

Removing the “mystery” in therapy: transparency as a continuous intervention in family psychotherapy

Brie Turns, Paul R. Springer & D. Scott Sibley


To cite this article: Brie Turns, Paul R. Springer & D. Scott Sibley (2018): Removing the “mystery” in therapy: transparency as a continuous intervention in family psychotherapy, *Journal of Family Psychotherapy*

To link to this article: <https://doi.org/10.1080/08975353.2018.1488127>



Published online: 20 Jun 2018.



Submit your article to this journal 



View related articles 



View Crossmark data 



Removing the “mystery” in therapy: transparency as a continuous intervention in family psychotherapy

Brie Turns^a, Paul R. Springer^b, and D. Scott Sibley ^c

^aMarriage and Family Therapy, Fuller Theological Seminary, Phoenix, AZ, USA; ^bDepartment of Child, Youth and Family Studies, Family Resource Center, University of Nebraska-Lincoln, Lincoln, NE, USA; ^cSchool of Family, Consumer and Nutrition Sciences, Northern Illinois University, DeKalb, IL, USA

ABSTRACT

When clients attend therapy, there is often “mystery” regarding the therapist’s model, use of specific interventions, and how change occurs in the therapy room. Unlike therapist’s use of self-disclosure, which is the exposure of the therapist’s personal thoughts, feelings, and experiences, this article introduces a new concept—therapeutic transparency. Therapeutic transparency allows an open dialogue between therapist and client regarding how change occurs and the tenets of the therapist’s model. This article discusses the importance of being transparent in the therapy process and five steps that therapists should engage in to help remove mystery and increase client participation.

While attending my yearly checkup appointment with my family practitioner, he began asking me (B.T.) a variety of questions including, “How much alcohol have you consumed in the last 30 days?” and “What is your stress load like?” Growing more concerned with the amount of questions he asked, I finally responded with: “I’m curious, why are you asking these questions? Is something wrong? Do you ask everyone these questions?” That afternoon I realized, I ask my clients numerous, invasive questions; I wonder if my clients are curious about my questions and the process of therapy? Why are mental health clinicians not more transparent with their clients?

Although some models of therapy (i.e., Emotionally Focused Therapy [EFT], Bowen Family Systems Theory) advocate for more disclosure regarding the therapist’s model of choice, there is a lack of how therapists can engage in an overt conversation with their clients regarding the therapeutic process, the questions that a therapist may ask, and the therapist’s thought process. This article introduces a five-step concept for mental health clinicians, which allows them to be more transparent with clients and engage in a new conversation with their clients, regardless of the model of therapy.

CONTACT Brie Turns  brieturns@fuller.edu  Fuller Theological Seminary Arizona, 1110 E. Missouri Drive Suite #530, Phoenix, AZ 85014.

© 2018 Taylor & Francis Group, LLC

Therapeutic transparency

It may be challenging for clients to not only seek therapeutic services, but to also trust their mental health clinician's expertise and guidance in the therapy room. For most, therapy is a foreign environment, one that is riddled with misinformation (perpetuated by others and media), stigma, and fear. Many clients are in distress and struggling to manage their lives, their relationships, and their sense of self. As a result, clients often become resistant to therapy; not because they are unwilling or unmotivated to face painful realities in their lives, but because therapists have yet to create levels of safety and attunement clients need to help them take the risks to trust in therapy. By adopting a more active, focused, and engaged stance, a therapist can engage with their client in new ways and help them become more comfortable and committed to the process. This article proposes a new concept called *therapeutic transparency*, which we believe can create more "buy-in" from clients and increase their trust in the therapeutic process.

Therapeutic transparency is an ongoing conversation that allows the client to see and understand the process of therapy. Therapeutic transparency consists of therapists describing their model of therapy, what theoretical assumptions guide their work, and how they believe clients change in- and outside of the therapy room. It also invites clients to clarify therapists' perceptions of the problem, the hypotheses they have formed, and the overall direction of therapy, because therapists are intentional in asking for clients' input. This involves therapists regularly asking clients to confirm whether therapists are truly understanding their problem and how comfortable clients feel engaging in an intervention. In many ways, therapeutic transparency is different from therapist self-disclosure, because it is not only about disclosing aspects of a therapist's personal life to create connection and hope (although this can happen). Rather, it is an intentional way of being and interacting with clients, which is focused on helping them unravel the mystery of therapy. It is our belief that intentional therapeutic discussions not only strengthen the therapeutic relationship but that it is instrumental in reducing power differentials while increasing client buy-in and elevating client agency in therapy. It is one thing to feel connected to the therapist because of similarities you hold inside or outside of therapy; however, it is different, for clients to feel that they have agency and choice in providing feedback and changing direction of therapy—the intent of therapeutic transparency.

Postmodern approaches, such as Narrative and Solution Focused Brief Therapy align most closely with the concept of therapeutic transparency. In these models, there is a belief that it is critical for the therapist to understand the subjective reality of the client, and that clients are the experts of their own lives (de Shazer, 1988; White, 1995). Consequently, principles such as coauthoring (White, 1995) or assisting clients in discovering solutions that have

previously worked elevate clients in the decision-making process (de Shazer, 1988). White (1995) was one of the first authors to introduce a similar concept to therapeutic transparency—decentering. He believed that shifting power dynamics in the therapy room led to client change. White would allow previous clients to share their experiences and advice to current clients, which assisted in the client becoming the expert in the room (White & Denborough, 2011).

