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Brittany A. Hollingsworth
The Effects of Therapist Self-
Disclosure on the Therapeutic
Alliance: A Relational Perspective

ABSTRACT

This exploratory/descriptive quantitative/qualitative study surveyed clinicians to ask their views about the effects of voluntary self-disclosure by therapists when the issue to be disclosed is one the therapist shares with the client. Clinicians surveyed were 51 licensed clinical social workers, or those with at least a year of postgraduate experience and working towards licensure. Opinions about this topic were often mixed. A majority of the clinicians who participated in the study said they rarely disclosed, but 72% had disclosed an issue shared by a client at least once; when they did so, 94% said their disclosures concerned issues that had been resolved for them. Many respondents said the effects of such disclosing on the therapeutic alliance would depend on several factors, and could only be foreseen on a case-by-case basis, but 86.5% said that foreseeing client benefit was the reason for disclosure. Clinicians were fairly evenly split as to how well or not well their graduate educations prepared them to handle issues of self-disclosure. These findings suggest that therapist self-disclosure may be so nuanced and difficult to generalize about in graduate coursework that it might best be handled in supervision. Future research could benefit from focusing also on clients' opinions about the effects of such therapist disclosures.

**THE EFFECTS OF THERAPIST SELF-DISCLOSURE ON THE THERAPEUTIC
ALLIANCE: A RELATIONAL PERSPECTIVE**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

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CHAPTER I

Introduction

In my first year internship for my master's program, I worked with a young girl for approximately two weeks. I will use the pseudonym, Rosa, hereafter when referring to her. Early on in meeting with Rosa she brought up a similar experience that I had encountered. A couple of sessions went by and I felt that we were developing rapport. I decided to disclose that I too had been through the same situation. The next session Rosa prematurely terminated therapy. I was devastated when she did not want to continue meeting with me, but I was also puzzled. I had done extensive reading in relational theory, and thought that relating based on a similar experience would prove effective in my work with Rosa. When it came time to develop this thesis I already had an idea in mind; I wanted to examine the issue of voluntary therapist self-disclosure and its effects on the therapeutic alliance from a relational perspective.

The purpose of this study was to explore the effects of self-disclosure on the therapeutic alliance. The research question that was addressed is: "What are the effects of voluntary therapist self-disclosure on the therapeutic alliance when it concerns analogous personal experience to that of the therapist's clients?"

Previous research had examined self-disclosure of various kinds, but the situation in which a therapist's personal issues closely match those of the client presented a particular challenge that had been under-researched. This circumstance is one fraught with potentially unhelpful countertransference over-identification and boundary issues; it is also one where the therapist who has thoroughly worked through a particular issue and "metabolized" it well might

have exceptional opportunities for empathic understanding and helpful guidance. It is this situation that can elicit new perspectives from my study that I hope will add to earlier research in this area. I was also interested in the extent to which participants experienced their graduate education as helpful in preparing them to deal with issues of self-disclosure.

Clinicians who participated in this study were asked to reflect on their own experiences with clients, which may have influenced them to be more cognizant of their decisions to use self-disclosure in future practice. This study presented multiple perspectives surrounding voluntary therapist self-disclosure and the findings highlight the various nuances of this issue in the field of Clinical Social Work. Some clinicians felt that self-disclosure is a valid therapeutic technique; others felt that it complicated the clinical process.

Many theories underlying this project focus on the therapeutic relationship and so it was impossible to specify one theoretical construct. However, from the perspective of relational theory, this technique has been found to affect the therapeutic relationship, and has the potential to significantly influence the process of change in psychotherapy.

Much of the literature in this area has focused on the inter-subjective qualities involved in the therapeutic alliance. I was able to review empirical research related to therapist self-disclosure used in individual therapy and the therapeutic alliance. Recently, there has been a great deal of literature in the area of neuroscience, specifically the field of interpersonal neurobiology. This material was relevant to understandings of the significance of affective communication, relationships, and this thesis study. Alan Schore (2010) and others have written extensively about the importance of right brain to right-brain communication in catalyzing therapeutic change and better understanding our patients. Few studies have looked at the emotion involved when discussing therapist self-disclosure in the clinical process of therapy.

The current study examines clinicians' opinions about actual shared experiences between therapist and client, wherein therapists self-disclose during therapeutic encounters; I feel that it is important to study such a potentially transforming intervention as therapist self-disclosure in order to thoroughly understand its effects on the therapeutic alliance (Quillman, 2011, Schore, 2010). This study asked about clinicians' perspectives on their past experiences working one-on-one with clients. Important issues that were addressed in the research question were the clinician's use of self in the clinical process with clients, the maintenance of professional boundaries, and how clinicians felt that their graduate education prepared them for handling self-disclosure in the clinical process.

CHAPTER II

Literature Review

This chapter provides a review of the literature that is applicable to my study of clinicians' perceptions of the effects of voluntary therapist self-disclosure on the therapeutic alliance when the disclosure concerns a personal issue similar to that of the client. My literature review will cover the evolution of the therapeutic alliance, relevant clinical social work theory with emphasis on a relational perspective, and empirical research related to self-disclosure and the therapeutic alliance. I will end with a short summary, which will demonstrate a gap in the literature that my study will attempt to fill.

The Freudian View of the Therapeutic Alliance

In 1913, the founder of psychoanalysis, Sigmund Freud, adopted the classical approach of the psychoanalyst, 'the blank-screen mentality.' "...like a mirror, reflect nothing but what is shown..." he said. Freud stressed the need for the therapists to remain neutral and never disclose. He considered the therapeutic alliance to be formed from transference from the patient to the therapist, believing that clients' own issues could be projected onto the therapist, which would most likely occur when the therapist disclosed nothing. As a result, the projection would clearly only be coming from the client. In the years since Freud, however, the field of psychotherapy has undergone significant transformations. Today, a large number of practicing therapists prescribe relational approaches, in which they use their own subjectivities to explore with clients in the clinical process.

The therapeutic relationship between the client and the clinician is complex, as it is intricately imbedded with the values, beliefs, expectations, attitudes, and experiences of both parties. Authors Bloomgarden and Mennuti (2009) believe therapist neutrality to be nearly impossible. In fact, many clinicians in the field of psychotherapy would state that therapists are always disclosing, as the therapist's personal appearance, nonverbal behavior, and other presenting characteristics offer much more than only a reflective mirror. Carew (2009) calls this non-disclosing style a form of "professional hypocrisy," as it suggests defensiveness and promotes inhibition. However, since the technique of self-disclosure retains an element of danger, in that it may serve as both a help and a hindrance to clients' progress, it remains outside of traditional analytic theory and practice.

A Relational View of the Therapeutic Alliance

Lynda Carew, psychologist at Cornell University (2009), defines therapist self-disclosure as "behaviors, either verbal or nonverbal, that reveal personal information about therapists themselves to their clients." Hill and Knox (2002) define self-disclosure as "therapist statements that reveal something personal about the therapist." Audet and Everall (2010) say the therapeutic alliance refers to the relationship between a helping professional and a client; it is the means by which the professional hopes to engage with and effect change in the client when the alliance engenders a bond between client and therapist. Sparks (2009) understands this dynamic through relational theory, believing that aspects of the therapist's identity should be expressed to create an authentic relationship.

As part of being human, we long for acceptance and have a natural drive toward relationships. Many advocates from a relational perspective believe that successful therapy is significantly influenced by the therapeutic relationship (Sparks, 2009; Audet and Everall, 2010).

Ackerman and Hilsenroth (2001) agree with this notion and stress the importance of the therapeutic alliance, defining it as, “the component of the therapeutic process encompassing the interaction between the patient and the therapist.” (p. 172)

According to Safran (2006) the therapeutic relationship is a fundamental part of the process of therapeutic change:

The idea that the alliance is negotiated between the therapist and patient on an ongoing basis highlights the fact that the alliance is not a static variable that is necessary for the therapeutic intervention to work but rather a constantly shifting, emergent property of the therapeutic relationship. Furthermore, we have argued that this ongoing process of negotiation between patient and therapist at both conscious and unconscious levels is an important change mechanism in and of itself, insofar as it helps patients learn to negotiate the needs of self and others in a constructive fashion, without compromising the self or treating the other as an object. This process of negotiation of needs in the therapeutic relationship thus plays an important role in helping patients to develop some capacity for inter-subjectivity (i.e., the capacity to experience both self and other as subjects) and to develop a true capacity for intimacy or authentic relatedness (Safran, 2006, p. 3).

Theoretical Frameworks of Therapist Self-Disclosure

It is impossible to specify a theoretical framework from which the issue of self-disclosure operates, but a number of theories are distinct in the rationale for therapists to disclose. For example, in humanistic therapy, therapist self-disclosure is expected, even desirable, as it is considered a means to achieve congruence and transparency with the client. Feminist therapy sees the value of timing and rationale of therapist self-disclosure to the therapeutic alliance between therapist and client (Hanson, 2005).

As human beings, we are defined by our relationships with others and the outside world, and they reflect back to us their value, meaning, and subjective nature. Karen Maroda (1999) discusses the inter-subjective context of the therapeutic relationship saying, “Without the use of self-disclosure we have no method for adequately exploring this deep and complicated relational pattern.” (p. 488). The technique of therapist self-disclosure has proven helpful in several empirical studies, but has remained outside the realm of accepted technique (Maroda, 1999).

Both Sterlin (2006), and Cooper and Levit (2005) understand self-disclosure as operating through the lens of relational theory. Thus, Cooper and Levit see self-disclosure from an object-relations perspective, while Sterlin (2006) perceives it as a therapist’s use of self in developing real and therapeutic attachments with clients. Sterlin believes this use [of self] encourages authenticity, thereby strengthening the alliance. Goldstein, Miehl, and Ringel (2009) discuss qualities such as spontaneity, genuineness, and empathic attunement as central to strengthening the therapeutic alliance, qualities such as those used in therapist self-disclosure.

Research done by Jourard (1971) and by Truax and Carkhuff (1965) substantiate what Jourard called the “dyadic effect,” meaning this collaboration of human exchanges contributes to demystifying the therapist, and to the client’s not feeling objectified. Their findings established that therapist self-disclosure could help to establish rapport through enhancing the therapeutic relationship by building genuineness, empathy, and positive regard.

The relational perspective of this study examines therapist self-disclosure from an inter-subjective and interpersonal theoretical framework. As clinicians, we are constantly using our own experiences in an attempt to navigate the inner-worlds of our clients in order to “better” hear them. Current relational theorists emphasize the inter-subjective nature of treatment where clients explore the meaning of their lives. Striving to create a “collaborative” process where the

client and therapist work together, Goldstein et al. have found the qualities of genuineness, authenticity, and spontaneity to create an interpersonal bond that is beneficial to the therapeutic relationship and treatment (Goldstein et al., 2009).

