conflicted about the connection with the therapist, and tend to have many internalized negative images of themselves in relationships with others and many negative meanings associated with these images. (For example, "If I say what I really feel or need, the other person will turn away from me. This occurs because I am defective and unlovable.") Therefore, they are more apt to project these negative relational images and meanings onto the new relationship with the therapist. In these situations, more—not less—judicious self-disclosure on the part of the therapist can create a safe working relationship with these patients.

If the therapist confuses anonymity (remaining unknown to the patient) with neutrality in working with characterologically impaired patients (especially, for example, patients with borderline personality disorder) or those with a history of trauma, the lack of therapist self-disclosure regarding the patient's impact on the therapist may leave the patient feeling abandoned, betrayed, and re-traumatized (a non-neutral effect). Neutrality in psychotherapy is not "detached objectivity." Rather, it is the optimal balance between the patient's experience of the therapy relationship as one involving an old negative relational pattern(s) and the experience of the relationship as one involving a new corrective relational pattern(s) (Greenberg, 1986). Patients with character disorder and a history of trauma benefit from judicious self-disclosure when they experience disconnection with the therapist that keeps them stuck in the former and obviates their experience of the latter.
TYPES OF THERAPIST SELF-DISCLOSURE AND THEIR RELATIONAL IMPACT IN AN RT APPROACH: CASE ILLUSTRATIONS

There are many types of therapist self-disclosures, and each should have a therapeutic purpose. Table 1 lists various reasons for therapist self-disclosure within an RT approach. This list is not an exhaustive one, but is illustrative of the reasons a therapist might self-disclose, with a larger goal to promote mutuality in the therapeutic relationship. Examples of specific therapist self-disclosures that correspond with each of the reasons listed in Table 1 are presented below.

Provide Validation

A 17-year-old male patient with restrictive anorexia has just revealed that he did not pass an exam and feels like a complete failure. I respond, “I know how important your grades are to you, especially since you are going to college next year. But you are being very hard on yourself right now. I remember the first time I failed a big exam. It was painful, like the way you are describing it now. It took me a while to work through that, and I had to talk to a number of people who helped me see how hard I was being on myself.”

Promote Empathy

A 35-year-old female patient with Eating Disorder NOS tells me in group that I have no idea what it is like at home for her as she tries to recover. This is in response to my attempt to validate that the patient is in a tough spot at home, trying to move ahead in recovery, while her family denies her illness and the family problems that contribute to it. I say, “You are right. I will never know what it is like to be in your family or to have an eating disorder. But I can tell you that I did feel a great deal of sadness and frustration for you as you described how much you have to turn yourself into a human

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<td>• Provide validation</td>
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<td>• Promote empathy</td>
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<td>• Move from “me” to “we”</td>
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<td>• Focus on normalcy</td>
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<td>• Move through disconnection</td>
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<td>• Share similar experiences</td>
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<td>• Use humor</td>
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<td>• Share relational dilemmas</td>
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<td>• Apologize</td>
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<td>• Clarify the therapy contract and limitations</td>
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pretzel to make everyone happy in the family. Are these feelings you are experiencing now or different ones?

Move from “Me” to “We”: Foster Universality

A 26-year-old female patient with a history of restrictive anorexia says she is tempted to just avoid the conflict in her relationship with her boyfriend and pretend it doesn’t exist or terminate the relationship. I say, “Do you remember when we were experiencing some bumps in our relationship last month? I remember you saying you felt the same way.” The patient says, “Yes, I wanted to just pretend everything was fine.” I respond, “Right, when you were actually upset with me and had thoughts of stopping therapy. You were concerned I would stop our work if you shared your anger, and I was worried you might not come back if you didn’t share it. I was relieved when you shared your feelings with me and felt good that you trusted our relationship enough to do that. Many of us avoid conflict with people we care about. It doesn’t feel good, and we worry about losing the relationship altogether. It’s hard to sit with uncertainty. It tempts us to respond in extreme ways. Let’s think more about how we moved through our tough time together. Maybe that might help us figure out how you want to respond in this situation.”

Focus on Normalcy of Patient Experiences

I am in group teaching the members about strategies for disconnection and the defenses that get in “our” way of recovering. I ask that everyone in the group identify one of their defenses and begin with a discussion of my own. I say, “Well, we all have our defenses and strategies for disconnection. Two of my favorites are intellectualization and rationalization. When I am stressed, sometimes I quickly come up with some meaning for why I might be experiencing something or some good reason for why I am feeling or doing something. These things always sound great and very persuasive in the moment, but they keep me away from what I am really feeling. Anyone else ever experience this?”

