The Role of Mutual Self Disclosure in Helping and Healing between Gay Clients and Therapists

Therapists are often taught to avoid personal self-disclosure with clients. Early in their training, counselors learn to use personal sharing rarely and with caution. Guidelines exist in professional literature suggesting when and how therapists may volunteer such material to clients, usually only within strict therapeutic constraints. Many gay clients, however, come to therapy specifically seeking gay or gay-friendly therapists. Gay clients may want and need more personal information from therapists, especially information that the therapist is truly gay-friendly and knowledgeable. For these clients, therapists may need to learn to share more of themselves with both honesty and ethical integrity. This narrative offers experiences and insights of gay and lesbian therapists in negotiating today's new and often challenging self-disclosure norms and values.

by
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Introduction

A new client once confronted me with an unsettling challenge. "But I thought you were gay!" I had encountered similar confusion before with other gay clients who had just learned I am a bisexual man, formerly married ... to a woman. Now, seeing the concern on Christopher's face, I realized I probably owed him an explanation.

Chris had been coming to therapy weekly for a month. He was making good progress on the grief and loss issues which first brought him in after his male lover left him suddenly. He had gotten my name from the local gay and lesbian hotline where I had given permission for staff to disclose my sexual orientation to callers.

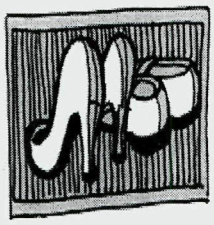
Like many gay or bisexual people, my coming out to self and others has been a gradual progression. While married, I self-identified as bisexual, although since my divorce, I have described myself as gay with bisexual tendencies. Apparently, hotline staff had placed me in their directory of gay therapists. At any rate, Chris now informed me that he had first come to me believing that I was exclusively gay. Without discussing that fact, we had established a good rapport in our first meeting and he had resolved to do a series of solution-focused sessions to rebuild his self-confidence in the aftermath of a devastating breakup.

Normally Chris sat beside my desk and failed to notice the family photos which cluttered its surface. Today he had chosen a seat across the room and spied the snapshots of my ex-wife and children. When he asked who the family was and I told him, his jaw dropped briefly before he confronted me with his consternation. As in the past, when presented with this situation, I reflected on the options for a moment.

Chris had never asked me details about my sexual orientation. He had assumed I was gay by virtue of the way he obtained my name from the hotline. Then, like many people, gay or heterosexual, based on his assumptions he had formulated an uncon-

scious mental picture about who I was and how I functioned in society. But as numerous authors have pointed out recently, gender identity and sexual orientation are complex social and political constructs, as well as biological ones (Wood, 1996; Knudson-Martin, 1997). Sexual orientation and gender identity encompass multidimensional, subtle, and spiritual sides of self. Watching Chris struggle with how to view me now, I wondered how to treat these subtleties.

I could explore several questions with him. What difference did my sexuality make? How would my orientation impact our



working successfully together? What prejudices did he harbor about gays or bisexuals involved in heterosexual marriages and how might these obstruct his relationships in a diverse society?

It has been my experience that many gay people question the legitimacy of bisexuality, claiming that all bisexuals are denying their true gay identity. Was Christopher operating under the belief that a bisexual married man couldn't relate to the gay experience? If so, perhaps I could reassure him with the story of how I fell in love with a woman before coming to terms with my predominantly homosexual identity. I could try a therapeutic use of humor and note that while waiting for my prince to come, a princess arrived first.

Or, I could set a boundary and declare the topic of my personal issues inappropriate and unethical for me to discuss with a client, citing pertinent codes of ethics and licensing standards which affirmed this stance. God knows there are plenty of them, I thought. I found myself running through the various theoretical frameworks which might guide me in responding to the very legitimate questions Chris posed for me at the moment. As sometimes happens in therapy, a client now felt a need to know more about me before committing to invest continued trust and do further work with me.

The Issues and Debate

Therapists are often trained to use self-disclosure of any personal information judiciously, if at all. Professional literature has long debated the relative value and risk of workers disclosing personal information to clients. Historically, the issue has been a loaded one. The prevailing wisdom has been that worker self-disclosure can be an effective and powerful tool to promote positive client change, especially at strategic points in the therapy process, but that it must be used with extreme consciousness and caution.

