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Family Medicine

NARRATIVE ESSAY

# Saying Just Enough: Self-Disclosure in Family Medicine

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As a physician associate practicing family medicine, I care for patients across the lifespan. Mental health conversations often unfold alongside diabetes, hypertension, chronic pain, and daily life.

A patient once sat across from me describing the quiet exhaustion of depression. Sleep had become unpredictable. Motivation had faded. Even small daily tasks felt overwhelming. What troubled the patient most was the sense of isolation.

"I feel like no one really understands what this is like," they said quietly.

In moments like this, I pause before responding. Not because I do not know what to say, but because I am deciding whether a small piece of my own experience belongs in the conversation.

Medical training teaches clinicians to maintain professional boundaries and keep the focus on the patient. The clinician's story should not overshadow the patient's. Yet medicine is practiced by human beings, and sometimes our own experiences quietly shape how we listen.

I have experienced depression and anxiety myself. Like many chronic conditions, they have required treatment, support, and ongoing management. These experiences are not something I routinely share with patients. Occasionally, however, I wonder whether acknowledging that experience might help the person sitting across from me.

Self-disclosure exists along a spectrum. At one end is complete distance. At the other is over-disclosure, where the clinician's story competes with the patient's. Neither extreme serves patients well.

When a patient describes the loneliness of depression or anxiety, I sometimes wonder whether hearing that their clinician has faced similar struggles would help them feel less alone or shift the focus away from them. There is no algorithm for answering that question. I think about where the patient is in their illness and how well we know each other. Some may find comfort in knowing their clinician understands the terrain. Others may prefer a guide rather than a fellow traveler.

I ask myself a different question: *Who is this disclosure serving?* If sharing something personal would primarily meet my own need to connect, reassure, or be understood, it is probably a sign that I should remain silent. The moment belongs to the patient.

If I choose to share something personal, it is brief and carefully framed. The goal is never to suggest that our experiences are identical, but simply to acknowledge that these illnesses are real and not something patients must face alone.

Sometimes that disclosure sounds like, "I have seen how challenging anxiety can be, both professionally and personally." Often the disclosure is only a sentence or two. Just enough to signal understanding without redirecting the conversation.

I remember one patient who viewed depression as a personal failing rather than a medical condition. After a brief disclosure, the patient paused and said, "I did not realize people in health care dealt with this too." The conversation shifted toward a greater willingness to discuss treatment and recovery.

There are also many encounters where I choose not to share anything. Some patients need a clinician who listens without introducing personal parallels. Others are navigating crises where the focus must remain entirely on their immediate needs. Over time, I have come to view self-disclosure less as a communication technique and more as professional judgment: whether it serves a therapeutic purpose while preserving the patient's central role in the encounter.

Mental illness still carries stigma. Patients may speak about depression and anxiety with shame, as though these conditions represent personal weakness rather than legitimate health concerns. Part of my role is to help patients understand that these illnesses deserve the same compassion and thoughtful care as diabetes, hypertension, or asthma.

Stigma also exists within medicine. Many clinicians quietly navigate their own mental health challenges while feeling pressure to appear unaffected. Acknowledging that clinicians are not immune can help shift that narrative.

Still, the purpose of self-disclosure is never to make the encounter about the clinician. The patient's story must remain at the center of the room. I have come to see this balancing act as part of the art of family medicine. Family medicine is filled with decisions that cannot be fully captured by guidelines or algorithms. The human aspects of care depend on judgment shaped by experience, empathy, and relationship.

The same challenge extends into medical education. Learners observe how clinicians navigate difficult conversations, establish boundaries, and build therapeutic relationships. Yet self-disclosure is rarely discussed explicitly during training.

As an educator, I wonder whether we spend enough time making these decisions visible. When a learner is present, I do not assume observation is enough. Afterward, I may name why I disclosed or chose not to, what I hoped the disclosure would accomplish, and what risk I was trying to avoid. I am also selective about what I disclose to the learner, modeling thoughtful boundaries requires boundaries with learners, too.

These debriefs can turn an intuitive choice into deliberate and reflective practice. A learner can consider what they noticed, how the patient responded, and whether the patient's needs remained at the center. Self-disclosure cannot be reduced to a checklist, but its trade-offs can be named, practiced, and reflected upon.

Medical education teaches us how to diagnose disease, interpret laboratory results, and prescribe medications. Far less attention is given to the quieter decisions that shape the therapeutic relationship. Perhaps the art of self-disclosure is learned through experience, reflection, mentorship, and deliberate attention to the choices we make.

For now, I continue to navigate that decision one patient at a time.

Sometimes the best choice is to remain silent. And sometimes, saying something is exactly what the moment requires.