Move Through Disconnection while Remaining in Connection

A 45-year-old female minister with chronic anorexia nervosa is weighed in and has lost 2lbs. She describes a weekend full of activity, and I validate how well she has cared for others and all she has accomplished. Then I ask if she has done anything to bring energy in and get something for herself. The patient responds by sharing with me the irritation she felt toward a woman in her congregation who said the patient should be spending more time taking care of herself. I ask if she feels judged by me
as well. She says, "Yes, that is such a typical psychology thing to say. You have to take care of yourself. Like I'm unbalanced. I'm sick of everyone telling me this! I could say the same about you. Just look around this office. I know you spend a great deal of time in action and taking care of others. Your work is a big part of your life. It fills you up. You love what you do." I say, "Yes, I agree. I have struggled with a similar thing—how to care for myself and others, how to balance these things. And because of this, it makes me more attentive, not less attentive to this with you. In fact, last week I thought about what we had discussed and it helped me to practice what I preach. You see our work together helps keep me honest." The patient says, "But isn't it a good thing to keep active, to fill your life up with things?" I reply, "Yes, but sometimes we may be taking action as a way to protect ourselves from what is compelling us to engage in it in the first place, like uncomfortable feelings". The patient becomes tearful and speaks about how alone she feels in response to what would have been her 15th wedding anniversary this weekend. She says, "Maybe the two of us increase our activity in the face of pain because it creates an illusion of control. I think I can change everything, fix everything, if I just work harder."

Share Similar Experiences to Empower the Patient

I am speaking to a 32-year-old woman with bulimia nervosa and her 56-year-old mother. As they talked about some of the disconnections they have experienced with each other, the mother begins to blame herself for her daughter's eating disorder. I respond, "You know, you are not alone in how you feel. I don't know exactly what it's like to be a parent of a child with an eating disorder, but I do know what it feels like when I have done something that hurts my son. I hate missing the mark with him. I feel like a failure. This is more apt to happen when I am stressed, rushed, tired—when I am not really able to listen and be with him in the moment. None of us is perfect. But what we can do is take responsibility for our part in an interaction, talk about it, and try to repair the relationship. Kids really appreciate this, and then they can learn how to do the same thing." The patient agrees, saying she didn't want a perfect mother, just one who tried to listen and validate what she felt. Then she began to share with her mother her struggles with her own 8-year-old daughter.

Use Humor to Teach a Therapeutic Lesson

A 23-year-old female patient with a long history of anorexia nervosa, depression, and anxiety was following me from our session to the medical record room to copy her log. She had spent the session being very self-critical, and felt like she had to always be competent for others to like her and be
connected with her. After arriving at the copier, I had made numerous unsuccessful attempts at getting the copier to work. I say, “Now this is scary. Here your therapist is asking you to entrust her with your most intimate concerns and she can’t even get this copier to work right. Makes you wonder if you are getting your money’s worth.” The patient says, “Oh, Mary, I don’t come here for your copying skills.” I say, “So, I guess I don’t have to be good at all things for you to keep coming to see me. Hmmm.” The patient replies, “OK, I got it,” and laughs.

Convey Flexibility and Openness to Change and Difference

A 19-year-old male patient with anorexia nervosa is trying to convince me that he can reach the 120 pounds required to avoid a referral to the partial program. It is only our third session, and he is not in any imminent medical danger, so I say to him, “OK. I could be wrong about my concerns. You may be able to gain the weight. In fact, I would like for you to prove me wrong. I am willing to let the referral go for two more weeks, as long as you aren’t in any medical danger. But if you aren’t able to increase your weight over the next two weeks, your body is telling us you need some extra help. This is very hard work, and everyone who has recovered tells me they can’t do it alone. I don’t mind being experimental with this, as long as I don’t feel I am doing anything that will hurt you in the long run.”