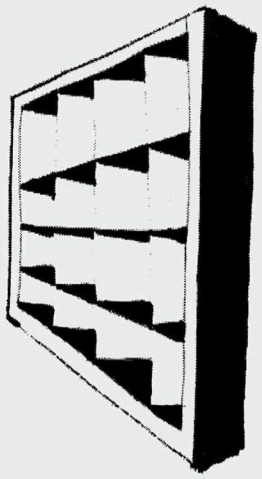
Numerous generalist texts outline specific applications of worker self-disclosure, including empathy building, rolemodeling, or infusion of hope and encouragement at pivotal times in the helping relationship (Middleman & Goldberg 1974; Hepworth, Rooney, & Larsen, 1997; Ivey, 1994). Middleman and Goldberg offer ways in which workers may use self-disclosure to enhance insight, clarify feelings, and forge stronger partnerships with clients. Hepworth, Rooney, and Larsen assert that the practice of authenticity, which they define as workers' sharing of self in open, genuine ways, is essential to effective casework or therapy. They further outline various levels of self-disclosure which can prove helpful to workers in empowering clients and give highly specific guidelines for authentic responding with clients, from giving feedback to assertive limit-setting. An evolving tradition of narrative therapy places great value on the skill of transparency with clients, or letting clients see us in our full humanness so that we may share a journey of change and growth together (Freedman & Combs, 1996).

The chief concern most authors express about worker self-disclosure is that clear boundaries must be observed, including seeking professional consultation and supervision when needed, to ensure the appropriateness of worker self-disclosure strictly as a means of benefiting the client (Meyer & Mattaini, 1995). Various sources clearly agree that worker self-disclosure for personal satisfaction or advice-giving reasons is a violation of client rights and codes of ethics. However, even the most recent revision of the (NASW, 1996) Code of Ethics offers no specific language ad-

dressing the matter of worker self-disclosure. Rather, the ways in which such disclosure poses ethical violations must be drawn from inference and by reading other sections of the code, including those dealing with conflicts of interest and dual relationships, wherein workers are cautioned against doing anything that might exploit, confuse, or otherwise place the client at risk.

Much of what helping professionals believe, say, and do in the matter of worker self-disclosure changes dramatically when we shift focus to worker disclosure of personal sexual information. Professional literature has seldom, if ever, supported the practice of workers sharing sexual thoughts, feelings, or experiences with clients. Traditionally, the very essence of effective psychotherapeutic relationships has been seen to hinge upon workers maintaining clinical objectivity and emotional detachment with clients. Strong prohibitions have always existed against the abuse of transference and counter transference events with clients, especially those involving an exchange of libidinal energies.

A recent report on an nationwide survey of practitioners suggests that workers may be at risk for malpractice litigation if they even thought sexual thoughts about or felt attracted to a client (AAMFT, 1998). It sometimes seems as if the integrity of the helping relationship is so fragile, and the potency of human sexual impulses so great, that no options exist at all for merging our sexuality and our professional practice with safety



and honor. However, this rather conservative stance can both limit creative casework possibilities and devalue the pivotal importance of workers exercising their own humanity and judgment as an essential part of the helping process.

Fickey and Grimm (1998) advocate for the more honest sharing of self by gay therapists working with gay clients. Few benefits are achieved, they assert, by workers hiding their gay identity from clients. They further state that few risks emerge through such self-disclosure which cannot be countered through the worker's careful exercise of healthy, professional boundaries and the use of close supervision and consultation by skilled clinicians sensitive to gay and lesbian issues.

Minuchin has spoken and written in numerous forums about "the heart and the art of therapy." He and other authors, including the narrative therapy school, agree that the essence of the therapeutic relationship is the genuine human connections forged between client and worker, rather than solely the clinical knowledge and skill of the therapist (Freedman & Combs, 1996). The following casework scenarios of actual therapy events affirm Minuchin's assertions and add to our growing body of knowledge about the importance of therapists' authentic sharing of self with gay and lesbian clients.

Case Scenarios

Troubled by my last session with Chris, I sought consultation with other gay and lesbian therapists, asking how they handled self-disclosure of their sexuality with clients. The cases below are drawn from dialogues with colleagues, all practicing in a large metropolitan area with a strong gay and lesbian community. In the following scenarios, client and worker names and other identifying information have been changed to protect confidentiality.

Scenario One: Mona and Jill– Disclosure as Reassurance and Socio-Emotional Support

Mona is a licensed clinical social worker working as a therapist in a large outpatient psychiatric clinic specializing in brief solution-focused work with families and children. Although out to her family and friends, she normally prefers to keep her lesbian sexual orientation private at work.

Jill had begun therapy with Mona when she first came to the clinic for a severe, adolescent depression. Mona followed Jill through several in-patient stays for suicidal ideation, some difficult college experiences, and nu-

merous break-ups with boyfriends. Now a young adult, Jill seemed to be reconstructing her life at last.