Empirical Research Related to Self-Disclosure and the Therapeutic Alliance

Hill and Knox conducted an empirical review of the research literature in 2003 and reported positive effects of therapist self-disclosure. In 1993, Ramsdell and Ramsdell performed a correlational study, surveying 20 people currently in therapy, and concluded that clients tend to rate therapist self-disclosure as having a beneficial effect on therapy. Clara Hill at University of Maryland conducted an empirical review of the research literature and found the technique of therapist self-disclosure to be rare, but potentially the most powerful of interventions (Hill et al., 2003). In a 1997 study, Knox, Hess, Peterson, and Hill provide an example of therapist self-disclosure eliciting positive effects, “both immediate and distal.” Included in Hill et al.’s 2003 review, a study by Barrett and Berman (2001) found that clients who received self-disclosures in response to similar client disclosures tended to like their therapists more and reported less symptom distress post-treatment.

Audet and Everall (2010) conducted a qualitative research study to explore clients’ perceptions of therapist self-disclosure. Using a phenomenological approach, nine participants were interviewed at the University of Ottawa in the United Kingdom. The sample consisted of eight Caucasian students and one Hispanic student, five males and four females, ranging in age from 22 to 56 years. All participants had received therapy prior to the study. Emphasis was placed on non-immediate disclosure of personal information regarding the therapist’s personal life outside of therapy, such as the therapist’s life circumstances, past experiences, beliefs, values, and emotional struggles.

Audet and Everall concluded that disclosures concerning life outside of the clinical process were generally found to be contentious, as it creates a greater risk for overstepping boundaries in psychotherapy. Immediate disclosures focus on the present moment in the clinical process, and tend to be the more acceptable form of disclosure. Analysis of transcribed interviews found therapist disclosure to have “both facilitative and hindering effects” on the therapeutic relationship. Audet and Everall understand misapplication of therapist technique to negatively impact the therapeutic alliance; clients tended to feel less trusting of the therapist’s competence after inappropriate disclosure. Dr. Karen Maroda (1999) offers insights on immediate self-disclosure used in the “here-and-now” of therapy; these disclosures have the potential to aid emotional regulation, but can also derail the therapeutic process, as it takes attention away from the client and may introduce new material.

The impetus for focusing on a relational perspective of the effects of therapist self-disclosure for this study is derived from a large body of research that focuses on various measurements of the therapeutic alliance. The California Psychotherapy Alliance Scale (CALPAS), the Helping Alliance Questionnaire (HAQ), and the Working Alliance Inventory (WAI) are noted in a discussion of the studies below (Goldstein et al., 2009; Hartley & Strupp 1983; Sexton, Hembre, & Kvarme, 1996; Ackerman & Hilsenroth, 2001).

In most of the studies that were examined in this literature review, a strong therapeutic alliance contributes to positive change and treatment outcomes. In one study, however, a strong correlation between alliance and treatment outcome was not reported. Piper, Debane and deCarufel. (1991) found clients’ motivations were a determining factor as to whether the therapeutic alliance was an effective agent of change regarding treatment outcome. These authors concluded that clients with little motivation tended to have better outcomes with a

positive alliance, while emphasis on the alliance for clients with higher motivation produced poorer outcomes or showed no correlation (Ackerman et al., 2001; Goldstein et al., 2009).

In a single-case study, Rosenberger and Hayes (2002) examined how the alliance can be affected if the material discussed in the session touched on the therapist's own unresolved issues. Based on a few additional qualitative studies, when therapists were faced with therapeutic impasses, they tended to implement self-disclosure. Researchers found these techniques to be inauthentic, and failed to repair such ruptures, and possibly even made things worse (Castonguay, Constantino, & Grosse Holteforth, 2006).

Hartley and Strupp (1983) conducted a quantitative correlational study focused on therapeutic interventions that impact the alliance. A sample of twenty-eight outpatient participants worked with one of nine experienced therapists, using varied techniques, in individual therapy twice a week. The Vanderbilt Therapeutic Alliance Scale (VTAS) from the first, middle, and last five-minute segments of sessions allowed the researchers to conclude that therapists' intrusive behaviors negatively impacted the alliance. Intrusive behavior may represent therapists' imposing their own values in work with a client, fostering dependency, or making irrelevant comments or inappropriate interventions (Ackerman et al., 2001).

Sexton, et al. (1996) conducted an exploratory quantitative study examining thirty-two outpatients who were undergoing ten sessions of time-limited unstructured therapy with therapists of a psychodynamic training orientation. After ten sessions, the analysts used patients' ratings on the Working Alliance Inventory scale, as well as analysis from independent judges who rated emotional and verbal content from sessions. Analysis of the Working Alliance Inventory concluded that therapist uncertainty and tension in the middle phase of treatment indicated a decrease in the alliance. According to the literature I reviewed, voluntary therapist

self-disclosure is often an intervention that is chosen when there is an impasse in the clinical process, which is often characterized by therapist uncertainty (Audet et al., 2010, Ackerman et al., 2001).

In 1993, Eaton, Abeles, and Gutfreund conducted a study examining therapists' failure to structure the session and the use of superficial and destructive interventions. He linked this style to the development of a weak alliance. Coady and Marziali (1994) found a negative relationship between therapist self-disclosure and expressing behaviors, such as belittling or blaming the patient. Price and Jones (1998) conducted a quantitative study in which fifteen psychodynamic therapists provided therapy to thirty outpatients. Ratings from the Psychotherapy Process Q-Set (PQS) and the California Psychotherapy Alliance Scale (CALPAS) were used to analyze results. Price and Jones (1998) found the CALPAS total alliance score to negatively correlate to the PQS item, saying, "Therapists own emotional conflicts tended to [interfere with] the therapeutic relationship ($r = -.26, p < .05$)." (p. 33) (Ackerman & Hilsenroth, 2003).

Ackerman and Hilsenroth (2003) reported on a study conducted by Price and Jones (1998), in which they concluded that therapists who disclosed their own emotional conflicts in the therapeutic setting had significantly lower ratings on the alliance. This type of self-disclosure may breach therapeutic boundaries and result in a weaker alliance. "It is likely that patients who experience this will feel less connected, less understood, and less willing to commit to the therapeutic relationship." (p. 3)

Following review of the research literature, Ackerman and Hilsenroth (2001) concluded overall that a therapist's inappropriate use of strategies reduces opportunities for change in the patient. These ruptures are likely to occur in the therapeutic alliance when a patient experiences negative feelings from the therapist or the therapeutic process. "Failure to establish a treatment

frame, incorrect use of interpretation and self-disclosures has been found to interrupt the development or maintenance of a positive alliance.” (p. 176)

Audet and Everall (2010) conducted a qualitative study, attempting to broaden the understanding of therapist disclosure’s impact on the therapeutic relationship from the client’s perspective. It was difficult for Audet and Everall to attribute disclosures the client received to the quality of the relationship. They observed that therapist self-disclosure tended to bring “internal focus” for the client, influencing clients to tune into themselves—their feelings, cognitions, and behaviors. Disclosure was also found to sometimes increase the breadth and depth of topics discussed. One client who participated in the study said, “It made it easier for me to talkBroke down some barriers. Opened doors.” (p. 337)

Audet and Everall’s 2010 study found disclosures to be helpful and hindering to the therapeutic process. Themes of a positive nature included early connection with the therapist, therapist presence, and engagement in therapy. Disclosures were found to be positive simply by virtue of the disclosing behavior, rather than the content of the disclosure. Disclosure also encouraged some clients to take risks by sharing vulnerable information or reveal thoughts or feelings. Clients saw the therapist as more human and imperfect, which tended to work as an equalizer from clients’ perspectives in the therapeutic relationship. The narrative work of Michael White (1997) elaborated on his experiences with this theme, noting that self-disclosure promoted transparency within the therapeutic relationship. Therapists operating from the framework of *systemic thinking* also encouraged the use of personal stories (for an example see Carew, 2009).

On the negative side, Audet and Everall (2010) found that some clients felt burdened by their therapist’s disclosure and inhibited in their exploration of treatment issues. The clients

wanted to protect the therapist's feelings, or tended to feel overwhelmed by the disclosure. Often the disclosure strained the therapeutic relationship, as clients were forced to reposition themselves within the relationship; for example, some clients felt misunderstood, and incapable of helping to address the problems of the therapist. Audet and Everall (2010) noted that disclosures sometimes reveal significant differences in personal values, which may prove difficult for the client to accept, and might potentially generate feelings of disappointment, as well as a loss of faith in the therapist's effectiveness.

Given the complexity and variations between therapeutic relationships presented above, it is nearly impossible for one study to reflect fully the effects of self-disclosing behavior. The researchers reported that the lack of cultural representation in their study restricted their findings, since the phenomenon of disclosure is likely to vary culturally. It is important to note that Audet and Everall (2010) found that the American Psychological Association Division 29 Task Force deemed therapist disclosure, "a promising and probably effective contribution to the relationship." (p. 328)

Lynda Carew, a psychologist counselor specialist providing training in clinical practice at Cornell University, conducted a qualitative study in which twenty students were recruited from a University Master's program in Psychological Therapies. Participants attended one of four focus groups on therapist self-disclosure approaches: psychodynamic, cognitive behavioral, systemic, and person-centered. The sessions were thematically analyzed to draw conclusions about the effects of therapist self-disclosure. The first theme suggested there was a spectrum of willingness to disclose based on training and the theoretical framework of the clinicians. The second theme suggested that past or current psychodynamic training implied that therapist self-disclosure was not appropriate. All participants agreed that they disclosed for the benefit of the

client. Finally, similar to Bloomgarden and Mennuti (2009), Carew (2009) thought that total restriction of therapist self-disclosure was impossible.

Exploring another nuance of therapist self-disclosure, Heidi LaPorte, Jay Sweifach, and Norman Linzer (2010) conducted a qualitative study exploring the perceptions of front-line social workers about their use of therapist self-disclosure (TSD) following disaster when working with clients who have experienced a catastrophic event. Fourteen focus group interviews were held with respondents from Israel, Canada, and the United States. Using a convenience sample at fourteen field placement agencies in the area, 102 social workers participated in the study; eighty-two percent of the participants were female; more than half of participants self-identified as Jewish; eight-percent were African-American, nine-percent were Caucasian, and five-percent were Hispanic. The age of participants ranged from 26 to 67 years old and they were all students or graduates of master's level social work programs. LaPorte et al. (2010) established that there was an overall uncertainty about the helpfulness of therapist self-disclosure, and concluded the study recommending that someone in the field of psychotherapy conduct a quantitative study surveying social workers in various settings.

LaPorte et al. (2010) found a majority of the participants agreed that therapist self-disclosure of a shared catastrophic experience was helpful, but that a shared experience is not reason enough to disclose. LaPorte et al. explained that trauma does not evoke the same response for people; what is traumatic for one may not be for another. According to the researchers' discussion of this study, if a disclosure were implemented, and the clinician and the client had disparate worldviews, the clinician's disclosure may expose conflicting beliefs or something the client does not want to hear or discuss (LaPorte et al., 2010).

Two of the research studies I reviewed implemented quantitative research designs. Hanson (2005) used a relatively small sample size of eighteen people currently in therapy in two Canadian cities to examine the controversy of self-disclosure and nondisclosure. Fatzinger (1997) conducted a quantitative study of 60 undergraduate university students in a psychology class—30 African American students and 30 Caucasian students. Hanson (2005) coded responses as helpful or unhelpful with a cross-tabulation of the results. After 40-minute interviews, Fatzinger (1997) used the data analysis tool of MANOVA to analyze multiple variables, focusing on the effect of ethnicity on client perceptions of therapist self-disclosure on the alliance. From responses on the Counselor Rating Form (CRF), participants who identified as African American tended to rate therapist's expertness and session depth higher after disclosure than Caucasian participants (Fatzinger, 1997). However, both the Hanson and Fatzinger studies found disclosures more likely to be experienced as helpful with the greatest effect to be on strengthening the therapeutic alliance.