Use Irreverence to Convey Concern and the Impact of Patient Behavior

A 28-year-old female patient with a chronic history of Anorexia Nervosa (binge/purge type), Borderline Personality Disorder, depression, and anxiety spent our session discussing how all the problems in her family are her fault, and she cannot ask for their help. (We had been working together for seven months, and I knew her well from consultations I had done with her in the past.) She feels they would be better off without her. Toward the end of the session, she finally admits she had become more suicidal over the weekend and taken an overdose. I ask why she did not call me. She says she did not want to bother me. I respond, “Oh, I get it. You felt you would spare me the burden of calling me and telling me you were suicidal last night, so I could come to your funeral later this week and bury you. I don’t really experience that as you sparing me anything (said in a calm and deliberate, not angry and blaming way). Your death would deeply upset me. You don’t have to get any louder with me to convince me that you are in pain. The call to me would have been fine. We need to help you practice asking for help early on when you hurt, so you don’t feel so alone. In your family, you felt it was dangerous to ask for help. I know it probably feels
the same now, but part of our work is to try and see if something different might come from asking for it.”

Share One’s Relational Dilemmas

Katie, a 33-year-old female patient with bulimia nervosa had just returned to group after missing two weeks. Half-way into the group I checked in with Katie. She said she was okay despite the fact that she looked depressed and seemed very disconnected from her own feelings. I said that she had done a great job supporting others today, but it seemed it was more difficult for her to let others care for her. The others agreed, and Katie became tearful.

I then shared with her my predicament at the start of the group when I wanted to let her know that her pain had not gone unnoticed. I said, “I want to share with you a dilemma I experienced earlier in group today. When we started group, and I asked who wanted to discuss a relational example from last week that involved all or nothing thinking, you and Ann had examples. However, you would not share yours first, even when Ann and I asked you a second time—probably because we both sensed you were in some kind of pain. (Ann and other members agreed, saying they felt Katie should have gone first.) I felt stuck at that point because I wanted you to feel that I respected your request and was hearing you, unlike how you experience things at home. Yet at the same time, I worried that my not insisting on you going first would leave you feeling alone in your pain, like you have felt with your partner and parents. I worried I was not responsive enough to you.”

Katie became more tearful and spoke about how she felt undeserving of the group’s time because she had coped with recent problems by not attending and becoming more symptomatic. She felt she needed to take more responsibility for her recovery before asking for group time and attention. The members shared with her that they did not see it this way. They said when she felt undeserving, she probably needed the group most. She was supposed to come up with answers and make changes with the help of the group, not totally alone. The members shared their feelings of sadness, anger, and anxiety for her and commended her on returning to group when it would have been so easy to think in an all or nothing way and not return.

Apologize for Hurting the Patient

I had returned to Lisa (a 30-year-old with bulimia nervosa) several times in group to ask how she felt in response to Laurie’s (another member) acknowledging to Lisa that she felt cut off by her in discussion last week. Lisa was using more self-blame about what had transpired, rather than seeing Laurie could like her and be annoyed with her. Lisa looked somewhat irritated but said she felt confused and could not label her feelings. I asked
if she was angry with me for pursuing her experience about the issue. She had trouble responding, began to cry, and pushed back her chair. I then wondered if I was reenacting an old relational pattern the patient had with her brother. I asked if I was being too hard on her and pushing her too much, if she had been trying to tell me she needed a break. I said I knew her family often didn’t give her a break, especially her brother. He felt relentless at times. She could not speak yet, but nodded. I said, “I am sorry for having pushed on you too much and causing you pain by not allowing you to have some space.”

Lisa shared how in her family, her words and experiences are changed into something they are not, and she begins to feel anxious, and can’t verbalize her feelings and needs. At times like these (like how she felt in group), she ends up feeling inept because she can’t articulate her experience. She moves quickly away from the anger and sadness, to self-doubt, self-blame, and helplessness. She could understand that I was trying to help her reexamine relational issues, but needed a break and had trouble asking for this. She wished I had known this but also realized part of her work was to help me know this. I said, “Talking today helps me know you appreciate my persistence in getting you to talk, but that same persistence could also feel hurtful at times. I’ll be attentive for cues that let me know you may be wanting a break, and we can help you practice slowing down, taking a risk, and putting your request and your feelings into words.”