"I have a terrible secret," Jill confided one day. "I want to share it, but I'm afraid you'll abandon me." Mona reassured Jill that she was committed to their work together and that she respected and valued Jill no matter what secrets she might harbor. Expecting a confession of parental physical or sexual abuse, Mona was relieved when Jill finally blurted, "I'm gay!"

Aware of the need to treat Jill's experience with tenderness, Mona thanked and affirmed Jill for her honesty. "It always takes great courage to come out," Mona said. "You may be relieved to know there's a large, cohesive gay community in this area and most of its members are happy, healthy people."

"So you know some gay people?" Jill asked.

At this point, Mona surmised that Jill might need strong role modeling and a clear face and name on which to place her evolving image of lesbian identity. Due also to the long-term nature of their therapeutic alliance, Mona decided that Jill deserved the truth. "More than that," Mona told Jill. "I'm a lesbian myself."

Jill expressed great relief at this news and the two spent the rest of the session redefining their therapeutic relationship through the lens of this pivotal shared experience. In subsequent months, Mona's role would shift to mentor and coach as Jill came out to her parents and co-workers. Not surprisingly, Jill's chronic battle with depression alleviated as she came to positive terms with her lesbian identity. She would eventually quit anti-depressant medications and terminate regular therapy sessions, attributing much of her success to the self-acceptance she had developed through Mona's mentoring.

Hearing Mona describe her experience with Jill, I reflected on my session with Chris. Central to Mona's response was the skill of using personal disclosure to reassure the client that she was not alone in her sexual orientation and would not be rejected by her therapist because of it. Perhaps this basic need for reassurance was what Chris had needed most from me.

Mona's scenario reminded me how important it is for gay therapists to reveal and explore the core sense of social and emotional isolation which often exists for gay clients in order to ultimately heal it. The therapist's self-disclosure of a personal gay identity may be especially helpful to the client at these times. However, the therapist's sharing of personal information which is unclear or ambiguous may simply confuse and frustrate the client. What the client may need to hear most from the therapist is a clear, concise affirmation: "It's good to be gay. I'm gay myself." Having thus established this shared reality, the therapist can then proceed to explore the meaning of being gay in the client's life and work on ways to strengthen the client's self-acceptance.

Scenario Two: Jay and Ron—Disclosure as a Means of Strengthening Client-Worker Partnerships

Ron was a young, unemployed gay male who initially stated that he wanted counseling due to anxiety about his relationship with his lover. "My partner can't come in for therapy because his work keeps him too busy," Ron told the therapist, Jay, in the first session.

Ron had found Jay by word-of-mouth referral from friends who had seen Jay for couples counseling. The friends had characterized Jay as a presumably straight man known in the community for being gay friendly. Several sessions into therapy, Ron confessed that he was HIV positive. Jay responded supportively. "I work with a lot of HIV-positive clients," he told Ron. "Let's explore your HIV history, your present health status, and your ongoing wellness regimen."

Jay believed that the rest of that session went well. However, the following week when Ron returned for therapy, he confronted Jay. "You changed when I told you I had HIV," he said. "You broke eye contact, took more notes, and seemed somehow detached."

Jay didn't try to correct Ron's hyper-vigilant perceptions but, rather, tried to address the heart of Ron's concern. "It's normal to feel alone and abandoned with HIV," he told Ron. "But I believe we're more alike than not on this topic. You see, I'm gay myself and have had HIV-positive sexual partners. I'm well-acquainted with the stresses HIV can place on relationships."

Jay's disclosure not only helped Ron feel greater accep-

tance but also increased trust, leading to a deeper level of work. Ron went on to share that his partner now feared having sex with him and that they had not been intimate for months. "How did you decide to be sexual with HIV-positive guys?" he asked Jay. "And can you talk to my partner about it?"

The new freedom to discuss shared relational dilemmas, which Ron developed in this in-

stance, served to deepen and enrich Ron's therapeutic alliance with Jay immeasurably. This degree of freedom would probably never have occurred, however, without Jay's disclosure of his own gay identity and personal steps in coming to terms with the risk of HIV in his own life.

Jay's scenario brought new light to my work with Chris. Jay's experience as a sexually active gay man, dealing personally with HIV-transmission issues, had clearly enabled him to forge a therapeutic link with the client. However, Chris, on learning I had a bisexual orientation and heterosexual marriage in my history, rightly assumed that I may not have had some of the same experiences that he had had as an openly gay man. His recognition of our clear differences had immediately distanced him and caused him to doubt my ability to empathize with him.

In this new light, I was able to envision other ways I could have responded to Chris. Remembering the narrative therapy school's emphasis on transparency with clients, I could have owned up to our differences, then explored Chris' experiences and fears around not being accepted by people who were different from him. Through embracing rather than minimizing our divergent perspectives, I might have established a level of genuineness and trust with him such that he could come to value my input, specifically because it was from a different reference point.