In contrast to Fatzinger's study, discussion of sample ethnicity was not included in Hanson's study. Tony Priest of the University of Leicester commented on Hanson's 2005 study: Essentially, Hanson has taken client statements as a direct window into the truth. If the client said the intervention was helpful, it is assumed that the intervention was helpful, and there is no more to be said about it. However, although clients are privileged observers of some aspects of their own lives, such as whether they felt trusting or untrusting to a particular therapist, they are not infallible any more than counselors are. Moreover, clients will in general have their own pre-existing theories of how people relate together, which may be drawn from 'folk psychology' or from other sources.

These will influence their interpretation of events and feelings, but again, cannot be taken as infallible. (p. 306)

Cooper of the University of Strathclyde in Glasgow, UK, suggested that the quality of the therapeutic relationship is one of the key factors in determining outcomes. Cooper (2005) conducted a qualitative study, in which eight clinicians were interviewed for descriptions of experiences of moments of relational depth with their clients. Five females and four males comprised the sample. Four additional practicing therapists were interviewed for a study concerning relational depth. Participants were informed that they would be asked about their experiences meeting clients at moments of relational depth, which was defined as:

[A] feeling of profound contact and engagement with an Other, in which one simultaneously experiences extremely high and consistent levels of empathy and acceptance toward the Other, and related to them [sic] in a highly transparent way. In this relationship, the Other is experienced as acknowledging one's empathy and acceptance – either implicitly or explicitly – and is experienced as fully congruent and real. (p._3_)

Audet and Everall (2010) reported a noteworthy comment from their study, “the client identified my disclosure as the single most beneficial moment in her 12-session therapy.” (p. 329) Beyond this anecdotal evidence, however, Audet et al. observed that clients tend to view disclosure more favorably than their disclosing therapist, even if the technique of therapist disclosure resonated with this particular client. Therapist self-disclosure can sometimes negatively affect clients and the therapeutic process, causing a disruption of boundaries, role confusion, and reversal. However, despite the reported hindrances in the process of psychotherapy, participants in Audet et al.'s 2010 study did not terminate therapy after such

disclosures. Cooper (2005) found relational depth to be one of the best predictors of therapeutic outcomes that would have major implications for the practice, training, and research of therapy. Cooper posits that one way of achieving relational depth is through open, genuine exploration of the inter-subjective worlds' of the client and therapist.

Barnett-Parker's 2008 thesis surveyed sixty-four participants using a mixed-method, deductive, exploratory design to look at how and why clinicians choose to disclose, with particular attention paid to race, sexual orientation and gender, or identity-based disclosures. Barnett-Parker reported that the majority of clinicians who participated believed self-disclosure to be a practical therapeutic technique, and while her thesis investigates identity-based issues around self-disclosure, my study has examined self-disclosure when the client and therapist share analogous personal experience. Monts' 2004 thesis focused on the experiences of the decisions of therapists to disclose or not in the treatment of clients with a similar issue to their own. This qualitative thesis is closest to mine in purpose, though with major differences in method and scope. Fourteen clinicians were interviewed at Monts' internship sites; half of the subjects reported using self-disclosure while the other half did not disclose (Barnett-Parker, 2008; Monts, 2004).

Mazzuchi's, Barnett-Parker's, and Monts' recent theses all note that this topic can usefully get more attention, given their small sample sizes and the fact that these researchers report frequent or semi-frequent use of self-disclosure, which contradicts Knox and Hill's (2003) research findings. Monts' 2004 thesis reported that theoretical orientation and clinicians' years of experience were more influential on the effects of disclosure than the relationship (Barnett-Parker, 2008; Monts, 2004; Mazzuchi, 2010).

Conclusion

The literature that was reviewed presents various theoretical frameworks and perspectives from which therapist self-disclosure operates. The literature revealed a gap in the clarity and the specificity of the phenomenon of voluntary therapist self-disclosure, as most studies do not specifically attend to therapist self-disclosure of analogous personal experience between the client and clinician, and whether the issues disclosed are resolved or unresolved for the therapist. The effects of therapists' disclosures of personal issues that were resolved rather than unresolved were not discussed. A study in this area would shed light on how the Carl Jung's concept of the Wounded Healer can be effectively applied to individual therapy. According to Jung, "It is his [the analyst's] own hurt that gives the measure of his power to heal" (Hayes, 2002, p. 10).

From the literature that I have reviewed, I understand that there is a correlation between the skill of clinicians' use of self-disclosure and the impact of the technique on the therapeutic alliance (Hanson, 2005). Authors Hanson (2005) and LaPorte, Sweifach, and Linzer (2010) stress the need for further research on the effects of skill on disclosure and non-disclosure, as it relates to the impact on the therapeutic alliance. Potentially contradictory information exists in the literature, such as the quantitative studies conducted by Browers (1997) and Fatzinger (1997). Both studies report empirical data that argue against the use of therapist self-disclosure, as evidenced by the adverse physiological responses from subjects.

A majority of the literature I reviewed also relied on qualitative studies from the perspective of the client; some quantitative studies were discussed, but they used complex measuring tools to quantify the client's perspective. This accented the need for a mixed-methods quantitative study design to explore both the objective and subjective perceptions of clinicians

from a cogent medium, like a survey (Browsers, 1997; Hanson, 2005; LaPorte, 2010; Fatzinger, 1997; Knox & Hill, 2003).

My study provides analyses of therapists' perceptions of the effects of voluntary self-disclosure on the therapeutic alliance when the nature of the disclosure concerns a personal issue similar to that of the client. I have attempted to provide clarity on the issue of voluntary therapist self-disclosure when it is used in therapy; my sample is much larger than the 14 involved in Monts's study, which perhaps was done prior to a time when internet availability allowed more sizeable samples to be accessed. Monts's qualitative method differed from the quantitative and partially qualitative one I used as well, and I believe mine offers a useful contrast to hers.

Lastly, although the populations of Licensed Clinical Social Workers (LCSW) and clients are both capable of error, I feel that clinicians may be in a better position than clients to speak on the topic of self-disclosure. The sample has been limited to Licensed Clinical Social Workers who have fulfilled educational and licensure requirements, which offered some potential depth to their perspectives. This study can be expected to have implications for social work practice, as it can help clinicians gain a better understanding of the effects of self-disclosure on the therapeutic alliance. In this study, I have been fortunate to gather rich, experienced and educated responses to convey that this relational world we live in today, whether we know it or not, influences the field of psychotherapy.

CHAPTER III

Methodology

Research Purpose and Question

The purpose of my study was to explore the effects of therapist self-disclosure on the therapeutic alliance. I investigated the following research question: What are the effects of voluntary therapist self-disclosure on the alliance between the client and the clinician when the disclosure concerns similar personal experience to that of the client?

Research Method and Design

For my study, I used an exploratory/descriptive research strategy to examine clinician's perceptions of the effects of voluntary self-disclosure on the therapeutic alliance when the disclosure concerned a personal issue similar to that of the client. Using a mixed-methods research design, I conducted my study through a survey that provided both quantitative and qualitative data. I chose this research design because I wanted both short-answer questions to provide objective responses and long-answer questions to provide open-ended, subjective responses. The literature I had reviewed on the topic of therapist self-disclosure was limited, as it was overwhelmingly filled with findings from qualitative studies. The quantitative studies I reviewed used complex measuring tools to collect the data. Both of these perspectives contributed to my decision to use a mixed-methods research design for the study. I felt that a combination of structured and unstructured questions would expand the study's findings as well

as enhance the internal validity of the data. The survey questions sought to gain rich, anecdotal evidence from the perspectives of knowledgeable clinicians about their experiences handling the issue of voluntary self-disclosure in individual therapy from a relational perspective. The survey that was used for this study can be found in Appendix C.

Regarding biases in the study, methodological bias was evidently possible, as some participants may not have felt comfortable taking an online survey. My interest in this area presented another bias, as the survey was designed based on the preliminary research I conducted and the research questions that I wanted to explore. I did attempt to negate bias by offering comment sections for participants to expand on their responses and the open-ended nature of some questions allowed the participants to choose how they shared their experiences, which also helped to negate bias. While the Comments sections beneath each question may have influenced clinicians to elaborate when they would not have otherwise, using only short-answer multiple choice questions may have elicited limited responses (Rubin & Babbie, 2010).

Sample

Based on a non-probability method, participants were recruited using a snowball sample through a small network of people I knew in the field of clinical social work who then solicited the interest of their colleagues about participating in my study; this comprised the study population. The sample universe was all Licensed Clinical Social Workers (LCSW). Sample selection was limited to Licensed Clinical Social Workers (LCSW) or those working toward licensure with one-year experience around my placement, Durham, NC. At least 50% of their work had to be individual therapy. Vulnerable populations were not included in the study. I wanted a sample size of at least 50 people and was able to exceed that goal, and included

characteristics of diversity based on demographics and background in my sample. I did not recruit for diversity, but rather, I sought to achieve diversity through my recruitment flyers, which were posted at Duke Medical Center, Durham Regional Hospital, a few local cafes, and at the School for Social Work at a historically black college in Durham, NC. The posters invited qualified clinicians to email me, requesting to participate in the study. I consciously posted the flyers at locations that I thought were frequented by people of diverse perspectives.

My study was very feasible, as several Licensed Clinical Social Workers were available through the network in which I recruited. The data that I collected were unable to achieve representation of all practicing licensed social work clinicians, or of all Master's of Social Work programs. The major limitations of this study were inherent, as all of the data were based on self-reported measures from clinicians. Omissions in the study of diverse ethnic perspectives were another natural consequence from the sample that informed my data (Rubin & Babbie, 2010).

Data Collection Methods

The survey was administered through an Internet survey provider. I assumed that all practicing clinicians were able to access the survey. For the purposes of this study, I used the words 'analogous,' 'similar' or 'shared' personal experiences interchangeably to mean when the client and the clinician had both experienced the same personal issue or experience; authors LaPorte, Sweifach, & Linzer (2010) define personal experience as past experiences of trauma, illness, death, disaster, and personal and familial relations, or childhood/life experience in general. As noted above, I recruited participants through a snowball sampling method by sending an email electronically containing my recruitment announcement to Licensed Clinical

Social Workers that I knew, asking that they inform other potential participants of my study via email.

There were no face-to-face interviews or personal contact for this study. The Director of Clinical Social Work Training at Duke University is a member of the American Association of Psychoanalysis in Clinical Social Work and forwarded the email to the listserv. My research advisor from Smith School of Social Work agreed to forward the email. In addition, a psychiatrist whom I knew who worked at the Durham VA Medical Center said that he would forward the survey electronically. I also recruited participants by posting flyers at local cafes and other public notice boards in Durham, NC. Participants who were recruited this way sent me an email to dotellclinicians@gmail.com, requesting to participate. A copy of the recruitment materials used can be found in Appendix B.

