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How Does Education and Experience Impact Therapist Self-Disclosure Among Clinical Social Workers?

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by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This mixed methods study asks clinical social workers about their experience with therapist self-disclosure. Clinical social workers (n=86) completed an online survey asking them about their understanding and use of self-disclosure, their comfort and competence in using self-disclosure, their experience and education regarding self-disclosure, and how education, licensure, training, and supervision might be strengthened or expanded to address the use of self-disclosure in clinical practice. Findings suggested that clinical social workers are comfortable and confident in their use of therapist self-disclosure. The majority of respondents believed education, training, and supervision could be strengthened or expanded to better address the use of therapist self-disclosure in clinical practice. Implications for social work practice and suggestions for future research are discussed.

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Introduction

Lack of consensus exists whether it is appropriate for clinical social workers to use self-disclosure with clients in clinical settings. There is a general lack of agreement in regard to if, how, and when self-disclosure should be used. Opinions vary among therapists in regard to theoretical identification, intrapersonal style, and professional affiliation. While often disputed, self-disclosure among practioners is common, with over 90% reporting they use it at least occasionally (Gibson, 2012). While many professionals practice self-disclosure, many also report confusion about its use (Knight, 2012).

Many professions work in therapeutic settings where therapist self-disclosure is discussed. According to the National Alliance on Mental Illness (NAMI), there are a variety of mental health workers who can provide therapeutic services including psychologists, psychiatrists, psychiatric mental health nurses and nurse practitioners, licensed professional counselors, peer specialists, and social workers (NAMI, 2013).

According to the National Association of Social Workers (NASW), there are more clinically trained social workers than any of the other mental health service providers. It is anticipated that the social work profession will grow 25% by 2020 (National Association of Social Workers, 2013). The number of social workers in the United States is growing. These social workers will provide many mental health services since at some point in their lives; one in four people will require mental health care (World Health Organization, 2011). Because of their large numbers and growing

presence, social workers are in a unique position to study, research, and educate regarding self-disclosure in therapeutic settings.

The use of clinical self-disclosure among mental health professionals can be challenging to navigate. Parameters around the use of self-disclosure vary. Due to a lack of consensus, clinical social workers may feel underprepared or lack confidence regarding how or when to use self-disclosure. It can be very difficult to know how the disclosure will affect the treatment process or therapeutic relationship (Bridges, 2001).

There are ethical concerns for clients when using self-disclosure in clinical settings. Sharing personal information in a clinical setting can run the risk of boundary violations. If not done appropriately, therapist self-disclosure can harm the client and take the focus off of the purpose of therapy. The common use of self-disclosure among practitioners along with the challenging nature and lack of unity about how to use it, make therapist self-disclosure a topic that necessitates further research and understanding among social workers.

This study asks the question "What education, licensure, training, or supervision helps clinical social workers address therapist self-disclosure?" The study will ask social workers what will be most helpful for them to use self-disclosure appropriately in their practice. The study will ask social workers about their levels of confidence and competence in using self-disclosure in their clinical practice. The study will also ask social workers in what areas of education, licensure, training, or supervision they feel could be expanded or strengthened to address the use of self-disclosure in clinical practice.

Literature Review

Much has been written about therapist self-disclosure in clinical settings. First, definitions and types of self-disclosure are reviewed as a structure to understand self-disclosure. Second, ideological frameworks will be discussed. Third, an overview of the research is examined. Next, implications for social work practice will be reviewed. Eight empirical articles will be introduced. Finally, a summary of the literature is discussed.

Understanding Self-Disclosure

The literature examines several ways to explain clinical self-disclosure. *Self-disclosure* has been defined by Knox and Hill as "…verbal statements that reveal something about the therapist" (2003, p. 530). Self-disclosure has been described to include the therapist disclosing information about their professional background and experience. For example, a therapist might spend time in the beginning of the relationship sharing their credentials and expertise. Self-disclosure has also been described as sharing thoughts and reactions to what is happening in the session with the client. This has also been referred to as "here and now" disclosures. For example, a therapist might share their perspective with a client about how they described a situation. Self-disclosure also includes sharing personal feelings and experiences not directly connected to what is happening in the session. For example, a therapist might share how they handled a particular disagreement in their own family. Self-disclosures can be intentional or unintentional. Raines points out the verbal and non-verbal messages a social worker is sending unintentionally by way of their dress or decorated office space (1996).

There are different groupings used to categorize therapist self-disclosure. Different types of self-disclosure have been said to include inescapable, inadvertent, and

deliberate (Carew, 2009). *Inescapable* (or sometimes called *unavoidable*) types of disclosure can include dress, pregnancy, and personality. For example, a therapist's dress might reveal their feelings about modesty or a belief in spiritual practices. *Inadvertent* (or sometimes called *unintentional*) types of self-disclosure can include tone or affect. For example, a therapist might reveal their tiredness by their low energy level. *Deliberate* (or sometimes called *intentional*) disclosure would include a deliberate sharing of information on behalf of the therapist. An example could include the therapist informing the client of their upcoming vacation. Even non-disclosure has been studied, as a therapist may choose not to disclose information, even when asked directly (Hanson, 2005). Many professionals and researchers now believe that it may be impossible to not self-disclose (Bottrill, 2010; Bridges, 2001; Carew, 2009).

Ideological Frameworks

Self-disclosure in the literature is rarely discussed without also discussing ideological frameworks. Various theories, perspectives, schools of thought, and therapeutic styles are mentioned in the literature as groundwork for understanding and conceptualizing self-disclosure. Theories mentioned include psychodynamic (e.g., Wells, 1994), cognitive (e.g., Satterly, 2006), behavioral (e.g., Satterly, 2006), cognitive-behavioral (e.g., Carew, 2009), humanist (e.g. Bottrill, 2009), existentialist (e.g., Raines, 1996), humanist/existentialist (e.g., Carew, 2009), feminist (e.g., Audet, 2010), and attachment (e.g., Knight, 2012). Relational (e.g., Knox, 2009), developmental (e.g., Bridges, 2001), intrapsychic (e.g., Bridges, 2001), eclectic (e.g., Knox, 1997), intersubjective (e.g., Siebold, 2011), systemic (Carew, 2009), and person-centered (e.g., Carew, 2009) models are included in the literature. Object relations (e.g., Knox, 2009),

interactional (e.g., Knight, 2012), symbolic interactional (e.g., Siebold, 2011), multicultural (e.g., Knight, 2012), and interpersonal (e.g., Raines, 1996) schools of thought are also mentioned. While many theories are discussed, psychoanalytic, humanistic/existential, and cognitive behavioral theories have dominated the theoretical conversation on self-disclosure (Bridges, 2001).

Psychoanalytic. Psychoanalytic theory is one lens used to understand therapist self-disclosure. Psychoanalytic theorists believe that the therapist should be a "blank screen" and appear neutral to their clients and that self-disclosure interferes with this (Bottrill, 2012; Knight, 2012; Knox, 2003, Wells, 1994). It is also believed that self-disclosure interferes with the client's transference (Carew, 2009; Hanson, 2003; Knox, 2003; Satterly, 2006; Wells, 1994) or is a manifestation of the countertransference of the therapist (Carew, 2001; Knight, 2012; Raines, 1996; Wells, 1994).

Historically, psychoanalytic theory has maintained the controversy over self-disclosure because of its views (Wells, 1994). In a study by Carew, it was found that classical training influenced a large majority of therapist's thinking about self-disclosure, no matter where their theoretical identification lie (2009). Psychoanalytic/psychodynamic orientations may be changing their thinking and seeing potential benefits in self-disclosure (Bridges, 2001; Carew, 2009; Knox, 2003).

Humanistic/Existentialist. Humanistic and existentialist theories propose another lens through which to view therapist self-disclosure**.** Humanists and existentialists both seem to advocate for self-disclosure (Raines, 1996; Satterly, 2006; Wells, 1994). A focus on the humanity of the therapist fits with their use of self-disclosure as a therapeutic tool (Raines, 1996; Satterly, 2006). Humanistic and existential theorists tend to see self-

disclosure as an intervention that increases openness and genuineness which also can improve the client's sense of intimacy and trust (Audet, 2010; Carew, 2009; Hanson, 1003; Knox, 2003; Knox, 1997)

Cognitive/Behavioral. Cognitive and behavioral theories assert another lens through which to view therapist self-disclosure. In the past**,** cognitive and behavioral theorists have been said to not attribute significance to the therapeutic relationship, and therefore not favor the use of self-disclosure (Carew, 2009; Satterly, 2006). Now, cognitive/behavioral theorists are seeing various benefits, including helping clients see the impact of their actions (Carew, 2009). These theorists also see the importance of using self-disclosure to enhance client disclosure (Carew, 2009; Knox, 2003). This "modeling and reinforcement" can teach positive ways of coping (Audet, 2010, p. 328).

Theory and Practice. The intersection between theory and practice has been examined briefly in the literature. Studies have found that self-disclosure is used regardless of theoretical belonging (Carew, 2009). In her study of therapists' theoretical backgrounds influencing their attitudes towards self-disclosure, Carew found inconsistency between theory and practice. Audet also found the same contradiction (2010). In her study of social worker's attitudes about self-disclosure, Knight found that 80% of social workers disagreed that their use of self-disclosure was grounded in any theory or research (2012). Botrill asserts that it can be difficult to ascertain if theory directs practice among new therapists as they don't often adhere to one theory (2009).

Historical Overview of Self-Disclosure Research

The research on self-disclosure has been covered broadly and covers a wide range of topics such as its value from a client's perspective and use with special populations.

Both quantitative and qualitative research studies have examined ideas about self-disclosure. Research has been done within and comparing different professions. Studies have emphasized the perspective of the therapist and the perspective of clients. This research has covered many components of clinical self-disclosure including perceived helpfulness, theoretical base, and effects on clients and the client/therapist relationship.

The majority of the research on clinical self-disclosure has been relatively recent. The last twenty years have been especially significant for studies on clinical self-disclosure, with the bulk of the research being done in the last 15 years. The majority of the research seems to come from the United States and the United Kingdom. The existing research on self-disclosure doesn't just assess self-disclosure from the therapist's perspective.

One inclination in self-disclosure research is the focus on client perceptions. These studies focus on the views and perceived helpfulness from a client perspective (Audet, 2010; Hanson; 2005; Knox, 1997; Rollins, 2008; Siebold, 2011; Wells, 1994). The client perspective has proven to be significant as clients report self-disclosure as being more useful than therapists (Knox & Hill, 1997).