Scenario Three: Kate and Celeste—Disclosure for Healing Internalized Homophobia

Celeste was a young university coed working part time as a hospital aide. She reported never having had a committed lesbian relationship due to being "too independent." She sought counseling for job-related stress and a desire to manage her study time better. However, her therapist, Kate, soon surmised that Celeste might have more to work on in therapy than job-stress and time-management issues.

Kate sensed that Celeste's emotional independence masked a fear of intimacy in her same-sex relationships. The more Celeste "slept around and partied," as she characterized her life, the more Kate suspected that Celeste might be manifesting a suppressed fear of her own emerging lesbian identity.

Taking a calculated risk after establishing sufficient trust with Celeste to try something creative, Kate shared her own experiences early in her coming out process. Now a recovering alcoholic and chemical dependency counselor, Kate had once abused substances in order to get up the courage to go to bars and meet women.

"I hated my lesbian self," Kate confided to Celeste. "Somehow I hated myself less when I was drunk ... at least while I was drunk!"

Celeste teared up. "I know what you mean," she said. "Only my anesthetic isn't alcohol. My anesthetic is 'the chase.' The more women I sleep with, the less I feel."

Once Celeste's central self-loathing and self-medicating behaviors were identified, she was able to begin taking steps to counter them. Kate's disclosure helped Celeste initially identify for herself the counter-effective, even destructive, ways in which she expressed her sexuality. If Kate had named these behaviors, Celeste's ability to admit to them and her incentive to change them would probably have been less.

Kate's experience with Celeste reminded me that it is sometimes the therapist's past personal struggles, rather than special training and skills, which empower the worker to be most helpful to clients. Relating this idea to my work with Chris, it occurred to me that it might have

been very powerful for me to acknowledge openly that a mistake had been made in the way in which he came to me for counseling. I could have conceded that my own journey to self-acceptance had been a confused and confusing one, but that overcoming this confusion had been an important learning experience for me. Finally, I could have shared the belief with him that surviving my own confused journey might ultimately empower me to be particularly helpful to him in sorting out his special issues.

Scenario Four: Tim and Jon—Disclosure as a Call to Social Action

Tim was a middle-aged gay man just beginning to deal with coming-out issues after leaving a heterosexual marriage of 20 years. He still remained largely closeted but in therapy sessions was beginning to speak longingly of a time when he could live openly as a gay man in his community. Recently, he had begun dating another man who was also not out yet. Tim felt that he might one day love this man deeply but was growing tired of seeing him solely at one of their tiny apartments for quiet dinners or rented movies. However, the thought of being seen when he was out with another man struck terror in Tim's heart.

Tim's therapist, Jon, was an HIV counselor and AIDS activist whose office sported colorful flyers and posters concerning support groups, rallies, and calls to legislative action. One day when Jon came out to the waiting area to welcome Tim, he found his client leafing through the pamphlets with a sad face.

"Doesn't all this gay AIDS information scare all your 'normal' clients off?" Tim asked. Jon reassured Tim that, in fact, no one had ever commented in negative terms on the literature. "I can't even imagine going to one of these rallies," Tim said sadly. Jon shared that he too had once harbored doubts about advocating for HIV issues. "I used to fear people would think I was HIV positive and hesitate to refer child and family clients to me as a result," he admitted. "But I went for it anyway and to the best of my knowledge I've never lost any business over the fact that I'm an 'out for AIDS' activist."

Tim received this information with skepticism. However, Jon let the discussion go at that and the two went on to deal with other matters.

Not long afterward, the community held its annual fundraising AIDS Walk. Jon's office served as a team sponsor and he was there with his colleagues in force. When someone called out his name, he looked up to see Tim across the crowd, waving a placard in one hand and giving him a thumbs-up signal with the other. Later during a therapy session, Tim thanked Ron. "I could never have gotten the courage to go to any public gay function without that comment you made about being 'out for AIDS' a while ago. Somehow coming out feels different when you do it to show support for a sick friend." While Jon hadn't considered the waiting room dialogue with Tim a significant therapeutic intervention, its impact on the client may have been greater than anything they had accomplished together during the confines of the formal therapy process.

