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HollyAnne Joyner Giffin  
Client's Experiences and Perceptions of the  
Therapist's Use of Swear Words and the  
Resulting Impact on the Therapeutic  
Alliance in the Context of the Therapeutic  
Relationship

Abstract

This thesis explores how clients perceive therapist swearing in the context of a therapeutic relationship. This was done via an exploratory, mixed methods research study. Individuals whose therapists had used swear words during their individual therapy were surveyed about their own personal swearing habits, their opinions of swearing and therapist swearing in general, their specific experiences and perceptions of their therapist swearing, as well as demographic information. The majority of the study's respondents reported that their therapist's use of swear words had helped their therapeutic relationship. While participants reported they were happy with the frequency and context of their therapist's swearing, they also preferred that, in general, therapists swear in moderation. This survey serves as a starting point for further investigation regarding how the use of swearing affects therapeutic rapport and also addresses the research gap on this particular topic.

*Keywords:* swear words in therapy, therapeutic relationship

CLIENT'S EXPERIENCES AND PERCEPTIONS OF THE THERAPIST'S USE OF SWEAR  
WORDS AND THE RESULTING IMPACT ON THE THERAPEUTIC ALLIANCE IN THE  
CONTEXT OF THE THERAPEUTIC RELATIONSHIP

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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Smith College School for Social Work  
Northampton, Massachusetts

2016

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## **CHAPTER 1**

### **Introduction**

This paper investigates how a therapist's swearing<sup>1</sup> affects the client's experience of their therapeutic relationship. This was done by surveying clients' opinions of therapist swearing and how their therapist's swearing affected their therapeutic alliance in the context of their therapeutic relationship. This research serves to inform clinicians around their use of profanity with clients and what effects using swear words might have with their client. It also provides context and guidance for future research on profanity in therapy.

It was my hypothesis that clients would report that some cursing is effective in the therapeutic dyad and that individuals who swear would report a stronger therapeutic alliance with therapists who swore during their therapy. The data collected demonstrated that a majority of clients found swearing to help their therapeutic relationship. It was also my hypothesis that individuals who do not swear or who find swearing offensive would report a more negative relationship with their therapist if that therapist swore. In this research, the clients' sentiments towards therapist swearing were so positive that there was not enough diversity in the data to determine whether or not there was a statistical relationship between clients' preference and their opinions of therapist swearing.

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<sup>1</sup> This thesis will use the words "swear," "curse," "profanity," "obscenity," and "expletive" interchangeably. Although technically speaking they allude to different topics ("profanity" historically referred to an irreligious or blasphemous phrase while "obscenity" to sexually explicit material), teasing out the various causes and effects of each genre in daily use is not within the scope of this study.

## **CHAPTER 2**

### **Literature Review**

In its Code of Ethics, the National Association of Social Workers creates an outline of how individuals are to behave as social workers. This code calls social workers to “work towards the maintenance and promotion of high standards of practice” (Code of Ethics, 5.01a, 2008). While the field of social work initially started as informal groups of volunteering philanthropists, it has since developed strict educational requirements defined by the Council on Social Work Education; organized a large professional organization entitled the National Association of Social Workers; and maintains licensing requirements, defined by individual state governments. These hierarchies enforce behavior wherein clinicians serve clients within the set boundaries of accepted norms. In short, social work, and with it therapy, has professionalized.

Some argue that the desire to maintain social work’s professionalism clashes with the ultimate goals of social work’s fundamental purpose, which are clearly outlined in the opening lines of the Code: social workers should “enhance human well-being and help meet human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (Code of Ethics, Preamble, 2008). Many authors have made the arguments that professionalism, and the distance that professionalism creates between client and worker, interferes with the quality of their relationship and the resulting outcomes (Green, Gregory, & Mason, 2006; Healy, 2000; Ife, 1997; Weeks, 1988). These arguments have been expanded towards inclusion of elements of the therapist’s personal life or

self-expression that were historically taboo. For example, Williams, Thomas, & Christensen (2014) argue that it is necessary to allow professional appearances to reflect therapists' "core values pertaining to human diversity, cultural competence, and empowerment" (p. 374) and as such permit therapists to show their tattoos and non-ear piercings.

Other areas of professionalism continue to be debated. One area of contention is self-disclosure. While there is no one definitive answer on whether or not therapist self-disclosure is clinically indicated overall, one review and case study pointed out "therapist self-disclosure is widely used" (Ziv-Beiman, 2013). There are, of course, diverse types of self-disclosure: some are much easier for the therapist to keep private (such as their thoughts and opinions) while others are much more difficult to obfuscate (such as the color of their hair, their weight, or their preference in clothing).

One type of self-disclosure exists in the gray space in between: speech. While the words' content might not disclose private information, the manner in which they are said does convey a considerable amount of information. The clinician's words are an unavoidable source of self-expression. As Jay (1999) points out, "The use of these words tells us who we are and how we fit in the world" (p. 82).

In addition to being an unavoidable form of self-disclosure, language is the basis of the therapeutic relationship (Wachtel, 2011) and is thus a critical part of any clinical practice. As such, there has been a wide array of research that discusses how therapists' words affect their therapeutic relationships. First and foremost, there are many textbooks that focus exclusively on therapeutic communication (Bender & Messner, 2003; Knapp, 2007; Tamparo & Lindh, 2008; Wachtel, 2011). There is also a huge variety of research on language use in therapeutic settings. Some of the available literature ranges from why the language in which the therapist and/or

client are speaking in therapy influences their relationship and affect expression (Caldwell-Harris, 2015; Pomeroy & Nonaka, 2013) to the use of specific scripts in some therapeutic practices. For example, in Solution Focused Brief Therapy, all of the therapist skills involve formulaic types of questions or phrasing, such as “The Miracle Question” or generating “Problem Free Talk” (De Jong, P & Berg, 1998). Similarly, Motivational Interviewing practices specifies therapists’ responses to clients, such as reflecting the content or the underlying values that the client has outlined or asking scaling questions to understand the importance of an action item for a client (Miller & Rollnick, 2013). Word choice is critical to the efficacy of both of these popular techniques.

It is clear that a clinician’s language is very important and many sources have analyzed and outlined how a clinician should speak. That being said, there are very few sources that include expletives in their discussion of clinical language. As Stone, Mcmillan, and Hazelton (2010) point out, there is a "dearth of methodologically sound literature caused by the general lack of serious research on swearing..." (p. 529). For example, the commonly used textbooks *Clinical Interviewing* (Sommers-Flanagan & Sommers-Flanagan, 2009) and *Therapeutic Communication: Knowing what to say when* (Wachtel, 2011) outline exact conversations that student clinicians can use as models but neither textbook mentions when or how a therapist should or should not swear.

By and large, the research that does exist around swearing in the fields of psychology, psychiatry, social work and counseling have focused on the *client’s* language instead of the therapist’s. Even in Stone, Mcmillan, and Hamilton’s (2015) extensive literature review of cursing’s various manifestations in health care settings, only half a page was dedicated to professionals’ use of language in health settings. This is problematic for two main reasons: one,



swear words are a nexus of power and communication (De Klerk, 2005); and two, swear words are a unique genre of words that are especially relevant to therapists, as “cursing provides for both emotional expressions about and emotional reactions to the world that create an aspect of self-awareness that noncurse words cannot provide—a deep emotional view of the world and the self” (Jay, 2000, p. 79). Emotional understandings are the currency of social workers and other therapists in clinical settings and that what and how the therapist communicates is the basis of the therapeutic alliance (Wachtel, 2011; Sommers-Flanagan & Sommers-Flanagan, 2009). Therefore, understanding more fully the way that using swearing in therapy affects the therapeutic relationship will help therapists to make more educated choices when speaking to clients.