Motivational interviewing (Miller & Rollnik, 2013) further recognizes the need to help people resolve ambivalent feeling and insecurities, prior to behavior changes occurring. This practical approach focuses on exploring clients' perceptions of the problem and helps people become motivated to change the behaviors that are impacting their lives. While motivational interviewing is focused on increasing a person's motivation for change, and assisting clients in making a commitment to change (Miller & Rollnik, 2013), therapeutic transparency engages clients in further exploration of therapy process by having therapists discuss their professional thoughts related to treatment, their therapy model, and where they see clients in this process.

Susan Johnson's Emotionally Focused Couples' Therapy (2004) further embraces this form of therapeutic transparency through interventions that are aimed at accessing and reprocessing of emotions. These calculated interventions bring to light, in new ways, clients' attachment needs through conjectures or hypothesis. Therapists actively share their hypotheses about what clients may be feeling or their perception of how negative interactional cycles have impacted the relationship. Therapists then turn to clients and ask them to accept or reject the hypothesis, increasing clients' agencies and providing immediate feedback for therapists in pursuing a direction in therapy.

In more recent years, Roberts (2005) attempted to continue the conversation about transparency; however, she primarily discusses the use of self-disclosure and how systemic models view therapists discussing their personal experiences. The two ideas are not synonymous, but rather, therapeutic transparency is educating the client about the process of therapy. It is important to clarify the differences between therapeutic transparency and self-disclosure.

Self-disclosure

Self-disclosure refers to a wide range of verbal and nonverbal behaviors (Gibson, 2012). It has been identified as two distinct categories (Audet, 2011; Knox, Hess, Petersen, & Hill, 1997). The first is known as self-involving or interpersonal self-disclosure. This occurs when therapists reveals their feelings about clients, by highlighting the process of therapy and, thereby, brings to clients' awareness how their behavior is impacting the therapeutic process. The second type of self-disclosure, which is the most common, is intrapersonal self-disclosure, or disclosure in which therapists share personal information

about their lives. This type of disclosure often shifts the focus away from clients and highlights human fallibility of therapists.

Regardless of the type of self-disclosure, research has yielded mixed results about its effectiveness. Ethical literature has discouraged self-disclosure because of its potential to alter boundaries and undermine the therapist's role (Barnett, 2011) and the fear that it can shift the focus away from the client, generate feelings of needing to care for the therapist and risking exploitation of the client (Gutheil & Gabbard, 1993; Zur, Williams, Lehavot, & Knapp, 2009). However, studies exploring therapist disclosure from the perspective of clients in actual therapy settings have helped us understand this phenomenon better. Findings have shown that it has the potential to reduce power imbalances inherent in the therapeutic relationship (Knox et al., 1997); and can humanize the therapist–client relationship. In fact, one study found that participants preferred a therapist who could balance fallibility and professionalism in therapy (Audet, 2011). Conversely, consistent with other research, disclosure revealing significant inadequacies did diminish the therapist's credibility and competence in the therapist (Audet, 2011; Wells, 1994).

The primary difference between therapeutic transparency and self-disclosure consists of the type of information that is shared with clients. Therapeutic transparency does not involve therapists discussing their personal background, thoughts, feelings, or ideas about clients or their presenting problem. Rather, therapeutic transparency allows therapists to disclose their professional thoughts on their therapeutic model of choice, how they believe clients change and grow from attending therapy, and revealing why they asked certain questions or had the clients complete tasks. Similar to self-disclosure, therapeutic transparency has the potential to be advantageous or harmful to both therapists and clients.

Code of ethics

Across all disciplines, self-disclosure has long been a debated therapeutic practice (Jeffrey & Austin, 2007). The most commonly cited concern is that self-disclosure can cause harm to clients, especially when not done for clinically therapeutic purposes (Roberts, 2005). Others have argued that inappropriate self-disclosure has the potential to blur therapeutic relationships, leading to dual relationships or situations where clients need to care for therapists (Gutheil & Gabbard, 1993). Decisions regarding boundary crossings should always be intended for the benefit of the client and firmly focused on the client's welfare (American Association of Marriage and Family Therapy [AAMFT] Code of Ethics, 2015; American Psychological Association [APA], 2017). For this reason, national organizations such as the APA, AAMFT, and the American Counseling Association (ACA) have

avoided including self-disclosure as a violation of their codes of ethics (AAMFT, 2015; ACA, 2014; APA, 2017); yet do include behaviors that can result from self-disclosure as prohibited, such as forming dual relationships, engaging in sexual intimacy, and avoiding conflicts of interest. All of these codes were created to safeguard clients and therapists from consequences related to these forms of boundary crossings.

Although there has been a great deal of information regarding self-disclosure within the code of ethics, there is limited information regarding disclosing information related to the process of change. While reviewing the most recent version of AAMFT Code of Ethics, the specific act of disclosing therapeutic information is not mentioned. However, there are two ethical codes that should be considered when deciding to engage in therapeutic transparency.