In their study of the helpfulness of self-disclosure from the client's perspective, Knox and Hill (1997), look at long-term therapy. Current clients (n = 13) in therapy were interviewed about their experiences with therapist self-disclosure and how helpful they understood it to be. The effects of disclosure on the power in the relationship, the feelings of shared experience, and role-modeling by the therapist were reviewed. The results showed that all clients had experienced some self-disclosure by their therapist that they

deemed helpful. Clients found disclosure helpful when they were discussed within the context of the client's important personal issues (Knox & Hill, 1997).

Another trend in the research is the growth in theoretical literature. Many authors have attempted to propose guidelines for self-disclosure based on theory and/or others' research (Bridges, 2001; Gibson; 2012; Knox, 2003; Raines, 1996; Siebold, 2011). Therapist self-disclosure is explored within these studies to provide context within legal and ethical structures (Gibson, 2012). The most popular among these, research-based suggestions for practioners (Knox, 2003), attempts to propose official guidelines for the use of clinical self-disclosure.

Mostly recently, self-disclosure usage with specific populations has been discussed. Therapist self-disclosure in clinical settings with the gay, lesbian, bisexual, and transgender (GLBT) community has been discussed as it relates to showing support to create a safe space. A therapist's self-disclosure of their own sexual orientation has also been discussed (Raines, 1996; Rollins, 2008; Satterly, 2006). Clinical settings with children, religious communities (Raines, 1996), and more severe clients (Raines, 1996) are mentioned as specific populations where self-disclosure may have a special emphasis. Authors advocate more research regarding the use of self-disclosure with these populations.

In the study by Satterly (2006), therapists were asked about their decision to disclose their sexual orientation to their clients. Focus groups were used to ask gay male therapists (n = 26) about their decision making process to disclose their sexual orientation to their gay or straight clients. Major themes that were found to influence the therapist's disclosure were in areas of identity creation and individual identity management, within

and outside of the client/therapist relationship. It was found that oppression, personal /professional/social identities, the client's best interests, and theoretical orientation were all factors included in their decision regarding whether or not to disclose. Ramifications for practice, including skills and guidelines were discussed (Satterly, 2006).

Implications for Social Work Practice

Many themes from the literature suggest implications for social work practice. The potential positive and negative ramifications of therapist self-disclosure are explored. Guidelines and therapist self-awareness are other relevant themes in the literature.

A breadth of the literature focuses on the positive and negative implications of self-disclosure from the perspective of theory, the client, the therapist, and effects on the therapeutic relationship and the therapeutic process. Impact is rarely altogether positive or negative (Bottrill, 2009).

Positive. A number of positive implications are named to encourage the use of self-disclosure in a clinical setting as an intervention tool. Using self-disclosure to model certain behavior can be considered as an intervention technique (Knox, 2003; Knox, 1997; Wells, 1994). For example, a therapist might tell the client about a way that the therapist addressed an issue with a family member, to give some insight into how the client might do so. Self-disclosure can offer new insights and perspectives to the client (Bridges, 2001; Knox, 1997; Wells, 1994). Self-disclosure can also be used to provide a sense of validation and to normalize the client's experience (Carew, 2009; Knox, 2003; Knox, 1997; Wells, 1994). An example of a self-disclosure used to normalize the client's experience could include a therapist sharing their feelings about how difficult it must be for the client to go through what they are experiencing.

Using self-disclosure with specific populations can have favorable outcomes. Self-disclosure can be especially helpful with children who, by virtue, require more personable communication (Jeffrey, 2007). In Audet's study, males felt that therapist disclosure removed them from the 'hot-seat' for a moment and added to their comfort (2010). Positive implications have been documented regarding clinical self-disclosure and the GLBT community (Rollins, 2013; Satterly, 2006).

The positive effects on the therapeutic alliance are not understated in the literature. The therapeutic alliance, or therapeutic relationship, is often a focus in the clinical process. Self-disclosure may deepen the conversation and relationship between therapist and client (Audet, 2010; Bridges, 2001; Hanson, 2005; Knox, 1997; Rollins, 2008; Satterly, 2006; Siebold, 2011; Wells, 1994). Hanson reported the main influence of self-disclosure (good or bad) in her study to be on the therapeutic alliance (2005).

Negative. Many negative implications are named to discourage the use of self-disclosure in a clinical setting. As previously mentioned by psychodynamic theory, self-disclosure may contaminate the subconscious transference and countertransference projections (Knight, 2012; Raines, 1996; Wells, 1994). Self-disclosure can make the client feel uncomfortable and contribute to confusion about roles (Audet, 2010; Wells, 1994). For example, it is often pointed out that a therapist who shares too much may put the focus on themselves, instead of the client. Clients may feel that they are put in the position of supporting the therapist.

An ethical consideration regarding therapist self-disclosure is the risk for boundary violations. The literature frequently mentions this risk (Audet, 2010; Carew, 2009; Knight, 2012; Wells, 1994), and some argue that it is inevitable (Knight, 2012). As

the therapist engages in self-disclosure, it can blur the roles for the client (Audet, 20120; Knight, 2012). Sharing personal information not related to the client can pose an increased risk (Audet, 2010). Over involvement on behalf of the therapist can also create overly fluid boundaries (Raines, 1996). Unclear boundaries may lead to a less professional atmosphere, and one that favors social, versus therapeutic, goals.

Many clinicians worry that using self-disclosure shifts the focus away from the client (Bridges, 2001; Carew, 2009; Jeffrey, 2007; Raines, 1996). The attention in the therapeutic environment should be on the client and the client's presenting issues. If the therapist is self-disclosing, this could potentially distract from the client's concerns. The client may feel the therapy is serving the therapist more than the client.

In one study by Wells (1994), clients were asked about their experiences with therapist self-disclosure. Former clients of therapy ($n = 8$) were interviewed about their exposure to self-disclosure in psychotherapy. The purpose of the study was to examine the effects of therapist self-disclosure from a client perspective. The results showed positive and negative implications for treatment. Positively, some clients reported increased feelings of mutuality and increased feelings of connection. Negatively, some clients felt unsafe due to their therapist's disclosure, felt their confidence in their therapist decrease after the disclosure, and felt uncomfortable about the boundaries in the relationship after the disclosure. Clients in the study made suggestions for self-disclosure usage in treatment based on their experiences (Wells, 1994).

Guidelines. Often discussed is whether or not certain guidelines can be helpful for therapists in navigating how and when to use self-disclosure. Some clinicians believe that using self-disclosure cannot be reduced to guidelines because of the wide variation in

clinical settings (Bottrill, 2009; Rollins, 2008; Satterly, 2006). Other clinicians advocate their own specific set of guidelines (Bridges, 2001; Knox, 2003; Knight, 2012; Maroda, 1999; Raines, 1996). While many agree that self-disclosure should not be based on impulse, they do not adhere to any specific standard procedure (Bridges, 2001; Seibold, 2011). Other researchers advocate for a standardization of guidelines so that the use of self-disclosure is based on technique and not intuition (Maroda, 1999).

There is some agreement in the literature around guidelines proposed by Knox and Hill (2003) (Carew, 2009; Knox, 2003). These guidelines for therapist self-disclosure are proposed based on a review of the empirical literature. Knox and Hill advocate using self-disclosure intently, infrequently, appropriately, and when it is helpful. Using disclosure to describe what is going on in therapy and to facilitate termination is recommended. They also promote using appropriate content, appropriate levels of intimacy, and being client focused during and after the disclosure (Knox, 2003).

In the previously mentioned study by Carew (2009), masters-level students studying to be therapists were observed in focus groups. The students (n = 20) were comprised of groups based on their theoretical orientation. The purpose of the study was to establish how attitudes towards self-disclosure were influenced by theoretical background and how this influenced practice. In Carew's study, the guidelines by Knox and Hill (2003) were named and advocated for use. The study demonstrated that the guidelines were generally followed, after the observations in focus groups noted that the therapists follow them, although it was not noted if this was intentional or not (2009).

Many researchers advocate for the use of self-disclosure specific to individual patients. Client-based guidelines are commonly mentioned and client-focused self-

disclosure is advocated (Carew, 2009; Hanson, 2005; Jeffrey, 2007; Knox, 2003; Knox, 1997; Siebold, 2011). When considering disclosure, therapists should consider if it fits the particular client's needs (Bottrill, 2009; Carew, 2009; Knox, 2003; Siebold, 2011).

Much of the literature recommends exploring the client's perception of the disclosure and how the disclosure affects the client (Bridges, 2001; Carew, 2009; Know, 2003; Siebold, 2011). Clients are not always forthcoming or honest about how the disclosure affects them (Bridges, 2001; Siebold, 2011; Wells, 1994). Knox and Hill suggest that researchers should look to the client to see how they react to the disclosure and to ask for feedback after the disclosure occurs (2003). Client experiences and opinions of self-disclosure are more recently explored (Audet, 2010; Hanson, 2005; Knox, 1997; Rollins, 2008; Siebold, 2011).

In the previously mentioned study by Audet (2010), clients ($n = 9$) were asked about their experiences with self-disclosure in therapy. Participants were interviewed about the use of self-disclosure by their therapist with specific attention paid to how the therapeutic relationship was affected. Results showed three main themes that emerged from the interviews: early connection with the therapist, therapist presence, and engagement in therapy. Clients found positive and negative implications on these three areas, and suggestions for practice were introduced (Audet, 2010).

Many sets of guidelines have been proposed for therapists to follow when using intentional self-disclosure. Researchers and therapists sometimes disagree about whether to have these guidelines in the first place. While the uses of guidelines are not always agreed upon, the need for therapist reflection has been seldom debated.

Therapist Skill and Self-Awareness. Frequently mentioned in the literature is the need for self-awareness on behalf of the therapist when considering and using self-disclosure (Bottrill, 2009; Bridges, 2001; Carew, 2009; Hanson, 2005; Knight, 2012; Knox, 2003; Wells, 1994). Therapist self-disclosure should not be self-serving (Bridges, 2001; Siebold, 2011). Therapists should not use self-disclosure for personal reasons; the disclosures should be therapeutically motivated. Therapists are encouraged to avoid self-disclosure around issues that for themselves are unresolved (Bottrill, 2009; Knox, 2003; Wells, 1994). For example, if a therapist is dealing with settling his/her own divorce, this should not be a topic of self-disclosure. Self-awareness is also mentioned in regards to the skill of the therapist.

In order to be effective in using self-disclosure, proficiency in therapist self-awareness is needed (Carew, 2009; Hanson, 2005; Knight 2012). Self-disclosure can be misused or unsuccessful if therapists are not aware of its intricacies (Carew, 2009). In the previously mentioned study by Hanson (2005), clients (n = 18) were asked about their perceptions of when therapists shared or didn't share. The researcher interviewed clients who were currently in therapy about their experience with self-disclosure using semi-structured interviews. It was found that skill, or lack of it, was the intervening variable that affected perceptions of the helpfulness of therapist disclosure or non-disclosure (Hanson, 2005).