Investigation of the interplay of therapist swearing and client experience is especially important given the paucity of information currently available. This lacuna is especially notable if one is looking for research about swearing outside of the fields of linguistics and communications. Ultimately, swearing is a common occurrence in everyday speech in the United States. We hear swear words all the time: Kaye and Sapolsky (2009) found that 89% of prime time television in the United States used at least one offensive word and one 2006 study found that 74% of its respondents reported they frequently or occasionally hear individuals swearing in public (Ipsos Public Affairs, 2006). Despite the prevalence of swearing, there is little research on the topic, especially in the mental health fields (Stone et al., 2010). Winters and Duck (2001) also point out that, not only is there a dearth of modern research on swearing which forces current discussions to rely on out-of-date information, but swearing’s “growing public presence in social behavior surely makes it a ripe topic for deeper analysis in light of today’s theoretical and empirical advances” (p. 60). This paper hopes to fill a piece of this literature gap.

## **Defining Cursing**

Before analyzing what literature there is on the subject of expletives in the therapeutic relationship, it is necessary to define what exactly is encompassed under the umbrella of “cursing.” According to Professor Timothy Jay, an expert on swearing in the field of communications, swearing is defined as strong words or phrases that are generally considered offensive (Jay, 2000). Curse words can also be used as intensifiers (Myers, Brann, & Martin, 2013). Furthermore, “In contrast to most other speech, swearing is primarily meant to convey connotative or emotional meaning...” (Jay & Janschewitz, 2008, p.268). That is to say, in many situations where swearing is used, the word is not referring to its literal meaning but is instead attached to some evocation of another (generally intangible) idea, which often also provokes emotion.

If indeed we accept that cursing is designed to share connotative and emotional messages or to intensify other messages, then it would seem to be the ideal language for therapeutic engagement. Of course in reality, swearing often includes more than just positive or neutral connotative and emotional meaning but also negative, derogatory, or offensive meanings as well (Jay & Janschewitz, 2008). In fact, Ljung (2011) asserts that “in order to qualify as swearing, an utterance must violate certain taboos that are or have been regarded as in principle inviolable in the cultures concerned” (p. 5). Curse words derive their power from violating those subjects considered untouchable in the language’s culture. These subjects generally fall into the category of religious and spiritual connotations or body parts and bodily activities (such as scatological words, sexual activities, phrases defining physical or mental disabilities, etc.). While these words often carry negative or, at least, strong associations, the same literal meaning of the words can be expressed with other words in acceptable ways. Thus it is not that the ideas cannot be

shared or the objects and actions cannot be described without these offensive words, but instead that there is something that the culture deems inappropriate *in the word itself* (Jay & Janschewitz, 2008).

While the details of why languages developed curse words (in addition to other words that convey the same content but not the same connotation or affect) are not fully understood (O’Callaghan, 2013), some researchers have investigated expletives’ unique potency. For example, Stephens and Umland (2011) found that in a laboratory setting, swearing lessens pain. This could be, in part, due to where profanity is situated in the brain: non-swear words are located in the cortex (O’Callaghan, 2013) while swearing is processed in the left frontal and temporal lobes, right cerebral hemisphere, and also in the amygdala (Jay & Janschewitz, 2008). Swear words are also more likely to get listeners’ attention and enhance memory specifically because of the areas of the brain that they activate (Kensinger & Corkin, 2004). Swear words can also be used to assert cultural capital or affiliation (De Klerk, 2005; Stone, 2009). Finally, profanity can be used as humor (Dewaele, 2004; Stone et al., 2015).

In summary, curse words have an interesting niche: they are taboo and supposedly forbidden but also serve a variety of uses, triggering reactions that other words cannot. Perhaps it should not be surprising, therefore, that profanity is an everyday part of communication (Jay & Janschewitz, 2008) which is increasing in its public use (DuFrene, 2002).

### **Arguments against the use of cursing**

There are many arguments used against swearing, all of which apply in the context of the therapeutic relationship. Firstly, there are scenarios wherein the swear words cause insult so extreme that it constitutes harassment, especially sexual or racial harassment (DuFrene, 2002; Wah, 1999). Not only are there serious legal repercussions for such use, but the negative

implications for the individuals involved and their relationships are profound. This study does not wish to advocate for the use of language that constitutes harassment or is sexually or racially derogatory and does not argue that expletives used in this manner could facilitate a positive therapeutic relationship.

In the discussion of the less extreme uses of profanity, there is the concern that using a curse word could insult the client, which would harm both the client and the therapeutic relationship. The NASW Code of Ethics (2008) states “Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients” (para. 1.12 “Derogatory Language). Some clients might find swear words to be derogatory or disrespectful. This injunction, in addition to a general respect for a client’s sensibilities, requires that therapist exercise caution if they were to choose to use such a word.

Maier and Miller (1993) outline another common line of logic used to prohibit the use of expletives, saying that while it is important to share feelings, these feelings must be shared in a socially acceptable way and, since swear words are not socially acceptable, therapists should not encourage their use. The fundamental problem with this logic, however, is the assumption that swear words are not acceptable. This argument is similar to the one that suggests that swearing is not an intelligent, eloquent, or meaningful manner of communication (which was recently scientifically disproven by Jay & Jay's 2015 study showing no correlation between use of profanity and poverty of language). I argue instead that swear words are not acceptable to those in power but are accepted and in fact embraced by disenfranchised communities. In her description of the use of swearing among adolescents as a way of demonstrating membership (or exclusion) from a group, De Klerk (2005) describes this phenomenon saying

Those adults who are successful and who acquire social status along with the trappings of wealth are very likely ultimately to impose and uphold the very taboos against the use of slang and expletives which they flouted in their own youth; those with less social power or those who lack alternative means of displaying power are far more likely, as adults, to retain their covert status symbols and conform to the need to fit into local subcommunities by using the very words which those who have the power reject. (p. 117-118)

Similarly, in his description of the use of swear words by the civil rights protesters of the 60s and 70s, Rothwell (1971) described how protester groups used profanity to gain the public's attention and also to delineate themselves from the general public, noting first that "verbal obscenity is, by definition, antithetical to the "establishment"(p. 233). He then goes on to vividly describe how entrenched the hierarchical structures of our society are lived out in language, describing how women are expected to be the gentler sex and, as such, not curse. This entrenched expectation contributed to guardsmen in the Kent State riot being especially violent towards female protesters because, "To hear obscenities in common usage from girls who could have been their sisters produced a psychic shock which ran deep. To many of the Guardsmen, these girls had removed themselves from any special category of 'women and children.'" (Rothwell 1971, p. 239). That is, once the female protesters were no longer using 'lady-like' language, they were no longer considered women, removing one of the fundamental descriptors of their humanity. By breaking this code of 'lady-like' language, the women stepped out of their expected societal roles and protested not just the war but also the patriarchal system from which the war was born.

By deciding who can and cannot swear, society dictates who can and cannot express extreme anger, sexuality, and areligious thoughts. As such, excluding curse words from social

workers' vocabulary would be colluding with the oppressive structure, which is explicitly condemned in the NASW's Code of Ethics. At the same time, if social workers do choose to use swear words with their clients, they also need to be careful to avoid insulting. Ultimately, it is crucial to better understand the context in which therapists have sworn and the impacts that this swearing has had on their therapeutic alliance. This information will help therapists know more about when, how, and if to use swear words with their clients.

### **Client cursing**

The literature on client swearing does give us insight into the role that such language plays in therapeutic settings, even if the various sources are not in agreement as to what that role might be. For example, Laskiwski & Morse (1993) reported that late adolescent to mid-30s quadriplegic and paraplegic male clients used swearing as a way to express intense emotion, especially in light of the fact that crying was not viewed as an acceptable method for sharing feelings. On the other hand, Robbins et al.'s (2011) study of women coping with illness found that when clients swore, it negatively affected their psychological adjustment, although it is questionable whether or not the sample population was large enough to justify such a conclusion.