Code 1.7-*Abuse of the Therapeutic Relationship* is the first code that touches on the power inequality that is created in a therapist–client relationship. The reality is that power differentials are unavoidable in therapy and are often associated with therapists being sought out by clients for their specific training, knowledge, and set of skills. Therefore, therapists' ability to influence the therapeutic process and direction is great and can take on many forms. A common form of abuse is giving out advice or telling clients what to do. Therapists need to be aware that our suggestions can greatly impact our clients' lives and can influence their decision-making. Therapeutic transparency assists therapists from a potential abuse of power, as it elevates clients as equal participants during therapy.

Additionally, the nature of therapy creates vulnerability and connection, which are hallmarks of the close friendships and intimate relationships. As a result, therapists and clients have the potential of developing feelings for one another. When this happens, the therapist has the potential to abuse this relationship by exploiting clients in intimate ways. Consequently, good professional boundaries are imperative to the integrity and success of any therapeutic relationship.

Code 1.8-*Client Autonomy in Decision Making* is another code that could influence the concept of therapeutic transparency. This code elevates clients' decision-making as being a critical piece of the therapeutic process. One of the traps therapists may fall into is unknowingly pushing their values or beliefs. One of the most common examples we have experienced in training our student therapists across three programs is helping them address domestic violence cases. Often, therapists struggle in wanting to elevate client autonomy because they fear for the client's life, or are fearful that the client will not choose to leave the relationship. As a result, they may push clients to leave the relationship, when this has serious safety implications. Supporting clients' autonomy involves helping them realize that they have choices. We would further argue that it is unlikely that a client can achieve full autonomy in decision making if therapists do not disclose to the process of therapy, and what decisions clients have in the process.

Advantages of therapeutic transparency

Employing the stance of therapeutic transparency can provide advantages and disadvantages for both clients and therapists. This approach should be done thoughtfully and intentionally and should be used to enhance the therapeutic relationship. Therapeutic transparency allows clients and therapists the opportunity to further join with one another. From our perspective, joining is an important, ongoing process throughout therapeutic treatment that can be difficult to teach. Therapeutic transparency allows therapists a specific way to join with their clients, with the ultimate goal being to inform clients about therapy and empowering them to take a more proactive role in session. The main advantages of using this approach include: increasing the client's motivation for therapy, clarifying myths and how the media portrays therapy, and enhancing the therapeutic relationship.

Therapeutic transparency is also a way of acculturating the client to the therapy experience and process. Similar to psychoeducation employed by many theories, therapeutic transparency is a proactive approach that helps clients learn about how therapy works and what can be expected. Clients are often hesitant to engage in the therapeutic process due to the uncertainty of why and how their presenting problems may be resolved. Therapeutic transparency allows therapists to be more candid with their clients by discussing the model they are operating from, which may increase clients' buy-in. For example, if therapists were to discuss the purpose behind the Miracle Question from SFBT (de Shazer, 1988; de Shazer, Dolan, & Korman, 2007), clients will likely better understand how to answer the question.

As clients are able to better understand the process of therapy, many myths can also be clarified. Numerous times in therapy, I (B.T.) have asked clients how they believe "therapy works" and how they plan to make lasting change. Clients often discuss watching shows such as *Dr. Phil* and drawing conclusions from those experiences. Therapeutic transparency allows therapists to clarify how they believe therapy helps clients change versus what makes good television. Clients are also able to discuss how they believe they can change.

Another major advantage of therapeutic transparency is that it can enhance the therapeutic relationship. First, we believe that clients, who are informed about the therapeutic process and given the opportunity to state their thoughts, will stay more engaged during sessions. By understanding why certain questions are asked, clients can answer those questions more thoughtfully. For the therapist, transparency is an opportunity to confirm and validate the direction therapy is going. This allows clients to build trust and to help them stay more engaged.

Next, divulging parts of therapy will create an open platform for clients to discuss their thoughts and feelings regarding their progress. By being more overt about the model, it creates an open platform for clients to discuss their

thoughts and feelings about the process. In this way, clients can confirm or deny our hypotheses, as they have an active role in the direction of therapy. This is an important part of the therapeutic process. Unfortunately, it has been our experience that therapists often formulate hypothesis and develop assumptions too quickly, without adequately asking the right questions and including clients as a sounding board in confirming the hypotheses they have made. What results are therapists develop treatment plans based on faulty assumptions and can lead to distrust or frustration from clients' perspectives.

When therapists disclose information about their model of therapy and include clients in the conversation, clients report feeling more understood, which creates greater trust in the therapy room. This results in more client self-disclosure, which has been shown to be a key indicator in the process of therapeutic change (Sprenkle, Davis, & Lebow, 2013).

Finally, we believe that therapeutic transparency is also an excellent framework when working with diverse clients and families where there may be cultural differences. Therapeutic transparency, by nature is inquisitive and takes a not knowing stance. Clients are asked to share their perceptions of what they believe is contributing to the problem, which can lead to discussions about racial and ethnic differences that are important in treatment. This elevates the client as experts in their lives and allows them to provide feedback in the direction of therapy, so the therapist can be more culturally sensitive and aware.