Some studies mentioned the discomfort that may arise within the therapist due to personal revelations (Bottrill, 2009; Bridges, 2001; Carew, 2009). In her theoretical article, Bridges suggested therapist's unwillingness to be vulnerable as a hurdle to self-disclosure (2001). When therapists are not comfortable with self-disclosure, or are

confused about it, they may not engage in it. This feeling of vulnerability can lead therapist's use of self-disclosure (Carew, 2009).

Bottrill asserts that therapists, like clients, can be exposed to the emotional reactions of divulging personal information (2009). In her review of the empirical literature, Bottrill points out the need for therapist reflection because of the mixed guidelines and ideas. By sharing information, the therapist may experience uncomfortable feelings due to the shift in power dynamics (2009).

In her empirical study, Bottrill (2009) looks at emerging therapists' use of self-disclosure and their training and supervision regarding it. Clinical psychology trainees (n=14) were interviewed about their experience with self-disclosure and surveyed about their theoretical orientation. Along with her literature review, Bottrill's study found major themes concerning therapist self-awareness. One major theme pertained to "the developing therapist" and reflected therapists' internal struggle as it related to their reflection and personal style, and external struggle as it related to experience, training, and supervision (p. 169).

In a study by Knight (2012), social workers were asked about their attitude and practice of using self-disclosure. Social workers, mostly at the graduate level, (n = 192) responded to mail surveys. The study found that the social workers questioned were generally positive about their opinion of therapist self-disclosure. While viewing their own use of disclosure, one third of respondents admitted there were times when they disclosed too much or too little. The majority of social workers studied disagreed that their use of self-disclosure was grounded in research. About half of the social workers thought that they were not prepared by their education and over half were not

comfortable getting direction from a colleague or supervisor about self-disclosure. The therapists' honesty and attitudes showed a need for more preparation (Knight, 2012).

Summary

The literature on clinical self-disclosure is broad. Often contested are the definitions and guidelines of therapist self-disclosure. Positive and negative implications are highlighted in the literature. Special attention is paid to the self-awareness and skill of the therapist. Based on the literature, there are many areas of self-disclosure that are contested and underdeveloped.

A lack of generalizability and broad application is evident in the literature. Small studies are the bulk of the research (Knox, 1997). Widespread definitions make comparison across studies difficult (Bottrill, 2009; Knox, 1997). With many studies choosing to not define self-disclosure for participants (Carew, 2009), a general lack of concurrence makes it difficult to assess agreement and understanding.

A needs assessment for social workers can direct fellow social workers, educators, supervisors, agencies, and the social work field where to give attention and energy to ensure that as a profession, self-disclosure is being used ethically and competently. By asking social workers what would be helpful for them to be skillful in this practice, research or curriculums can be developed accordingly.

Conceptual Framework

The theoretical discussion as it relates to self-disclosure is vast, covering many ideas of how to understand therapist self-disclosure. As referenced previously, there are many different theories used to understand self-disclosure in a clinical environment as it relates to the therapeutic relationship, therapeutic interventions, and therapeutic success. Theoretical frameworks have been used to direct therapists' use of self-disclosure and to examine its effects on clients. Over time, psychoanalytic theory and its more contemporary subtype called intersubjective theory have been at the forefront of understanding self-disclosure.

Psychoanalytic Theory

Psychoanalytic theory in the context of clinical social work focuses on the human personality: conscious and subconscious (Cohen, 1996). This perspective will lead the clinician to assist clients in understanding their subconscious and resolving conflicts that might exist there. Client history, defenses, and meanings are examined (Cohen, 1996). Psychoanalytic theory and its connection to the therapeutic relationship are discussed.

In the clinical setting, the focus on the therapeutic relationship has been discussed as a significant component that is central to success in therapy (Satterly, 2006). The therapeutic relationship or *therapeutic alliance* refers to the therapeutic bond that can be influenced by a therapist's empathy and authenticity. Examples could include how much a client feels connected to their therapist, or how much a client feels that the therapist cares about them. Currently, the significance of the client-therapist relationship is generally agreed upon by professionals as a key component to the success of therapy (Audet, 2010).

Changes in psychoanalytic theory over time have brought to attention the therapeutic relationship in different ways. In the past, psychoanalytically oriented therapists focused upon on a model of therapy that did not include the therapist as an active participant. The therapist was to remain objective without exerting influence or being influenced (DeLaCour, 2010). This theory argued that therapists should maintain a neutral stance by not contributing in a personal way (Knight, 2012). This detachment from the client served to maintain respect for the profession and a focus on professionalism and skill (DeLaCour, 2010).

These views have now shifted to a more "two-person model" of thinking (Siebold, 2011). The relationship is now seen as one in which the therapist and the client influence one another, consciously and unconsciously (DeLaCour, 2010).

Psychoanalytic theory is an effective theory in understanding self-disclosure because of the focus on the therapeutic relationship (Raines, 1996). Psychoanalytic theory's focus on the therapeutic relationship involves relational work, and processing the relationship (Hill, 2009). A major focus of classic psychoanalytic theory is the transference and countertransference reactions taking place within this relationship (Knox, 2009).

Transference refers to feelings, beliefs, and reactions the client is having toward the therapist that do not belong to the therapist. For example, a client who has trouble trusting and depending on the people close to them, may experience these feelings as the therapist announces their upcoming vacation. Exposing a client's transference is seen as beneficial because it brings to light otherwise underlying material (Knox, 2009).

Countertransference is defined as the reaction of the therapist to the client's transference. For example, the client may remind the therapist of someone else they know, which may evoke positive or negative feelings. In classical psychoanalytic theory, countertransference is advocated to be regulated by the therapist so that it does not interfere with transference or blur boundaries (Knox, 2009). Some authors have suggested that self-disclosure by the therapist is a "countertransferential" reaction (Wells, 1994, p. 25).

Early psychoanalysts generally discouraged the use of self-disclosure. More traditional views of psychoanalytic theory can explain therapist self-disclosure as a product of the client's wishes (Raines, 1996). It is proposed that if a therapist discloses personal information, the client's knowledge of the therapist interferes with their transference. It is said that transference can only occur when the client does not have knowledge of the therapist (Wells, 1994). For example, if a therapist shares personal information about themselves, the transference that might have arisen without this personal information, might not come to fruition. Besides the dilution of transference and countertransference, self-disclosure has other potentially negative effects, including interfering with the neutrality and anonymity of the therapist (Knight, 2012).

As theories of psychoanalysis progressed, the early eighties introduced the relational theorists (Perlman, 2009). While early psychoanalysts believed Freud's teachings regarding human motivation being primarily instinctual, relational psychoanalysts believed relationships to be vitally significant. According to Perlman and Frankel (2009), "A cornerstone of all relational theory is the premise that human beings are born with a primary need for relatedness and communication with other human

beings" (p. 108). Relational understanding became a root to which many other theorists understood human motivation with their own lenses (Perlman, 2009).

Relational constructs tend to support therapist self-disclosure (Knight, 2012). Relational theorists may believe that therapist disclosures can contribute positively to the dynamic between the therapist and the client. For example, a therapist using self-disclosure may promote a more positive attachment between themselves and the client. A focus on the transparency of the therapist is also a focus of relational theory, which may support some therapist self-disclosure (Knight, 2012).

Self-Disclosure Within Intersubjective Theory-Based Therapies. Under the umbrella of relational psychoanalysis, the concept of *intersubjectivity* has become a major focus of relational thinking. Intersubjectivity refers to the concept of the capacity to enter the subjective experience of another person (Perlman, 2009). In the therapeutic setting, intersubjective perspectives understand that the two subjects (therapist and client) are influencing each other. According to Knight (2012), intersubjective theorists stress empathy and "…the therapists' capacity to understand and appreciate the perspective of the client, as distinct from their own subjective reality" (p. 298). In her writings about intersubjectivity and self-disclosure, Maroda (1999) asserts that intersubjective theory is very compatible with therapist self-disclosure.

Self-disclosure can also be used to elicit the type of transparency that intersubjective theorists also favor (Knight, 2012). This transparency, via self-disclosure, can be used to show the therapists' humanness, validate feelings, normalize a client's experiences, and model healthy behavior (Knight, 2012). This transparency may also serve as a way to acknowledge the therapist's influence on the therapeutic process.

Self-disclosure may also be used to model how to "…manage and express affect…" another component of intersubjective theory (Knight, 2012, p. 299). Many clients in therapy may lack the ability to manage and express their affect (Knight, 2012). By using self-disclosure, therapists may show clients how to do this in a functional way (Bridges, 2001; Knight, 2012). The therapist may also use their own affective or relational experience to provide a more meaningful connection and understanding (Bridges, 2001).

Self-disclosure can be used to display the empathy that intersubjective theorists highlight. By the therapist sharing their feelings regarding a client's situation, empathy can be expressed. Empathy could also be expressed by the therapist sharing their thoughts or opinions about a client's situation.

Similar to empathy, *mentalization* is used by intersubjective theorists in clinical practice (Allen et al., 2008). Mentalization is defined as "…interpreting behavior as based on mental states, such as desires, beliefs, and feelings" (Allen et al., 2008). In other words, mentalizing involves being aware of mental states and their connection to behavior. When we are able to mentalize, we are able to see behavior from multiple perspectives (Allen, et al., 2009).

In therapy, mentalizing may be a skill used by the therapist or a target area for the client. For clients in therapy, their lack of ability to mentalize may be the focus of therapeutic interventions. Those with some psychiatric disorders may be unable to mentalize which can lead to problems in self-regulation, identity, and poor relationships (Allen, et al., 2009). The ability to mentalize is crucial to meaningful relationships (Allen

et al., 2009). Since the ability to mentalize is crucial to meaningful relationships, it is also important for the therapist/client relationship.

The therapeutic relationship may provide a sense of attachment that can be used to develop mentalization (Allen, 2009). The lack of the ability to mentalize may itself stem from the quality of attachment relationships, especially from early in life (Fonagy, 2009). While therapists will attempt to assist the client in developing attachment for former and current relationships, the therapist may also encourage attachment in the therapist/client relationship.

Therapists may use mentalization in different ways. A therapist may use mentalization as a form of transparency. In one example a therapist may say aloud "I wonder if you are having a bad day". This type of self-disclosure, elsewhere described as a *here and now* disclosure describes what is happening within the session. The therapist would be making a connection between a client's behavior and mental state. Using mentalization-based treatment has proved useful for some conditions, specifically borderline personality disorder (Fonagy, 2009).