Stone et al. (2010) studied the effects of client cursing on nurses in mental health settings. They found that as many as 100% of the nurses surveyed experienced verbal aggression from clients (or from clients' family/care-givers) and 32% reported being cursed at one to five times per week by clients (Stone et al., 2010). While these nurses also reported experiencing high levels of distress as a result of being sworn at, they did not report the instances to their superiors and generally considered ignoring the behavior easier than directly dealing with it. The authors suggested that the nurses' experiences could be improved by providing a sociocultural context for increased understanding and by nuancing the "Zero Tolerance" policies (that is, dismissing

clients or staff who make one error or use language inappropriately once) around client cursing at the administrative level, with the goal of respecting the diverse needs of both patients and staff.

Zimmerman and Stern's (2010) case study of curse words in a general hospital setting took a broader lens to the swearing, saying that in all medical settings it will be inevitable to have some patients who use profanity. The authors suggested that swearing should be included in the general biopsychosocial analysis of a client firstly because swearing is commonplace in hospitals but also because the client's word choice and speech patterns are an important aspect of how a clinician formulates an understanding of the client's internal world. While the use of expletives can be a marker of a neurobiological disease, such as Tourette syndrome (Jay, 2000; Zimmerman & Stern, 2010), their use can also assist the clinician in understanding the psychological status of the client or as a sociocultural marker (De Klerk, 2005; Ljung, 2011; Zimmerman & Stern, 2010). In many cases, the clinician can mirror the client's language style in order to build a therapeutic alliance (Zimmerman & Stern, 2010). Zimmerman and Stern (2010) concluded that swearing can be useful in building rapport and provide a cathartic release of aggressive drives for both professionals and patients. They simultaneously urged caution in the use of profanity by professionals as "it is a form of verbal expression with the power to both hurt and heal" (Zimmerman & Stern, 2010, p.385) and reminded practitioners that, while client swearing can be disruptive and hurtful, it also provides considerable insight into their state of mind. Specifically, they suggested a correlation between the kind of swear word that the client uses or that others use to describe the client and their developmental stage.

## **Therapist Cursing**

Unfortunately, while there is very limited research on the subject of swearing, as many other articles have pointed out (Jay et al., 2006; Stone et al., 2010; Stone et al., 2015; Zimmerman & Stern, 2015), there is even less research investigating if or how swearing affects the therapeutic relationship. Locher & Watts (2005) noted in their theory of politeness that, “Impolite behavior is thus just as significant in defining relationships as appropriate/politic or polite behavior” (2005, p. 12); as such, in a field dedicated to the “importance of human relationships” (NASW Code of Ethics, “Preamble”) guidance on the use of vulgar language needs just as much attention as polite language.

The NASW Code of Ethics suggests that “For additional guidance social workers should consult the relevant literature on professional ethics...and seek appropriate consultation when faced with ethical dilemmas” (Purpose of the Code of Ethics, NASW 2008). This suggestion is not especially helpful, however, when there is no literature relevant to the subject of therapist swearing in social work, counseling, or psychology, and no two consultants suggest the same word choice.

There are a few studies that directly address the role of therapist cursing in the client’s perception of their working alliance. The few that do exist are considerably dated at this point. Heubusch and Horan’s (1977) study directly addressed this topic (although it used the phrase “nonstandard English” to describe the use of profanity) and found that clients rated the cursing therapists as “less effective and satisfying” (Heubusch & Horan, 1977, p. 456). However, their study had several important limitations including that the clients had never met the therapists prior to their exchange, the clients spent on average fifteen minutes and at most thirty minutes with the therapist, and the dyad conversation was framed as an “opportunity to role play a



common counseling concern” not around a genuine therapeutic problem (Heubusch & Horan, 1977, p. 465). In short, the cursing did not occur in the context of a meaningful relationship. Another dated survey of psychotherapists and psychiatrists suggested that the client and the therapist need to use the vocabulary with which they feel the most comfortable, as that will provide the most effective communication between the two parties, although ultimately the therapist should alter their language towards the preferences of the client (Ross, 1962).

Kottke and Macleod (1989) took a different approach to studying perceptions of cursing in therapy. Their investigation had test subjects listen to an audio recording of a therapist and client, with several different testing groups: in one, the therapist swore and the client didn't; in the second, the client swore and the therapist didn't; and in the third, both parties swore. In the end, “The counselor who swore was viewed as being insensitive to the needs of the client, disrespectful and unprofessional” regardless of whether or not the client swore (Kottke & Macleod, 1989, p. 633) and when the client swore and the therapist didn't, the therapist was perceived in a more favorable light (Kottke & Macleod, 1989). Interactions wherein both the counselor and client swore were viewed as neutral. Unfortunately, this research does not directly investigate the therapeutic relationship but instead people's perceptions of swearing in therapy: outside individuals who knew neither the therapist nor the client were the ones judging the quality of the therapeutic interaction in this study. Furthermore, the study participants reported a unique power dynamic between the two parties: in addition to the power that any therapist holds over a client in a therapeutic relationship, in this setting the therapist worked for the client's school and was perceived to also have access and control in the client's academic world as well as their psychological and emotional one. With that much of a power differential, it seems reasonable to expect that the students who were the test subjects would see the therapist's

swearing in unfavorable light. Jay and Janschewitz (2008) reported similar findings in academic settings, wherein students found it less acceptable for a dean to use expletives than it is for a student.

Maier and Miller's (1993) legal and clinical review of the impacts of obscene language in psychotherapy settings described how profanity can be both effective and detrimental to quality therapeutic care. Their one definitive conclusion was that racialized slurs are never appropriate. Their other conclusions are less absolute but ultimately they stated "it is the contention of the authors that, under the right circumstances, obscene language can be used by mental health" (Maier & Miller, 1993, p. 240).

The literature clearly supports that swearing is simultaneously quotidian and powerful (Jay, 2000; Ljung, 2011; O'Callaghan, 2011) and that more research on swearing in mental health settings is necessary to understand its implications for therapy and client health (Heubusch & Horan, 1977; Kottke & Macleod, 1989; Stone et al., 2010; Stone et al., 2015; Zimmerman & Stern, 2015). As such, this thesis proposes to investigate clients' perceptions of therapists' swearing and the implications that the therapists' swearing has on the clients' understanding of their therapeutic relationship.

## **CHAPTER 3**

### **Methodology**

The purpose of this study was to investigate the client's experiences and perceptions of the therapist's use of swear words and the resulting impact on the therapeutic alliance in the context of their therapeutic relationship. This was achieved through a mixed methods exploratory study. This survey included Likert scaling and multiple choice questions to gather quantitative data around clients' experiences and opinions of therapist swearing. Open ended questions and a qualitative analysis were used to understand the context of therapists' use of swearing.

### **Sample**

The target population was anyone over the age of 18 who lives in the United States and speaks English (because the survey is in English). These individuals must have been in individual therapy with a social worker, counselor, or psychologist at some point. The therapy did not need to be ongoing in order to participate in the study. The therapist needed to have used swear words during therapy with the client. The participants must have been over the age of 18 at the time of the survey so as to ensure that they did not meet the requirements for a "protected population;" they must have been in individual therapy and had a therapist who swore because the purpose of this study was to investigate the context of swearing within a therapeutic relationship. In order to complete the survey, the participants must have had access to a computer with internet and Facebook, as they survey was shared over Facebook. They must also

have been able to read and write in English. Individuals were excluded from the study if they did not have access to the internet, a computer, Facebook; if they were unable to read and write in English; if they were under the age of 18 at the time of taking the survey; or if they had never had an individual therapist who used swear words during their therapy sessions.

Recruitment occurred via Facebook and this survey required a minimum of 50 participants. It was posted on my personal Facebook page, including various groups that I am a part of. In addition to reaching my 1,018 Facebook friends, I requested that individuals post it to their own Facebook pages and groups in the hopes of reaching a larger population and a more diverse group of participants, thus utilizing a convenience sampling augmented by snowball sampling.