Clarify the Therapy Contract and the “Therapist’s Limitations”

A 21-year-old female with Eating Disorder NOS, Borderline Personality Disorder, depression, and a history of trauma, had seen me for eight weeks and still refused to be weighed. I did not want to agree to a treatment contract that allowed her to avoid intermittent weights. She had also not followed through with recent lab work we requested. She maintained she did not have an eating disorder and smiled when she said this. She became quite angry with me when I said I could not see her in treatment again without some biological markers of her physical health. I had a responsibility to help her create internal and external safety, as we had agreed to in our treatment contract. She had numerous rationalizations for why my requests were unreasonable. I listened to each of these and said, “I can understand why you feel the way you do about my requests for lab work and weights, but I cannot let these go. In doing so, I would be hurting you and not promoting your safety, similar to your complaints about your family. I know we see a number of things differently, and how we negotiate our differences now will affect how we work in our relationship in the future. We can agree to disagree, but I can’t participate in anything that would hurt you in the long run—like ignoring your physical health. If I don’t want you to ignore
your self-care, I can’t do that either. I would feel like a hypocrite, and I know you can’t stand hypocrisy and inconsistency in people.”

The patient said I tend to blow things out of proportion and that I can be a real “pain in the ass.” I admitted I had certain limitations as a person and a therapist and that another therapist might see things differently. However, I didn’t feel comfortable compromising on this particular issue.

THE CRITERIA FOR THERAPIST SELF-DISCLOSURE WITHIN AN RT APPROACH

The RT approach espouses that authentic therapist self-disclosure is an informed and judicious relational response. It is used to empower the patient and move the relationship toward mutuality (Miller et al., 1999). As the therapist invites the patient to bring more of herself into the relationship, the therapist also must take the risk of bringing more of who she or he is into the relationship. The therapist does this carefully and thoughtfully within the context of the patient’s best interests and needs, at a pace that is safe and appropriate, and in a way that enlarges, not restricts relational growth and opportunities for the patient. In an RT approach the therapist is encouraged to carefully consider a variety of factors before self-disclosing to the patient. These include the patient’s unique relational history, level of functioning, presenting history of illness, and readiness for change, in addition to other contextual factors (Miller et al., 1999). The latter are listed in Table 2. The therapist should proactively consider her or his own feelings about the self-disclosure first. She or he should consider her or his intention for the disclosure, level of comfort regarding it, and hopes and expectations regarding the patient’s response (Peterson, 2002). It is also assumed that a therapist practicing an RT approach would maintain contact with colleagues, supervisors, and mentors to obtain consultation regarding cases and the use of self-disclosure within those cases.

**TABLE 2.** Contextual Factors to Consider when Deciding Whether to Use Therapist Self-Disclosure

- The purpose of the therapy
- The stage of therapy
- Analysis of the power dynamics that influence the relationship
- Present knowledge of the patient
- The working hypotheses regarding what the patient and therapeutic relationship need at the present time
- History of the therapy relationship (especially in terms of negotiating empathic failures/disconnections)
- The patient’s and therapist’s strategies for disconnection
- Strengths and vulnerabilities of patient and therapist (e.g., ability to hear and work through the impact of the disclosure)
- Availability of time to deal with what follows the disclosure
- Therapist’s level of self-care and stressors (e.g., unmet therapist biological or psychological needs such as sleep deprivation, fatigue, and recent relationship losses)
TABLE 3. Situations in which the Therapist Should Not Disclose

If the disclosure:
- Is primarily meeting an unconscious/unresolved or conscious therapist need (e.g., gratifies a need for acceptance and validation or solves personal problems)
- Is used as a strategy for disconnection (e.g., helps the therapist and patient avoid working through conflict or painful feelings)
- Is a means to manipulate, control, or be intrusive with the patient
- Is an assault or attack versus an invitation to engage in an authentic connection
- Reflects a disrespect of the patient’s relational images, meanings, or patterns
- Would be followed by the therapist’s being unable or unwilling to discuss the patient’s responses to the disclosure

Therapist self-disclosure and the ensuing discussion about the self-disclosure should occur within the context of empathic attunement and responsiveness (Rachman & Ceccoli, 1996). The therapist should not self-disclose in certain situations. These are listed in Table 3. Also, the therapist should not self-disclose in response to a patient request, if she or he does not feel comfortable with this. The therapist should decline in an empathic manner (e.g., “I don’t feel comfortable responding to that question just yet. I am not sure whether my answering it would help our work or hinder it in some way. Let me think a bit more about it. Meanwhile, tell me a little more about what makes you ask.”). The latter statement allows the patient “into the therapist’s head” and into her or his thinking about how to respond. Both therapist and patient have a right to privacy and self-protection, and both need to feel safe and comfortable to remain in the therapeutic relationship. Sharing one’s uncertainty regarding how to respond and demonstrating how one says “no” or states one’s limitations, are also important lessons in authenticity and mutuality. The therapist must feel comfortable with what is revealed to remain in authentic connection with the patient.