From these perspectives, many intersubjective therapists are open to using many types of self-disclosure (Bridges, 2001). Some intersubjective therapists have argued that disclosure happens whether intentional or otherwise. Some also deem the use of self-disclosure to be "essential" (Bridges, 2001, p. 22).

Modern psychoanalytic views on self-disclosure have become increasingly accepting of its use and have accepted that is sometimes occurs unintentionally. Some still advocate the use of self-disclosure sparingly as to not pollute transference and countertransference (Satterly, 2006). Some analysts argue for greater use of self-

disclosure, putting its potential positive effects on the therapeutic alliance first and negative implications on transference and countertransference second (Siebold, 2012). Others view self-disclosure by the therapist as inevitable (Knox, 2003). A therapist's office, clothing, or demeanor can all be defined as self-disclosure.

As mentioned previously, a study across orientations found that all therapists who participated were influenced by traditional psychodynamic understanding (Carew, 2009). The study also revealed that psychoanalytic theory was found to inhibit "insight and awareness of unintentional" self-disclosure (Carew, 2009, p. 271). This research speaks to the pervasiveness of psychodynamic views as they relate to self-disclosure.

Personal and Professional Lens

My interest in self-disclosure as a research topic began when I conducted a research project on best practices in domestic abuse support group facilitation earlier in my masters program. Self-disclosure was identified as a major theme coming from the qualitative interview. The support group facilitator who I interviewed identified self-disclosure as a facilitation skill she used in leading the group. This facilitator was passionate about the proper use of self-disclosure to evoke understanding and safety, and to set the tone for the depth and details of sharing. Because of this experience, I may be biased toward the positive implications of self-disclosure.

As a researcher, I identify most with the theoretical ideologies of the humanistic/existentialist and feminist parties. In the context of the client/therapist relationship, the humanistic/existentialist theorists allow for the humanity of the therapist to be present in the treatment. The practice of self-disclosure is seen as communication of authenticity, honesty, and openness (Satterly, 2006).

The feminist theorists believe that self-disclosure balances the power in the client/therapist relationship. By the therapist disclosing, they are promoting a more egalitarian relationship (Knight, 2012). It has also been said that feminist theorists will use therapist self-disclosure particularly when a subject may be a politically debated one, so that the client will know where the therapist stands. This can allow the client to see that the therapist will be non-judgmental (Carew, 2009).

Methodology

An online, mixed methods questionnaire was created in an effort to survey clinical social workers about their perspectives on use of therapist self-disclosure in their work with clients. The survey itself was a descriptive study that employed a cross-sectional research design. The researcher used the Qualtrics research tool to disseminate surveys via e-mail.

Eligibility Criteria for Participation in the Study

In order to take part in the study, eligible participants met two inclusion criteria. First, respondents had to be social workers who have completed a graduate degree in social work. Second, each respondent had to be currently licensed by the Minnesota Board of Social Work as a Licensed Independent Clinical Social Worker (LICSW).

If would-be respondents did not meet the above criteria, they were unable to participate in the study. Two examples of social workers who were ineligible to participate in the study because of exclusion criteria were social workers who had not yet completed a graduate program or who were not licensed at the clinical level (as an LICSW).

Research Design

This study asked the question "What education, licensure, training, or supervision helps clinical social workers address therapist self-disclosure? The study asked social workers what will be most helpful for them to use self-disclosure appropriately in their practice. The study asked social workers about their current comfort and competence with their use of self-disclosure in their practice. The study also asked social workers in

which areas of education, licensure, training, or supervision they feel could be expanded or strengthened to contribute to their use of self-disclosure.

For this study, clinical social workers were asked to complete a mixed methods questionnaire that contained 30 quantitative and five qualitative questions. First, respondents were asked to accept that they met the inclusion criteria and that they agreed to the informed consent. Participants then answered four questions related to their education and licensure. Participants were asked about using self-disclosure in their practice and the value they gave self-disclosure as a therapeutic tool. Participants were also asked about their comfort and competence with self-disclosure in their clinical practice. The questionnaire also included questions that related to self-disclosure and professional development in regards to the discussion of self-disclosure in education, formal training, licensure, and supervision.

Recruitment

The researcher gained access to clinical social workers through the Minnesota Board of Social Work. The researcher requested in writing 500 e-mail addresses of social workers who are licensed as Licensed Independent Clinical Social Workers. This list was purchased at a cost of $50 to the researcher. The researcher requested that the contacts be chosen randomly. Only the e-mail addresses of the contacts were requested. A letter of permission was obtained from the Minnesota Board (see Appendix A).

The researcher used a purposive sampling method to reach social workers. *Purposive sampling* is defined by Monette and colleagues as a "…non-probability sampling technique wherein investigators use their judgment and prior knowledge to choose people for the sample who best serve the purposes of the study" (2011, p. 506).

Purposive sampling was used with the intent to choose respondents who are social workers doing clinical work. This intentional sampling method was used to target clinical social workers who are affiliated with the Minnesota Board of Social Work because of their licensure status as Licensed Independent Clinical Social Workers.

Protection of Human Subjects

The protection of the human subjects in this study was considered. Besides the researcher, many other professionals were involved in the approval of the study. This study was reviewed and approved by a research chair and a committee that included two practicing professionals in the area of therapeutic work. This study was also reviewed and approved by the Institutional Review Board at the University of St. Thomas.

Informed consent was established by a letter of consent presented to all participants. Specifics about the study were presented to respondents prior to their participation in the questionnaire via a consent letter (see Appendix B) which was the first thing that appeared after respondents clicked on the link to the survey. The consent letter informed participants of the voluntary nature of the study, the number of questions and expected time commitment, the lack of benefits, the potential risks, and confidentiality protections. Participants were also informed about the purpose of the study.

Anonymity of the participants was maintained in several ways. While the researcher had initial access to social workers' e-mail addresses, she did not have the names associated with the addresses. The researcher blocked the identifying information, including IP (internet protocol) addresses using the Qualtrics system. The researcher

ensured that responses were not connected to specific e-mail addresses. No identifying information was asked for within the survey.

In addition to anonymity, confidentiality was also ensured through thoughtful consideration of the researcher. The records of the study shall not include any information that connects data to particular participants. The results of the study will be kept confidential on the researcher's personal computer which is password protected and kept at the researcher's home. The data will be destroyed within one year of the completion of the study.

The level of review for the St. Thomas Institutional Review Board was exempt due to the low level of vulnerability and risk involved. Participation in the study was voluntary. There were no direct benefits to participation in this study. The level of risk in this study was low and primarily due to mild discomfort. This mild discomfort could have been created by revealing potential inadequacies of graduate programs or supervisors. Care was taken to address risk by stating that participants can skip questions or decide to quit at any time. A resource list was available for participants at the end of the survey (see Appendix C).

Data Collection

The researcher sent out 507 surveys to the e-mails provided by the Minnesota Board of Social Work**.** After two weeks, the researcher sent out a reminder e-mail to participants. The researcher left the survey open for an additional week and then closed the survey at that time. Out of the 507 e-mails sent, 371 were opened. While 371 opened the survey, only 97 started the survey. The estimated response rate was 17%.

Data was collected via questionnaires using Qualtrics online survey that consisted of 35 questions (see Appendix D). Questions addressed the participants' educational and practice background, use and regulation of self-disclosure, and professional development related to self-disclosure. Questions regarding definitions, guidelines, and practice with specific groups were informed by the literature. Qualitative and quantitative data was collected through these questions. If participants did not fit the inclusion criteria they were exited from the survey.

Qualitative data was collected within the questionnaire using open ended questions and semi-structured questions. Examples of qualitative questions included "Please indicate in your own words, how you might expand, modify, or correct inaccuracies in this definition", and "I would like to see education strengthened or expanded to address use of self-disclosure in clinical practice in the following way (please specify)."

Quantitative data was collected within the questionnaire using likert scale and yes/no questions. Examples of quantitative questions include questions included "I have a Master's degree in Social Work (Yes, No)" and "I believe my graduate schooling fully prepared me to make informed decisions about the use of self-disclosure in my clinical practice" (Strongly Disagree, Disagree, Neither Agree or Disagree, Agree, or Strongly Agree).

Data Analysis

The data collected was analyzed in different ways**.** *Qualitative data*, defined as using inductive reasoning to see themes emerging through raw data (Hall, 2013), was analyzed using inductive analysis. *Open coding*, referred to as using "unrestricted coding

to produce concepts and dimensions that seem to fit the data fairly well" (Monette et al., 2011), was used to determine themes present in the data.

Quantitative data was analyzed using descriptive analysis and inferential analysis. Descriptive statistics analyzed included frequency distribution and measures of central tendency. Inferential analysis investigated whether there was an association or a relationship between the practice setting of respondents and their agreement with the use of self-disclosure as an important therapeutic tool.

Eighty-six respondents participated in this study. The survey was e-mailed to 507 social workers who were registered as Licensed Independent Clinical Social Workers (LICSW) through the Minnesota Board of Social Work. Eighty-six participants fit the inclusion criteria and completed the survey (n= 86). The response rate for completed surveys was 5.9%

Description of Participant's Experience

Participants described their work experience by how long they have been practicing as a clinical social worker, the areas of practice they worked in, what setting they worked in, which populations they provided support for, what age groups they worked with, and what special populations with which their clients identified. Participants had a wide range of years of experience, from zero to five years up to 21 or over, spread fairly evenly across the years (see Table 1). Many participants identified their area of practice as psychotherapy with brief and ongoing focuses (n=74, 78% and n=68, 72%). Besides supervision/education, group work, case management, and macro practice, others also identified as working in crisis intervention (see Table 2). Most

identified providing support for individuals and families (*n*=81, 77% and *n*=75, 80 %). Respondents were asked to identify what groups their clients identify with.

Table 1

Description of Practice Experience Among Clinical Social Worker Participants

Years of practice	*n* = 82 *(%)*
0-5	19 (23%)
6-10	18 (22%)
11-15	17 (21%)
16-20	15 (18%)
21+	13 (16%)

Note. Practice experience refers to the number of years a respondent has been practicing as a licensed clinical social worker.

Table 2

Descriptions of Participant's Practice Area Among Clinical Social Workers

Practice area	Yes	No
Psychotherapy (brief) (*n*=74)	58 (78%)	16 (22%)
Psychotherapy (ongoing) (*n*=68)	49 (72%)	19 (28%)
Supervision/education (*n*=67)	45 (67%)	23 (34%)
Group work (*n*=63)	37 (59%)	26 (41%)
Case management (*n*=62)	32 (52%)	30 (48%)
Macro practice (*n*=58)	17 (29%)	41 (71%)
Other (*n*=67)	17 (25%)	20 (30%)

Note. Macro practice was defined for respondents as "work with communities or larger systems, planning/development."