Effectively being transparent: engaging in therapeutic transparency

In many psychotherapy-training programs, students complete assignments discussing topics such as their therapeutic model of choice, how they believe clients change, and their preferred interventions. For example, Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Accreditation Standards requires all students in accredited programs to develop or present either a capstone project or a theory of therapy/change paper. These formal assignments are a powerful and useful way for therapists to begin engaging in therapeutic transparency. The following steps are suggestions for how a therapist can engage in therapeutic transparency with their clients. These steps should not be interpreted as phases that should take place throughout the first or second therapy sessions, but rather should be a fluid and consistent conversation between the therapist and client. [Appendix A](#) provides clinicians with a printable worksheet to complete and bring into the therapy session.

Step 1: explaining the therapeutic model

The first step in therapeutic transparency consists of the clinician explaining their therapeutic model. Although we advise against going into unnecessary

detail with clients, we do believe that informing clients of the model's basic tenets and assumptions is crucial to the beginning stages of therapeutic transparency. In order to walk this balance, we recommend providing a few tenets and assumptions. For instance, after discussing some of my (B.T.) background I will inform my clients of the specific name of the model that I use, solution-focused brief therapy (SFBT). I then explain why I adhere to the model by providing the tenets and assumptions that guide my work. Regardless of the model, we have found that this step facilitates a level of buy-in from clients and reduced resistance as clients can see immediately that the therapist has a model and a plan for facilitating change.

Although it is out of the scope of this article to review all of the tenets and assumptions from every model, we have provided a few examples to begin conceptualizing this initial step. When explaining SFBT to clients some of the points that a clinician can include consist of, believing that the clients are the experts of their lives, there are times that the problem does not exist, and knowing that your clients are resourceful and have strengths. A contextual therapist might discuss the importance of love, trust, and loyalty, and viewing relationships from a fairness lens. From a Bowen family systems perspective a clinician could focus on the differentiation of self, and how anxiety can move through a system. An EFT therapist will provide more context about attachment theory and the role that emotions and attachment injury plays in a relationship and the current presenting problem. The majority of models are not founded on the idea that clients are incompetent. Helping clients see these tenets helps them develop hope that their problems are not insurmountable, and that the therapist has a "treatment" available to assist them.

Step 2: verifying the client's understanding

The second phase of engaging in therapeutic transparency is verifying the client's understanding of the therapist's model and its assumptions. It is important to note that therapists should never assume that clients understand therapists' explanations of step 1. Therapists should give clients the opportunity to think about any questions they may have and openly state that if clients do have any questions during therapy, they are welcome to ask them at any time. We have found that oftentimes client's distress level makes it difficult to process all the data they are receiving. As a result, it should be the therapist's responsibility to go slow, and ask reflective questions that can assist the client in making sense of what they are learning.

Seeing a professional in the health care field can be overwhelming and possibly a scary experience for clients. It is possible that clients fear that they may never "get better" or have their problem "fixed." Providing an open-space for dialogue can model for clients that they, and their problems, are important to the therapist. There is numerous ways therapists can verify a

client's understanding aside from simply asking, "Do you understand?" Various examples that each of the authors has used in order to further the conversation include: (a) What is your opinion on these stances? (b) What were some of your beliefs on what therapy "is" before attending? (c) Out of the statements that I explained, which do you agree with the least?

Step 3: ask clients how they believe change occurs

The next step in engaging in therapeutic transparency is asking clients how they believe change will occur in their lives. Many clients are unaware why they are experiencing the problems that are bringing them to therapy or how they can begin to change them. The first purpose is to help clients begin to think about what role they will have in their own therapeutic change. We believe that by focusing on what the client can control, based on the strengths they have, that hope is instilled. We also believe that therapists do not engage in this conversation early enough in therapy, which often leads to clients terminating early due to the therapist "not helping them." The second purpose of asking clients about their perceptions is to clarify potential myths and misnomers that the clients may hold about therapy. For example, clients often state that their lives would be better "if my loved one would change" or if a problem went away. Helping client's see that they have an important role in facilitating therapeutic change, puts more of the responsibility in their hands, thus elevating them as an important member of the treatment team.

To begin asking clients about their role in the therapeutic process, questions may include: (a) "How do you think people change as a result of coming to therapy?" (b) "What do you think your role is for reaching your goal in therapy?" (c) "What are things you could do to improve your situation?" and (d) "What do you believe my role is in helping you achieve your goals?" The second question can be beneficial when working with multiple family members who believe that their loved one is "creating" or "causing" the problems in their life. The later question may help clarify the different roles that the therapist and client have in the therapy room. This clarification can also assist in creating an effective, collaborative therapeutic relationship.