IMPLICATIONS FOR RESEARCH, TRAINING, AND PRACTICE

As yet there is no research regarding therapist self-disclosure that has specifically examined (a) RT theoretical assumptions regarding therapist self-disclosure or (b) the impact of self-disclosure with eating disordered patients in comparison to other patient groups. The research literature regarding therapist self-disclosure, in general, is limited and results have been conflicting possibly due to the use of inconsistent criteria to identify therapist disclosures and examination of different types of therapist self-disclosure (Barrett & Berman, 2001; Hill, 1992). Early research favoring therapist self-disclosure reveals that it seems to increase patient self-disclosure, contributes to a stronger and more effective therapeutic relationship, and relates to positive treatment outcome (Dies, 1973; Hill, 1992; May & Thompson, 1973). More recent research (Barrett & Berman, 2001) that systematically varied level of therapist self-disclosure, revealed that the frequency and intimacy
of patient self-disclosure did not seem to increase in response to therapist self-disclosure, but that increased therapist self-disclosure did lead to improved treatment outcome and a more positive experience of the therapeutic relationship. It is still unclear how therapist self-disclosure affected the above improvements. More research is needed to examine the impact of various types of therapist disclosure, clarify the nature of its healing potential, and identify with whom and when it is best utilized (Barrett & Berman, 2001).

Research conducted regarding self-disclosure within the RT approach can further our understanding of whether certain types of therapist self-disclosure are more helpful than others with eating disordered patients, (e.g., validating, universalizing, sharing openness to difference) and whether self-disclosure is more effective with some patient groups versus others. Also, research can show whether therapist self-disclosure is more effective at particular times. For example, it may be that therapist self-disclosure is most powerful at times of disconnection in the therapeutic work. Further research can clarify the impact of different types of therapist disclosures at these times (e.g., admitting one's errors or demystifying the role of therapist and the process of therapy by sharing with the patient one's response to a relational dilemma experienced with the patient). Therapist self-disclosures can prevent a reenactment of past disconnections and can foster psychological growth, change, and healing. Maybe it is not the frequency and intimacy of therapist self-disclosure that matter as much as its timing and whether it is accompanied by a more mutual and authentic overall stance on the part of the therapist. These issues are critical in the training of new therapists and in the ongoing work of seasoned practitioners.

The advisability of therapist self-disclosure will continue to be an ongoing debate, with some of this debate naturally fueled by various theoretical perspectives. Regardless of theory, the decision to self-disclose remains an ethical one. This decision should be made after considering the unique circumstances of each clinical situation and whether the disclosure will be in the best interest of the patient. It is difficult to predict if the patient will respond favorably or negatively, and in the latter case, one needs to be prepared to do the work required to move through a possible disconnection. The therapist must be mindful of how the unequal nature of the therapeutic relationship affects delivery and receipt of therapist self-disclosures. Despite our best efforts to promote mutuality, therapist self-disclosure can be used or experienced in an exploitative, intrusive, or distracting way. Some patients fear the closeness experienced with therapist self-disclosure and some will feel obligated to care for the therapist. Female therapists need to avoid self-disclosures that may be based on overgeneralizations from their experience to the experiences of other women, who may differ in terms of race, class, sexual orientation, and age, as well as in terms of needs, skills, and resources (Brown & Walker, 1990).
Our own personal and professional development affects how much of ourselves we choose to represent in our therapeutic work and specifically, in our self-disclosures with patients. Continued research and dialogue among practitioners from different theoretical schools can promote a richer understanding of why, when, and with whom we should use self-disclosure, as well as the impact and risks of not disclosing. Movement from a focus on the intrapsychic to the intersubjective space means movement from the sole use of fantasy and the transference relationship to the increasing use of the real relationship and therapist self-disclosure in treatment to promote healing, growth, and recovery. The use of therapist self-disclosure within an RT approach seems helpful in the work with eating disordered patients, as patients struggle to let go of their relationships with food and be more of whom they genuinely are in relationship with the therapist. Self-disclosure is one way the therapist can authentically represent herself or himself in the relationship to foster this relational movement and growth.

REFERENCES