Findings

This section reports findings from the study. First, this section covered the descriptions of the participant's experience. Second, participants answered questions that addressed their understanding and use of self-disclosure as it relates to its use and significance as a therapeutic tool, how respondents view self-disclosure's definition, and how they direct their use of self-disclosure. Third, respondents answered questions that asked them to identify their comfort and competence with their current use of self-disclosure. Finally, findings discussed participants' history and suggestions regarding self-disclosure in education, training, and supervision.

Understanding and Use of Self-Disclosure

Respondents indicated their understanding of self-disclosure by stating their level of agreement with a proposed definition, and suggesting changes to this definition. Respondents indicated their use of self-disclosure by stating their level of agreement with the use of self-disclosure in their practice and their agreement with its significance. Respondents also indicated their use by explaining their level of agreement with using strict guidelines.

A majority of respondents (n=74; 81%) agreed that they use self-disclosure as a clinical tool in their therapeutic practice. Just over half of the respondents (n=75; 54%) agreed that they considered the use of self-disclosure as a therapeutic tool to be important. About a third (n=21; 28%) neither agreed nor disagreed (see Table 3).

Table 3

Participant Perceptions Regarding Using Self-Disclosure in Their Clinical Practice

Self-disclosure is used in practice	*n*=74 (%)
Strongly disagree	2 (3%)
Disagree	2 (3%)
Neither agree or disagree	10 (14%)
Agree	51 (69%)
Strongly agree	9 (12%)
Self-disclosure is an important therapeutic tool	***n*=75 (%)**
Strongly disagree	6 (8%)
Disagree	7 (9%)
Neither agree or disagree	21 (28%)
Agree	33 (44%)
Strongly agree	8 (11%)

Definition. The researcher provided the following definition of self-disclosure: "…an interaction in which the therapist reveals personal information about him/herself, and/or reveals reactions and responses to the client as they arise in the session" (Knox & Hill, 1997, p. 275). The majority of respondents (*n*=78; 83%) agreed with this definition (see Table 4).

Table 4

Participants Agreement with Definition of Self-Disclosure	*n*=78 (%)
Strongly disagree	4 (5%)
Disagree	5 (6%)
Neither agree or disagree	4 (5%)
Agree	50 (64%)
Strongly agree	15 (19%)

Guidelines. Over half of the respondents (*n*=75; 59%) agreed that they followed strict guidelines regarding their use of self-disclosure. Participants were asked to explain their level of agreement with their adherence to strict guidelines for self-disclosure (*n*=52). For respondents who disagreed with using strict guidelines and further explained (*n*=4), one main reason was cited. For respondents who neither agreed nor disagreed with using strict guidelines and further explained (*n*=6), one main reason was cited. For respondents who agreed with using strict guidelines and further explained (*n*=52), one main reason and three secondary reasons were cited.

For respondents who disagreed with following strict guidelines, their main cited reason was their belief that self-disclosure should be used based on its benefits to the client. For respondents who neither agreed nor disagreed with strict guidelines, the cited reason was their practice to view each situation on a case by case basis as it relates to their use of self-disclosure. One respondent who neither agreed nor disagreed said “Each situation is different and each client is unique”.

Respondents who agreed that they follow strict guidelines with their use of self-disclosure further explained that the main reason they would use self-disclosure is in

regards to the client. They spoke of using self-disclosure in regards to the client when the disclosure may benefit the client and when it is in the best interest of the client. One respondent said "I use it when it's in the best interest of the client".

Other explanations for those who agreed with using strict guidelines included using self-disclosure sparingly, when it will serve a therapeutic goal, and making sure that it does not serve the therapist's personal needs. For example, one respondent who agreed with using strict guidelines said "Only when there is a therapeutic benefit." Another respondent who agreed with strict guidelines said "I make sure the disclosure is not about 'me' and my issues."

Comfort

Respondents were asked questions about their comfort with self-disclosure. Almost all of the respondents (n=73; 93%) indicated that they were comfortable with their current use of self-disclosure. When asked what has contributed to their current comfort with self-disclosure, most respondents (n=72; 97%) indicated that their practice experience contributed to their current comfort (see Table 5). Respondents were split about whether education, training, or supervision could increase their comfort with using self-disclosure (see Table 6).

Table 5

Contributions to Comfort with Self-Disclosure Among Clinical Social Workers

	Disagree	Neither	Agree
Practice (*n*=72, %)	0 (0%)	2 (3%)	70 (97%)
Supervision (*n*=73, %)	4 (5%)	10 (14%)	59 (81%)
Specific populations (*n*=72, %)	3 (4%)	14 (19%)	55 (76%)
Education (*n*=73, %)	12 (16%)	11 (15%)	50 (68%)
Theory/research (*n*=72, %)	11 (15%)	21 (29%)	40 (56%)
Licensure (*n*=71, %)	18 (25%)	22 (31%)	31 (44%)
Agency training (*n*=72, %)	18 (25%)	24 (33%)	30 (42%)

Table 6

Needs for More Comfort Using Self-Disclosure Among Clinical Social Workers

	Disagree	Neither	Agree
Supervision (*n*=69)	20 (29%)	25 (36%)	24 (35%)
Training (*n*=71)	24 (33%)	31 (44%)	16 (22%)
Education (*n*=69)	25 (36%)	28 (41%)	15 (21%)

Competence

Participants were asked questions about their competence with self-disclosure**.** A majority of respondents (*n*=67; 93%) indicated that they felt competent in their current use of self-disclosure. When asked what has contributed to their current competence with self-disclosure, nearly all of the respondents (*n*=68*;* 94%) indicated that their practice experience contributed most. When asked what could increase their competence with

self-disclosure, respondents thought either training or supervision, or didn't feel strongly (see Table 7).

Table 7

Needs for More Competence Using Self-Disclosure Among Clinical Social Workers

	Disagree	Neither	Agree
Supervision (*n*=66, %)	15 (23%)	23 (25%)	28 (43%)
Training (*n*=68, %)	13 (19%)	28 (41%)	27 (40%)
Education (*n*=66, %)	18 (27%)	27 (41%)	21 (32%)

Experience and Needs

Education. Respondents were fairly split as to whether they thought their graduate school fully prepared them to make informed decisions about self-disclosure in their clinical practice. Close to one-third of the respondents (*n*=72; 39%) agreed that their graduate school prepared them while close to one-third disagreed (*n*=72; 39%), while the remaining *(n*=72; 22%) neither agreed nor disagreed (see Table 8). While respondents were fairly split about whether their graduate school experience prepared them to use self-disclosure, the majority of the respondents (*n*=72; 82%) did agree that social work education could be expanded or strengthened to address the use of self-disclosure in clinical practice.

Respondents were asked in what ways they believe social work education could be expanded or strengthened to address the use of self-disclosure in clinical practice (*n*=42). Respondents gave one main suggestion and one minor suggestion.

The most cited suggestion (*n*=10) respondents gave for expanding or strengthening social work education was to provide more hands-on experiences using

self-disclosure. Many respondents mentioned using field experiences and practical application to provide this learning. As a suggested way to strengthen or expand education to address use of self-disclosure one respondent said "I think that in the practicum course it could be highlighted." After practical experience, respondents mentioned addressing when to use self-disclosure as the next best way to expand or strengthen social work education in regards to the use of clinical self-disclosure. One respondent said "More information about the purpose of disclosing and when/how it can be helpful in the therapeutic relationship."

Table 8

Participants Agreement with Graduate School Preparation for Self-Disclosure (n=72, %)

Strongly disagree	6 (8%)
Disagree	22 (31%)
Neither agree or disagree	16 (22%)
Agree	25 (35%)
Strongly agree	3 (4%)

Training. Respondents were asked if they believed social work training should be strengthened or expanded and in what areas they would like more training**.** Over half of the respondents (*n*=69; 64%) agreed that social work training could be strengthened or expanded to address the use of clinical self-disclosure. Respondents named how to gauge the effectiveness of their use of self-disclosure (*n*=71; 72%), theory or research as it relates to the use of therapist self-disclosure (*n*=71; 69%), and how to develop personal self-awareness as it relates to use of self-disclosure (*n*=71; 68%) as the three main areas in which they would like more training.

Supervision. Respondents were asked if they had discussed self-disclosure in supervision. Respondents were also asked if they believe social work supervision could be strengthened or expanded to address self-disclosure and in what ways. The majority of respondents (*n*=71; 85%) agreed that they have discussed therapist use of self-disclosure in clinical practice in supervision. The majority of respondents (*n*=72; 78%) also agreed that social work supervision could be strengthened or expanded to address the use of self-disclosure in clinical practice.

Respondents were asked in what ways they believe social work supervision could be expanded or strengthened to address the use of self-disclosure in clinical practice. Several responses were given (*n*=37) with two main responses. The most cited responses were that supervisors should initiate the discussion on self-disclosure (*n*=6) and that supervisors should get more training on self-disclosure (*n*=6). In regards to suggesting more supervisors initiate the discussion on self-disclosure, one respondent said "By more supervisors addressing the subject." Another suggestion for strengthening or expanding supervision in regards to supervision one respondent said "More training for supervisors in how to address these issues."

Inferential Statistic

The inferential statistic is used to determine if there is a relationship between two variables. The researcher chose one nominal and one ordinal variable to examine. The independent variable is the nominal variable labeling the respondent's practice setting. This is operationalized by asking the respondent "I currently practice in the following settings" with respondents choosing University or Affiliated Research Institute (Yes/No), Government/Public Organization (Yes/No), Independent Private Practice (Yes/No),

Consultant/Supervisor (Yes/No), Non-profit Agency (Private) (Yes/No), Non-profit Agency (Public) (Yes/No), Religious/Faith Affiliated Institute (Yes/No), Hospital/Clinic (Yes/No), Home Visits (Yes/No), and Other (please specify) (Yes/No). The responses most commonly cited for "Other" category are School, For-profit company, and Unemployed. The dependent variable is the ordinal variable asking the respondent's agreement with the importance of self-disclosure as a therapeutic tool. This is operationalized by asking the respondent "I consider self-disclosure to be an important therapeutic tool in my clinical practice" with respondents choosing Strongly Agree, Agree, Neither Agree or Disagree, Disagree, or Strongly Disagree (see Table 9). The research question for this study is "Is there a relationship between practice setting and the use of self-disclosure as an important therapeutic tool?" The hypothesis for this study is: There is a relationship between practice setting and the use of self-disclosure as an important therapeutic tool. The null hypothesis for this study is: There is not a relationship between practice setting and the use of self-disclosure as an important therapeutic tool.