Clients often attend therapy with numerous thoughts, beliefs, and ideas regarding therapy. Some of these ideas may be damaging and create unrealistic expectations before therapy has even begun. Step 3 in therapeutic transparency allows the therapist to openly ask about potential preconceived ideas that may have been a result of a television show or movie. For example, we have had several experiences where clients were fearful that therapy would look like the Dr. Phil show, where sessions would get escalated and the therapist would make demeaning comments towards them. Others have expressed concern that therapy would involve them lying down on a couch and talking about "mommy" or "daddy" issues. In each case, it provides a good opportunity for us to discuss

what is “good television” versus “good therapy.” For example, when this occurs, the therapist can begin exploring how the client views their role in treatment. What role do they play in achieving the goals? How they believe people change? We can then juxtapose their roles with those of the therapist. This allows the therapist to explore further how the client views their role in treatment, and for the therapist to be more transparent in the treatment process.

Step 4: discuss how therapists believe clients change and grow within therapy

After discussing how the client(s) believe change will occur in the therapy room and the roles of the therapist and client, the fourth step is for the therapist to discuss his or her beliefs on the topic. Effectively, therapeutic collaboration is often achieved with the exchanging of thoughts and ideas. Therapists are encouraged to openly discuss how they believe clients change in and outside of the therapy room. Therapists should also discuss what their role in the therapy room is and how they help their clients reach their goals. Many perceptions therapists will have about their role in therapy and client growth will likely be influenced by the therapeutic model.

We recommend therapists begin this step with stating a similarity that they have with their clients’ opinion on client change. The smallest agreement can help build a foundation while also indicating to the client that they are not in “left field.” Therapists can also build upon what the client has stated by integrating more of their own beliefs about client change. We then recommend discussing the therapist’s role in regards to the client reaching their goal. Specifically, why would the client need to come to therapy rather than reading self-help books; what makes the therapist an integral part of therapy?

We also believe that it is critical to demystify the therapy process. Oftentimes clients are hoping for a “magic pill” or the wave of a “wand” to take away their problems. It is our job to be transparent about the therapeutic process and what role we both play in it. For example, I have found that it is helpful for clients to recognize that, while therapy can be the catalyst for change, it is only 1 of the 168 h in a week. As a result, clients recognize that it is essential to follow through on tasks and assignments given in between therapy. In addition, helping clients have a basic understanding of systems theory can help them see how one small change, like a ripple in a lake, can affect the entire system.

Step 5: discuss the assessments, interventions, and various questions that therapists use

The final step of therapeutic transparency is the discussion of various assessments, interventions, and questions that are used throughout the therapeutic process. It is important to note that step five should be continuously used throughout each client’s therapeutic sessions.

When clients are asked to complete assessments, we believe that it is important to briefly discuss why the therapist is asking the client to complete the assessment. First, some assessment items may cause clients to become curious about why the therapists asked the client to complete the assessment. For example, the PhQ-9 (or RDAS) is commonly used by therapists and often creates anxiety and questions about why these questions are being asked, and what we will do with them. Clarifying to clients why the therapist is asking certain items will likely increase the therapeutic relationship and decrease client resistance.

On the same note, it is also important that we are transparent with our clients about what their assessment instruments are telling us about them, their diagnoses, and the direction of treatment. There have been many instances in my own practice where clients have expressed relief after learning about their diagnosis; and have felt empowered as we work together to develop a treatment plan. We also regularly use assessment instruments in our practices and in our training facilities where we are able to track client's success at various points in treatment. This has provided an important and significant opportunity to be transparent with clients and discuss how treatment is progressing, where they are improving, and areas where there is a need for growth. Clients have reported feeling empowered by this process, and that it is nice having actual data to support the fact that they are really improving.

Similarly, interventions and specific questions asked by therapists can cause clients to become hesitant or cautious about the therapeutic process. For example, I (B.T.) often ask my clients the miracle question during the beginning stages of therapy. Because I work with families raising a child with special needs, it helps to clarify why I ask the "miracle" question and the purpose behind the question. Often times, the word "miracle" can appear insensitive to clients who are raising a child with a lifelong disorder. However, after explaining why the question is useful, clients often become less resistant and provide more thoughtful responses.

Case example

In this section, we present an example of Matthew, a beginning therapist who actively engaged in therapeutic transparency. The couple first sought therapy due to engaging in a negative interactional cycle and struggling to connect with one another. Hannah and Chris came to couples therapy. They reported dissatisfaction in their marriage, lack of intimacy, and an inability to connect with one another without fighting. Hannah presented as angry and hurt because she felt that Chris ignored her needs and was uninterested in the relationship. Chris reported feeling neglected by Hannah because she refused to be physically intimate with him.

Matthew asked why the couple was seeking therapy and a brief summary of their relationship history. When explaining their story, both Hannah and Chris quickly became stuck in a negative interactional cycle where they were vilifying each other. Hannah claimed that Chris was abandoning her in her time of need and that she spent much of her day crying since their daughter moved to college. During these bouts of sadness, she believed that Chris no longer loved her and did not understand her grief. Chris responded by stating that Hannah knows nothing about his sadness and that when he attempts to “be there” for her, he is dismissed and ignored. He angrily stated, “Why should I try? She has made her mind up that she isn’t happy.”