Jon's experience reminded me that sometimes helping professionals have to challenge clients therapeutically. Therapeutic challenges can occur either directly, through the therapist using overt, positive confrontation techniques, or indirectly, through the worker subtly pointing out a contradictory truth or modeling a different way of doing things. Applying these ideas to my work with Chris, I realized I could have challenged him to a dialectic on the function of his assumptions in his life. I could have explored with him how these assumptions helped or hindered him in relating to me and others like me. There are many diverse ways of being a sexual person in our society: heterosexual, homosexual, bisexual, and others. Did Chris plan to cloister himself in an exclusively gay world and only seek the counsel of other strictly gay individuals? How might he benefit from widening his sphere of influence to include more diverse advisors and viewpoints? When was it important for him to seek input from a clearly gay mentor, and when would he benefit from another perspective? Through exploring these questions with Chris, we might have reached a richer, deeper level of helping and healing.

Summary and Conclusions--Some Success Stories and Some Not

The above case scenarios all deal with success stories experienced by therapists who came out to gay and lesbian clients.

But for every success, there are failures as well.

I ruminated on this pessimistic thought as I watched Chris sift through his conflicting emotions upon learning about my ex-wife and family. Finally I resolved to be fully genuine with him.

First, it seemed important to seek his permission for sharing more of my own story during his therapy time. I asked if it would be helpful for him to know more about my own journey and he gave me an emphatic yes. I shared with Chris a *Reader's Digest* version of my life as a bisexual/gay man once married to a woman. He listened closely and asked some important clarifying questions, wanting to know how my wife first dealt with the knowledge that I was attracted to men, how my children accepted my coming out to them as they grew older, and how family friends who knew the truth accepted me. I answered each question honestly, striving to be as forthright as possible even as I remembered the painful scenes with my angry, bewildered adolescent son and thought of the family friends who had fallen away through the years. Shortly, the story and questions were done and Chris thanked me for the truth. We ended the session on what seemed a positive note soon afterward. However, Chris never came back to me for therapy. I ran into him some time later at a mall, where he greeted me cordially enough, apologizing for never returning my messages after our last session and explaining that he had just been too busy. But I have always wondered whether the decision I made to self-disclose to him that day was the right one.

Epilogue: The Importance of Clinical Supervision and Consultation

My experience with Chris provided ample fodder for several discussions with clinical colleagues. The consensus from my sessions with a clinical supervisor and several peers was that I did the right thing with Chris but with an unfortunate, realistic consequence. Such is often the case with this inexact endeavor we practice called therapy, half science, half magic; we do the best we can with the knowledge, values, and skills at our calling. The rest is up to the client, good fortune, or whatever spirits guide the therapy world.

In the ongoing quest to achieve greater genuineness and integrity in working with clients, it also seems the right thing for therapists to question themselves and face some feelings of self-doubt at times. Here the role of doing our own work in our own therapy, as well as clinical consultation with supervisors and colleagues, cannot be overemphasized (Fickey & Grimm, 1998). Through seeking the support and constructive criticism of clinicians whose honor and skills we trust, we empower ourselves to be not only more clinically competent with clients, but more fully human as well.

Reflecting on my experiences with Chris after consultation with peers, I now recognize many additional options for responding to him that day. In retrospect, I believe I might have served him better by volunteering less of my personal story and listening more to his specific questions and concerns about me, then addressing each of these in reassuring and problem-solving ways. Clearly, Chris invited my sharing more, but only after I asked him. The NASW Code of Ethics (1996) reminds us that, as helping professionals, we are always in a position of power in our clients' eyes and that we need to take special steps to equalize the balance of power with clients. Asking the client's permission, while important, cannot ensure an honest response from the client who may feel a need to please us. In such situations, it may be more empowering to the client for the therapist to suggest a therapeutic strategy and take responsibility for the outcome: "I'd like to share a brief personal story in order to facilitate your process here, and would welcome your feedback afterward."

Since seeing Chris, I have become more acutely aware that the therapy hour belongs ultimately to the client. We professional helpers may justifiably feel that we have been charged with certain ethical responsibilities for promoting positive gains during that hour. However, in therapy, it is the client's experiences we are there to discuss, not our own. Particularly when working with gay and lesbian people, whose stories have often been negated by a heterosexist world, therapists have a special duty to focus most on the client's perspective. Personal self-disclosure of the therapist's own gay identity may be especially helpful to gay clients at strategic points in the therapy process, but the level of sharing

by the therapist should be extremely focused and targeted solely on empowering the client.

Now when a client asks me about my family and marital history, I generally respond briefly: "I once identified as bisexual. Now I'm divorced and identify as gay." We then go on to discuss the client's questions and feelings around this information. However, since Chris, I've never had clients take issue with my bisexual history. More often than not, they are pleased to hear that I have biological children when so many gay men do not.

It may well be that in the matter of therapist's self-disclosure with clients, two old truisms best capture the ideal practice. These are, "honesty is the best policy," and "less is more."

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