I provided a link in the email I sent out that directed participants to the Survey Monkey site where the survey was posted. The survey was the only method of data collection for this study. The Internet survey provider took participants through an informed consent before they continued to the survey questions. Following the survey, I asked the participants to respond to a few demographic questions so that I could accurately characterize the diversity of my sample. Participants were asked to provide their age and to choose from different options for their race and gender. This demographic data were relevant to my study because variables that may have affected my findings were identified.

The survey that I designed was relatively short with 22 questions, and written in simple English language. The survey should not have taken more than half an hour to complete. This may have encouraged more clinicians to respond, especially those who may have been constrained for time. The short-answer questions in the survey provided the quantitative data

and were structured, as the answers were provided in the questions, e.g., “ Do you disclose rarely, often, fairly often, or none of these?” The lengthy questions of the survey were unstructured and informed the qualitative data of my study, e.g., “How do you determine whether you disclose?” Responses to these questions were recorded in the Internet survey program, Survey Monkey.

The quantitative data were analyzed by coding the short-answer questions through a multiple-choice question format, which were then illustrated with graphs so that readers could better visualize the data. For the qualitative data analyses, responses to the open-ended questions were first grouped into separate themes as results were collected in Survey Monkey. I then synthesized these groupings and discussed thematic trends in clinicians’ attitudes toward this phenomenon. In the findings chapter, I selected quotes from the Comments section below the survey questions. These selections were based on common themes across the sample; other responses were selected because they either presented a unique perspective or a thought-provoking statement about the effects of therapist self-disclosure on the therapeutic alliance (Rubin & Babbie, 2010).

Data Analysis

The general strategy I used for analyzing the data was accomplished through grouping similar responses to the survey questions based on theme. I thematically coded the content that was offered in the Comments sections beneath the survey questions to analyze the open-ended questions. The Internet survey program, Survey Monkey, tabulated the frequencies and graphed the responses to the short-answer questions. The findings for some short-answer questions were illustrated using a bar chart; others were displayed with a pie chart.

For the quantitative data, I sent the spreadsheet of all the data collected to the analyst at Smith College School for Social Work to run frequencies for all variables and descriptive statistics for ratio level variables; in the case of this study the only ratio level variable was the identified age of participants. Parametric statistics were used to analyze relationships between answers participants gave and their demographic characteristics. The results of these analyses are presented in **Chapter IV: Findings**.

CHAPTER IV

Findings

The purpose of this study was to explore the effects of self-disclosure on the therapeutic alliance. The research question addressed was: “What are the effects of voluntary therapist self-disclosure on the therapeutic alliance when it concerns analogous personal experience to that of the therapist’s clients?”

Using an exploratory/descriptive research design through a mixed-methods study, I investigated therapists’ perceptions of the impact of voluntary therapist self-disclosure on the therapeutic alliance. The major findings from this study presented multiple perspectives. Frequencies are provided for the objective items and verbatim quotes from the long-answer items and the comments boxes are also provided. The survey consisted of 20 items: 12 multiple-choice items, five subjective items, and three items concerning demographic data of the participants. The implications of this study are presented in the **Discussion** chapter that follows.

The first item of the survey said, “In your opinion, attitudes toward therapists’ disclosing information about themselves and their own issues are accepting or positive.” Respondents were given the following answer choices: strongly disagree, disagree, neutral/ unsure, agree, and strongly agree. A comments box was available under the answer choices for participants to elaborate if they wanted to do so. This item elicited various responses, but most respondents tended to disagree (42.9%) or state that they were neutral/unsure (38.8%) about attitudes toward therapists’ disclosing information about themselves. A small percentage of the sample chose

agree (12.2%) and about half as many respondents chose strongly disagree (6.1%). Two participants or 3.9% of the sample did not respond to this item.

Many participants said that the wording of the item was unclear. Six out of eighteen responses in the comment box said they did not understand whose attitudes were being referred to in the item e.g., “whose attitudes? society’s? clients’? other therapists’?” Other responses said their attitude toward disclosure was dependent on the content and circumstances: “Each situation is unique... and depends on the reason for the disclosure.” One response specified disclosure “...only to clarify a transference/counter-transference issue for the client’s benefit.”

The next item of the survey examined the rationale for disclosure, stating “One important issue in therapists’ decisions to self-disclose is whether the therapist’s disclosure is beneficial to the client when the disclosure occurs in therapy.” As in the previous item, options for responses asked participants to choose the measure to which they agreed with the statement from the following options: strongly disagree, disagree, neutral/unsure, agree, or strongly agree.

An overwhelming majority of my sample strongly agreed (62.7%) or agreed (23.5%) that an important issue in clinicians’ decisions to self-disclose was whether the disclosure was beneficial to the client at the time. Two percent of responses were neutral/unsure and 11.8% strongly disagreed. All participants responded to this item. The comments made regarding this item gave credence to the importance of the issue of client benefit.

That’s the only time to self-disclose ... I can’t think of any other reason to self-disclose, other than it be beneficial to the client.” Another participant brought forth a unique response, saying that it’s pretty hard to know ahead of time what will be ‘beneficial.’

Item three on the survey was, “A therapist who has dealt well with an issue similar to a client’s own may be in a better position to offer help than one who has never experienced a similar issue.” Options for responses again asked participants to choose the measure to which they agreed with the statement from the following options: strongly disagree, disagree, neutral/unsure, agree, or strongly agree. All participants answered this item.

About one half of the responses for this item, 47.1%, answered that they were neutral/unsure. There were 31.4% of the participants who agreed with the statement, 17.6% disagreed, and 3.9% strongly agreed.

An overwhelming majority of comments indicated that the therapists’ having experienced a similar issue might lead to increased capacity for empathy and would aid the therapist’s ability to work with the client. A majority of responses suggested that for some clients it could help; for others it could be an “impediment.” Many of the comments said it would depend on the situation; others referred to the idea of similar issues still being “charged” for the therapist and questioned their capacity to listen with an unbiased ear.

Ideally, it seems that from a relational perspective, the therapist is always working through his/her own “issues” in tandem with clients – but this requires a good deal of insight, personal psychotherapy, and at times good supervision to ensure boundaries aren’t being crossed.

Not necessarily. At times yes. But other times, a therapist could project onto the client’s experiences their own feelings or experiences in a way that inhibits really hearing the client’s struggle.

The fourth item of the survey asked participants to indicate the degree to which they agreed with the following statement: “A client is likely to perceive a therapist’s disclosure about an issue of her/his own which is similar to that of the client as a violation of professional boundaries.” Respondents were once more given the following answer choices: strongly disagree, disagree, neutral/ unsure, agree, and strongly agree.

Responses to this item were fairly evenly split between three answer choices: disagree, neutral/unsure, and agree. Most participants strongly disagreed, disagreed, or said they were neutral/unsure, a combined 79.2% of responses. The other respondents (20.8%) agreed that the client was likely to perceive a therapist’s disclosure of analogous personal issue to be a violation of professional boundaries. None of the participants skipped this item.

Similar to the previous ones, many responses said that many factors would influence whether they or their clients understood a disclosure to be a violation of boundaries. The type of therapeutic situation, the skill of the clinician, the client’s perspective, the therapeutic relationship, timing, and delivery of the disclosure were among those factors. Some participants thought that if the issue were thoughtfully approached and the reason for sharing were discussed and explored, the disclosure was likely not to be perceived as a violation. One respondent noted that self-disclosure of personal experience is “...not the only way to be authentic” in the clinical process.

The fifth item of the survey asked participants the measure of their agreement or disagreement with the following statement: “Disclosure by a therapist about his/her own personal issue similar to that of the client is likely to lead to more openness and increased disclosure from the client.” Respondents were given the following answer choices: strongly

disagree, disagree, neutral/ unsure, agree, and strongly agree. One participant's response (2%) was missing.

Responses to this item were nearly evenly split among three of the answer choices: disagree, neutral/unsure, and agree. Most participants strongly disagreed, disagreed, or said they were neutral/unsure, a combined 82% of responses. Only 18% answered that they agreed, and no one said they strongly agreed.

The disclosure of information about a therapist's personal life may create a false feeling of connection and jeopardize the neutrality of the therapeutic relationship. An addicted therapist, who has already identified as having significant sobriety for example, need not disclose details of her addiction and recovery to her patient. That [sic] can be found at any 12-step meeting. Empathy, knowledge, hope, and understanding within the relationship are the therapeutic essentials, not disclosing information.

This could happen, but the opposite could also be true... if the therapist reveals some detail about her/himself, the client may now perceive them as 'fragile' or 'broken' and not want to disclose further helpful information because they need to 'protect' the therapist.

Item six asked the question: "In your present work do you disclose never, rarely, fairly often, or quite often?" A majority of the sample answered that they rarely disclosed, 82%. The remaining participants answered that they disclosed fairly often, 18%. All participants responded to this item.

Item seven of the survey was completely open-ended, asking participants how they determined whether they disclose to a client in therapy. Many responses (49) were recorded and a few of those are listed separately below. Two participants skipped the item. Many of the responses said that there were obvious disclosures at an appearance level; the presence of a wedding ring on the clinician, their office décor, and accent are such disclosures. Other clinicians felt that some items, about training, expertise, and sometimes even religion, were part of the patient's criteria for finding a therapist who feels like an "appropriate" match. These clinicians said that they tended to offer answers to these items in the first session. Many participants said that they first thought about their urge to disclose and considered the effects of such a disclosure would have on the client and the therapeutic alliance. Most of the responses for item seven said they would only disclose if they were sure it would benefit the client, but that ultimately would depend on the client and be situational. Appropriate timing of the disclosure was mentioned as a significant variable in many responses.

I have to have a 'good reason' to self-disclose; that it will truly 'help' the client in some way or that I THINK it will and have considered it in depth and consulted with my peer supervisor; that they are in a stage of therapy that [sic] breaking the 'idealization' bubble would actually further the therapeutic process.

For my work with younger children, disclosure of 'when I was small...' can create a bridge for the child into his/her own experience and its validity, as well as a vocabulary for speaking, experiencing, and relating. For the parents, I am more circumspect, but if it helps normalize an experience or emotion, I can often share the feeling without sharing

the details. For adults or adolescents in their own individual treatment, I'd be less inclined.

I believe a solid working alliance should be established, and a thoughtful understanding of the client's needs and relational patterns reached before disclosing to avoid the above-mentioned possible intrusiveness. For example, if a client has had a narcissistic parent whose needs have usurped the client's needs, I would be less likely to self-disclose - not wanting to re-create a relationship in therapy that could cause such a client to feel invisible or unimportant. In contrast, a client who struggles to feel a sense of connection or who has an intense need to feel that the therapist is a 'real person' may need more self-disclosure in order to establish a strong alliance.

Almost only ever [sic] within the transference-counter-transference, as opposed to some historical autobiographical data, which I hardly ever share. With more regressed, paranoid, or concrete patients, I may.

If it is necessary for the treatment to evolve or if the treatment is at a standstill.

If the thing I am disclosing is not a 'charged' issue for me. In other words, it has to be something that is not a tender spot for me, or something I feel that need to guard myself in general. I don't share that stuff because it would shift me away from being able to focus on the client experience. I also consider how the information would make the client feel; will it provide insight, perspective, or support to the client to hear a detail about my life or a perspective or experience from my life?