Typically in most sessions, the couple is attempting to ensure that their story is heard by reiterating their past emotional experiences and blaming their partner in order to justify their position. Instead of challenging their perspectives, Matthew decided to be more transparent in describing how he is viewing the problem, from his therapeutic lens. The goal of this step is to help the clients’ see how the problem is conceptualized and allow them to comment and validate what their therapist stated. To engage in **Step 1**, Matthew stated:

“Before I learn more about the problem from each of your perspectives, I think it is important for you to know how I view couple’s problems from my theoretical perspective and ways to address them. I view problems in marriages as a result of attachment injuries, or attachment needs not being met. From this perspective disconnection, isolation, or hurt are powerful emotions that shape how we experience and interact with one another. Each of us then define ourselves and our partners as either trustworthy or dangerous, or lovable or unworthy. When we are hurt in a relationship, and we cannot find a way to address this with our partner, we either get caught in (1) a fear of abandonment, and then demand our partner to validate our fear and hurt or (2) we detach from our partner and attempt to shut the other person out because of how painful it is. Both of these strategies push each other further away from one another, and leads to more anger and frustration. Both of you seem to be crying for attention or a desire that the other partner recognizes your pain; yet it feels that this is too hard to hear or acknowledge because of how painful this experience is for each of you. I wonder how this perspective fits for both of you?”

In **Step 2**, Matthew began to engage the clients in responding and acknowledging what they heard and understood from the explanation of Matthew’s theory and also having them own what feels accurate for them. Matthew stated:

“I wonder how this perspective fits for both of you? Can you tell me what things I described fit for you? If something didn’t fit, could you please help me understand how you view the way you are experiencing your relationship?”

As Hannah and Chris were engaged in this process, both described a cycle of where they were both hurt or disappointed by one another. Hannah reported that she saw Chris as someone who constantly “shut her out”

especially when she was asking for her needs to be met. She validated many of the things Matthew discussed from his theory and reported feeling alone, and not heard by her partner. Chris further validated the sense that Hannah seems to demand too much of him. He reported feeling overwhelmed by how angry she gets at him, and that no matter what he does, he will never be good enough. He confirmed that one way he deals with it is to shut down, as a way to protect himself. Both acknowledged feeling alone and isolated from each other but a desire to find a way to make the relationship work.

The next step (**Step 3**) in therapeutic transparency is asking clients how they believe change should occur. We have found that it is important for clients to share their perspective on what needs to change, and how they pictured change should occur. This helps clients begin to think about the role they have in therapeutic change. Matthew started by stating:

“I am curious, prior to coming to therapy today, how did you envision therapy would go? What were you hoping would happen that would lead to change in your partner and in yourself?” This question provided an opportunity for more self-reflection in Hannah and Chris, as well as getting them to think about what needed to change in themselves. For example, Hannah was quick to respond by stating that she was hoping to have someone on her side, who could point out the things that Chris was doing wrong that was hurting her. Hannah said, “If he could only listen to how much he is hurting me, I think he could change. He just can’t hear me, because he shuts me out. I am hoping that he could listen to you.” As Hannah was able to be more transparent and vulnerable about the therapeutic process, Matthew was able to reframe this statement to one that elevates her desire to have an emotional connection with Chris, one in which her emotions were validated and understood. This reframe shapes a new interaction and new emotions, helping move Chris from feeling desperate anger, to an expression of fear and longing.

As clients are able to be more transparent in how they view change, the therapist can then build on those beliefs, and move onto **Step 4**. In this step, the therapist is encouraged to openly discuss how they believe clients change, and what their expectations are of the client, in and outside of therapy. Setting clear expectations early in therapy helps establish healthy boundaries between client and therapist and facilitates client buy-in. Mathew stated:

“As I described earlier, my belief on the role that attachment needs plays in relationship cannot be overestimated. It is my belief that part of therapy is about re-establishing the creation of secure lasting bonds between intimate partners. However, this will require work, because we often distrust our partner because of our fear of being hurt, which is rooted in our fears of abandonment. Unfortunately, our responses to our underlying fears is what puts a strain on the relationship and often what we are fighting about (e.g., sex, money), actually has nothing to do with the underlying issue or insecurities, that we are not valued,

loved or appreciated in the relationship. Part of therapy then will be for us to learn ways to express our deeper feelings and respond to them in more compassionate way. When this is accomplished deeper bonds are created, in which we feel validated loved and appreciated.”

This explanation helps clients understand the “why” of therapy, and further builds trust in the therapist that he/she has a specific treatment plan that will lead to improved relational outcomes. For example, as Matthew is able to highlight Chris’ anger as fear of rejection and fear of being unable to meet his wife’s needs, Hannah is able to observe the partner not only as saying new and different things, but to hear his vulnerabilities in a way that pulls for more compassion and a caring response. As the therapist continues to be transparent by reframing negative interactions such as anger and sadness as underlying attempts for intimacy and connection, the couple begins to experience each other in new ways. The therapist can then engage the clients in describing how they perceive one another and evoke more compassion and curiosity.

In **Step 5** of the transparency techniques, the therapist discusses the various assessments, interventions, and questions that are used throughout the therapeutic process. This is particularly important because clients are often unfamiliar with therapy. It is often overwhelming for them to fill out packets of surveys, and not understand how they will be used, and what it is telling the therapist. Clearly discussing the purpose of the assessments can allow clients to understand the therapist’s mindset and, possibly, complete the assessments more accurately.