The p-value for variable of the use of self-disclosure as an important therapeutic tool and the variable of practice setting is: University or Affiliated Research Institute (p=.76), Government/Public Organization (p=.29), Independent Private Practice (p=.76), Consultant/Supervisor (p=.20), Non-profit Agency (Private) (p=.56), Non-profit Agency (Public) (p=.02), Religious/Faith Affiliated Institute (p=.06), Hospital/Clinic (p=.39), Home Visits (p=.19), and Other (please specify) (p=.35). The only p-values that is less than .05 is the responses for Non-profit Agency (Public) (see Table 10). For this setting we can determine that there is a significant relationship between social workers who

work in this setting and their view of self-disclosure as an important therapeutic tool. For the Non-profit Agency (Public) setting we accept the hypothesis. For all other settings we fail to reject the null hypothesis determining that there is not a significant relationship between these practice settings and the importance of using self-disclosure as a therapeutic tool.

Table 9

Relationship Between Practice Setting and Agreement with Importance of Self-Disclosure

	S. Agree	Agree	Neither	Disagree	S. Disagree
Practice Setting					
University (*n*=5, %)	1(20%)	0(0%)	1(20%)	2(40%)	1(20%)
Govt. /Public (*n*=23, %)	1(4%)	2(9%)	8(35%)	8(35%)	4(17%)
Private (*n*=20, %)	2(10%)	1(5%)	4(20%)	11(55%)	2(10%)
Supervisor (*n*=18, %)	1(6%)	1(6%)	6(34%)	6(34%)	4(22%)
Non-profit private (*n*=16, %)	1(6%)	3(19%)	3(19%)	7(44%)	2(13%)
Non-profit public (*n*=8, %)	3(38%)	1(13%)	3(38%)	0(0%)	1(13%)
Religious (*n*=1, %)	0(0%)	1(100%)	0(0%)	0(0%)	0(0%)
Hospital (*n*=19, %)	2(11%)	2(11%)	7(67%)	6(32%)	2(11%)
Home Visits (*n*=15, %)	0(0%)	2(13%)	6(40%)	6(40%)	1(7%)
Other (*n*=8, %)	0(0%)	0(0%)	3(38%)	5(63%)	0(0%)

Note. The numbers of respondents under practice setting indicate the number of respondents who indicated "Yes" under the specified settings after "I currently practice in the following settings". Practice settings in table are abbreviated.

Table 10

P-value of Relationship Between Practice Setting and Importance of Self-Disclosure

	Chi-Square	P-Value
Practice Setting		
University (*n=5)*	1.89	.76
Govt. /Public (*n*=23)	4.96	.29
Private (*n*=20)	.66	.96
Supervisor (*n*=18)	6.04	.20
Non-profit private (*n*=16)	2.99	.56
Non-profit public (*n*=8)	11.65	.02
Religious (*n*=1)	9.16	.06
Hospital (*n*=19)	4.15	.39
Home Visits (*n*=15)	6.12	.19
Other (*n*=8)	4.45	.35

Note. The number of respondents under practice setting indicate the number of respondents who indicated "Yes" under the specified practice setting after "I currently practice with the following populations". Practice settings in table are abbreviated.

Discussion

This research study examines social workers understanding and use of self-disclosure, their degrees of comfort and competence and what contributes, and what roles education, licensure, training, and supervision play and how they could be strengthened to better address the use of self-disclosure in clinical practice.

Understanding and Use of Self-Disclosure

Respondents were asked to consider Knox & Hill's definition of self-disclosure and to state their agreement with that definition. The definition explains self-disclosure as "an interaction in which the therapist reveals personal information about him/herself, and/or reveals reactions or responses to the client as they arise in the session" (1997, p.275). The majority of the respondents agree with the definition of self-disclosure provided by Knox and Hill (1997).

While there is some agreement in the literature, the literature also names confusion and debate in regards to the definition of self-disclosure. The authors in the literature discussed many different definitions and types of self-disclosure. A common way to define self-disclosure in the literature consisted of separating two types of disclosure, here and now disclosures, defined by disclosing thoughts or beliefs about what is going on in the session and personal disclosures, disclosing thoughts or beliefs from outside of the session. Knox and Hill's definition includes both types of self-disclosure. Surprisingly, many of the respondents did agree with the definition provided and only a small number chose to expand, modify, or correct the given definition. This may indicate that there may be more agreement as to the definition of self-disclosure in practice than there is in the literature. This may also be attributed to the fact that the definition was provided, and may have had different results were respondents asked to

provide their own definition. To gauge their understanding and use of self-disclosure, respondents were also asked about employing guidelines to direct their use of self-disclosure.

Respondents were asked about their agreement with following strict guidelines that direct their use of self-disclosure. The majority of respondents agree that they follow strict guidelines in their use of self-disclosure. When asked to expand on their use of guidelines, participants most commonly described their use of guidelines as rooted in the best interest of the client.

The literature is more divided in views, with some proponents of using guidelines, and some proponents of using self-disclosure differently on a case by case basis. The literature also shows some consensus around guidelines proposed by Knox and Hill (2003) (Carew, 2009; Knox, 2003). By those who advocated formal guidelines, client-based guidelines were commonly mentioned in the literature (Carew, 2009; Hanson, 2005; Jeffrey, 2007; Knox, 2003; Knox, 1997; Siebold, 2011). The results mirrored the literature in a focus on the client when determining use of self-disclosure.

When respondents were asked to expand on their use of guidelines, a minor theme of making sure the disclosure doesn't serve the therapist's needs came up. This was described by respondents as requiring intentional thought on behalf of the respondent. This fit with the literature as the need for self-awareness on behalf of the therapist when considering and using self-disclosure was frequently mentioned (Bottrill, 2009; Bridges, 2001; Carew, 2009; Hanson, 2005; Knox, 2003; Knight, 2012, Wells, 1994). In Bottrill's study (2009), major themes concerning therapist self-awareness emerged. The findings again reiterated the literature as a focus on therapist self-awareness was mentioned by the

literature and by the respondents as an important component to consider when using self-disclosure.

There are many similarities between the understanding and use of self-disclosure among social workers and the literature. Majority of respondents agree with the definition of self-disclosure by Know and Hill (2003). The acceptance of the provided definition might suggest a standardization of Knox and Hill's definition of therapist self-disclosure for practice use to reduce confusion and provide a common understanding. When asked to expand on their guidelines, respondents identified a minor theme of making sure that the disclosure did not serve the therapist's needs. When discussing therapist self-disclosure in practice settings, the self-awareness of the therapist as it pertains to their disclosure should be considered.

Comfort

Respondents were asked about their current comfort with their use of self-disclosure and what has contributed. When respondents were asked about whether theoretical backgrounds influenced their comfort with self-disclosure, respondents in this study neither agree or disagree or did agree that a theory had influence. Of those respondents who agree that a theory had influenced them, psychodynamic theory was the least popular. Respondent's lack of influence from psychodynamic theory was in contrast to the literature.

In the literature, authors name psychodynamic theory as one of the main theories to have influence over how self-disclosure is viewed. Carew's study of how theoretical backgrounds influence attitudes about self-disclosure found that all participants' attitudes were influenced by psychodynamic training (2009). The popularity of psychoanalytic

theory as a basis for understanding self-disclosure in the literature does not fit with the findings of this study. Respondents indicated that psychodynamic theory contributes the least, of the theories mentioned, to their comfort with using self-disclosure. According to respondents, the most popular theoretical background to have an influence on comfort with self-disclosure is humanist/existentialist.

Respondents were asked what experiences contribute to their comfort with self-disclosure. Working with specific populations was one of the three choices chosen by respondents to indicate what experiences contribute to their current comfort with self-disclosure. The literature finds that positive implications have been seen regarding clinical self-disclosure and the GLBT community (Rollins, 2013; Satterly, 2006). The literature names self-disclosure with specific populations and cultures to be one of the future research needs regarding therapist self-disclosure. This may be exceedingly important since the findings of this study indicate that working with specific populations has contributed to therapist comfort with self-disclosure.

Competence

The respondents were asked about their current competence with their use of self-disclosure and what has contributed. The current study found high levels of perceived competence among social workers in regard to their use of self-disclosure. Almost all of the respondents agree that they are competent in their current use of self-disclosure. The findings of the study conflict with the literature's general idea that social workers are not confident in their use of self-disclosure.

The literature reports that while many clinicians use self-disclosure, they also express confusion about it (Knight, 2012; Knox & Hill, 2003). The literature put some

emphasis on therapist skill in self-disclosure. In Knights study, more than one third admitted to times when they disclosed too much, and one third admitted to times when they disclosed too little (2012). In one study it was found that skill, or lack of it, was the intervening variable that affected perceptions of the helpfulness of therapist disclosure or non-disclosure (Hanson, 2005). The findings of the current study may indicate higher than believed levels of competence among social workers with regard to self-disclosure. It may also speak to higher levels of competence among certain groups of clinical social workers.

In regard to their competence, respondents indicate that their practice contributed the most to their current competence in use of self-disclosure. Theory and research were among the least popular choices listed by respondents as experiences that may have contributed to their competence using self-disclosure. The top choices were practice, working with specific populations, and social work education. The findings of this study fit with ideas presented in the literature.

The lack of theory and research's impact on use of self-disclosure coincides with the literature in regards to theory and practice. An inconsistency between theory and practice is found in the literature (Audet, 2010; Carew, 2009). Knight found that most social workers didn't believe their self-disclosure was based on theory and research (2012). Although self-disclosure is rarely discussed by researchers without mentioning theoretical influences, the findings of the literature and of the current study, indicate that theory may not contribute to therapists' competence in using self-disclosure.

Experience and Needs

Education. Regarding education, respondents in this study had different opinions about how their self-disclosure was influenced by their social work education. About one third of respondents agreed their education prepared them to make informed decisions about the use of self-disclosure in their practice and about one third disagreed that their education prepared them to make informed decisions about the use of self-disclosure in their practice. A majority of respondents also agreed that education could be strengthened or expanded to address the use of self-disclosure in clinical practice. These findings coincide with the literature.

The literature discusses areas for opportunity in social work education. One author asserts that self-disclosure does not get the focus it needs in education (Knight, 2012). Knight's study found that one-half of social workers didn't feel prepared by their education to engage in self-disclosure (2012). One may acknowledge the literature's general lack of agreement on how to define self-disclosure and if and when to use it as an assumption that social work education is varied or inconsistent.

Supervision. A majority of respondents have discussed therapist use of self-disclosure in supervision. A majority of respondents also agreed that social work supervision could be strengthened or expanded to better address use of self-disclosure. The findings of this study correspond with the literature in regard to areas of opportunity in supervision. The findings of the current study sometimes concur and sometimes differ in regard to the discussion of therapist self-disclosure in supervision.

The literature discusses supervision as an important component of therapist self-disclosure. In her study of trainee's experiences, learning through supervision was a

major theme of learning to master self-disclosure (Bottrill, 2009). Opportunities for supervision expansion in the literature included more time and better support by supervisors (Bottrill, 2009). The literature suggests that clinicians sometimes had experiences with self-disclosure in supervision and sometimes did not. Often clinicians did not feel comfortable addressing self-disclosure with their supervisor (Bottrill, 2009; Knight, 2012). The findings of the current study and the literature suggest that supervisors provide a comfortable place in supervision to discuss therapist self-disclosure.

Strengths and Limitations

Strengths. The current study has an important strength. The wide range of experience among social workers provided a rich sample. Respondents indicated being new and experienced clinical social workers. Respondents indicated practice experience in a number of types of interventions and settings including psychotherapy, supervision and education, and case management. It is beneficial to have various levels and types of experience represented when asking what has contributed to comfort and competence regarding self-disclosure and what needs might be present in education, licensure, training, and supervision, which may occur at different intervals in a social worker's career. Since the literature suggests ambiguity and confusion around the topic of self-disclosure, and even around its usefulness, this research contributes to practice by making suggestions, from social workers in the field, as to how we might better understand and develop the topic of therapist self-disclosure.

Limitations. There are a few limitations due to the structure of the study. Many of the questions were skipped by the respondents as the researcher did not require the participants to answer every question resulting in missing data. While 97 surveys were

started, only 86 were completed. While 86 respondents completed the survey, the mode for the number of responses for each question is 72. The lowest response number is 23 and the highest response number is 96. This may be because some questions required significant thought, or because the survey was lengthy at 35 questions.

Another limitation of the study is that it does not clarify between the two types of self-disclosure, here and now disclosures and personal disclosures. While these two different types are described differently in the literature, they refer to disclosures that are either descriptive of what is happening in the session with the therapist and client, or personal information about the therapist brought from outside of the session. As described in the literature, 'here and now' disclosures are more widely accepted than personal disclosures. In regard to defining self-disclosure, it might have been more helpful to ask respondents to provide their own definition of self-disclosure. This might have better shown how social workers are defining self-disclosure in their practice and if they are in fact distinguishing between the two different types.

Another limitation of the study is some of the inferences drawn about competence on behalf of the respondent. It is assumed by the researcher that perceived levels of competence of the respondent by the respondent reflect actual levels of competence. For example, a respondent's belief in how competent they are does not necessarily reflect their actual competence. Almost all of the respondents described themselves as competent in their current use of self-disclosure with almost a third feeling strongly about their competence. It could be possible that perceived levels of competence differ from actual levels of competence in regard to therapist self-disclosure.

Recommendations for Future Research

More research is needed about therapist self-disclosure in clinical settings. Specifically, additional research is needed about therapist self-disclosure with specific populations. These specific populations could include the GLBT community and those experiencing chemical dependency. The current literature describes a lack of diversity in the research in regard to respondents, clients, and culture of both therapist and client (Audet, 2010; Bottrill, 2009; Knight, 2012; Satterly, 2006). Future research could focus on how work with specific populations affects therapist self-disclosure and how its use and benefits might differ among different therapists and clients. For example, it may be helpful in certain situations for a therapist to disclose a similar experience as the client, like when the therapist has also experienced deployment or chemical dependency or is a member of a similar group, like the GLBT community or a parent. Almost two-thirds of respondents in the current study did indicate that they have found self-disclosure to be useful in regard to specific populations, diagnosis, or situations.

Implications for Future Social Work Practice

The findings of the current study have ramifications for social work practice in regards to therapist self-disclosure. Social work practice can be enhanced by strengthening or expanding social work education, training, and supervision as suggested by the respondents. Respondents were not in agreement that their education prepared them to use self-disclosure and the majority believes that education can be improved to better address the use of self-disclosure. Respondents believe covering self-disclosure in practical ways may be a good way to do this. Respondents believe that training could be improved and asked for more training in the areas of how to gauge self-disclosures effectiveness, theory/research, and self-awareness. Respondents believe social work

supervision could be strengthened or expanded by supervisors addressing self-disclosure and being trained on the topic. Besides the focus on clinicians, there are other practice implications.

Another implication for social work practice is the idea of analyzing client perspectives. A large portion of the literature focuses on what clients think about therapist self-disclosure. Several studies analyze client perceptions of self-disclosure (Audet, 2010; Knox & Hill, 1997; Wells, 1994). Practice may be directed by this literature that examines how self-disclosure might be the most useful according to clients.

Conclusion

This research study explored the topic of therapist self-disclosure among clinical social workers. The study asked social workers about their understanding and use of self-disclosure, their comfort and competence regarding the intervention of self-disclosure, and their experience and needs in regard to education, training, licensure, and supervision.

The findings of this have many practical applications in the field of clinical social work. The profession may benefit from generalizing the definition of self-disclosure and the guidelines for practioners. Respondents suggested many ways to benefit social work education, training, and supervision.

References

Allen, J., Bleiberg, E, & Haslam-Hopwood, T. (2006). Understanding mentalizing. Retrieved from http://www.menningerclinic.com/education/clinical-resources/mentalizing

Allen, J., Fonagy, P., & Bateman, A. (2008). *Mentalizing in clinical practice*. Washington DC: American Psychiatric Publishing.

Audet, C. & Everall, R. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance and Counseling, 38*(3), 327-342. doi: 10.1080/03069885.2010.482450

Barret, M., & Berman, J. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology, 69*(4), 597-603. doi: 10.1037//0022-006X.69.4.597

Bottrill, S., Pistrang, N., Barker, C., & Worrell, M. (2013). The use of therapist self-disclosure: Clinical psychology trainees' experiences. *Psychotherapy Research, 20*(2), 165-180. doi: 1080/10503300903270947

Bridges, N. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy*, *38*(1), 21-30.

Carew, L. (2009). Does theoretical background influence therapists' attitudes to therapist self-disclosure? A qualitative study. *British Association for Counselling and Psychotherapy, 9*(4), 266-272. doi: 10.1080/14733140902978724

DeLaCour, E. (2010). How has the therapeutic relationship changed in psychoanalytic psychotherapy? *Smith College Studies in Social Work, 68*(2), 171-183. doi: 10.1080/00377319809517522

Fonagy, P. & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology, 21*, 1355-1381. doi: 10.1017/S0954579409990198

Gibson, M. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal, 40*, 287-296. doi: 10.1007/s10615-012-0391-4

Hall, S. (2013). What is inductive content analysis? *The Houston Chronicle*. Retrieved from http://smallbusiness.chron.com/inductive-content-analysis-24666.html.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *British Association for Counselling and Psychotherapy, 5*(2), 96-104. doi: 10.1080/17441690500226658

Jeffrey, A., & Austin, T. (2007). Perspectives and practices of clinician self-disclosure to clients: A pilot comparison study of two disciplines. *The American Journal of Family Therapy, 35*(2), 95-103. doi: 10.1080/01926180600814528

Knight, C. (2012). Social workers' attitudes towards and engagement in self-disclosure. *Clinical Social Work Journal, 40*, 297-306. doi: 10.1007/s10615-012-0408-z

Knox, S., Hess, S., Petersen, D., & Hill, C. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44(3), 274-283.

Knox, S., & Hill, C. (2003). Therapist self-disclosure: Research based suggestions for practitioners. *JCLP/In Session, 59*(5), 529-539. doi: 10.1002/jclp.10157

Knox, S., & Hill, C. (2009). Processing the therapeutic relationships. *Psychotherapy Research*, *19*(1), 13-29. doi: 10.1080/10503300802621206

Maroda, K. (1999). Creating an intersubjective context for self-disclosure. *Smith College Studies in Social Work, 69*(2), 474-489.

Monette, D., Sullivan, T., & DeJong, C. (2011). *Applied social research: A tool for the human services*. Belmont, CA: Brooks/Cole.

National Association of Social Workers. (2013). Social work profession. Retrieved from http://www.socialworkers.org/pressroom/features/general/profession.asp

National Alliance on Mental Illness. (2013). Mental health professionals fact sheet. Retrieved from http://www.nami.org/factsheets/mentalhealthprofessionals_factsheet.pdf

Padgett, D. (2008). *Qualitative methods in social work research*. Thousand Oaks, CA: Sage Publications.

Perlman, F. & Frankel, J. (2009). Relational psychoanalysis: A review. *Psychoanalytic Social Work, 16*, 105-125. doi: 10.1080/15228870903200277

Raines, J. (1996). Self-disclosure in clinical social work. *Clinical Social Work Journal, 24*(4), 357-375.

Rollins, L. (2008). A client perspective on therapist self-disclosure. *Journal of Gay and Lesbian Social Services*, 6(4), 71-82. doi: 10.1300/J041v06n04_07

Satterly, B. (2006). Therapist self-disclosure from a gay male perspective. *Families in Society*, 87(2), 240-247.

Siebold, C. (2011). What do patients want? Personal disclosure and the intersubjective perspective. *Clinical Social Work Journal, 39*, 151-160. doi: 10.1007/s10615-011-0337-1

Sweezy, M. (2005). Not confidential: Therapist considerations in self-disclosure. *Smith College Studies in Social Work, 75*(1), 81-91. doi: 10.1300/J497v75n01_06

Wells, T. (1994). Therapist self-disclosure: It's effect on clients and the treatment relationship. *Smith College Studies in Social Work, 65*(1), 23-41.

World Health Organization. (2011). WHO highlights global underinvestment in mental health care. Retrieved from http://www.who.int/mediacentre/news/notes/2011/mental_health_20111007/en/

Appendix A: Agency Approval Letter

State of Minnesota
Board of Social Work
2829 University Ave SE, Ste 340
Minneapolis, MN 55414-3239

Telephone 612.617.2100
social.work@state.mn.us
www.socialwork.state.mn.us
Fax 612.617.2103
Toll Free 888.234.1320
TTY 800.627.3529

BOSW

November 26, 2013

Dr. Eleni Roulis, Chair
Institutional Review Board
University of Saint Thomas
2115 Summit Ave
Saint Paul MN 55105

Dear Dr. Roulis:

At the request of the Ashley Grahek, I am writing this letter.

Ashley will be requesting a list, including email addresses, of randomly selected Licensed Independent Clinical Social Workers (LICSWs) as part of her research project. The information that will be provided to her is classified as public data pursuant to Minnesota Statutes, section 13.41, subdivision 5. No private or confidential data will be furnished.

According to Minnesota Government Data Practices Statutes, public data must be provided to anyone who requests it, although agencies may charge a fee for the service.

If you have any questions, please contact me at 612-617-2111.

Sincerely,

Connie Oberle
Office Manager

Appendix B: Informed Consent

What Education, Licensure, Training, or Supervision Helps Clinical Social Workers Address Therapist Self-Disclosure?

I am a graduate student completing my Master's of Social Work degree at St. Catherine University/University of St Thomas. As part of my graduate education, I am conducting a study on therapist self-disclosure. I am conducting this study under the supervision of Dr. Kari Fletcher and as approved by the St. Thomas University Institutional Review Board. You were chosen to participate in this study because of your status as a Licensed Independent Clinical Social Worker and affiliation with the Minnesota Board of Social Work.

This study asks the question "What education, licensure, training, or supervision helps clinical social workers address therapist self-disclosure?" The study will also ask social workers in which areas of education, licensure, training, or supervision they feel could be expanded or strengthened to address use of self-disclosure in clinical practice. The study also asks social workers what will be most helpful for them in contributing to their comfort and competence in using self-disclosure.

Your participation in this survey is voluntary. If you chose to participate, please click on the link below and follow the directions listed. The link will direct you to the online survey consisting of 35 questions estimated to take about 35 minutes of your time. You may stop taking the survey at any time or skip any question you do not wish to answer. There are no direct benefits to this study. A potential risk could be to reveal possible inadequacies of social work graduate programs, agencies or supervisors. The survey will not ask you any identifying information. Your name, e-mail address, and IP address will not be connected to your results. Your participation in the study assumes your informed consent.

If you have any questions about this survey you may contact me at xxx-xxx-xxxx. You may also contact my research committee chair, Dr. Kari Fletcher at 651-962-5819, or the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

Thank you very much for you time and attention.

Sincerely,

Ashley Grahek

Appendix C: Resource List

RESOURCE LIST

A resource list for clinical social workers participating in the study "How Does Education and Experience Impact Therapist Self-Disclosure Among Clinical Social Workers?" Resource list includes resources targeting a wide variety of personal issues including self-awareness, support systems, and burnout.

Awareness of Self – A Critical Tool
Applications of Self-Awareness for All Levels of Clinical Practice
http://www.bu.edu/ssw/files/2010/10/Awareness-of-Self-A-Critical-Tool.pdf

Burnout Self Check
Tool to self-check for symptoms of burnout
www.thecallalily.com/f/BurnoutSelfTest.pdf

Online Network for Mental Health Professionals
Psychotherapists, social worker support group for those working in mental health field
http://www.linkedin.com/groups/Psychotherapists-social-worker-support-group-4314168

Professional Quality of Life Scale
Tool to self-test for compassion satisfaction and compassion fatigue
http://www.proqol.org/ProQol_Test.html

Social Workers Assistance Network
Professional consultation and referral to any social worker dealing with personal problems
http://www.naswma.org/displaycommon.cfm?an=1&subarticlenbr=50
Call 1-800-635-SWAN (7926)

Social Workers Helping Social Workers
A membership organization providing assistance to social workers by social workers
http://www.socialworkershelping.org/

Appendix D: Survey

How Does Education and Experience Impact Therapist Self-Disclosure Among Clinical Social Workers?

In order to participate in this study, you must: a. have a Master of Social Work Degree (M.S.W)b. be licensed through the state of Minnesota as a Licensed Independent Clinical Social Worker (L.I.C.S.W.)Do you agree that you meet criteria for both of these items?

- ❍ Yes
- ❍ No

By checking the box below that says "I Agree", you are indicating that you have read about the study and have had the opportunity to ask questions about the study, your participation and your rights, and that you agree to participate.

- ❍ I Agree
- ❍ I Disagree

Professional and Practice Background

I have a Bachelor's degree in Social Work.

- ❍ Yes
- ❍ No

I have a Master's degree in Social Work.

- ❍ Yes
- ❍ No

Please select which of the following best describes your current level of licensure.

- ❍ LGSW
- ❍ LICSW
- ❍ LISW
- ❍ Other (please specify) _____

I have been practicing as a licensed clinical social worker for _____ years.

- ❍ 0-5
- ❍ 6-10
- ❍ 11-15
- ❍ 16-20
- ❍ 21+

My clinical practice encompasses the following areas:

	Yes	No
Psychotherapy (Brief focus)	❍	❍
Psychotherapy (Ongoing focus)	❍	❍
Group Work	❍	❍
Supervision/Education	❍	❍
Macro Practice (work with communities or larger systems, planning/development)	❍	❍
Case Management	❍	❍
Other (please specify)	❍	❍

I currently practice in the following settings:

	Yes	No
University or Affiliated Research Institute	❍	❍
Government/Public Organization	❍	❍
Independent Private Practice	❍	❍
Consultant/Supervisor	❍	❍
Non-profit Agency (Private)	❍	❍
Non-profit Agency (Public)	❍	❍
Religious/Faith Affiliated Institute	❍	❍
Hospital/Clinic	❍	❍
Home Visits	❍	❍
Other (please specify)	❍	❍

I provide support for the following populations:

	Yes	No
Individual	❍	❍
Couples	❍	❍
Families	❍	❍
Groups	❍	❍
Caregivers	❍	❍

I work with clients in the following age groups:

	Yes	No
Young Children (0-5)	❍	❍
Children (6-12)	❍	❍
Adolescents (13-18)	❍	❍
Adults (19-65)	❍	❍
Older Adults (65+)	❍	❍

I work with clients who identify with being part of the following group/s:

	Yes	No
GLBT community	❍	❍
Substance Use Disorders	❍	❍
Incarcerated	❍	❍
Abuse survivor	❍	❍
Under commitment (court ordered/on probation)	❍	❍
Homeless	❍	❍
Hospitalized (outpatient or inpatient)	❍	❍
Major mental illness	❍	❍
Racial minorities	❍	❍
Military-connected service member, veteran, or family member of service member	❍	❍

Definition of Self-Disclosure

The following questions ask about how you use and think about self-disclosure in your practice. Please note that all references to self-disclosure in this survey are referring to clinical social worker's use of self-disclosure.

Knox and Hill define self-disclosure as: "an interaction in which the therapist reveals personal information about him/herself, and/or reveals reactions and responses to the client as they arise in the session" (1997, p. 275).

How strongly do you agree or disagree with this definition?

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

Please indicate, using your own words, how you might expand, modify, or correct inaccuracies in this definition:

- ❍ Expand (please explain) _____
- ❍ Modify (please explain) _____
- ❍ Correct inaccuracies (please explain) _____
- ❍ This definition fits with my definition.

Use of Self-Disclosure in Social Work Practice

Please indicate how strongly you agree or disagree with the following statements.

I use self-disclosure as a therapeutic tool in my clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

I consider self-disclosure to be an important therapeutic tool in my clinical practice

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

I follow strict guidelines that direct my use of self-disclosure.

- ❍ Strongly Disagree (please explain) _____
- ❍ Disagree (please explain) _____
- ❍ Neither Agree nor Disagree (please explain) _____
- ❍ Agree (please explain) _____
- ❍ Strongly Agree (please explain) _____

I have found self-disclosure to be useful in regards to specific populations, diagnosis, or situations.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

Comfort Using Self-Disclosure

Please indicate how strongly you agree or disagree with the following statements.

Overall, I am comfortable with my current use of self-disclosure in my clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

The following have contributed to my current comfort with self-disclosure.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Social work education	❍	❍	❍	❍	❍
Licensure	❍	❍	❍	❍	❍
Theory/Research	❍	❍	❍	❍	❍
Agency trainings	❍	❍	❍	❍	❍
Supervision	❍	❍	❍	❍	❍
Practice	❍	❍	❍	❍	❍
Working with specific populations	❍	❍	❍	❍	❍

The following theoretical backgrounds have influenced my comfort using self-disclosure in my clinical practice.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Psychodynamic Theory	❍	❍	❍	❍	❍
Cognitive/behavioral Theory	❍	❍	❍	❍	❍
Humanist/existentialist Theory	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

My degree of comfort with self-disclosure has changed over time.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

To be more comfortable using self-disclosure I would need more:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Education	❍	❍	❍	❍	❍
Training	❍	❍	❍	❍	❍
Supervision	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

Competence Using Self-Disclosure

Please indicate how strongly you agree or disagree with the following statements.

Overall, I am competent in my current use of self-disclosure in my clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

The following have contributed to my current competence with self-disclosure.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Social work education	❍	❍	❍	❍	❍
Licensure	❍	❍	❍	❍	❍
Theory/Research	❍	❍	❍	❍	❍
Agency trainings	❍	❍	❍	❍	❍
Supervision	❍	❍	❍	❍	❍
Practice	❍	❍	❍	❍	❍
Working with specific populations	❍	❍	❍	❍	❍

The following theoretical backgrounds have influenced my competence using self-disclosure in my clinical practice:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Psychodynamic Theory	❍	❍	❍	❍	❍
Cognitive/behavioral Theory	❍	❍	❍	❍	❍
Humanist/existentialist Theory	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

My degree of competence has changed over time.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

To be more competent using self-disclosure I would need more:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Education	❍	❍	❍	❍	❍
Training	❍	❍	❍	❍	❍
Supervision	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

Addressing Use of Self-Disclosure in Education and Licensure

I believe my graduate schooling fully prepared me to make informed decisions about the use of self-disclosure in my clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

Overall, I believe social work education could be strengthened or expanded to address use of self-disclosure in clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

I would like to see education strengthened or expanded to address use of self-disclosure in clinical practice in the following way (please specify).

Overall, I believe social work licensing could be strengthened or expanded to address use of self-disclosure in clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

I would like to see licensing strengthened or expanded to address use of self-disclosure in clinical practice in the following way (please specify).

Addressing Use of Self-Disclosure in Training

Overall, I believe social work training could be strengthened or expanded to address use of self-disclosure in clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

I would like more training in the area of:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Information regarding definitions and types of self-disclosure	❍	❍	❍	❍	❍
Theory or research as it relates to therapist use of self-disclosure	❍	❍	❍	❍	❍
Guidelines of when to use self-disclosure	❍	❍	❍	❍	❍
How to gauge the effectiveness of my use of self-disclosure	❍	❍	❍	❍	❍
How to develop my self-awareness as it relates to my use of self-disclosure	❍	❍	❍	❍	❍
Other (please specify)	❍	❍	❍	❍	❍

Addressing Use of Self-Disclosure in Supervision

I have discussed therapist use of self-disclosure in clinical practice in supervision.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

Overall, I believe social work supervision could be strengthened or expanded to address use of self-disclosure in clinical practice.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree

I would like to see supervision strengthened or expanded to address use of self-disclosure in clinical practice in the following way (please specify).