Survey item eight asked participants to indicate their frequency of choice to disclose. There were 41 people who answered the item, some of which are recorded below. Ten people skipped the item. Other clinicians' responses said that the population they were working with would determine the frequency of their choice to disclose.

I disclose benign things (i.e. 'I don't like black coffee, I have to have cream in it') to humanize myself, to connect on a human level. I am careful about disclosing more personal things, only if I think it is to benefit the client.

Disclosure is NOT personal but more humanistic – in other words my self-disclosure was something common in the population and not completely specific to me (i.e.- 'when I was in grad school, during finals, I had a lot of stress and anxiety trying to meet all of the deadlines so yes, I have been through periods of pressure and worry before'). Also, the issue must be resolved—not current.

It is rare. I have disclosed a familiarity with someone's cultural background b/c my mother lives in the country where the client grew up. I mostly will disclose things in terms of how they help establish rapport (more living in the south than I ever would elsewhere!) but I don't discuss 'I felt that way' or 'I've struggled with this.' There is a therapy scene in the old movie *An Unmarried Woman* where she is in therapy and the therapist discloses that she herself felt lonely after her divorce. It was an attempt at empathy (and it was in a different era!) but I sort of cringed. From my perspective, the client seemed – as most will – to wonder 'why are you telling me this?' I think it is better

to frame things in terms of ‘people often feel/respond/experience...’ in a general way or globalized way than to ever say – Yeah, I really hurt when my heart is broken. Another thing I do is talk about the future – ‘You won’t always feel this way’ or ‘You will look back and feel differently,’ etc... Now these answers, of course, are for emotional life experiences. There are the other many areas of potential self-disclosure that may differ. I often encounter older therapists that will disclose more. In a small town, disclosure might happen more inadvertently. Physically there is much that is disclosed in office appearance, obvious physical disability, accent, vehicle... in these cases a more direct line of iteming may arise organically from the client. I typically will answer in a way that still meets my criteria above, the item of how will what I say be helpful to the client. This will vary.

I’m more likely to disclose in supportive therapy than in insight-oriented therapy.

I believe a solid working alliance should be established, and a thoughtful understanding of the client’s needs. I would be less likely to self-disclose -- not wanting to recreate a relationship in therapy that could cause such a client to feel invisible or unimportant. In contrast, a client who struggles to feel a sense of connection or who has an intense need to feel that the therapist is a ‘real person’ may need more self-disclosure in order to establish a strong alliance.

Item nine of the survey asked participants if they had ever disclosed a personal issue similar to a client’s. Fifty people answered the item; only one person skipped it. A large

majority of the sample answered that they had disclosed a personal analogous issue, 72%, leaving 28% of the sample who answered they had not disclosed a personal issue similar to a client's.

My frequency is contingent upon client population and experience; my clients have a similar life experience (e.g., military environment), therefore some self-disclosure is automatic when they see awards and decorations. I am also more of a CBT clinician and do not attempt to foster transference reaction.

The infrequency of my self-disclosure is based on my training and 35 years experience as a therapist and that has taught me to develop and protect the therapeutic relationship as the most valuable asset in the process of healing, change, and growth. It is a unique experience where the transference is protected by a significant degree of neutrality. It is a two-person relationship where I am neither blank nor detached and where being fully present, connected and empathic does not require the disclosure of personal information.

I find that the clients with whom I work are keenly aware of the socioeconomic differences between us and self-disclose regarding how I have navigated a similar situation could present a rupture in that the client may experience as suggesting that the variables are the same and they too could navigate their situation in a similar way when, in reality, I have a wider support network and privileges that my clients often do not have.

Psychotherapy is about relationships – relationships are about intimacy – people come into therapy because of difficulty in relationships – it makes no sense to me to have a distant relationship with a client and I think that many of the attitudes of opaqueness in psychoanalytic circles has just as much to do about character of therapists who are drawn to psychoanalysis (potentially more private and distant) than it does about the actual theory of the usefulness of the blank slate.

I am very relational in my approach to therapy, and so sometimes presenting a shared human journey – kind of processing with the client, is helpful. I am very conscious of when I self-disclose, and more significantly of what I choose to disclose.

Item 10 on the survey asked participants if they had disclosed to a client about a personal issue, was that issue resolved for them, or unresolved, at the time of disclosure. An overwhelming majority of participants said that their disclosure was resolved for them at the time of disclosure, 94.4%; only 5.6% of those who answered said that the issue was unresolved at the time. However, only thirty-six participants answered the question while 15 people skipped it – a large omission in comparison to previous items.

Several participants said that they didn't think they would ever disclose an unresolved personal issue, that it's "usually not a good idea" and "unfair to the client." Some responses specified their answer for the population they provide therapy.

I might disclose to teen clients about similar emotional concerns or conflicts during teenage years ... [or] adjusting to life after deployment ... I work at a college counseling

center. At times I disclose something having to do with my miserable first year in college, because I think it can be very encouraging to a student to know that I went through something similar.

I'm not sure I believe things are resolved, as much as better understood.

Survey item 11 read, "Discussing the concept of 'the wounded healer,' psychologist Carl Jung said, 'a good half of every treatment that probes at all deeply consists in the doctor's examining himself... it is his own hurt that gives a measure of his power to heal.' Please note how much you agree with Jung's opinion. Respondents were given the following answer choices: strongly disagree, disagree, neutral/ unsure, agree, and strongly agree. An overwhelming majority of respondents agreed with Jung's statement, 52%; 40% strongly agreed; 6% of the sample was neutral/unsure, and 2% disagreed. Fifty people answered the item and one person skipped it. Seventeen participants left a comment in the space provided. Some of the comments were in complete agreement with Jung's statement; others were hesitant to make a connection between this quote and the topic of therapist self-disclosure.

Absolutely! I believe ongoing self-evaluation is essential if we are to be of service to our clients. We are all wounded -- we either examine that and use it for healing, or we hurt others out of our unrecognized wounds.

I agree with this quote so long as the doctor's examining himself is done outside the sessions with the patient.

In this way – self-examination arises naturally in the process of listening, in the space that forms between client and therapist—the transference, countertransference.

Item 12 asked, “If you answered yes to item 9 please discuss any impact, whether positive or negative, that you feel the disclosure had on the therapeutic alliance or the client’s progress in therapy.” Thirty-three participants answered the item. Eighteen people did not. All responses said the disclosure had a positive impact on the alliance with the exception of one participant who said “not applicable.” Many responses suggested that the impact of the disclosure helped to normalize the client’s struggles, allowing clients to see therapists as “human, capable of error.”

Varies. I think with clients who have been in graduate school, sometimes psycho-education or empathy from someone who’s been through the process can be useful. However, not everyone has had experiences like mine—and many are vastly different from mine. Some students I’ve worked with have actively expressed relief at knowing I “get” something – and others have seemed avoidant of knowing about some of my own personal experiences (seeming to need to ‘create’ me in the transference, and suspend my ‘real’ life outside therapy).

Item 13 asked, “Why do you think your disclosure had an impact, whether positive or negative, on the therapeutic alliance or the client’s progress in therapy?” Thirty people responded; 21 people skipped the item. Typical responses indicated that the normalizing of the situation through disclosure helped the client feel more at ease.

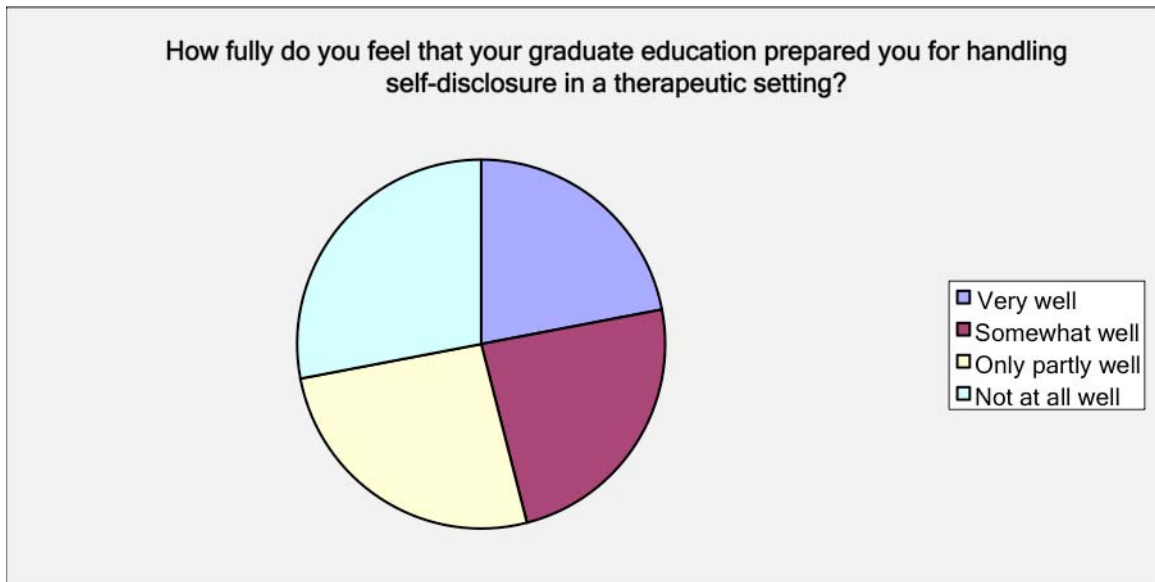
Because we ARE bigger to our clients and there is a lot of unconscious material that does play out in this ‘power’ dynamic. We are not just a friend sitting across from someone, but a trained professional, and with that comes hopes, fears, and expectations.

Because the client was able to feel more comfortable, more trusting in talking with me. She was able to play more into the transference, allowing herself to share more about her history. She was able to see that I was not judging her and took her issue seriously. I think it overall empowered her to be able to discuss her incontinence with no shame. I think it empowered her to be able to discuss her sexual abuse.

Item 14 on the survey asked, “Have you ever presented an experience of your own as someone else’s while providing therapy to a client – perhaps in order to avoid self-disclosure while still offering the perspective to the client?” A majority of the responses answered “yes” (64%), while 34% said “no.” 50 people responded to this item; only one person did not.

Item 15 asked “How fully do you feel your graduate education prepared you for handling self-disclosure in a therapeutic setting?” This item provided the following options: very well, somewhat well, only partly well, not at all well. This item elicited very interesting responses with a fairly even split among the options: 22% of participants answered very well; 24% said partly well; 26% said only partly well, and 28% answered not at all well. See Figure 1 for a graphic representation of these responses.

Figure 1
Graduate Preparation of Respondents (survey item 15)



Number 16 of the survey asked, “Have your views changed about self-disclosure since graduation?” The following answer options were provided: very much, somewhat, very little, not at all. Fifty-four percent of the sample said that their views of self-disclosure had changed somewhat; 22% said that their views had changed very little, and 22% answered that their views had changed very much. Two percent of participants said that their views had not changed at all.