The “5 transparency steps” discussed in this article provides new information for and about the client that fosters a sense of connection and shared humanity to one another. It is also our belief that as we increase transparency with our clients it increases the therapeutic alliance as well as therapeutic “buy-in” from the client. We have found that these steps are particularly important for clients who are more ambivalent about the therapeutic process and may have a general distrust in therapy. As we move to a more collaborative environment, such as the Medical Family Home, and interdisciplinary teams where the client and patient becomes equal decision makers in their care, being more transparent in the care we provide, will only enhance client agency and autonomy.

Clinical and research implications

The use of therapeutic transparency has numerous implications for clinicians. The first implication is related to how therapeutic transparency can improve patient outcomes. While research has not been done specifically with this approach, researchers found that models like SFBT, Motivational Interviewing, and EFT, which are more overt about the therapy process have

significantly improved outcomes (Kim, 2008; Forsberg, Ernst, Sundqvist, & Farbring, 2011; Greenberg, Warwar, & Malcolm, 2010), when compared to other approaches. Although these models are not doing therapeutic transparency, it does raise the question if transparency plays a more significant role in the effectiveness of these approaches. Future research in this area is needed.

The second implication is how therapeutic transparency may increase patient engagement in the therapy process. One study found that therapist attitudinal behaviors toward clients and their ability to not elevate client agency in decision-making were significant barriers to client engagement (Buckingham, Brandt, Becker, Gordon, & Cammack, 2016). Therefore, it can be assumed that as clients feel more involved in their own treatment, they will feel empowered in being agents of change in their own lives. This will not only affect change, but also strengthen the therapeutic relationship where feelings and thoughts are more readily shared.

Finally, when working with more than one individual in the therapy room, such as couple and family therapy, there are numerous ideas, thoughts, and beliefs in that should be discussed. For example, often times one spouse believes that the other spouse needs to change in order for their situation to improve. Therapeutic transparency provides all clients the opportunity to their perspectives and thoughts. Parents also bring their children to therapy without discussing the reason of attending therapy. Therapists who discuss their models with all members of the family allow parents and children to know that all members hold important roles in order to make change within the family unit.

Therapeutic transparency as a framework has yet to be researched in determining how it affects therapeutic engagement and overall outcomes for clients. What we know is that some postmodern and modern approaches use pieces of therapeutic transparency as we describe it in this article; however, it is not identified as a specific, proactive way of engaging clients in the treatment process. As a result, we recommend future researchers assess if the use of therapeutic transparency could assist in increasing client change at a faster rate. By becoming more transparent with clients about the therapist's techniques and interventions, we believe that clients will show an improvement in client change at a more rapid rate. Next, we do expect that some therapists may become hesitant to engage in therapeutic transparency. Future researchers should assess therapists' willingness to be more transparent with their clients. Finally, we recommend that future research assess clients' thoughts and feelings regarding how therapeutic transparency has impacted their growth and change. It is likely that clients may appreciate having a more active role in therapy by their therapists openly discussing each person's roles in therapy.

Potential drawbacks to therapeutic transparency

Like other approaches, there are potential disadvantages or drawbacks to engage in therapeutic transparency. The first is the possibility that clients may disagree and become resistant with therapists' reasoning and thought processes. Oftentimes, clients come to therapy because they do not know how to solve their problems. A client may disagree with the therapist's assessment and seek a new clinician. The more open and transparent a therapist is, the more opportunity clients will have to disagree with the therapist. If clients openly disagree, clinicians have an opportunity to reformulate hypotheses, and facilitate client buy-in. However, there is clearly a subset of the client population that would prefer to be "told what to do" as opposed to "understanding" the underlying reasons of why or how the problem developed.

The second disadvantage is that a client may believe that their therapist is not competent, due to their one down and transparent approach to treatment. We have found this to be true, especially among clients who consider themselves self-educated in the therapeutic process. These clients often use web-based resources to self-educate and self-diagnose. Subsequently, they come to treatment with specific expectations of what direction therapy should go and the treatments they should receive. When therapists do not comply, they often question their therapist competence, and the therapeutic process at every level.

We have also found that therapists also may experience interpersonal challenges when attempting to use therapeutic transparency in their work. The first is when their therapeutic model does not align with being therapeutically transparent. For example, strategic family therapists may purposely not disclose their hypotheses or reasons for giving homework due to the strategic nature of the interventions. The "mystery" that the therapist has created in the room may help clients reach their goals.

The third drawback is that therapists may feel uncomfortable with the amount of vulnerability they need to express when being transparent. We have especially seen this among beginning therapists who struggle with feeling competent, and believe that they need to have the answer to every problem. Therapists who also struggle with receiving negative feedback from clients or believe that the therapist is the expert may shy away from using transparency.

Finally, therapeutic transparency requires that therapists have a greater awareness and knowledge related to their own model of therapy and that they are aware in how transparency can be used in facilitating change. Consequently, the reason for assigning specific tasks needs to be clearly identified and often modified to ensure that transparency can be implemented in treatment. Many therapists may enjoy the freedom of "just going with it" rather than thoughtfully returning to their model to ensure they are being true to the change process, so they can make intentional decisions of how therapeutic transparency can be used in treatment.