### **Ethics and Safeguards**

In order to protect confidentiality, the survey was completely anonymous and gathered no identifying information about the participants. I used Qualtrics, which is an online survey platform. Qualtrics did not gather identifying data from the participants' digital information, such as IP address or email. All research materials, including the consent and survey, will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Potential risks to the participants included discomfort or emotional distress upon considering their therapeutic relationship with their therapist or upon considering swear words. Before beginning the survey and after completing the survey, the clients received information for supportive counseling hotlines which they could contact via phone or over the internet in case

they experienced emotional distress as a result of the survey. However, I suspect that the risks of completing this survey were minimal. Potential benefits included the possibility of learning more about their relationship with their therapist, more about their own opinions and perceptions of swear words, and also the satisfaction of knowing that they are contributing to the field of social work and the knowledge of the helping professions in general. Clients were fully informed of both the potential risks and benefits of the study via the consent form before beginning the actual data collection process. This research was approved by the Smith College School for Social Work Human Subjects Review Committee; see Appendix A. See Appendix B for the informed consent form used in this survey.

Participants received information regarding their right to ask questions or report concerns to either the researcher or Smith College School for Social Work Human Subjects Review Committee in the consent form. They also received information about how to get therapeutic support from the NAMI Helpline or the Helpline Center. This information was repeated on the “Definitions” page immediately prior to beginning the survey, and on the last page of the survey. Participants were asked to either print the consent document or take a screen shot of it for their records.

### **Data Collection**

Both quantitative and qualitative data was collected via the same anonymous online survey hosted on Qualtrics. Qualtrics is an online software which facilitates data collection and analysis via surveys. Given that there is little research on the subject (Stone et al. 2010, Winters & Duck, 2001) and no standardized measures to follow, it was necessary to design a set of questions to understand the context in which swearing occurs in a therapeutic relationship.

After defining “the therapist” and “swear words,” the survey explored the participant’s opinions on swearing, swearing in therapy in general, and swearing in the specific context of their relationship with their therapist and what role the swear words had on their therapeutic relationship. See Appendix B for the entire questionnaire. There were 21 questions in the survey that address topics related to swearing. Four questions used Likert scaling (such as, “In general, how do you feel about swearing?” and “Generally speaking, how is your relationship with your therapist?”); three frequency questions (such as, “How often do you typically swear?” and “How often does your therapist typically swear?”); six true-false questions (such as, “Therapist swearing is unprofessional” and “Therapists should only swear if the client swore first”); and eight open-ended narrative questions (“In general, please describe how you feel about your therapist’s swearing” and “How did you feel the first time a swear word was used in your therapy?”). In the last section, participants answered demographic information including the race and gender of both the client and the therapist and the age and religious affiliation of the client.

The survey included questions about the participant’s general opinions of swearing in order to see if individuals who think positively or negatively of profanity in general use would feel the same way about that type of language in a therapeutic setting. Similarly, the aim of questions about the general professionalism and acceptability of therapist swearing was to see if clients might find their own therapist’s swearing acceptable because the cursing is done in the context of a relationship, even if the participant did not approve of therapist swearing at large. There were questions about the individual’s own swearing habits in order to know if therapists were matching the client’s language use and preferences. For example I wondered if an individual who swore regularly would report having a therapist who swore more frequently than

individuals who rarely swear. There were also questions about frequency and who swore first to determine if there is a relationship between client sentiments towards swearing and how often or when the swearing was used. For example, I wondered if the client felt more comfortable if the therapist used swear words only on the rare occasion or if the client might prefer that the therapist use expletives as part of their everyday language. The qualitative questions served to explore the context in which the swearing occurred and tease out the client's emotional and cognitive experience of having their therapist use profanity during session. Since little research has examined this topic, the qualitative questions were opened ended and served to explore the client's opinion of the role of swearing in the context of a therapeutic relationship.

The demographic questions were included specifically due to prior research suggesting a correlation between age, racial identity, gender identity, and religious affiliation and the social acceptability of profanity. I was curious to see whether demographic differences would be a factor in the therapeutic setting.

### **Data analysis**

The qualitative data was coded thematically in order to find the most prevalent trends in client opinions on therapist swearing. For each of the questions, I sorted the responses (or pieces of the responses) into detailed categories based on keywords in that portion of text. Once all of the responses were coded, I combined less common categories under larger headers for that question. For example, when asked how they felt the first time a swear words was used in their therapy, once participant wrote "More relaxed, it helped build rapport." When coding the data, this response was divided into two different categories initially. The phrase "more relaxed" was initially coded as "relaxed" while "it helped build rapport" was coded as "increased rapport." The idea of increased rapport was quite common among participant answers, so that discrete

category remained. However, the category “relaxed” only had two participant responses with that specific keyword, and so it was collapsed under the larger header “more comfortable.” Once all of the questions had been fully coded, I counted how many “pieces” of responses there were for that question. I then used this total to find a rough percentage of the category’s prevalence in the question. Since one person’s answer could be divided into many pieces and each of those pieces put in a different category, I could not use the total number of participants in order to calculate the percentages. For example, for the question asking how clients felt the first time a swear word was used in therapy there were 77 total “pieces” of responses. Sixteen of those pieces were coded “increased rapport,” which means that the idea of increased rapport accounted for roughly 21% of the responses to this prompt.

For the quantitative data, Spearman’s rho correlations and Pearson correlations were used to determine the relationships between various sets of data. However, because there was so little variation amongst the participants’ opinions around swearing in general and therapist swearing, no significant correlations between opinions on swearing and other information (such as demographic categories) could be found. As a result, descriptive statistics were used almost exclusively.



## **CHAPTER 4**

### **Findings**

The data collected shows significant client support for the use of therapist swearing. 92% of respondents (n=46) reported that in general therapists should be able to swear around their clients and 80% (n=40) reported that their therapist's use of swear words helped their therapeutic relationship. While generally the clients suggested a conservative use of swear words that mirrored the client's own language, a majority of participants reported that when their therapist swore they felt an improved sense of rapport in their therapeutic relationship. This was demonstrated in all of the qualitative questions and exemplified by the responses to the prompt "In general, please describe how you feel about your therapist's swearing" wherein over 88% of the responses described an explicitly positive experience with therapist swearing.

This findings section first covers participant and therapist demographics. It then addresses the quantitative data including the participants' perceptions of the use of swear words in general, the clients' own personal swearing habits, their perceptions of therapist swearing in general, and their thoughts on the use of swearing in their individual therapy. This section also briefly clarifies why inferential statistics are not used extensively in this research. The third section discusses the qualitative data including how participants felt that instances of swearing improved the therapeutic rapport, how some clients felt swearing to be a widely accepted part of speech, and how clients found the frequency with which their therapists swore to be acceptable.

## Demographics

**Client demographics.** The participants reported belonging to age categories ranging from 18 to over 65 years old. The median and most common age range was 25-34 years old, with 58% (n=29) of the participants, and the 35-44 years old bracket represented 26% (n=13) of the study's participants. 56% of respondents reported being in therapy between the ages of 25-34 (n=28). The majority of the sample (72%, n=36) identified as female, with 22% (n=11) identifying as male and three participants identified their gender as other (6%). Religious affiliation was divided across a variety of categories, with 12% (n=6) identifying as atheistic, 14% (n=7) as Christian/Catholic, 10% (n=5) as Jewish, 4% (n=2) as Muslim, 30% (n=15) as spiritual not religious, 14% (n=7) as other, 16% (n=8) as none. When asked how important their religion was to them, 12% (n=6) reported that their religion was extremely important, 28% (n=14) said that it was important, 28% (n=14) said neutral, 24% (n=12) said unimportant, and 8% (n=4) said extremely unimportant. In terms of race and ethnicity, 94% (n=47) of respondents identified as white or European-American, 4% (n=2) as Chicano, Hispanic, or Latino, and one respondent (2%) each from the categories Asian/Pacific Islander, Middle Eastern, Native American or American Indian, and Other. None of the people who responded to the survey reported to be black or African American. When reporting their race, clients could select multiple racial and ethnic identifiers. Clients also reported their therapists' demographic information. Respondents noted that their therapists were mostly 35-44 years old (40%, n=20), 70% (n=35) were female identified, and 92% (n=46) were white or European-American. See Table 1.

There was not enough diversity amongst the data to compare responses across different demographic categories. Generally speaking, the respondents responded positively to therapist

swearing and so there was not enough variance to tease out differences based on demographic identification. Furthermore, there was limited demographic diversity among respondents given that most of the participants identified as female (72%), white (92%) and between the ages of 25-34 (58%). As such, it was not possible to find statistically significant trends through inferential statistics.

### **Quantitative data**

**General perceptions of swear words.** Participants were initially asked “In general, how do you feel about the use of swear words?” and could choose from the following responses: “extremely positive,” “positive,” “neutral,” “negative,” “extremely negative.” 72% (n=36) reported either feeling “positive” or “extremely positive” towards their use, while 24% (n=12) felt “neutral” and only 4% (n=2) felt negatively. None of the participants felt “extremely negative” about swear words in general usage. Similarly, when asked if they felt swearing was offensive, choosing between “never,” “rarely,” “sometimes,” “most of the time” or “always,” 74% (n=37) found swearing offensive “never” or “rarely,” while 24% (n=12) found swearing offensive sometimes and one participant (2%) said that swearing is offensive to them most of the time.

**Clients’ swearing habits.** Respondents also shared information about their own swearing habits. In response to the statement “I swear but only around my friends,” only 14% (n=7) said “true.” However, in response to the prompt “I change or monitor my use of swearing based on the people I am talking with or the people around me,” 98% (n=49) answered “true.” In terms of frequency, 70% (n=35) of participants admitted to swearing more than once a day, 20% (n=10) reported swearing once a day, and 10% (n=5) said they swear once a week. No participant said that they swear once a month or never.

**General perceptions of therapist swearing.** Regarding their opinions on therapists' use of curse words in general, 92% (n=46) said that therapists should be able to swear around their clients and only 12% (n=6) found therapist swearing to be unprofessional. In response to the statement "I believe that swearing is appropriate for therapists in some situations," only one person chose "false," meaning that 98% (n=49) of individuals felt that therapists can use profanity in some situations. No significant relationship was found between the clients' general attitudes towards swearing and the clients' attitudes to therapist swearing.

There was no clear consensus among the participants regarding which member of the therapeutic dyad should swear first. 54% (n=27) of respondents thought that therapists should only swear if their client has already used a swear word and 46% (n=23) felt that the therapist should be able to swear even if the client had not yet used such language in session.

**Perceptions of swearing in clients' own therapy.** Participants were asked "In your opinion, what effect did your therapist's swearing have on your relationship?" and could choose between "The therapist swearing helped our relationship," "The therapist swearing didn't affect our relationship," or "The therapist swearing damaged our relationship." While 20% (n=10) of the respondents felt that the therapist's use of profanity did not affect their relationship, 80% (n=40) felt that the therapist swearing helped their relationship. Perhaps most notably, none of the respondents felt that the use of curse words hurt their therapeutic relationship. This is interesting, as 6 respondents reported that therapist swearing was unprofessional, but did not report that it harmed their therapeutic relationship.

When asked about initial use, 60% (n=30) of clients said that they swore first in their therapeutic exchange with their therapist; 32% (n=16) reported not remembering if they swore first or their therapist did; 8% (n=4) said that their therapist was the first to swear.

Regarding the frequency of therapist swearing, 54% (n=27) of clients noted that their therapist typically swore only once a month or less, 28% (n=14) said that the therapist swore two or three times a month, 14% (n=7) once a session, and only two clients (4%) reported that their therapist swore multiple times a session. The frequency with which the therapist swore also demonstrated no significant correlations to the clients' opinions of therapist swearing. There was also no significant connection between the age of the client, the length of therapy, and the therapist's age and the clients' feelings around therapist swearing. By and large, participants felt positively about therapist swearing; as a result, there was too little variation in the respondents' opinions to find nuances among different populations or experiences or make use of inferential statistics.

### **Qualitative data**

**Qualitative questions and central themes.** As for the quantitative data, the qualitative short answer questions provided similarly accepting responses to therapist swearing. Three notable themes emerged. Across all eight of the qualitative questions, the most common theme was that the use of swearing served to improve the therapeutic relationship. Also prevalent was the idea that swearing is an accepted part of speech and, as such, it was normal for a therapist to swear. In terms of opinions on frequency, clients felt that their therapist's swearing was appropriate in terms of both context and quantity but also preferred that therapists swore in moderation. Figure 1 outlines the three most common themes from each of the qualitative questions.

**Swearing improves the therapeutic relationship.** As can be seen in Figure 1, the concept of swearing improving the therapeutic relationship emerged as a primary concept in five of the eight qualitative questions. Even in the questions where clients did not expressly say that

the swearing helped the relationship, participant responses pointed towards swearing supporting the rapport. For example, respondents were asked to describe a time in which their therapist had used expletives and they had found it unhelpful, not useful, or negative. Of the 44 participants who responded, 37 answered “not applicable” or “never.” This suggests that the majority of clients viewed their therapist swearing as helpful or useful.

Across the majority of the questions, most prevalent was a sense of increased rapport and comfort with the therapist as a result of the therapist’s use of swear words. Figure 1 shows that in addition to swearing leading to a positive change in the relationship, other motifs included feeling validated and “good” or “great.” One participant noted that when the therapist swore it made them feel “affirmed, connected, honest, human, normalized.” Interestingly, the idea of swear words humanizing the therapist came up in multiple client responses; when asked about their general opinions on therapist swearing one individual said “[The swearing] made me feel he [the therapist] was willing to drop the persona and act like a human” while another noted “It made him feel humanized.” The humanizing power of profanity and its role in improving the relationship accounted for nearly 14% (n=11) of the data for that prompt and the phrases “humanizing,” “more human,” or “a real person” also appeared in some of the responses describing the first time the therapist swore, how clients felt that first time, and in their examples of how swearing was helpful. Some participants even described the therapist’s use of profanity to be freeing: one person said that “it made me feel more able to communicate freely with her [the therapist], and not worry about watching my own language.” Another noted that when their therapist swore, “I felt validated, since that was what I thought, as well, but hadn’t wanted to be the first to swear.” Thus, even when not directly talking about the relationship between client and

therapist, participants demonstrated that the use of swear words generally led to increased comfort and thus rapport between the two parties.

Another way swear words support therapeutic rapport is through “mirroring,” wherein the therapists used swear words to mirror the clients’ own language and experiences. As one respondent said, “My therapist's swearing acted as a mirror to my language and emotion. It helped me connect to what I was feeling and look at it closer.” Clients also mentioned that their therapists mirrored them in frequency of use: “It (the therapist’s swearing) varied based on how often I swore in therapy.” These comments suggest that clients noticed that therapists swore in a manner that replicated their own use. Thus, in a variety of ways, the therapists’ swear words had helped develop the therapeutic alliance.

**Swearing as accepted part of speech.** Distinct from the concept of relational importance, the idea that swear words are not especially noteworthy, even swear words coming from the therapist, emerged from the data. When asked “How did you feel the first time your therapist used a swear word in session?” one client said “Indifferent. It's as if she [the therapist] said the sky is blue. It's part of the adult lexicon.” Someone else, when explaining their opinions on therapist swearing in general, noted “These words [expletives] are expressive, and part of the English vocabulary.” These statements allude to the idea that, because swear words are a part of the quotidian parlance, it is assumed that therapists will include them in their communication with their clients.

**Clients’ opinions on frequency of swearing.** Clients were also asked how they felt about the frequency with which their therapist swore and whether they would like their therapist to swear more or less. While three people said they would like more swearing and one person explicitly said they would like less, over 69% of the responses to this question suggested that the

client found the therapist's swearing acceptable and appropriate. Another 18% of the responses suggested that the clients didn't have an opinion or care how frequently their therapist swore (see above section regarding swearing as an accepted part of speech). Similar to responses found in other questions, some participants noted that they thought that their therapists' swearing was done in moderation and it felt acceptable because it was used in a restrained fashion. One participant said, "He [the therapist] is very particular with words (as am I), and it feels to me that he uses swear words only when they are the best words to convey meaning and emotion." Another respondent was more direct, noting "It's best not to do it [swear] too often." These comments support the idea that clients are accepting of occasional swearing and also feel that their therapists have been using profanity in an appropriate frequency during their sessions.

As illustrated, the data gathered in this survey through both quantitative and qualitative methods suggest that clients are accepting of and find value in their therapists' use of swear words in session. Clients report that it improves their sense of comfort with their therapist and helped their therapeutic relationship. Multiple clients added that they found the swear words to be effective in part because of the great care and caution the clinicians utilized when employing such language. The overwhelming majority of clients found the frequency and usage of swear words in session to be positive.



## **CHAPTER 5**

### **Discussion**

The purpose of this thesis was to explore clients' perceptions of therapist swearing when the swearing took place in the context of an established therapeutic relationship. Overall, this research found that clients appreciated limited amounts of profanity from their therapists, reporting that swear words facilitated increased rapport between themselves and their therapist. How this research compares with previous research will be discussed below. Also included are the limitations of this research and suggestions for further investigation. Lastly, implications for therapists as a result of this research will be explored in more depth.

#### **Comparison to previous literature**

Previous research on therapist swearing did not attempt to understand the context of the therapeutic relationship, which was the main focus of this research project. Moreover, cultural perceptions of profanity might have evolved in the years since the most recent article was published on this topic (DuFrene, 2002; Winters & Duck, 2001), which is why this study may be of particular value to modern therapists. The participants of Heubusch and Horan's 1977 study investigated participants' perceptions in a role play activity that simulated therapy. They found that therapists who used swear words seemed "less effective and satisfying" (Heubush & Horan, p. 456). This is quite different from the reports of this study's participants who were directly

asked to consider swearing in the context of a current or previous therapeutic relationship. Participants in this study reported that swearing either did not affect their relationship with their therapist (20% of responses) or that the swearing helped their relationship (80% of participants). The difference in the results between this study and Heubush and Horan's (1977) could be a result of a cultural change in the use of profanity or the role of therapist in the past 30 years. On the other hand, the difference could also be attributed to context: Heubush and Horan's investigation used a simulated therapeutic encounter where the participants had no genuine relationship with the therapist. There is no way to know whether the differences found are related to a change in cultural norms or because swearing is perceived differently when it is used within the context of a therapeutic relationship. Although this is a limitation, the results are still useful for current practicing therapists.

Similarly, Kottke and Macleod (1989) found that when both the therapist and the client swore during a therapeutic exchange, an unrelated outsider felt that the therapist was less professional when they used swear words. This is problematic again because it does not actually discuss the use of profanity in the context of a therapeutic relationship but instead the outsider's perceptions of therapist swearing in general. While an outsider might have a negative opinion of a swear word used in a therapeutic exchange, a therapist and client working together likely have a different understanding of the context in which the profanity was used. In this regard, the participants of this paper reported different experiences than those noted by the previous literature: in this study, 92% of respondents said that, in general, therapists should be able to swear around their clients and 98% believed that swearing was appropriate for therapists in some situations. So while Kottke and Macleod's (1989) participants thought that therapist swearing was generally inappropriate, the participants of this study did not feel that way. Again, this

divergence from previous literature could be the result of a 25 year difference, during which conceptions of swearing or therapy have changed. An alternative explanation is that the participants in this study were more accepting of therapist swearing because it happened in the context of an established therapeutic relationship, whereas Kottke and Macleod's (1989) participants were listening to a session as outsiders. As mentioned before, it is not possible to know if this difference represents a larger shift in cultural acceptance for swear words or a shift in perceptions of therapist swearing.

It could be that all three studies actually point towards a similar trend, which is the importance of the therapeutic relationship. Both of the older studies (Heubush & Horan, 1977; Kottke & Macleod, 1989) suggested that therapist swearing was perceived poorly by the participants, and in both of the older studies the participants did not have a relationship with the therapist when the therapist swore. In this study, however, the participants had an established relationship with their therapist; 64% (n=32) of respondents reported that they worked with their therapist for a year or more. This could point to acceptance of therapist swearing when it happens in the context of an established relationship and therapists are able to make good clinical judgments around language use and employ profanity in a meaningful, attuned manner.

Some previous literature had been more supportive of therapist swearing. In their legal and clinical literature review on the impacts of swearing in psychotherapy settings, Maier and Miller (1993) asserted that in some situations, profanity used by mental health professionals can be used. The research of this paper supports their argument and takes it a step further: not only can therapists use swear words, but in some scenarios, swear words can positively change therapeutic interactions. The literature also supports the idea among respondents that therapist cursing is not especially noteworthy because profanity is an everyday part of speech. As Jay and

Janschewitz (2008) noted, reviewing multiple field studies of swearing, “most instances of swearing are conversational” (p. 268). Many of the respondents in this research asserted this point. For example, clients reported that therapist swearing made them feel “Indifferent. It's as if she [the therapist] said the sky is blue. It's part of the adult lexicon.” By extension, this also supports the theme of swearing as humanizing of the therapist: when the therapist speaks to the client in a “normal” way, the client feels that the therapist is treating them in a respectful, genuine manner which improves the therapeutic rapport.

### **Limitations**

There were many limitations to this study. First and foremost, the participant pool was small (n=50) and decidedly homogeneous (the average participants was female, white, and in the 25-34 age bracket). It is possible that the “typical” respondent was accepting of therapist swearing more because of their sociocultural identity and less because of the specific dynamics of their therapy. This research was not able to tease out this distinction. Similarly, this research did not investigate how perceptions in the use of profanity have changed over time. A better understanding of how opinions about swear words have changed in society and in participant’s personal lives could help explain the gap between the previous literature, which was largely against therapist swearing and published over 20 years ago, and this modern research.

Furthermore, there is concern that individuals who would be willing to participate in a study on cursing might be more comfortable with cursing in general as they self-selected to participate in the study. As Stone, McMillan, and Hazelton (2010) pointed out in their study of the experience of nurses in mental health settings with clients who swear, “some nurses who are greatly offended by swearing would probably not opt to take part in the study, skewing the

results towards those less distressed by swearing” (p. 532); the same bias could have occurred in this study as well, which would skew the data in favor of therapist swearing.

Ultimately, this study depended on accurate self-report from participants. Their responses might be somewhat unreliable if the instance of therapist swearing occurred a long time ago. It is also possible that the participants did not remember in what contexts the therapist cursed or that their impressions of how they felt about cursing have since been altered based on other things that happened in the therapeutic relationship.

This research was also limited by the survey design: because this was exploratory research, there were no standardized measures around therapist swearing. Furthermore, because the survey was distributed through my personal Facebook page, it was limited to individuals who actively use a Facebook account, have access to the internet, and have a connection to me or one of my friends. There were also limitations in the data analysis; because the participants reported responding so positively towards the therapist’s swearing, there was not enough diversity of data to perform inferential statistics. As a result, only descriptive statistics were used in this study.

### **Suggestions for future research**

More research on the subject of therapist swearing would certainly be useful to clinicians, especially given the exploratory nature of this limited thesis and the small pool of participants. Future research would do well to gather responses from participants who did have negative experiences with therapist swearing; this study was unable to do so. Similarly, a larger and more diverse group of participants would clarify if there are differences among different demographic lines, which would be important contextual information for therapists. Furthermore, it would be beneficial to clarify socioeconomic status of the client, as profanity is often perceived in classist ways (Maier & Miller, 1993), and this demographic marker was not included in the survey. It

would also be useful to gather more detailed information of exactly how the therapist swore with the client, so that clinicians could know which applications were most or least effective. This could be achieved by interviewing both client and therapist around a single instance of swearing. It would also be helpful to investigate whether clients were accepting of their therapist's swearing because it happened in the context of an established relationship or because of a larger cultural shift in attitudes towards the use of swearing.

### **Implications for therapists**

This information is critical for therapists of all kinds, since it provides guidance regarding the use of profanity within the context of a therapeutic relationship. This research suggests that swear words can be used in therapeutic practice to build alliance and to convey strong emotional content or make a point. While the data does not support excessive use of obscenities by the therapist, it does seem to support the use of clinicians practicing good clinical judgement regarding when and how to use such words. Specifically, clients were, by and large, satisfied with the frequency with which their therapists swore. This could suggest that therapists are correctly using their understanding of their relationship with the client in order to judge when to use or not use a swear word.

In the survey, participants were asked what advice they would give therapists regarding their use of swear words in therapy. In general, they advised clinicians to use profanity in moderation and to be mindful of their client's various needs when choosing their words. Clients suggested that therapists "follow the client's lead" and that therapists "use it if [the] patient uses it to mirror their language." Participants wanted the clinician to be attuned to the client's needs, saying "Make sure you get a sense of your patient, first" and "Is it about the client or you?" Participants hoped that therapists would be true to themselves (as one respondent said, "Do not

go outside of your comfort zone or you may come across as inauthentic”) but also insisted that therapists focus on the needs of the client first and foremost. There were also many comments urging moderation: “Don’t over use swearing,” “Use it intentionally when developmentally/culturally appropriate,” and “Use caution.” While participants recognized that therapists must decide carefully when to use and not use profanity (“It’s a balancing act,” said one client) ultimately they supported the therapist’s abilities to use swear words in session. As one client said “I think it’s been really freeing for me to communicate on that level [with swear words].” Clients’ advice to therapists mirrors the general findings of the survey: if swearing is used with good clinical judgment, it can have a positive effect on the therapeutic alliance.

## **Conclusion**

The data suggests clients appreciate carefully used swear words and feel that—when appropriately used—they can improve the therapeutic relationship. Clients appreciate the use of profanity in part because it humanizes the therapist and helps the client feel more understood and validated. This occurs in part through mirroring, wherein the client feels attuned to when the therapist uses their language, and in part because cursing emphasizes feelings in a way that other parts of speech cannot. This author suggests continued research on this topic as this research was exploratory in nature. Further research may provide therapists with more insight as to when and how to use or not use swear words in the context of therapeutic relationships with clients. Until then, this study urges therapists to continue using their clinical judgment to decide when and how to use swear words.

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## Tables

*Table 1. Demographic data*

<b>N=50</b>	<b>Participants</b>	<b>Therapists</b>
	<i>N (%)</i>	<i>N (%)</i>
<i>Age range in years</i>		
18-24	5 (10%)	2 (4%)
25-34	29 (58%)	20 (40%)
35-44	13 (26%)	18 (36%)
55-64	2 (4%)	9 (18%)
65 or over	1 (2%)	1 (2%)
<i>Race/ethnicity</i>		
Asian/Pacific Islander	1 (2%)	1 (2%)
Black or African American	0 (0%)	0 (0%)
Chicano, Hispanic, or Latino	2 (4%)	0 (0%)
Middle Eastern	1 (2%)	1 (2%)
Native American or American Indian	1 (2%)	1 (2%)
White or European-American	47 (94%)	46 (92%)
Other	1 (2%)	0 (0%)
Unknown	n/a	1 (2%)
<i>Gender Identity</i>		
Male	12 (24%)	11 (22%)
Female	36 (72%)	35 (70%)
Other	3 (6%)	4 (8%)
<i>Religious Affiliation</i>		
Atheist	6 (12%)	n/a
Christian	7 (14%)	n/a
Jewish	5 (10%)	n/a

Muslim	2 (4%)	n/a
None	8 (16%)	n/a
Other	7 (14%)	n/a
Spiritual not religious	15 (30%)	n/a

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*Note: The client participants reported the demographic data for their therapists and it was not verified by the individual therapists. For “Race/ethnicity” participants could choose more than one category.*

**Figure**

<b>Survey prompt or question</b>	<b>Three most common themes in participant responses for each qualitative question</b>
1. How did you feel the first time a swear word was used in your therapy?	<ul style="list-style-type: none"> <li>○ Swearing improved the relationship.</li> <li>○ Client felt more comfortable.</li> <li>○ Swearing is an accepted part of speech.</li> </ul>
2. In general, please describe how you feel about your therapist's swearing.	<ul style="list-style-type: none"> <li>○ Swearing improved the relationship.</li> <li>○ It is a way the therapist mirrors the client.</li> <li>○ Leads to feeling validated.</li> </ul>
3. What are your opinions around how frequently your therapist swore? For example, do you wish that they swore less often? More often? Less or more often in specific scenarios?	<ul style="list-style-type: none"> <li>○ The frequency was good.</li> <li>○ No opinion/"I don't care"</li> <li>○ Be careful not to use too much.</li> </ul>
4. Please describe an example of a time that your therapist swore.	<ul style="list-style-type: none"> <li>○ Emphasizing a point.</li> <li>○ Bonding with or empathizing with client.</li> <li>○ Expressing difficult emotions/describing difficult experiences.</li> </ul>
5. How did you feel when your therapist used the swear word in the example you described above?	<ul style="list-style-type: none"> <li>○ Swearing improved the relationship.</li> <li>○ Client felt validated.</li> <li>○ It felt good or great.</li> </ul>
6. Please describe a time when your therapist swore and you found it helpful or useful. If you don't think that the swearing has ever been positive in this way, please put "not applicable."	<ul style="list-style-type: none"> <li>○ (21 out of 40 participants referred back to the example they had described previously.)</li> <li>○ Swearing improved the relationship.</li> <li>○ During an emotional situation, it was used to emphasize a point</li> </ul>
7. Please describe a time when your therapist swore and you found it unhelpful or not useful. If you don't think that the swearing has ever been negative in this way, please put "not applicable."	<ul style="list-style-type: none"> <li>○ (37 out of 44 participants responded "Not applicable.")</li> <li>○ Client was initially unsure of swear word but agreed with choice upon reflection.</li> <li>○ Therapist's use of profanity did not feel attuned to the client's experience.</li> </ul>
8. What advice would you give to therapists regarding the use of swear words during therapy?	<ul style="list-style-type: none"> <li>○ Use swear words with caution.</li> <li>○ Swear in the context of an established relationship.</li> <li>○ Follow your client's lead.</li> </ul>

*Figure 1.* Three most prevalent themes from qualitative data.

**Appendix A: Informed Consent Form**



**2015-2016**

**Consent to Participate in a Research Study  
Smith College School for Social Work • Northampton, MA**

.....

**Title of Study:** Client’s experiences and perceptions of the therapist’s use of swear words and the resulting impact on the therapeutic alliance in the context of the therapeutic relationship

**Investigator(s):** HollyAnne Giffin, Smith College School for Social Work, xxx xxx xxxx

.....

**Introduction**

You are being asked to participate in a research study examining client’s experiences and perceptions of the therapist’s use of swear words and the resulting impact on the therapeutic alliance in the context of the therapeutic relationship. In other words, this study hopes to learn more about how client’s in therapy feel if their therapist uses swear words during conversation.

You elected to be a possible participant because you are 18 years old or older and have participated in individual therapy with a social worker, counselor, or psychologist and your therapist used swear words during your time together. This therapy could be ongoing or it could be that you are no longer in therapy.

Please read this form and ask any questions that you may have before agreeing to be in the study.



Completing this survey is entirely voluntary and will not affect my relationship with you in any way. I will have no way of knowing whether or not you have completed the survey.

### **Purpose of Study**

The purpose of the study is to learn about client's experiences and perceptions of the therapist's use of swear words and the resulting impact on the therapeutic alliance in the context of the therapeutic relationship.

This study is being conducted as a research requirement and will be included in my thesis towards my master's degree in social work.

Ultimately, this research may be published or presented at professional conferences.

### **Training**

I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.

### **Description of the Study Procedures**

If you agree to be in this study, you will be asked to answer multiple choice and short answer questions about the following topics: your opinions on swearing and how often you swear, how often your therapist swore, the context in which your therapist swore, how you feel about your relationship with your therapist, how you think your therapist's swearing affected the quality of your relationship, and demographic information (including subjects such as age, gender, and racial identity) about you and your therapist. You can choose to skip any of the questions. Answering all of the questions in this survey will require about 15 minutes of your time. Please only respond to this survey once.

### **Risks/Discomforts of Being in this Study**

It is possible that you might experience discomfort as a result of participating in this study. The study has the following risks: First, you might become uncomfortable thinking about your therapeutic relationship with your therapist. This is only somewhat likely, as the questions are very general and you can skip any question that you feel uncomfortable with. Secondly, you might become uncomfortable because this survey discusses swear words. While this survey does not contain any swear words if you are uncomfortable considering such language, please do not complete this study.

If you feel that you need support before, during, or after completing this survey, please reach out to someone you trust, such as a friend, a family member, or a therapist. You could also call the National Suicide Prevention Lifeline, which provides free, non-judgmental counseling services over the phone at 1-800-273-8255 or chat with them online at [suicidepreventionlifeline.org](http://suicidepreventionlifeline.org).

### **Benefits of Being in the Study**

The benefits of participation are that you might learn more about your relationship with your therapist, your own opinions of swearing, or how your own experience of swearing influences your relationship with your therapist and other individuals. You will also be contributing to the field of social work in general.

The benefits to social work/society are that currently there is no research for therapists about how their use of swear words in the session affects the relationship with the client from the client's point of view. Your participation will help therapists understand when and if it is useful or appropriate to swear. This information will also be helpful to practitioners in the fields of medicine and psychiatry, as they often face similar judgment calls about when to use or not use swear words with their clients.

## **Confidentiality**

This study is anonymous. I will not be collecting or retaining any information about your identity that could identify you personally. I have no way of knowing who has or has not completed this survey.

All research materials, including the consent and survey, will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

## **Payments/gift**

You will not receive any financial payment or gifts for your participation.

## **Right to Refuse or Withdraw**

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point in the survey. If you wish to withdraw at any time, simply exit the survey or do not hit “Submit survey responses” at the end of the survey. If you exit the survey, I will not use any of your information collected for this study. Once you submit your survey responses, I will not be able to withdraw your information as I will have no way of identifying your responses.

## **Right to Ask Questions and Report Concerns**

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the

study, at any time feel free to contact me, HollyAnne Giffin at hgiffin@smith.edu or by telephone at xxx xxx xxxx. If you would like a summary of the study results, one will posted on my personal Facebook page by mid-July of 2016. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

### **Consent**

Clicking “I agree to the terms of this study” below will serve as your signature and indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

**[Button] I agree to the terms of this study**

**Form updated**

## Appendix B: Human Subjects Review Committee Approval



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### School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

January 19, 2016

HollyAnne Giffin

Dear HollyAnne,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*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.

Congratulations and our best wishes on your interesting study.

Sincerely,



Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Tonya Strand, Research Advisor

### Appendix C: Survey Questions

1. In general, how do you feel about the use of swear words?

Extremely positive      Positive      Neutral      Negative      Extremely Negative

2. How often do you swear on a typical day?

- a. More than once a day
- b. Once a day
- c. Once a week
- d. Once a month
- e. Never

3. I find swearing offensive.

Never    Rarely      Sometimes      Most of the time      Always

4. I swear, but only around my friends.

True      False

5. I change or monitor my use of swearing based on the people I am talking to or the people around me.

True      False

6. Therapist swearing is unprofessional.

True      False

7. Therapists should be able to swear around their clients.

True      False

8. Therapists should only swear if their client swore first.

True      False

9. I believe that swearing is appropriate for therapists in some situations.

True            False

10. Who swore first, you or your therapist?

- a. I swore first.
- b. My therapist swore first.
- c. I don't remember.

11. How did you feel the first time a swear word was used in your therapy?

[Short answer response]

12. In general, please describe how you feel about your therapist's swearing.

[Short answer response]

13. How often did your therapist typically swear?

- a. Once a month or less frequently
- b. Two or three times a month
- c. Once a session
- d. Multiple times a session

14. What are your opinions around how frequently your therapist swore? For example, do you wish that they swore less often? More often? Less or more often in specific scenarios?

[Short answer response]

15. In your opinion, what effect did your therapist's swearing have on your relationship?

- a. The therapist swearing helped our relationship.
- b. The therapist swearing didn't affect our relationship.
- c. The therapist swearing damaged our relationship.



16. Please describe an example of a time that your therapist swore.

[Short answer response]

17. How did you feel when your therapist used the swear word in the example you described above?

[Short answer response]

18. Please describe a time when your therapist swore and you found it helpful or useful. If you don't think that the swearing has ever been positive in this way, please put "not applicable."

[Short answer response]

19. Please describe a time when your therapist swore and you found it unhelpful or not useful. If you don't think that the swearing has ever been negative in this way, please put "not applicable."

[Short answer response]

20. Generally speaking, how is/was your relationship with your therapist?

Very good      Good      Neutral      Bad      Very Bad

21. What advice would you give to therapists regarding the use of swear words during therapy?

[Short answer response]

### Demographics

1. Which best describes your age?

a. 18-24

b. 25-34

c. 35-44

d. 45-54

- e. 55-64
  - f. 65 or over
2. Which best describes your age group while you were in therapy? Choose the answer that you feel fits best, even if the therapy bridged two or more age ranges.
- a. 17 or under
  - b. 18-24
  - c. 25-34
  - d. 35-44
  - e. 45-54
  - f. 55-64
  - g. 65 or over
3. Which best describes the age of your therapist? Please choose your best guess if you don't know their actual age.
- a. 18-24
  - b. 25-34
  - c. 35-44
  - d. 45-54
  - e. 55-64
  - f. 65 or over
4. Specify your race/ethnicity. Choose as many as you feel apply to your identity.
- a. Asian/Pacific Islander
  - b. Black or African American

- c. Chicano, Hispanic, or Latino
- d. Middle Eastern
- e. Native American or American Indian
- f. White or European-American
- g. Other

i. Specify other: [Short answer response]

5. What was the race/ethnicity of your therapist? Choose as many as you feel apply to their identity.

- a. Asian/Pacific Islander
- b. Black or African American
- c. Chicano, Hispanic, or Latino
- d. Middle Eastern
- e. Native American or American Indian
- f. White or European American
- g. Other

i. Specify other [Short answer response]

h. Unknown

6. How do you define your gender? Choose as many as you feel apply to your identity.

- a. Female
- b. Male
- c. Other

i. Specify other [Short answer response]

7. What was the gender of your therapist? Choose as many as you feel apply to your therapist's identity.

- a. Female
- b. Male
- c. Other
  - i. Specify other [Short answer response]
- d. Unknown

8. How long did you and the therapist work together?

- a. Shorter than two months
- b. Two to six months
- c. Six months to a year
- d. A year or longer

9. Which best describes your religious affiliation?

- a. Atheist
- b. Christian
- c. Jewish
- d. Muslim
- e. None
- f. Other
  - i. Specify other: [Short answer response]
- g. Spiritual not religious

10. How important is your religion to you?

Extremely Important  
Unimportant

Important

Neutral

Unimportant

Extremely