Item 17 asked, “If you answered that your views about therapist self-disclosure have changed, would you elaborate as to why you think they have changed?” Forty-one participants answered the item and ten participants skipped. Many responses hinted at a ‘gut’ feeling after years of experience, training, and supervision. Others strongly endorsed a ‘neutral’ position of the clinician. Finally, some of the responses referenced clinical practice as a whole.

I graduated 30 years ago and since then have trained as a psychoanalyst. I have done a great deal of study and supervision related to this issue. I think that neutrality and abstinence are ideals that are not possible to attain, our own personality and theoretical

biases heavily color the treatment. But I feel it is useful to try to keep one's own material from entering the room in a sloppy or thoughtless way. And when disclosure has occurred intentionally or by third party, one must carefully discuss the impact on and meaning to the patient.

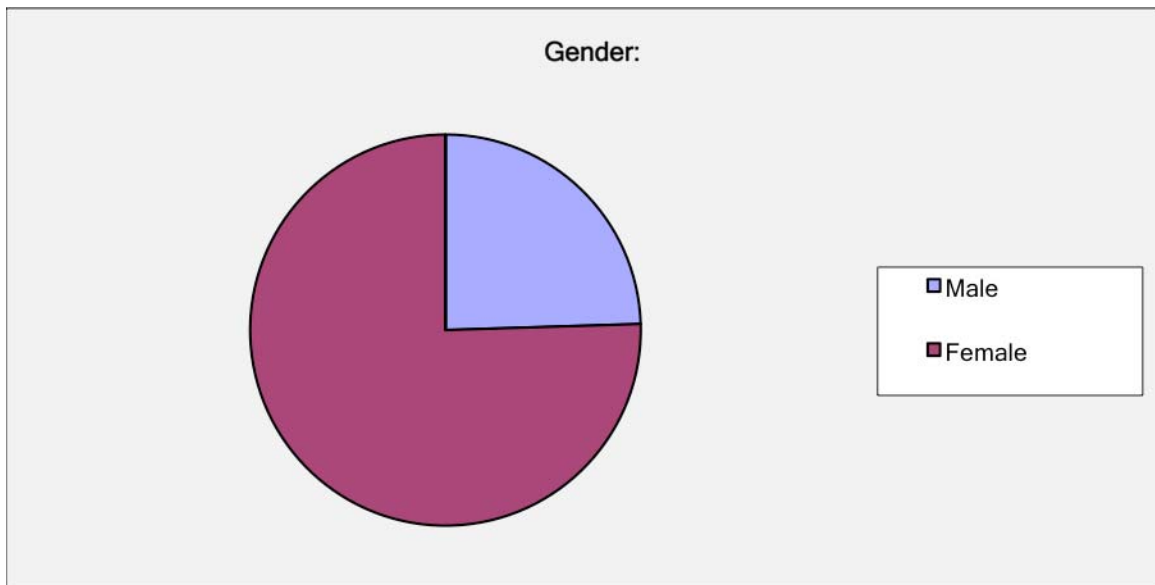
Feedback from clients has been positive when I have (briefly) disclosed. I work mainly with trauma, and clients often have a lot of shame associated with the trauma. Therapist disclosure in these situations helps diminish the shame aspect.

I think that it is simply the growth curve as a therapist – lots of things change as you grow and develop your clinical skills and as you grow and change in your life.

Clinical practice is very nuanced and it is difficult to capture that in training.

With item 18, the survey began to ask participants about their personal demographics. Number 18 asked about the identified gender of participants, giving the options of male, female, transgender, or other (please specify). Forty-nine people answered this item; two people did not respond. Of those who answered, 75.5% identified as female, 24.5% as male. See Figure 2 for a pie chart representation of participants' identified gender.

Figure 2
Identified Gender of Participants



The data analyst at Smith ran a number of statistical tests in order to determine if there was a relationship between participants' demographics (items 18, 19, & 20) and participants' responses to survey items. Looking at whether there was a difference in the mean response to each of the attitude/belief questions by gender, the analyst ran T-tests to determine if there was a difference in the mean response to each question by gender. Some of the questions were also combined into a scale (described below). On items one, three, four, five, six, 11, 15, and 16 there was no significant difference in any of these questions by gender. Tests run on item two indicated a significant difference by gender ($t(47)=-2.299$, $p=.026$, two-tailed). Males had a lower mean ($m=3.5$) than females ($m=4.46$) suggesting males had less agreement with the importance of whether self-disclosure is beneficial in deciding to self disclose. Item 11 presented a significant difference by gender ($t(25.45)=-2.801$, $p=.010$, two-tailed). Males had a lower mean ($m=3.92$) than females ($m=4.444$) suggesting males had less agreement with the Jung quote. Items nine and 10 were looked at differently because the responses to

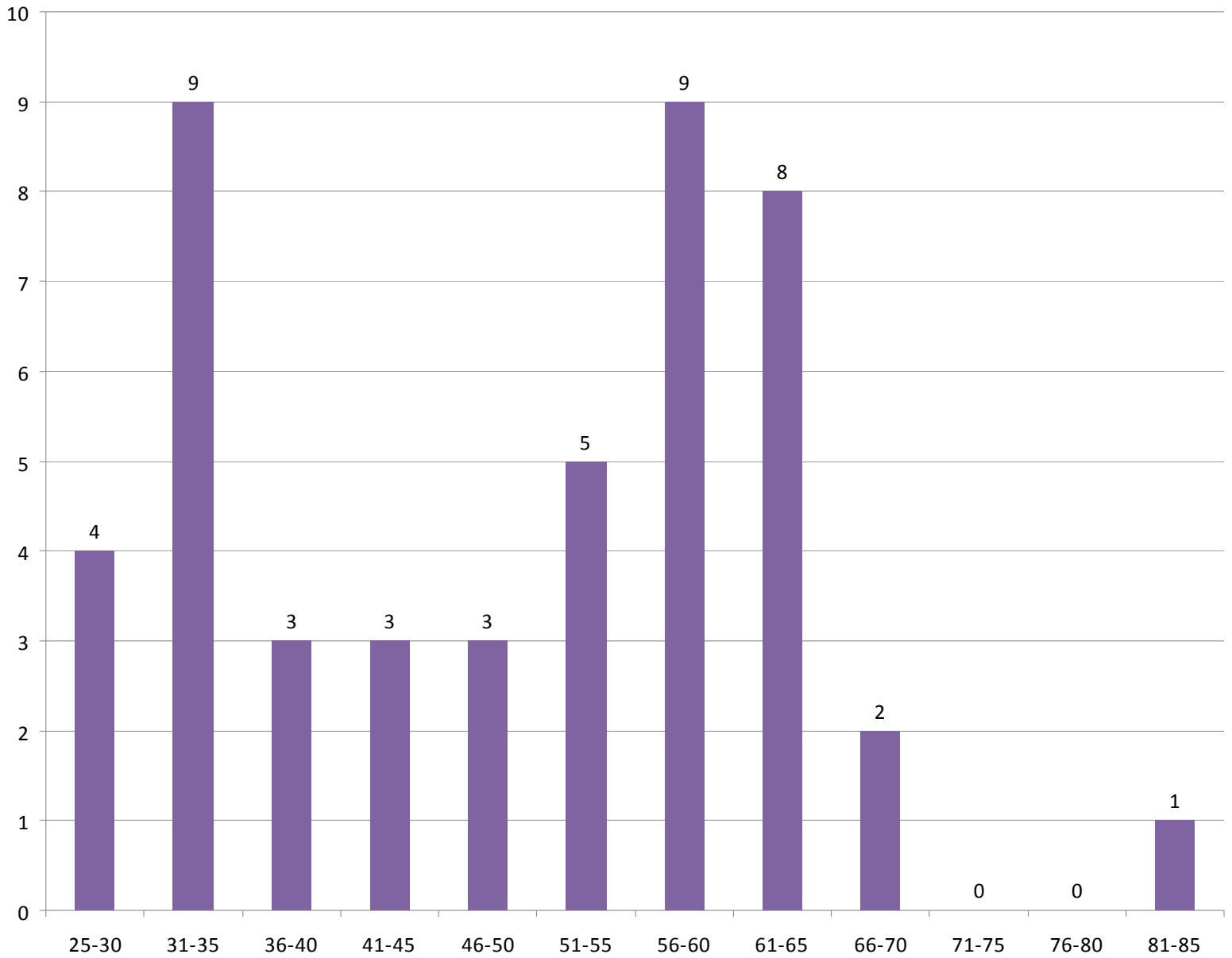
those questions were YES/NO rather than Likert scales. For both questions, the analyst tried to run a chi square analysis to see if there was a difference in either question by gender. Chi square could not be used because more than 20% of cells had expected value less than five, which violates an assumption for using chi square. The crosstab indicates how the frequencies breakdown by gender. Item 10 had three categories (resolved/unresolved/neither). Since only two people indicated unresolved to this item and no one answered neither, the analyst could not use this variable in an analysis.

The analyst also created a scale out of the following questions: q1, q3, q4 (reversed), q5. These questions all had the same response categories and seemed to be measuring the same thing. Question four was worded in the opposite way from the others (more agreement indicated a more negative attitude) so she reverse scored this question. The analyst then ran Cronbachs alpha, which is a test of internal reliability (how well a group of questions "fit together"). (Alphas range from 0 to 1 with higher scores indicating greater internal reliability. Any score above 0.6 is considered acceptable.) The alpha for this group of questions was .63. The analyst created the scale by taking a mean of the four questions, and then ran a t-test to determine if there was a difference in this scale by gender. No significant difference was found.

Item 19 asked participants to fill in their age. 48 people answered this item and three people (5.9%) omitted it. The Smith college data analyst ran statistical tests to determine the minimum value, maximum value, and the mean age of the participants, as well as the standard deviation. The minimum age of participants was 27 years; the maximum age was 84 years. The mean for the sample was 49.416, and the standard deviation was 14.019. See Figure 3 for a representation of the distribution in age of participants.

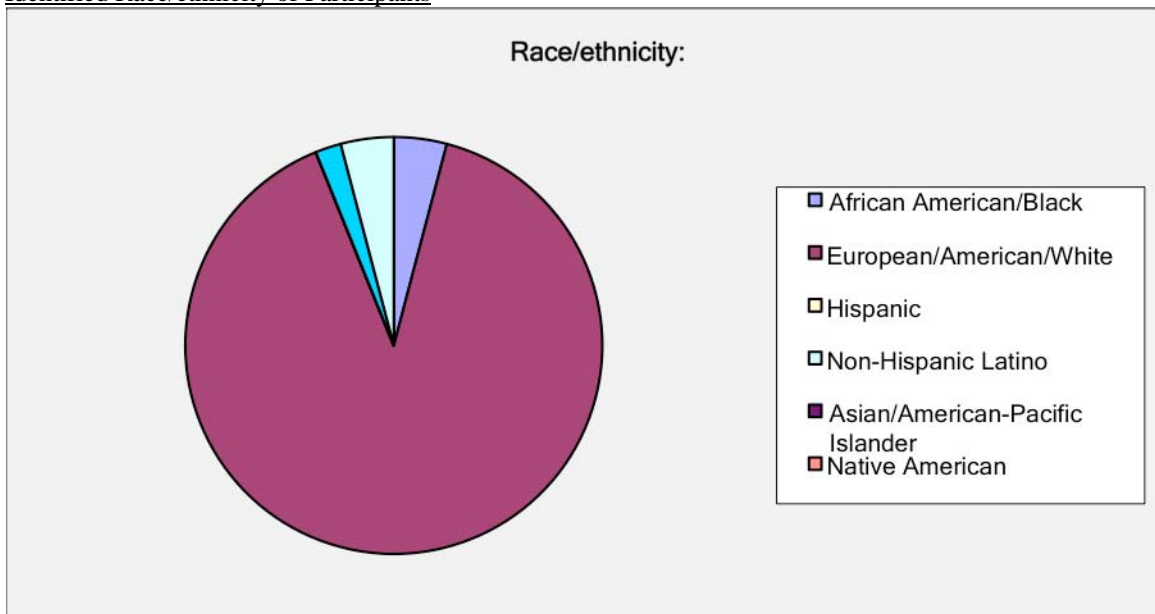
Figure 3: Identified Age of Participants

Age of Participants



Item 20 of the survey asked participants to choose their identified race/ethnicity from the following options: African American/Black, Hispanic, Asian/American-Pacific Islander, Indian, Bi-/Multi-Racial, European/American/White, Non-Hispanic Latino, Native American, Alaskan, and Other (please specify). Forty-nine people answered this item and two people omitted it. An overwhelming majority of my sample, 89.8%, identified as European/American/White. 4.1% identified as Africa American/Black, leaving 2% who identified as Bi-/Multi-Racial and 4.1% who identified as Other, Bi-cultural Hispanic and Anglo-Semitic. Figure 4 presents the ethnicity of the respondent sample graphically.

Figure 4
Identified Race/ethnicity of Participants



Regarding the race/ethnicity of participants: no tests of significance were run due to the small numbers that did not identify as European/American/White. The analyst also ran Spearman rho correlations for the age of respondents to see if there was a relationship between age and items 1,2,3,4,5,6,11,15 and 16. There was a significant positive correlation between item 15 and age ($\rho=.333$, $p=.021$, two-tailed). A positive correlation suggested that as age

went up, so did how well these participants reported thinking their education prepared them for handling self-disclosure. This correlation was in the weak range and there were no significant correlations between the age of participants and any of the other questions. The analyst also ran a t-test to see if there was a difference in the mean age based on whether they said YES versus NO on questions nine and 10. No significant difference was found.

Through an exploratory/descriptive research design, I captured therapists' perceptions of the effects of voluntary therapist self-disclosure on the therapeutic alliance with an Internet survey (Rubin & Babbie, 2010). The wording to some of the short-answer survey questions was problematic, as several respondents indicated that the answer options that were provided were limiting. These participants tended to say "neither" in the comments for a few of the questions, which omitted some of the data. The strengths of my methodology were evident in the data tool collector, Survey Monkey; an Internet survey is accessible to most clinicians and can be taken when convenient. The requirements to participate in the survey with regard to education and experience in individual therapy represented another strength, as it strengthens the potential value of my sample's opinions.

The sample that informed the data for my study was adequate, as the size was 51 participants. The Smith data analyst was then able to use parametric statistics, which are more powerful and require an N of 50; the findings from these analyses are discussed below. According to the informed consent procedures that respondents were offered prior to completing the survey, all of the respondents fulfilled requirements to participate. While the sample was adequate in terms of size, I had hoped to attract a more racially/ethnically diverse sample of respondents through my recruitment materials and the locations at which the flyers were posted. The sample was nearly all European/American/White race/ethnicity. In the society of the United

States, however, the field of psychotherapy is mostly comprised of this race/ethnicity, so that this study's respondents may not be unrepresentative of the overall clinical population.

CHAPTER V

Discussion

When the findings were collected and the analysis was complete, I thought about my work with the client I have called Rosa. At every stage of this study I realized that my views about therapist self-disclosure seemed to change, and I knew why. Findings from this study indicate that the effects of therapist self-disclosure on the therapeutic alliance depend on a number of factors, and cannot be generalized to all those involved in the clinical process. My experience with Rosa in which I had disclosed a similar personal issue to hers had negatively affected the therapeutic alliance between us. My disclosure had taken away from the meaning of the experience to her. It blurred the boundaries of our proscribed roles as clinician and client. Rosa had not asked about my life. Having the capacity to relate to clients is essential in the clinical process, but self-disclosure is not the only way to accomplish authenticity, and I fully understand this now.

The purpose of this study again was to explore the effects of self-disclosure on the therapeutic alliance. The research question that was addressed is: “What are the effects of voluntary therapist self-disclosure on the therapeutic alliance when it concerns analogous personal experience to that of the therapist’s clients?” This chapter will discuss implications of the key findings from the study, show the connection or lack thereof between findings and the literature, and state the implications for clinical social work practice. Lastly, I will provide suggestions for future research done in this area.

Through an exploratory/descriptive research design, I captured therapists' perceptions of the effects of voluntary therapist self-disclosure on the therapeutic alliance with an Internet survey (Rubin & Babbie, 2010). The wording to some of the short-answer survey questions was problematic, as several respondents indicated that the answer options that were provided were limiting. These participants tended to say "neither" in the comments for a few of the questions, which omitted some of the data. The strengths of my methodology were evident in the data tool collector, Survey Monkey; an Internet survey is accessible to most clinicians and can be taken when convenient. The requirements to participate in the survey with regard to education and experience in individual therapy represented another strength, as it strengthens the potential value of my sample's opinions.

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Results of the study were both consistent and inconsistent with the empirical research that I reviewed prior to eliciting the perspective of clinicians. Several of the studies focused on the perspective of clients. After a review of the literature, I was able to form a few hypotheses

before the data collection phase. First, I assumed that therapists would only disclose personal experiences similar to clients' if it was beneficial for them to hear; this component of therapist self-disclosure was consistent with the literature. Based on participants' responses, however, the impact/value of therapist self-disclosure of a shared experience played less a role in strengthening the therapeutic alliance than I had previously thought. Although this idea was one I had certainly experienced in my work with Rosa, and was at times referenced in the literature, I still thought that a shared experience could at times be important to convey to a client. Finally, I did not expect such an even split across the answer choices for the item fifteen concerning the preparation clinicians felt from their graduate education to handle self-disclosure in the therapeutic setting. Please see Figure 1 for a chart illustrating the responses for this item.

Several items on the survey were inconsistent. First, participants' responses to the survey items presented such a multitude of perspectives that I was not able to make any generalizations. For example, on the first item of the survey 21 respondents indicated that they disagreed, while 19 respondents were neutral/unsure; two participants (4% of the sample) did not respond. The next item indicated more conclusive findings; this item asked participants the measure to which they agreed or disagreed that an important issue of disclosure is whether it is beneficial to the client. Sixty-three percent strongly agreed and 24% agreed (a total of 87%), but even here two percent indicated that they were neutral/unsure. Twelve percent of respondents strongly disagreed. Item three of the survey asked participants if clinicians were in a better position to help a client if they had experienced a similar issue; forty-seven percent indicated that they were neutral/unsure, 31% agreed, 18% disagreed, and 4% strongly disagreed. All of the participants responded to this item. Most of the comments for this item referred to greater empathy being communicated through such a disclosure, positively influencing the therapeutic alliance.

Item six of the survey indicated that most of the respondents rarely disclose. Item nine asked participants if they had ever disclosed a personal issue that was similar to a client's; seventy-two percent said that they had, while 28% said that had not disclosed one. I realize that one disclosure in a career as a clinical social worker is rare, but the tremendous majority (72%) that had disclosed a personal issue similar to a clients' validates that it does happen. Item 14 asked respondents if they had ever presented an experience as someone else's while providing therapy to a client, perhaps in order to avoid self-disclosure while offering the perspective. Sixty-six percent of participants indicated that they had presented such an experience in this way. This suggests that therapist self-disclosure may sometimes work as a valid technique for some clients to more authentically normalize their experience.

The next item asked participants how they felt that their graduate education had prepared them for handling self-disclosure in the therapeutic setting. Results were nearly equally divided among answer options very well, somewhat well, only party well, and not at all well. Please see Figure 1 for a chart representation of the responses for item 15. The answer options somewhat well and only party well are nearly the same; in retrospect I would delete the "somewhat" from that option, leaving it as "well" to set it apart from other options.

Items on the survey that were omitted as well as those that were responded might have influenced the data that was collected. The items toward the end of the survey were more often omitted than items at the beginning of the survey, which suggests that the survey took too much time. If the survey were shorter or with less subjective items the findings would possibly be more conclusive.

Overall, the implications for practice are difficult to capture since the data presented multiple perspectives. One respondent on the survey said that clinical practice is very nuanced

and is difficult to capture in graduate education. Covering this issue during post-graduate clinical supervision may be the most effective way to get at this issue.

For future research done in this area I would suggest a closer examination of the issue of therapist self-disclosure again from the perspectives of clinicians but also of clients. A mixed-method research design would enable participants to complete a survey; afterwards participants could then be interviewed in person. Asking participants their rationale for the items they did not answer, as well as items they did respond to, would offer another angle from which to study therapist self-disclosure, and could illuminate ways in which survey questions could be further improved. Face-to-face interviews could also offer the depth and immediacy of a more intimate dialogue. Finally, examining the impact on the clients of such disclosures has been under-researched and would greatly enhance the field of clinical social work.

The work of Sydney Jourard offers an intriguing perspective related to therapist self-disclosure that I reviewed in the literature; however, Jourard was not mentioned in any of the responses. Jourard's research found a "dyadic effect" whereby increased disclosure from clinicians did lead to greater openness from their clients. Not one participant in this survey seemed aware of Jourard's work, and it is possible that further research to determine whether his results are replicable would highlight the influences of the clients' and clinicians' subjectivities on one another.

Finally, it is noteworthy to mention that several respondents in this study indicated that disclosures of some kind are inevitable -- e.g., office décor, clothing, the clinician's facial expressions, as well as how each operates in the clinical process. As human beings, we are always disclosing things about ourselves through our subjectivities and relationships with one another whether by intent and design or inadvertently. The overarching implication from the

respondents to this survey seems to be that therapist self-disclosure of a personal issue can have both positive and negative effects on the therapeutic alliance; that those effects in the end may depend on a myriad of factors; and clinicians currently will often disagree about the advisability of voluntary self-disclosure.

References

- Ackerman, S J., & Hilsenroth, M.J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance; A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Clinical Psychology Review*. 1(33).
- Audet, C. T., & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance & Counseling*. 38(3), 327-342.
- Barnett-Parker, Sarah (2008). *Enough about you, let's talk about me: Clinicians' use of self-disclosure and (un)conscious awareness of race, sexuality, and gender*. (Masters thesis). Retrieved from Smith College School for Social Work Dissertations and Theses Database.
- Bloomgarden, A., & Mennuti, R. B. (2009). Therapist self-disclosure: Beyond the taboo. In A. Bloomgarden, R. B. Mennuti, A. Bloomgarden, R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 3-15). New York, NY US: Routledge/Taylor & Francis Group. Retrieved from EBSCOhost.
- Castonguay, L.G., Constantino, M.J., & Grosse Holteforth, M. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice Training*. 43, 271-279.
- Cooper, S. H., & Levit, D. (2005). Old and new objects in Fairbairnian and American relational theory (1998). In L. Aron, A. Harris, L. Aron, A. Harris (Eds.), *Relational psychoanalysis: Innovation and expansion*. 2, 51-74. Mahwah, NJ US: Analytic Press. Retrieved from EBSCOhost.

- Fatzinger, T. (1997). Effects of therapist self-disclosure on client perceptions of the therapeutic alliance and session impact. *Dissertation Abstracts International*, 58. Retrieved from EBSCOhost.
- Ginot, E. (2009). The empathic power of enactments: The link between neuropsychological processes and an expanded definition of empathy. *Psychoanalytic Psychology*, 26(3), 290-309.
- Goldstein, E., Miehls, D. & Ringel, S. (2009). *Advanced clinical social work practice: Relational principles and techniques*. New York: Columbia University Press.
- Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counseling & Psychotherapy Research*, 5(2), 96-104.
- Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, 59(5), 529-539.
- LaPorte, H., Sweifach, J., & Linzer, N. (2010). Sharing the trauma: Guidelines for therapist self-disclosure following a catastrophic event. *Best Practices in Mental Health: An International Journal*, 6(2), 39-56. Retrieved from EBSCOhost.
- Mazzuchi, Allyson L. (2010). *Therapist self-disclosure: A current look at therapists' attitudes and practices* (Masters thesis). Retrieved from Smith College School for Social Work Dissertations and Theses Database.
- Monts, Erica R. (2004). *Should therapists who have experienced their client's issue self disclose* (Masters thesis). Retrieved from Smith College School for Social Work Dissertations and Theses Database.
- Fosha, D., Seigel, D.J., Solomon, M.F. (2009). *The Healing Power of Emotion: Affective Neuroscience, Development & Clinical Practice*. W.W. Norton & Company: NY, NY.

Schore, A. N. (2009). Right-brain affect regulation: An essential mechanism of development, trauma, dissociation, and psychotherapy. In D. Fosha, D. J. Siegel, M. F. Solomon, & (Eds.), *The healing power of emotion: Affective neuroscience, development & clinical practice* (pp. 112-144). New York, NY.

Siegel, D.J. (2008). The neurobiology of “we”: How relationships, the mind, and the brain interact to shape who we are. Sounds True, Inc.: New York, NY.

Sparks, E. (2009). Learning to be authentic with clients: The untold journey of a relational practitioner. In A. Bloomgarden, R. B. Mennuti, A. Bloomgarden, R. B. Mennuti (Eds.) *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 163-179). New York, NY: Routledge/Taylor & Francis Group. Retrieved from EBSCOhost.

Sterlin, R. A. (2006). Where relational theory and attachment theory intersect: A real relationship and a real attachment. *Clinical Social Work Journal*. 34(2), 161-174.

Quillman, T. (2011). Neuroscience and therapist self-disclosure: Deepening the right brain to right brain communication between therapist and patient. *Clinical Social Work Journal*. 40(1), 1-9.



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January 4, 2012

Brittany Hollingsworth

Dear Brittany,

Your changes meet the requirements of the Human Subjects Review Committee. Thank you for your diligence and attention to detail. You have a neat project and I wish you the very best as you move forward!

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Happy New Year!

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B Recruitment Materials

DO TELL...

Did your graduate education prepare you to deal with the issue of self-disclosure in the clinical process?

If you are a Licensed Clinical Social Worker, or are working towards licensure (with one year of experience practicing individual therapy), I would like to hear from you. Participation will entail taking a brief survey to share your perspective on therapist self-disclosure.

My name is Brittany Hollingsworth and I am a Master of Social Work student at Smith College School for Social Work conducting quantitative research for the MSW thesis and presentation summer '12. The purpose of this study is to explore the effects of self-disclosure on the therapeutic alliance when it concerns analogous personal experience.

There will be no monetary compensation for participating in this study, but benefits will include broadening your understanding of therapist self-disclosure used voluntarily in therapy.

Clicking anywhere on this email will take you to an informed consent prior to administering the survey.

Thank you for sharing,

Brittany

Appendix C Informed Consent

Dear Prospective Participant,

As you know from my flyer or email announcement, my name is Brittany Hollingsworth. I am in my second year of graduate school at Smith College School for Social Work, conducting a research survey about therapist self-disclosure. This consent form is to let you know more about the purposes of my study, what your participation would involve if you decide to complete my survey, as well as how I plan to protect your rights as a participant. I want to know your views about the effects of voluntary therapist self-disclosure on the therapeutic alliance when it concerns a therapist's personal issue, which is similar to that of a client. I am also interested in whether you felt your graduate education prepared you for dealing with self-disclosure issues. The data I gather from the survey will be used for the thesis report and potentially future publications of the findings.

If you are:

- a Licensed Clinical Social Worker (LCSW) or MSW clinician working towards licensure,
- with at least one year of experience practicing individual therapy,
- and are comfortable completing an English language survey over the internet, you are eligible for my study.

To participate in this survey, you will click on the link below to begin sharing your personal beliefs and experiences with self-disclosure. I will also ask for general demographic information about you and other participants so that I can accurately describe my respondents.

Completing the survey should take no more than 30 minutes. Responding to some of the questions may cause emotional discomfort, and this is a possible risk of involvement in this study. However, you will not be provided a list of referral sources for dealing with these feelings since, as a mental health professional, you are aware of them. You may find participating in this study to be satisfying, in exploring your own feelings and reflecting on past experiences surrounding therapist self-disclosure. I am not able to provide financial compensation for your participation, but I hope you will be rewarded by contributing to knowledge about a topic of some importance to clinical practice and education.

Your responses to the short answer survey questions will be anonymous: the Internet survey service removes all identifying data about the participants before I receive the surveys. If you inadvertently provide potentially identifying information about yourself or a client in the comment boxes, I will carefully disguise that information in any illustrative quotes I offer in the thesis report or any future publications.

My research advisor will be the only person who might have access to the comments before the data are disguised, but the advisor is ethically bound to keep any identifying information confidential. All of the data will be kept in a secure location for a period of three years as required by Federal guidelines; data will be stored electronically, password protected and destroyed when no longer needed.

Participation in this study is entirely voluntary. You may withdraw from the study at any time until you submit the survey by simply exiting without submitting. You may also refuse to answer any single question without withdrawing from the survey as a whole. Once your survey is submitted, your answers cannot be removed, since there will be no way for me to identify your responses as yours. Incomplete surveys will indicate that you do not wish to participate and will not be collected. Should you have any concerns about your rights or any aspect of this study, I encourage you to email me, Brittany Hollingsworth at bhollin@smith.edu or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____ I AGREE.

Thank you for your willingness to participate. I encourage you to print a copy of this Informed Consent for your own records.

Appendix D Survey:

Voluntary Therapist Self-Disclosure to Clients When Therapist's and Client's Issues are Similar

Some therapists are taught about the importance of remaining "opaque" to clients so that a transference neurosis could emerge and clients' projections of their own issues onto their therapists could take place.

Please rate the degree to which you agree or disagree with the statements about voluntary self-disclosure by therapists. The spaces for "Comments" invite you to expand upon your responses if you wish.

*Q*₁ "In your opinion, attitudes toward therapists' disclosing information about themselves and their own issues are accepting or positive"

1 ___ Strongly disagree 2 ___ Disagree
3 ___ Neutral/unsure 4 ___ Agree 5 ___ Strongly agree

Comments: _____

*Q*₂ "One important issue in therapists' decisions to self-disclose is whether the therapist's disclosure is beneficial to the client when the disclosure occurs in therapy"

1 ___ Strongly disagree 2 ___ Disagree
3 ___ Neutral/unsure 4 ___ Agree 5 ___ Strongly Agree

Comments: _____

*Q*₃ "A therapist who has dealt well with an issue similar to a client's own may be in a better position to offer help than one who has never experienced a similar issue"

1 ___ Strongly disagree 2 ___ Disagree
3 ___ Neutral/unsure 4 ___ Agree 5 ___ Strongly agree

Comments: _____

*Q*₄ "A client is likely to perceive a therapist's disclosure about an issue of his/her own which is similar to that of the client as a violation of professional boundaries"

1 ___ Strongly disagree 2 ___ Disagree
3 ___ Neutral/unsure 4 ___ Agree 5 ___ Strongly agree

Comments: _____

*Q*₅ "Disclosure by a therapist about an issue of her/his own personal issue similar to that of the client is likely to lead to more openness and increased disclosure from the client"

1 ___ Strongly disagree 2 ___ Disagree

3 ___ Neutral/unsure 4 ___ Agree Strongly agree

Comments: _____

*Q*₆ In your present work do you disclose never, rarely, fairly often, or quite often?

Never ___ Rarely ___

Fairly often ___ Quite often ___

*Q*₇ How do you determine whether you disclose?

*Q*₈ Please explain the frequency of the choice to disclose.

*Q*₉ Have you ever disclosed a personal issue similar to a client's?

Yes ___ No ___

*Q*₁₀ If you have disclosed to a client about a personal issue, was that issue resolved for you, unresolved, or neither, at the time of disclosure?

If you chose "neither" please specify. If a specification does not apply for you, only choose "neither."

Resolved ___ Unresolved ___

Neither ___ -- please specify: _____

Q₁₁ Discussing the concept of 'the wounded healer,' founder of analytical psychology Carl Jung said, 'a good half of every treatment that probes at all deeply consists in the doctor's examining himself...it is his own hurt that gives a measure of his power to heal.' Please note how much you agree with Jung's opinion:

1___ Strongly disagree 2___ Disagree
3___ Neutral/unsure 4___ Agree 5___ Strongly agree

Comments: _____

Q₁₂ If you answered yes to Q₉ please discuss any impact, whether positive or negative, that you feel your disclosure had on the therapeutic alliance or clients progress in therapy.

Q₁₃ Why do you think your disclosure had an impact, whether positive or negative, on the therapeutic alliance or the client's progress in therapy?

Q₁₄ Have you ever presented an experience of your own as someone else's while providing therapy to a client – perhaps in order to avoid self-disclosure while still offering the perspective to the client?

Yes___ No___

Q₁₅ How fully do you feel that your graduate education on therapy prepared you for handling self-disclosure in a therapeutic setting?

1___ Not at all well 2___ Only partly well

3___ Fairly well 4___ Very well

Q₁₆ Have your views changed about self-disclosure since graduation?

1___ Not at all 2___ Very little

3___ Somewhat 4___ Quite a bit

Q₁₇ If you answered that your views about therapist self-disclosure have changed, would you elaborate as to why you think they have changed?

Comments: _____

If you are willing, please respond to the following questions so that I can accurately characterize the diversity of my sample. This is a way to measure that the data of my study is from multiple perspectives.

Gender (Male)___ (Female)___ (Transgender)___ (Other –please specify) _____

Age _____

Race/ethnicity: AfricanAmerican/Black___ European/American/White___ Hispanic___ Non-

Hispanic Latino___ Asian/ American-Pacific Islander___ Native American ___ Indian ___ Alaskan

___ Bi-/Multi-Racial___

Thank you most sincerely for your participation in my study. An Abstract of findings of this study will be available from the Smith College library resources by mid-July 2012.