Conclusion

The general population knows very little about the process of therapy. What will help resolve my problem? How does the therapist help? Why did my therapist ask me to complete this task? Therapeutic transparency removes a lot of the questions and mystery that clients often experience in the therapy room. By engaging in the five steps of therapeutic transparency, clients and therapists are better able to discuss the basic components of the therapeutic process and clarify the roles that each member has in the session. Therapeutic transparency also encourages therapists to continuously discuss the reasoning behind selected interventions, questions, and assessments; increasing buy-in as well as encouraging clients to stay true to their models of change. It is our belief that therapeutic transparency can be a process that can elevate the client's voice as an equal partner in the change process, while at the same time demystifying therapy and increasing client buy-in.

Notes on contributors

Brie Turns is an assistant professor in the Marriage and Family Therapy Program at Fuller Theological Seminary.

Paul R. Springer is an associate professor in Marriage and Family Therapy at the University of Nebraska-Lincoln.

D. Scott Sibley is an assistant professor in Human Development and Family Sciences at Northern Illinois University.

ORCID

D. Scott Sibley  <http://orcid.org/0000-0003-3951-8168>

References

- American Association for Marriage and Family Therapy (AAMFT). (2015). *Code of ethics*. Alexandria, VA: Author.
- American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.
- American Psychological Association. (2017). *American Psychological Association ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/ethics-code-2017.pdf>
- Audet, C. T. (2011). Client perspective of therapist self-disclosure; violating boundaries of removing barriers. *Counseling Psychology Quarterly*, 24(2), 85–100. doi:10.1080/09515070.2011.589602
- Barnett, J. E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. *Psychotherapy*, 48(4), 315–321. doi:10.1037/a0026056

- Brandt, B. S., Becker, N., Gordon, K., & Cammack, N. (2016). Collaboration, empowerment, and advocacy: Consumer perspectives about treatment engagement. *Journal of Child & Family Studies*, 24(12), 3702–3715.
- de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: W. W. Norton.
- de Shazer, S., Dolan, Y. M., & Korman, H. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, NY: Haworth Press.
- Forsberg, L. G., Ernst, D., Sundqvist, K., & Farbring, C. A. (2011). Motivational interviewing delivered by existing prison staff: A randomized controlled study of effectiveness of substance use after release. *Substance Use & Misuse*, 46(12), 1477–1485. doi:10.3109/10826084.2011.591880
- Gibson, M. F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal*, 40(3), 287–296. doi:10.1007/s10615-012-0391-4
- Greenberg, L., Warwar, S., & Malcolm, W. (2010). Emotion-focused couples therapy and the facilitation of forgiveness. *Journal of Marital and Family Therapy*, 36(1), 28–42.
- Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry*, 155, 409–414. doi:10.1176/ajp.155.3.409
- Jeffrey, A., & Austin, T. (2007). Perspectives and practices of clinician self-disclosure to clients: A pilot comparison study of two disciplines. *American Journal of Family Therapy*, 35(2), 95–108. doi:10.1080/01926180600814528
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection*. New York, NY: Brunner-Routledge.
- Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice*, 18(2), 107–116. doi:10.1177/1049731507307807
- Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis on client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44, 274–283. doi:10.1037/0022-0167.44.3.274
- Miller, R. W., & Rollnik, S. (2013). *Motivational Interviewing: Helping people change*. New York, NY: Guilford Press.
- Roberts, J. (2005). Transparency and self-disclosure in family therapy: Dangers and possibilities. *Family Process*, 44(1), 45–63. doi:10.1111/j.1545-5300.2005.00041.x
- Sprenkle, D. H., Davis, S. D., & Lebow, J. (2013). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York, NY: Guilford.
- Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work*, 65, 23–41. doi:10.1080/00377319409517422
- White, M. (1995). S. Adelaide Eds. Turning points and the significance of personal and community ethics. *Re-authoring lives: Interviews & essays*. Adelaide, South Australia: Dulwich Centre Publications.
- White, M., & Denborough, D. (2011). *Narrative practice: Continuing the conversations*. New York, NY: W.W. Norton.
- Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice*, 40(1), 22–30. doi:10.1037/a0014745

Appendix A. Steps of Therapeutic Transparency

Step 1: Explaining the Therapeutic Model

Note several assumptions and tenets that you believe are important to mention in session.

Name of model(s):

-
-
-
-
-

Step 2: Verifying the Client's Understanding

Examples of questions you can ask. Feel free to add others.

1. What is your opinion on these stances?
2. What were some of your beliefs on what therapy "is" before attending?
3. Out of the statements that I explained, which do you agree with the least?
- 4.
- 5.
- 6.

Step 3: Ask Clients how They Believe Change Occurs

Examples of questions you can ask regarding the client's beliefs about change.

Make a few notes regarding how a client believes change can occur.

Step 4: Discuss how therapists believe clients change and grow within therapy.

Step 5: Discuss the assessments, interventions, and various questions that therapists use.

Assessment in use:

Reason for using above assessment:

Intervention in use:

Reason for using above intervention:

Question to ask client(s):

Reason for asking above question: