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The Impact of Personal Therapy on Therapists' Use of Self-Disclosure

by

Anne L. Breckbill, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial Fulfillment of the Requirements for the Degree of
Masters of Social Work

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

Abstract

This study explored how therapists' subjective experiences as client recipients of therapist self-disclosure impact their attitudes about therapist self-disclosure. Additionally, it investigated how therapists' personal therapy and theoretical orientation impact their use of self-disclosure with clients. Two specific types of therapist self-disclosure were studied: 1) emotional disclosures – or self-involving/transparent disclosures – in which therapists allow clients to see their emotional responses or reactions to the dynamics of the therapy session, and 2) personal disclosures – or self-disclosing/self-revealing disclosures – in which therapists share non-immediate personal information with clients. The nonprobability sample consisted of licensed psychotherapists who themselves had been psychotherapy clients. In an anonymous online survey, participants (n=101) reported on their experiences with therapist self-disclosure as clients and their subsequent use of self-disclosure as therapists. Data were analyzed using Spearman's Rank Order Correlations (quantitative) and Grounded Theory method (qualitative). Findings indicated both moderate and strong significant correlations between therapists' experiences as recipients of therapist self-disclosure and their use of self-disclosure with clients. Regarding both disclosure types, respondents were distinctly positive about their experiences of their therapists self-disclosing to them and identified the therapeutic alliance as the primary beneficiary of such disclosures. While respondents reported experiencing emotional disclosures negatively less frequently than personal disclosures, there is some indication that – when a disclosure is experienced negatively – the risk of damaging the therapeutic alliance may be greater for emotional disclosures than for personal disclosures. No significant relationships were found between theoretical orientation and respondents' experiences or use of therapist self-disclosure. Based on the findings in this exploratory study, further study into the impact of personal therapy on therapists' use of self-disclosure is warranted.

Keywords: therapist self-disclosure, personal therapy, apprenticeship of observation

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- Bill and Emilie Britton Norman

Dedication

For my parents, Bill and Ina Ruth Breckbill. Thank you for believing in me. Always.

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“Life is difficult. This is a great truth, one of the greatest truths” (Peck, 1978, p. 15). These opening lines of M. Scott Peck’s best-selling book, *The Road Less Traveled*, directly reference the first of Buddhism’s four noble truths, typically translated as the noble truth of suffering (Tsering, 2005). Adopting a multitude of strategies throughout history, humans consistently seek to make meaning of struggle, to cope with adversity, to change destructive behaviors, to understand reactions, and to stop or minimize suffering. In modern western society, many people turn to psychotherapy to address their internal struggles. A 2007 study conducted by Olfson and Marcus found that 3.18% of Americans participated in more than one outpatient psychotherapy session that year (2010). Given an estimated U.S. population of 315,091,138 in 2013, just over 10 million Americans will utilize outpatient psychotherapy to address their mental health issues (U. S. Census Bureau, 2012).

Psychotherapy is a dynamic process shaped by the unique contributions of therapist, client, and context. Given human diversity and the wide spectrum of social contexts, no two therapeutic interventions can ever be identical. While lending richness, interest, and mystery to the work of psychotherapy, this experiential diversity makes accurate measurement of the efficacy of specific therapeutic interventions extremely difficult. In their seminal meta-analysis of psychotherapy outcome data, Asay and Lambert (1999) identify four broad categories of therapeutic factors that function as determinants of client outcomes. They conclude that client variables and extratherapeutic events, such as social support and life events, account for a full 40% of client improvement. This category is, by definition, outside of the therapist’s direct control. The client’s expectation of improvement upon intake, to which 15% of positive outcomes are attributed, is also beyond the therapist’s direct control. Surprisingly, the therapeutic

techniques and approaches employed – the factor over which the therapist has the most influence – is the major contributing factor in only 15% of positive outcomes as well. However, the therapist does have profound influence in forging an effective therapeutic relationship, the factor to which 30% of positive outcomes are attributed. These findings suggest not only that the sphere of a therapist's influence in psychotherapy may be smaller than originally thought but also that creating an effective therapeutic alliance is the therapist's most influential contribution to a positive client outcome. To maximize the influence of both the alliance and techniques used, an effective therapist must utilize techniques that will enhance the alliance and create an alliance capable of augmenting the positive impact of the techniques employed (Asay & Lambert, 1999). Despite growing pressure within the practice of psychotherapy to develop and employ "evidence-based practice," much of the therapeutic process is subjective.

The therapist's subjective self is situated at the intersection of the therapeutic alliance and the therapeutic technique. As Kaiser (1997) notes, "...the very nature of clinical work is such that a practitioner's primary tool is him- or her-self" (p. 74). Consequently, it is this subjective self – a construct of beliefs, theoretical understandings, personal and professional experiences, educational training, values, and personality – that builds a unique alliance with a client and decides what techniques to employ. How a therapist makes use of his or her subjective self in the context of psychotherapy affects the therapeutic intervention, the therapeutic alliance, and the ethical integrity of the therapist's practice. The presence and significance of the therapist's self in psychotherapy is evident in the use of terms such as "judicious use of self," "self-awareness," and "countertransference" that pepper social work research literature and educational textbooks. Where therapists lack consensus however, is in defining what specific uses of self are appropriate, judicious, and helpful.

Therapist self-disclosure – a self-referent therapeutic technique to some and a clinical mistake to others – remains one of the most hotly contested uses of the therapist’s self (Peterson, 2002). Opinions and practices about therapist self-disclosure vary from therapist to therapist, often by discipline, theoretical framework, and therapist demographics (Jeffrey & Austin, 2007; Knight, 2012). What is clear, however, is that therapists are using self-disclosure in their work with clients (Henretty & Levitt, 2009; Kelly & Rodriguez, 2007). Most report that, while they do it infrequently, when they choose to disclose information to clients they usually do so with a specific rationale in mind. Additionally, the majority of therapists report that they engage in therapist self-disclosure when the need for it is clear (Knight, 2012; Mathews, 1988; Simi & Mahalik, 1997; Simone, McCarthy, & Skay, 1998). Unfortunately, a situation in which therapist self-disclosure might be helpful is rarely unambiguous (Heydt & Sherman, 2005).

In many cases, existing research has contributed to this ambiguity. Although there are numerous studies on the use and efficacy of therapist self-disclosure, research findings are frequently in conflict with one another as some studies indicate that therapist self-disclosure is generally harmful and others that it is generally beneficial. In addition, the majority of empirical studies on the subject, with a few notable exceptions, base their findings on the perceptions of the therapist alone, leaving questions about perceived versus actual harm or benefit (Hill, Mahalik, & Thompson, 1989; Knox et al., 1997; Wells, 1994).

Where does this confusion and conflicting data leave a therapist trying to decide how, whether, or when to use the technique of self-disclosure? Is the decision one dictated solely by theoretical orientation? How does a therapist judge the efficacy of using self-disclosure if, as has been noted, nearly all the existing research measures therapists’ perceptions of harm or benefit rather than clients’ actual harm or benefit?

When faced with such questions and ambiguity, perhaps a therapist's subjective personal and professional experiences with self-disclosure wield the most influence. Therapists who have personally experienced being a client in therapy – an estimated three-quarters of all therapists – offer a unique opening into understanding the impact of subjective personal experiences on the use of self-disclosure (Norcross & Guy, 2005). These therapist-clients, as they will be referenced throughout this study, hold their own understandings of how therapist self-disclosure (or non-disclosure) was therapeutically helpful or harmful. Their unique position provides opportunity for them to reflect on how these client experiences have impacted their own use of self-disclosure as a therapeutic technique. Given the high percentage of therapists who have participated in personal therapy, understanding the impact of personal therapy on professional practice is key to appreciating the subjective nature of therapy. The purpose of this study is to explore how therapists' subjective experiences as client recipients of therapist self-disclosure impact their attitudes about therapist self-disclosure. Additionally, this study will investigate how therapists' personal therapy and theoretical orientation impact their use of self-disclosure.

Literature Review

Personal Therapy: A Psychotherapist's Psychotherapy

Personal treatment – receiving, recommending, and conducting it – is, in many respects, at the epicenter of the educational universe for psychotherapists. Psychotherapists' training, identity, health, and self-renewal revolve around the personal therapy experience.

– John Norcross (2005, p. 841)

Therapists are granted no exception to the great truth that life is difficult. It is not surprising that the majority of therapists have participated in therapy as clients at some point in their lives. It seems logical and compelling that those who provide psychotherapy believe in its

efficacy enough to seek it out in their own lives as needed. Although the prevalence of therapists who have also been therapy clients fluctuates across disciplines and theoretical orientations, 75% of all therapists have been clients at some point in their lives (Norcross & Guy, 2005). As will be discussed later, certain disciplines and theoretical orientations either mandate or highly suggest that students participate in personal therapy as part of their training process.

Interestingly, this fact does not inflate the percentage of therapists who have had personal therapy as much as one might imagine. In fact, a 2005 meta-analysis study of prior research indicates that between 43% and 65% of therapists return to or seek personal therapy after completing their formal training or obtaining their terminal degree (Norcross & Guy, 2005). Over the last 30 years, John Norcross and colleagues have undertaken numerous longitudinal meta-analyses of psychotherapists' personal psychotherapy. Their research provides an interesting synopsis of the psychotherapists seeking psychotherapy, the type of psychotherapy selected, their presenting concerns, and the impact their personal therapy has on their professional practice.

The impact of theoretical orientation on personal therapy. Of all therapist-client variables studied, none wields more direct influence on the incidence of personal therapy than does theoretical orientation. As previously noted, participation in personal psychotherapy is a mandated component for certain theoretical orientations. Primary among these is psychoanalysis, the historical ancestor of most modern psychotherapies. Evidenced in his essay, *Analysis Terminable and Interminable*, Freud (1937/1964) strongly believed personal therapy was foundational to the practice of psychoanalysis: "But where and how is the poor wretch to acquire the ideal qualification which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins" (p. 246). It comes as no

surprise that the percentage of psychoanalytic therapists who have received personal therapy (82%-100%) is higher than in any other orientation (Norcross, 2005). Psychodynamic therapists, in keeping with their psychoanalytic roots, participate in personal therapy only slightly less (82%-97%) than their psychoanalytic counterparts (Norcross & Guy, 2005). In contrast, behavioral therapists have the lowest incidence (44%-66%) of personal therapy. Therapists who identify with humanistic, systems, and eclectic theories fall between these two extremes.

The more interesting findings about theoretical orientation concern the type of therapy therapists choose for personal therapy. Irrespective of professional orientation, psychotherapists most frequently choose psychoanalytic/psychodynamic therapy for their personal therapy (Norcross & Grunebaum, 2005). Given Freud's position, it may come as no surprise that 94% of psychoanalytic and 79% of psychodynamic therapists seek personal therapy from a psychoanalytic or psychodynamic therapist (Norcross, Strausser, & Faltus, 1988). Although across all orientations (with the exception of behavioral therapy) there exists some relationship between the therapist-client's orientation and that of their therapist, psychoanalytic and psychodynamic therapists show the highest loyalty to their orientation (Norcross & Grunebaum, 2005). Interestingly, behavioral therapists, showing no loyalty to behavioral therapy, choose their own orientation for their personal therapy only six percent of the time (Norcross, et al., 1988)! They, like therapists of most orientations – and, increasingly, psychoanalytic and psychodynamic therapists as well – exhibit a breadth of variety in the theoretical orientation of their personal therapist.

The purpose of personal therapy. The reasons therapists seek personal therapy are surprisingly not directly connected to their practice of psychotherapy. In fact, their presenting issues are nearly identical to those of therapy clients with similar levels of education (Norcross,

2005). However, despite the fact that therapists seek personal therapy for reasons similar to those of non-therapists, they do so with an understanding that their personal therapy may secondarily benefit their professional practice. When therapists were given the opportunity to identify multiple reasons for seeking therapy, 60% selected personal growth, 56% selected personal problems, and 46% selected training (Orlinsky, Norcross, Rønnestad, & Wiseman, 2005).

Therapists struggle with difficulties and issues similar to those of the clients they serve. Although therapists bear huge responsibilities in their practice, personal issues rather than professional ones are what precipitate personal therapy. In two studies involving hundreds of practitioners, only one therapist sought personal therapy in response to a client issue (Norcross, Strausser-Kirkland, & Misar, 1988; Norcross & Prochaska, 1986). It appears that while specific client concerns may activate the therapist's own issues, client concerns are rarely the central focus of therapists' personal therapy.

Personal therapy's impact on professional practice. Given the impossibility of conducting ethical experimental research on a therapist's personal therapy and client outcome data, there is no reliable evidence that personal therapy has either a positive or negative effect on client outcomes. In fact, this has been the nearly unanimous conclusion of researchers who have studied existing client outcome data (Macran & Shapiro, 1998; Orlinsky, Norcross, et al., 2005). The existing data is compromised by small sample sizes, confounded variables, and unsophisticated outcome assessments. Ultimately, information on personal therapy's impact on therapists' professional practices will likely come from reflections and perceptions of psychotherapists themselves.

Personal therapy as a professional development and training tool. Overwhelmingly, therapists who have participated in personal therapy perceive it as beneficial to their professional

development. In an early study, only 4% of therapists who had participated in personal therapy identified it as being unimportant as a prerequisite for providing psychotherapy (Norcross, Dryden, & DeMichele, 1992). Interestingly, only 38% of therapists who had not participated in personal therapy maintained that it was unimportant as a prerequisite for clinical work. This suggests that the majority of therapists – irrespective of their history of personal therapy – assign some importance to personal therapy as a prerequisite to conducting therapy. In fact, personal therapy is ranked as the third most critical source of positive professional development by therapists in general (Orlinsky & Rønnestad, 2005). Only direct client contact and formal case supervision were ranked higher. Although a small number (3%) of therapists have reported any negative impacts of personal therapy on their professional practice, the vast majority (75%) believes that personal therapy has had a strong positive influence on their professional skills (Norcross & Guy, 2005).

Areas of impact. This strong, positive influence appears to significantly impact the therapeutic alliance. Such an impact is critical if Asay and Lambert's (1999) findings are accurate – that 30% of positive outcomes are attributable to the therapeutic alliance. In a survey of process studies containing both self-reported and rater-observed effects of personal therapy, therapists who had participated in personal therapy showed increased empathy toward clients, decreased dislike of clients, increased warmth and genuineness, increased awareness of the transference/countertransference matrix, and an increased emphasis on the therapeutic relationship (Norcross, 2005). In 1987 and again in 2008, Norcross and his colleagues surveyed the lessons that therapists learned by having participated in personal therapy (Norcross, Strausser-Kirtland, et al., 1988; Bike, Norcross, & Schatz, 2009). While the second study revealed some lessons not identified in the earlier study, four lessons remained constant: warmth

and empathy are critical to the alliance, clients require patience and tolerance from their therapists, psychotherapy is effective and change is possible, and the therapist's use of self is essential. In offering his own summary of the lasting impact of personal therapy on a therapist's professional practice, Norcross (2005) states:

It seems virtually impossible to have undergone personal therapy without emerging with heightened appreciation of the interpersonal relationship between patient and therapist and the vulnerability of the patient. It is also worth noting that very, very few of the psychotherapists related that their lasting lesson from personal therapy concerned the effectiveness of a specific technique (p. 844).

Therapist Self-Disclosure

We are never truly 'neutral' observers and interpreters. In every word and comment we implicitly convey something of our own life experience, our standards and beliefs, something we feel about the patient as a human being. How could it be otherwise?

– Emmanuel Peterfreund (1983, p. 108)

While existing literature does not identify the use of any specific technique as being one of the fundamental lasting lessons therapists acquire during personal therapy, it does imply that therapists who have participated in personal therapy have an increased appreciation for the therapist's use of self in therapy. Disclosing information about oneself is one dimension of the ways in which a therapist's self is used in the course of therapy. As the Peterfreund quote above suggests, there is a growing recognition within the profession of the ubiquitous nature of self-disclosures. In an effort to investigate the prevalence and impact of therapist self-disclosure, the multiple types of self-disclosure warrant clear operational definitions.

Definitions and types of therapist self-disclosure. Although the term therapist self-disclosure may suggest one specific therapist behavior, what constitutes self-disclosure varies greatly between therapists, researchers, theoretical orientations, and therapeutic disciplines

(Jeffrey & Austin, 2007; Knox & Hill, 2003). Self-disclosures have been defined and categorized a variety of ways. For instance, Pizer's (1993) categories of self-disclosure, determined by the therapist's reason for disclosing, include disclosures that are inescapable (such as pregnancy or illness), inadvertent (the affective disclosures fueled by countertransference and the therapist's personal affect), and deliberate. Constantine and Kwan (2003) define self-disclosure as the behavior – either verbal or non-verbal – of revealing personal information to a client. Most researchers, however, define and categorize therapist self-disclosure based on the nature of the content disclosed. For Hill and O'Brien (1999), this process of definition and categorization resulted in four distinct types of disclosures: factual, feelings, insights, and strategies. Knox and Hill (2003) expanded these four types of disclosures into seven discrete types, including facts, feelings, insights, strategy, reassurance/support, challenge, and immediacy.

Operational definitions. Therapist self-disclosures occur verbally and nonverbally, as well as intentionally and unintentionally. Therapists reveal something of themselves to clients in every question, in every technique, and in every shrug, nod, or smile. Therapists' demographic identities such as race, age, and gender are personal disclosures as are the cars they drive, the clothes they wear, the location of their office, and their office décor. While each of these disclosures merits investigation, this study focuses on two specific types of therapist self-disclosure. Knox, Hess, Peterson, and Hill (1997) defined therapist self-disclosure as “an interaction in which the therapist reveals personal information about him/herself, and/or reveals reactions and responses to the client as they arise in the session” (p. 275). The current study, while utilizing this broader definition, distinguishes between self-disclosing (revealing personal information) and self-involving (revealing reactions or responses) types of disclosure. This

distinction is congruent with much of the recent research (Hanson, 2005; Henretty & Levitt, 2010; Knight, 2012).

Self-disclosing disclosures. Self-disclosing disclosures, sometimes called self-revealing disclosures, occur when therapists share non-immediate personal information with clients. Non-immediate, in this case, refers to information about a therapist's life outside of the therapy session. Although the disclosure may be very closely connected to the content of the session, it references events, facts, or experiences about the therapist that are not occurring in the session itself. This is the type of disclosure that is most frequently researched and that typically comes to mind when one hears the term "therapist self-disclosure." This type of disclosure occurs when therapists tell clients about their own experiences in hopes of making connections, sharing strategies or insights, normalizing clients' experiences, eliciting similar client disclosures, or offering understanding and support. The majority of existing research explores this type of disclosure, even though in many cases this operational definition is not clarified (Barrett & Berman, 2001; Constantine & Kwan, 2003; Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Knox & Hill, 2003).

Self-involving disclosures. Self-involving disclosures, sometimes called transparent disclosures, occur when therapists allow clients to see their emotional responses or reactions to the dynamics of the therapy session. These responses or reactions may be verbal or nonverbal, are immediate to the session, and are rooted in the transference/countertransference matrix. Given that both countertransference and human emotion often originate from subconscious origins, therapists may not always intend to make self-involving disclosures. For instance, as a therapist listens to a tragic client story of loss and grief, she may find her own eyes welling with tears before she has the opportunity to decide how she wishes to respond. In other cases,

therapists might intentionally decide to make their reactions of countertransference explicit to the client. Knox and Hill (2003) provide an example of such a disclosure in their description of disclosures of immediacy: “As you describe the cold relationships in your family now, I am aware that I am feeling very distant and closed off from you. I wonder if that is similar to how you felt with your family?” (p. 530). Self-involving disclosures are typically affective reactions or responses to the content and relational dynamics of the session.

Therapist self-disclosure and theoretical orientation. Although an alarming 80% of respondents in a recent study either disagreed or strongly disagreed that their self-disclosing behaviors were grounded in theory and research, neither theory nor research has been silent on the topic of therapist self-disclosure (Knight, 2012). In fact, the exact opposite is closer to the truth. Proponents of various theoretical schools of psychotherapy have offered passionate arguments for and against the use of therapist self-disclosure.

Psychoanalytic/psychodynamic approaches. As is frequently the case in debates concerning the practice of psychotherapy, the controversy regarding therapists’ use of self-disclosure can be traced back to Freud’s psychoanalytic theory. Most literature reviews concerning self-disclosure point to Freud’s metaphorical stance that therapists should be “like a mirror, reflect nothing but what is shown” (Freud, 1912/1963, p. 124) as the origin of the idea that self-disclosure is bad psychotherapeutic practice. However, citing a letter Freud wrote to Ferenczi, Geller (2003) suggests that Freud himself found the fervor and rigidity with which his followers obeyed his instruction troubling:

I thought it most important to stress what one should not do, to point out the temptations that run counter to analysis. Almost everything one should do in a positive sense I left to tact. What I achieved thereby was that the obedient submitted to those

admonitions as if they were taboos and did not notice their elasticity (Grubricht-Simitis, 1986, p. 270, in Geller, 2003).

Similarly, Bloomgarden and Mennuti (2009) contend that while Freud's "therapeutic neutrality" constituted a call for therapist objectivity, the rigidity with which it has been interpreted often suggests that achieving objectivity requires being nondisclosing and distant.

Consequently, it should not be surprising that adherents to a pure psychoanalytic model of therapy offer the loudest admonishments against the use of therapist self-disclosure. In traditional psychoanalytic thought, self-disclosure interferes with transference – the client's projections of early relationships onto the therapeutic relationship. In psychoanalysis' purest doctrine, even countertransference – the therapist's responses towards the client – is considered an obstacle to positive therapy outcomes (Carew, 2009).

Psychodynamic theorists, in extending psychoanalytic thought, place increased importance on the relational aspects of psychotherapy while decreasing focus on the classical drive theory and its projections (Carew, 2009). In psychodynamic thought, countertransference is no longer regarded as an impediment to therapy, but as a tool that can provide additional insight into the client's psyche. In keeping with this shift toward a more relational approach, many psychodynamic therapists have incorporated the use of self-disclosure into their practice with clients (Bridges, 2001).

Humanistic/person-centered approaches. During the mid-1950s, Carl Rogers and others developed a highly relational approach to psychotherapy. This "person-centered" or humanistic approach was a substantial departure from the two major schools of psychotherapy, neither of which supported the use of therapist self-disclosure. These existing schools – Freud's psychoanalysis and the behaviorism theories of B. F. Skinner and Ivan Pavlov – occupied opposite ends of the spectrum explaining human behavior (Forte, 2007). At one end,

psychoanalysis proposed that human behaviors have their roots in early childhood experiences and are internally motivated by the unconscious drives of the id, ego, and superego. At the other end, behaviorism suggested that human behavior could be explained scientifically as conditioned responses to external antecedents and consequences. Rogers, on the other hand, conceptualized humans as aware, creative beings, shaped by their social and environmental relationships and equipped with free will. Central to his theory is that individuals' phenomenological experience – “the touchstone of validity” – constitutes their reality and becomes the nonpositivist perspectival frame for understanding the individual. Where individuals' experiences offer perspective and understanding, it is relationships – marked by warmth and “unconditional positive regard” – that provide avenues for personal growth and change:

...In my early professional years I was asking the question, How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth (Rogers, 1961, p. 32)?

Leading theorists in this approach identified a similar central element of an effective therapeutic relationship. For Rogers (1957), this element was congruence; for Jourard (1964), transparency; for Bugental (1965), authenticity; for Kaiser (1965), openness; for Truax and Carkhuff (1967), genuineness.

In service of providing this essential element, person-centered or humanistic psychotherapists value honest, genuine self-disclosure. Therapists give clients information about themselves as part of the therapeutic process (Carew, 2009). In this way, they establish transparency and authenticity in the client/therapist relationship and can meet clients' reality with their own credible experiences. Jourard (1964) – the first to call the revelation of personal information “self-disclosure” – also introduced the idea of the “dyadic effect.” Person-centered

therapists identify this phenomenon – in which personal self-disclosure invites disclosure from its recipient – as a valuable derivative of therapist self-disclosure.

Cognitive-behavioral approaches. Although early behaviorists discouraged using self-disclosure, Albert Ellis identified potential merits to this device as he combined behavioral ideas with the more cognitive approaches in rational-emotive therapy (Dryden, 1990). Specifically, he believed that self-disclosure could be effective in modeling behavior, strengthening the therapeutic relationship, and providing hope to clients. Aaron Beck, a former psychoanalytic practitioner and the creator of cognitive-behavioral therapy, endorsed judicious use of self-disclosure as a means of creating a warm, empathic connection with clients and to encourage reciprocity (Carew, 2009). Beck et al. (1960) noted that self-involving disclosure, in particular, could be effectively utilized to help clients understand their impact on others (p. 66).

Systemic approaches. A number of modern and post-modern approaches to psychotherapy understand human behavior as predicated on the context and system in which it occurs. A premise of postmodernism is that a single objective reality is unknowable; rather, humans live in a world of multiple realities (Hoffman, 1990). All concepts of reality are social constructs, contextual in nature, and mediated through language (Kogan & Gale, 1997). With this premise as a theoretical foundation, an individual experience cannot be viewed independently from the social context and conversations that give the experience meaning and direction (Gergen, 1985).

Family therapy theorists differ in their approach to therapist self-disclosure (Carew, 2009). The structural family therapy approach discourages its use so as to keep the focus on the family. Minuchin did propose, however, that carefully chosen stories from the therapist's life might be used as a bridge to join the family. Bowen's family systems and symbolic-experiential

approaches, on the other hand, view therapist self-disclosure as essential to the therapy and the therapeutic relationship.

Feminist therapy, also influenced by postmodern thought, identifies the power imbalances inherent in the social constructs of patriarchy, classism, racism, and heterosexism. Feminist therapists may disclose to clients as a means of mitigating the power imbalance between therapist and client, to demystify therapy, or to remove a sense of status (Brown, 1994). By disclosing bias, experiences, or identities, the feminist therapist provides the client a context to assess whether the therapist will be able to provide unbiased and nonjudgmental support (Brown & Walker, 1990).

Narrative therapy, developed by Michael White and David Epston, is one of the more recent therapeutic approaches to emerge from postmodern thought. As a postmodern therapeutic framework, narrative therapy does not submit to socially constructed definitions of mental health and mental illness. Problems themselves are seen as constructions and stories that exist outside of the individual. There is significant emphasis on externalizing these problems or stories to provide a perspective for objectifying and investigating them (White & Epston, 1990). For the narrative therapist, therapy is a conversational collaboration between the therapist and the client. In this collaboration, the client is always at the center and is attempting to critically assess the stories that have shaped his or her identity and create alternate stories if needed. The therapist's role is always de-centered but is influential in bringing curiosity, interest, and an expertise in using questions to help the client externalize his or her story. Like feminist therapists, narrative therapists maintain a vigilant awareness of power. This includes the awareness of power within the conversation as well as the power of hegemonic narratives that have prominence over marginalized narratives. Based on this awareness of power, narrative therapists strive to be

cognizant about their positions of power/marginalization and identities of power/marginalization in their work with clients. For many narrative therapists, this includes providing clients with information about their power-related positions and identities, thus allowing clients a perspective for situating their therapeutic experiences.

Incidence of therapist self-disclosure. Although over 90% of therapists have, on at least one occasion, intentionally disclosed personal information (self-disclosing disclosures) about themselves to their clients, it appears that they make such disclosures relatively infrequently (Mathews, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987; Edwards & Murdoch, 1994). For example, Knight's (2012) study of clinical social workers reveals that out of eight topics of self-disclosing disclosures, 85% of respondents indicated that they infrequently or never make similar disclosures. In the same study, 80% of respondents agreed or strongly agreed that they were comfortable making self-disclosing disclosures to clients if appropriate. Not surprisingly, self-involving disclosures appear to be made more frequently and with less hesitation. In fact, 40% of respondents reported that they frequently or very frequently allowed clients to observe their reactions to the clients' disclosures.

Impact of therapist variables on self-disclosure. Henretty and Levitt's (2010) qualitative study of existing quantitative research regarding the use of therapist self-disclosure provides a useful summary of the many factors that impact the use of therapist self-disclosure and of the effects of disclosures on clients. Some common therapist and client demographic variables, such as age and gender, show no relationship to the incidence or amount of therapist self-disclosure. Although the results are mixed, there may be a slight relationship between the therapist's amount of clinical experience and the amount of self-disclosure used – with less experienced therapists using less self-disclosure. Theoretical orientation is another therapist variable that appears to

have some impact on the amount of self-disclosure used although the results are once again mixed and inconclusive. If any difference exists between therapists' theoretical orientation and self-disclosure, it is that psychodynamic/psychoanalytic therapists engage in less self-disclosure than therapists identified with other orientations. However, it is significant that this difference is small enough to lack statistical validity, challenging the broad assumption that psychodynamic/psychoanalytic therapists are far less disclosing.

Impact of client variables on therapist self-disclosure. Diagnosis and symptomology are the only client variables that appear to affect the amount of therapist self-disclosure. Therapists tend to disclose less to clients with personality disorders (Mathews, 1989) and disclose more to clients with minimal pre-treatment symptomology (Kelly & Rodriguez, 2007). While client demographic variables do not appear to impact the amount of therapist self-disclosure, ethnicity and sexual orientation appear to have some impact on client preferences regarding therapist self-disclosure. The research on client ethnicity and therapist self-disclosure is insufficient to establish clear relationships between the many different combinations of culture within the therapeutic dyad and the impact of therapist self-disclosure. However, Henretty and Levitt's (2010) summary of existing studies suggests that clients of Mexican cultures may prefer therapists who do not self-disclose while African-American clients may prefer therapists who do. Finally, it also appears that clients of minority sexual orientation prefer that therapists disclose their sexual orientation and prefer that they share the same sexual orientation. However, it is worth noting that the research in this area is relatively old (1980-1990) and societal stigma regarding sexual orientation is rapidly changing. Therefore, these findings may not reflect current preferences.

Impact of therapist self-disclosure. The combination of theoretical orientation, therapist variables, and client variables exerts a powerful influence on therapists' decisions concerning self-disclosure with clients. While existing research shows that most therapists report using self-disclosure (particularly self-disclosing disclosures) infrequently, the vast majority of therapists indicate that when they do make disclosures to clients, they do so with a specific therapeutic rationale in mind (Knight, 2012). Even those therapists who indicate that they rarely or never use self-disclosure with clients report that they would be comfortable doing so if the need for it were clear. Essentially, it appears that therapists do or would use self-disclosure as a therapeutic technique if they think it will help clients.

Is therapist self-disclosure helpful to clients? Findings regarding the impact of therapist self-disclosure on client treatment outcomes are mixed and unreliable. However, Henretty and Levitt's examination (2010) of existing research offers insight into how therapists' self-disclosure impacts client perceptions and therapeutic behaviors. This qualitative review clarifies the impact of therapists' use of self-disclosure on client perceptions of the therapist, on client perceptions of the therapy, and on the clients' own disclosing behaviors.

Impact on client perceptions of the therapist. In their amalgamation of the past four decades of research, Henretty and Levitt (2010) gauged the impact of therapist self-disclosure on clients' perceptions of therapists by assessing eight therapist-related variables: expertness, trustworthiness, attractiveness, level of regard, empathy, congruence, unconditionality, and warmth. Therapist self-disclosure had no reliable, significant effect – in either the positive or negative direction – on the five variables of trustworthiness, level of regard, empathy, congruence, and unconditionality. Warmth, the only variable upon which therapist self-disclosure had both a reliable and significant effect, was positively impacted. The effect on the

variables of therapist attractiveness and therapist expertness was not reliable. However, each of these two variables exhibited a discernable trend. If therapist self-disclosure impacts these variables, the impact is slightly negative on expertness and slightly positive on attractiveness.

Impact on client perceptions of the therapy. Henretty and Levitt (2010) found that therapist self-disclosure had a perceived positive effect on clients. Clients identify a stronger liking for therapists who self-disclose and report feeling a stronger relational connection to them. However, clients responded more positively to self-involving therapist disclosures than to self-disclosing disclosures.

Impact on client disclosures. The compilation of existing research appears to support Jourard's "dyadic effect" (Jourard, 1964). Moderate therapist self-disclosure appears to elicit increased client self-disclosure. However, it is unclear whether therapist self-disclosure impacts only the amount of client self-disclosure or whether it impacts the quality or intimacy of those disclosures as well.

Research questions

This study examines how therapists' subjective experiences as client recipients of therapist self-disclosure impact their attitudes about therapist self-disclosure. It will also investigate the role of theoretical orientation in decisions regarding therapist self-disclosure. The research questions for this study are:

1. Is there a statistical relationship between therapists' experiences of therapist self-disclosure in their own personal therapy and their use of self-disclosure in their therapy practices?
2. How do therapists' experiences of therapist self-disclosure in their own personal therapy impact their use of self-disclosure in their therapy practices?

3. Is there a relationship between therapists' theoretical orientations and their use of therapist self-disclosure in their therapy practices?

Conceptual Framework

Theoretical Orientations to Psychotherapy

As noted in the literature review, therapists' decisions both to seek personal therapy and to self-disclose to clients are impacted by theoretical orientation. For the purposes of this study, the abundant theories within the field of psychotherapy have been roughly categorized into four groups: psychoanalytic/psychodynamic, humanistic/person-centered, cognitive-behavioral, and systemic. These broad categories of psychotherapy theories – as well as each category's understanding or acceptance of therapist self-disclosure – have been previously described. Although clearly reductionistic, this categorization provides a crude means of assessing congruence between therapists' use of self-disclosure and their espoused theory's position on self-disclosure.

“Apprenticeship of Observation” Concept

The apprenticeship concept in teacher education. In an attempt to understand the impact of therapists' experiences in personal therapy on their professional therapeutic practice, this study adapts a concept from the field of teacher education. Lortie first identified the concept – “apprenticeship of observation” – in his seminal mixed-methods study of schoolteachers (Lortie, 1975). In establishing the importance of having observed teachers prior to becoming teachers, Lortie states:

...participation in school has special occupational effect on those who do move to the other side of the desk. There are ways in which being a student is like serving an apprenticeship in teaching; students have protracted face-to-face and consequential

interactions with established teachers. Those who teach have normally had sixteen continuous years of contact with teachers and professors ... we can estimate that the average student has spent 13,000 hours in direct contact with classroom teachers by the time he [sic] graduates from high school (Lortie, 1975, p. 61).

Although this idea has intuitive resonance, the apprenticeship of observation possesses a largely negative connotation. For those involved in providing teacher education, it suggests pre-service teachers are already inflexibly entrenched in conventional pedagogy by the time they reach teacher education programs and that such programs lack the power to influence novice teachers' beliefs and practices (Mewborn & Tyminski, 2006). Lortie's apprenticeship of observation arose from a broad sociological study of teachers rather than a specific review of education pedagogy. Yet rather than signifying the influence of observing a variety of teaching styles – both effective and ineffective – on a pre-service teacher's understanding of the profession, the term has unfortunately become nearly synonymous with the idea that “teachers teach the way they were taught” (Heaton & Mickelson, 2002, p. 51). Lortie himself identified significant limits to the apprenticeship metaphor. He acknowledged that students observe teachers from a unique vantage point as students rather than watching “the teacher's performance from the wings; they are not privy to the teacher's private intentions and personal reflections on classroom events” (Lortie, 1975, p. 62). Consequently, their lessons about effective teaching are connected more closely to intuition and imitation than to pedagogical principles.

Mewborn and Tyminski (2006) offer a more balanced approach to Lortie's apprenticeship metaphor. They suggest that students' experiences of observing teachers, while highly influential in shaping their beliefs and attitudes about teaching, do not fatalistically determine how those students will teach:

Invoking Lortie's apprenticeship of observation, as an explanation for the failure of

teacher education programs and practices, leads to a downward spiral in which teacher educators are either absolved of all responsibility for making change or are rendered powerless by the influence of prior experience (Mewborn & Tyminski, 2006, p. 32).

Rather, they suggest that students' apprenticeship of observation is a valuable asset to teacher education. The entirety of student observations and experiences – both positive and negative – form the substance of their beliefs and attitudes about teaching. Teacher educators, then, must provide opportunities for new pre-service teachers to critically analyze the origin and merit of their beliefs about teaching in order to develop, amend, or reject them as necessary.

The apprenticeship of observation as conceptual framework. While the “apprenticeship of observation” concept may have been over-privileged as an explanation for the eventual decisions teachers make when teaching, it may be under-privileged as an explanation for the decisions psychotherapists make when providing psychotherapy. The apprenticeship therapist-clients experience in their personal therapy is quite similar to the apprenticeship future teachers experience as students. As students in a classroom observe their teachers at work, therapist-clients observe their therapists at work. They, too, observe from a position in which they are not privy to their therapists' rationale, intentions, impressions, or thinking. What is unique and rich about this position is not its capacity for transmitting theories and concepts or for building skills and analyzing techniques. Its inimitable richness is the access it provides for therapist-clients to experience the subjective impact of therapy – therapy done well or done poorly – and of a therapeutic relationship. Focused specifically on therapist self-disclosure and using an apprenticeship of observation lens, this study will explore how the subjective experiences of therapists' personal therapy influence their work as therapists.

Methods

Research Design

In expanding the current findings regarding therapists' use of self-disclosure and whether that use is influenced by similar experiences in their personal therapy, this study utilized a mixed-method design. The predominantly quantitative data was collected through a voluntary, anonymous survey. Given the exploratory nature of aspects of this research, respondents were given an opportunity to offer their own insights and understandings about the research topic.

Sample

This research studied a uniquely defined target population of individuals who a) were currently in or had been in personal psychotherapy, b) were currently providing or had provided psychotherapy in a practice setting, and c) were currently or had been professionally licensed to provide psychotherapy in the state in which they practice(d). Based on these specific characteristics and the private nature of personal therapy, it was impossible to develop an exhaustive sampling frame of this population. Consequently, the study employed a nonprobability sample using availability and snowball sampling methods.

Protection of Human Subjects

Sampling and recruitment process. In order to make the combination of availability and snowball sampling methods effective, a two-pronged recruitment strategy was employed. The researcher utilized formal, informal, personal, and professional connections with practicing psychotherapists to disseminate information about this study. Professional colleagues and acquaintances of the researcher and research team members were either contacted by telephone

or emailed with information about the study and instructions for accessing the survey (see Appendices A and B).

The second prong of the recruitment strategy focused on ways to encourage survey respondents to invite their personal and professional contacts to participate in the survey as well. At the end of the survey, respondents were directed to a web page thanking them for their participation (see Appendix C). This page also provided participants with resources for inviting colleagues to the survey, such as:

- A short post about the study (including a link to the survey) for inclusion in email lists, electronic newsletters, blogs, or online bulletin boards
- A survey link to copy into an email
- A more detailed customizable email to send to colleagues
- A printable page of informational cards for distribution at face-to-face meetings (see Appendix D)
- A printable page with study information and tear-off survey links for posting on bulletin boards (see Appendix E)

Confidentiality and anonymity of participants. All study data was collected anonymously using the online survey tool, Qualtrics. Rather than employing Qualtrics' anonymous distribution feature, the survey link was sent to potential respondents using the recruitment methods described above. Using this approach, the researcher was able neither to identify whether a specific individual completed the survey nor match specific responses with a specific individual. The Qualtrics survey tool collected and stored the data anonymously in a password-protected electronic database. Additionally, prior to data collection, the research design and methods for this study gained approval from the University of St. Thomas Internal Review Board.

Informed consent. Each study participant was given a clear description of the study and was asked to read an “Informed Consent Form” prior to taking the actual survey (see Appendix F). This form indicated that the respondent’s decision to begin the survey and submit it when completed was indication of consent. At any point during the survey, respondents had the option to cancel rather than submit the survey. Additionally, participants were free to skip questions of the survey. These instructions, along with information about the voluntary and anonymous nature of the survey, were detailed in the “Informed Consent Form.”

Risk and benefits to participants. Due to the personal nature of seeking therapy and the taboo against therapist self-disclosure in some circles, the focus of this study included some areas of sensitivity and vulnerability. However, it did not pose significant risks to participants since participation in the survey was voluntary and all responses were confidential and anonymous. Participants of the study likewise did not receive significant benefits from having participated. After submitting the survey, respondents were directed to a web page that thanked them for their participation. Additionally, this page provided information about how to access the study’s findings as well as a short bibliography of relevant research regarding therapist self-disclosure and personal therapy (see Appendix C).

Operationalizing and Measuring Study Variables

While the topics of personal therapy and therapist self-disclosure have been extensively researched, there was a paucity of existing research focused on the nature of the relationship between these two topics. Consequently, this study was designed to explore the viability of further research on the hypothesis that there is a statistically significant relationship between therapists’ experiences of therapist self-disclosure in their own personal therapy and their use of therapist self-disclosure with their clients. In order to answer the research questions, variables

pertaining to therapist self-disclosure, their experiences of self-disclosure in their personal therapy, and their professional use of self-disclosure with clients needed to be operationalized and measured. Theoretical orientation, a fourth variable referenced in the final research question, was included due to its ubiquitous presence in discussions of both therapist self-disclosure and personal therapy. In keeping with the study's exploratory nature, these variables were operationalized and measured from a number of angles. Based on their inherent vulnerabilities of subjectivity, interpretation, and self-report, they are admittedly imprecise. However, using multiple measurements for each variable provided opportunity to triangulate correlations between the variables for improved consistency and broader insight.

As mentioned earlier, this study focused on only two types of disclosures – self-involving disclosures and self-disclosing disclosures. To put these concepts into a more informal parlance for respondents and to mitigate any pejorative connotation connected to the term “self-involving,” the survey referred to self-involving disclosures as “emotionally-transparent disclosures” and to self-disclosing disclosures as “disclosures of personal information.” However, in the interest of readability, the remainder of this study will use the term “emotional disclosures” when referring to self-involving disclosures by therapists and “personal disclosures” when referring to self-disclosing disclosures by therapists. Table 1 traces the terminology used for each disclosure type within existing research, the survey presented to participants, and the remainder of this report. Table 2 shows the terms, descriptions, and examples respondents were given for each type of disclosure.

Table 1

Terminology Used for Disclosure Types

Existing Research Terminology	Terms Used in the Survey	Variable Names in this Report
Self-involving disclosures Transparent disclosures	Emotionally-transparent disclosures	Emotional disclosures
Self-disclosing disclosures Self-revealing disclosures	Disclosures of personal information	Personal disclosures

Table 2

Survey Definitions and Examples of Disclosure Types

Disclosure Types: Survey Definitions	
Emotionally-transparent disclosures	
Definition:	An intentional disclosure in which a therapist makes a decision to bring her or his own emotions into the therapeutic session. In this type of disclosure, what is being disclosed is the emotional impact that the client, the content of the session, or the progress of the therapy is having on the therapist. It is the therapist’s transparent emotional response to the client, to the therapeutic relationship, or to the content of the client’s disclosures.
Examples:	<ul style="list-style-type: none"> • <i>A therapist is angered by a client’s behavior and allows the client to see that anger.</i> • <i>A therapist shares his or her own feelings in response to what the client is sharing or doing. (i.e. “I feel scared for you.” “I am so happy for you!”)</i> • <i>A therapist is emotionally transparent nonverbally in a session (i.e. becoming teary, becoming irritated, cringing, etc.)</i>
Disclosures of personal information	
Definition:	An intentional disclosure in which a therapist makes a decision to introduce relevant personal information about her or his life or experiences outside of therapy. While this may include emotional disclosures, the emotions disclosed are not in response to the client’s experience but to the therapist’s experience. This study’s focus is not on inappropriate self-disclosures made primarily to serve the therapist. Rather, it focuses on disclosure – while revealing something about the therapist’s life outside of session – made for the client’s perceived benefit and used to assist the treatment process.
Examples:	<ul style="list-style-type: none"> • <i>A therapist reveals to a client that he has also struggled with anxiety, depression, eating issues, addiction, etc.</i> • <i>A therapist tells a personal story as an illustration of a concept she is trying to describe.</i> • <i>A therapist shares a part of his personal identity that he believes will be helpful for the client to know. (“I am also divorced.” I have an adopted child.” “I am gay.” “I was raised Catholic.”)</i>

For each disclosure type, the survey attempted to quantify and/or qualify therapists’ disclosure experiences and their use of self-disclosure. Tables 3 and 4 list each variable’s name, what it measures, and how it was operationalized in the survey.

Table 3

Emotional Disclosure Variable Names, Definitions, and Measurements

Variable name	Operationalized by item:
Disclosure event* – Measures whether respondents have ever experienced this type of disclosure from a therapist in their personal therapy	Item: “In your personal therapy, has a therapist ever disclosed his or her emotions regarding the content of your session or your work in therapy?”
	Options: “yes” “no”
Professional use – Measures respondents’ perception of the frequency of their own use of emotional disclosures with clients	Item: “Place yourself as a psychotherapist on this continuum regarding your use of emotionally-transparent self-disclosure. (Click and drag the marker in the center of the continuum to the desired degree.)”
	Options: 11-point continuum from zero (“I rarely or never allow clients to know my emotional responses to the content of the therapy session”) to ten (“I frequently allow clients to know my emotional responses to the content of the therapy session”)
The following three variables concerning emotional disclosures were prefaced with the instructions: “As you answer the following questions, please consider one significant emotionally-transparent therapist self-disclosure in your experience in personal therapy. The impact of this disclosure may have been positive, negative, or neutral.”	
Subjective experience – Measures respondents’ subjective experience of the emotional disclosure	Item: “Please check all the items that describe your experience of this emotionally-transparent self-disclosure:”
	Options: Along with a write-in option, respondents were given a list of 23 statements that might describe their experience.
Impact – Measures respondents’ perception of the comprehensive impact of the emotional disclosure event	Instructions: “Please respond to the following question regarding the overall impact of this emotionally-transparent disclosure.”
	Item: “How would you rate the impact of this disclosure?”
	Options: 7-point Likert scale where 1=“Very harmful”, 4=“Neither harmful nor helpful” and 7=“Very helpful”
Likelihood – Measures respondents’ perception of the degree to which the emotional disclosure event has influenced the likelihood of using emotional disclosures with clients	Instructions: “Rate the influence this experience (and others like it has had on your own use of emotionally-transparent self-disclosures in your professional psychotherapy practice.”
	Item: “This experience as a client makes me:”
	Options: 1. Much less likely to disclose session-related emotions to clients 2. Slightly less likely to disclose session-related emotions to clients 3. No more or less likely to disclose session-related emotions to clients 4. Slightly more likely to disclose session-related emotions to clients 5. Much more likely to disclose session-related emotions to clients

*Also referenced as the “qualifying question.”

Table 4

Personal Disclosure Variable Names, Definitions, and Measurements

Variable name	Operationalized by item:
Disclosure event* – Measures whether respondents have ever experienced this type of disclosure from a therapist in their personal therapy	Item: “In your personal therapy, has a therapist ever disclosed relevant personal information to you that pertained to his or her life outside of the therapeutic session or therapeutic relationship?”
	Options: “yes” “no”
Professional use – Measures respondents’ perception of the frequency of their own use of personal disclosures with clients	Item: “Place yourself as a psychotherapist on this continuum regarding your use of personal self-disclosure. (Click and drag the marker in the center of the continuum to the desired degree.)”
	Options: 11-point continuum from zero (“I never share information about my life outside of the therapeutic session with clients”) to ten (“I frequently share information about my life outside of the therapeutic session with clients”)
The following three variables concerning personal disclosures were prefaced with the instructions: “As you answer the following questions, please consider one significant disclosure of personal information that a therapist made to you in the course of your personal therapy. The impact of this disclosure may have been positive, negative, or neutral.”	
Subjective experience – Measures respondents’ subjective experience of the personal disclosure	Item: “Please check all the items that describe your experience of this disclosure of personal information.”
	Options: Along with a write-in option, respondents were given a list of 23 statements that might describe their experience.
Impact – Measures respondents’ perception of the comprehensive impact of the personal disclosure event	Instructions: “Please respond to the following question regarding the overall impact of this personal self-disclosure.”
	Item: “How would you rate the impact of this disclosure?”
	Options: 7-point Likert scale where 1=“Very harmful”, 4=“Neither harmful nor helpful” and 7=“Very helpful”
Likelihood – Measures respondents’ perception of the degree to which the emotional disclosure event has influenced the likelihood of using personal disclosures with clients	Instructions: “Rate the influence this experience (and others like it) has had on your own use of personal self-disclosures in your professional psychotherapy practice.”
	Item: “This experience as a client makes me:”
	Options: 1. Much less likely to disclose relevant personal information to clients 2. Slightly less likely to disclose relevant personal information to clients 3. No more or less likely to disclose relevant personal information to clients 4. Slightly more likely to disclose relevant personal information to clients 5. Much more likely to disclose relevant personal information to clients

*Also referenced as the “qualifying question.”

Operationalizing theoretical orientation. In distilling the hundreds of theories used by psychotherapists into a manageable number of values for data analysis, the survey provided respondents with five general theoretical category options. Four of these five categories – psychoanalytic/psychodynamic, person-centered/humanistic, cognitive-behavioral, and systemic – emerged from the review of existing literature. The fifth category, experiential/somatic, was

added despite a paucity of research on the use of self-disclosure in these approaches. However, as a result of advances in neurobiology, many of these therapies have gained increased attention and were included in this research. Descriptions of the five theoretical categories of psychotherapies (see Table 5) were preceded by the following caveat: “These five broad categories are not exhaustive of all the theoretical orientations and overlap between them exists in both theory and practice.”

Table 5

Survey Definitions of Theoretical Orientation Categories

Theoretical Orientations: Survey Definitions	
Psychoanalytic/Psychodynamic	This category includes classical and contemporary forms of psychoanalysis and psychodynamic psychology as well as other psychologies focused on an individual’s internal world. These include Jungian analysis, Adlerian psychology, depth psychology, ego psychology, self psychology, etc.
Person-centered/Humanistic	This category includes therapies in which the client’s unique experiences constitute his or her reality and a warm, empathic, respectful therapeutic relationship is used as the vehicle for growth and change. Therapies include Rogerian, humanistic, existential, and phenomenological, etc.
Cognitive-Behavioral	This category includes therapies focused on tracking and changing behaviors and thoughts. Therapies include cognitive-behavioral therapy (CBT), dialectical-behavioral therapy (DBT), rational-emotive therapy (RET), behavioral modification, etc.
Systemic	These therapies, many of which utilize some elements of the theories above, understand human behavior as predicated on the context and system in which it occurs. These mostly modern and post-modern therapies endorse multiple realities and suggest that clients’ internal psyches, interpersonal relationships, and behaviors/cognitions cannot be viewed independently from their power-laden social contexts. Therapies include structural therapy, feminist therapy, narrative therapy, family therapy, environmental psychology, and systems psychology.
Experiential/Somatic	Experiential therapies are founded on the belief that the human body and mind are inherently self-righting or self-healing if the conditions are right. The right conditions include safety, attunement to the moment-to-moment experience of the client (including emotional, somatic, relational, cognitive, and possibly spiritual experience) and a method of processing the experience (eye movement or bi-lateral stimulation, dyadic processing, somatic processing, imagery, expressive processing, mindfulness, and others) to reach a more adaptive, healthy or even transformative experience of self and the world. These neurobiologically-informed therapies include Eye Movement Desensitization and Reprocessing (EMDR), Somatic Experiencing, Sensory Motor Processing, Accelerated Experiential Dynamic Psychotherapy (AEDP), Mindfulness-based therapies, Expressive Therapies, etc.

Data Collection Instrument and Process

The online survey, a measurement instrument designed specifically for this study, consisted of five content sections (see Appendix G). A short preface to the survey provided respondents with an overview of these five sections: personal therapy experience, emotional disclosures (emotionally-transparent), personal disclosures (disclosures of personal information), demographic information, and additional comments.

Personal therapy experience. This section requested information regarding the respondents' personal therapy history and its perceived personal and professional impact. Data collected included respondents' ages upon starting and ending therapy, number of courses of therapy, and reasons for seeking therapy. Respondents were also asked to use 7-point Likert scales to rank their personal therapy's helpfulness, impact (both degree and nature) on professional practice, and influence on theoretical orientation.

Emotional disclosures. This first section of questions related to therapist self-disclosure asked respondents to reflect on an emotional disclosure made to them in the course of personal therapy and to identify their feelings and perceptions about that disclosure from a checklist. Using a 7-point Likert scale, respondents were asked to rate the helpfulness of such a disclosure. The last two questions explored the self-disclosing practices of respondents. Respondents were asked to indicate how experiencing emotional disclosures has influenced their perceived likelihood of using similar disclosures with clients. Responses for this question range from 1-5 with 1= "Much less likely to disclose," 3= "No more or less likely to disclose," and 5= "Much more likely to disclose." Finally, using a scale of 1-10 where 1= "Rarely or never" and 10= "Frequently," respondents were asked to rank the degree to which they make these types of disclosures to clients.

Personal disclosures. The questions and format of this section were identical to that of the previous section except that its questions pertained to relevant disclosures of non-immediate personal information rather than emotional disclosures. Again, this study departs from the terminology of most existing literature in an effort to establish a clear distinction between these two types of disclosures for therapists who are not versed in the research on self-disclosure (see Table 1).

Demographic information. The fourth section collected demographic information regarding the gender, ethnicity, age, discipline, licensure, educational degree, and the number of years in practice of the respondents. Additionally, respondents were asked about the location and setting of their clinical practice.

In order to understand the interplay of personal therapy experiences and theoretical orientation, respondents were asked to identify the theoretical orientations most resonant to them. In an effort to produce data that could be compared to existing research on theoretical beliefs regarding self-disclosure, the researcher categorized existing theories into the five broad groups shown in Table 5. Respondents were instructed to rank the five categories based on the degree to which they resonate with each approach. They were instructed to omit any theoretical categories with which they were unfamiliar or by which they had not been influenced.

Additional comments. The final section invited respondents to share their thoughts, perceptions, insights, and experiences with personal therapy and self-disclosure. This free-form section provided an opportunity to clarify prior responses or add any information on the research topic that they deemed helpful.

Data Analysis

Given the exploratory nature of this study, data analysis largely consisted of descriptive statistics of the sample's characteristics and experiences. Frequency distributions were calculated to identify the personal and professional demographic composition of the participant sample. Similarly, frequency distributions were run to determine the sample's experiences in personal therapy (age, duration, presenting issues, perceived helpfulness, and perceived professional impact), and experiences with both emotional disclosures and personal disclosures (subjective impact of the experience, its value to therapy, and its perceived influence on the respondent's future use of self-disclosure).

Inferential statistics were employed to determine the relationship between respondents' disclosure experiences as therapist-clients and their professional use of self-disclosure as therapists. Because survey responses were largely ordinal-level data, nonparametric tests were used for statistical inferences. Spearman's rho tests were used to determine the presence of relationship between ordinal variables and Mann-Whitney U tests were used to detect differences in respondents' use of self-disclosure between groupings of theoretical orientation (Laerd Statistics, 2013a; Laerd Statistics, 2013b).

The minimal qualitative data in this study – the additional comments made by respondents – was analyzed using grounded theory methods. In this textual analysis method, open coding, also called descriptive coding, is applied first to name the content (Strauss & Corbin, 1998). Then further and more interpretive coding is conducted of the same material to discover similarities among data. Themes, or more abstract and encapsulating ideas, are created to explore common subjective realities among therapists and to inform future research.

Findings

This study examined how therapists' subjective experiences as client recipients of therapist self-disclosure impact their attitudes about using self-disclosure in their practice with clients. Specifically, it sought to determine if a relationship exists between these experiences as clients and their professional attitudes and behaviors. If such a relationship does exist, the study intended to reveal the nature and quality of the relationship. Finally, the researcher investigated whether therapists' theoretical orientations were associated with either how they regarded their experiences of therapist self-disclosure in their personal therapy or how they employ self-disclosure professionally.

Sample Composition

Between January 16 and February 15 (2014), 133 respondents opted to begin the survey. Of those respondents, 101 individuals completed more than 50% of the survey. This group of respondents served as the study's sample. Personal, professional, and practice-related demographics were collected and analyzed to contextualize the results of this study (see Table 6).

Table 6

Demographics of Study Sample

Sample Demographics (n=101)	
Personal	
Gender	Female=85 (85.1%); Male=15 (14.9%)
Race	White=96 (95%); American Indian/Alaskan Native and white= 2 (2%); Other=2 (2%)
Age	Range=26-71; M=47; SD=13.01 (bi-modal distribution)
Clinician	
Educational discipline*	Psychology=44 (43.56%); Social work=41 (40.59%); Marriage/Family=17 (16.83%); Chemical dependency=10 (9.90%); Counseling=7 (6.93%)
Educational degree*	Bachelor=25 (24.75%); Master=74 (73.27%); Doctor=21 (20.79%); Other=13 (12.87%)
Licensure*	LICSW/LGSW=40 (39.60%); LP=35 (34.65%); LMFT=13 (12.87%); LPCC/LPC=8 (7.92%); LADC=7 (6.93%); Other=6 (5.94%)
Years in practice	Range= (<1)-40; M=15.44; SD=11.92
Clinical	
Location	Minnesota=88 (87.13); Indiana=5 (4.95%); Wisconsin=3 (2.97%); Illinois=1 (.99%); Virginia=1 (.99%); Missing=3 (2.97%)
Setting*	Private practice= 45 (44.55%); Outpatient mental health clinic=40 (39.60%); Hospital=13 (12.87%); School=10 (9.9%); Day treatment=9 (8.91); Other=19 (18.81%)

*Respondents could indicate more than one answer on these items. Consequently, totals for these demographic variables exceed 100%.

Personal demographics. With the exception of age, the personal demographics of the study sample were quite homogenous. Racially, 96 (95%) respondents identified as white while two (2%) identified as both American Indian/Alaskan native and white. Two other respondents signified their race as “Other” with write-in responses of “Jewish atheist” and “human race.” The gender demographic also lacked diversity and parity. All respondents chose the binary classifications of male or female with 85 (85.1%) identifying as female and 15 (14.9%) as male.

The sample’s most interesting demographic parameter was age. Participants ranged from a minimum age of 26 and a maximum age of 71. The mean age statistic was 47, but given the large standard deviation (13.01), relatively few respondents were located close to the mean age. By distilling respondent ages into five-year groupings, a very distinct bimodal pattern emerged (Figure 1). The bimodal pattern showed that the primary and secondary mode values for each peak in the pattern were exactly equal. The first peak showed 18 respondents within the age

range of 30-34 and 13 respondents in range of 35-40. The second modal peak consisted of 18 respondents between 55-59 and 13 between 60-64. This second peak had a high tertiary mode of 12 respondents between the ages of 50-54. So distinct was this bimodal split that the age group containing the sample's mean age of 47 had the second lowest modal value of all the groups.

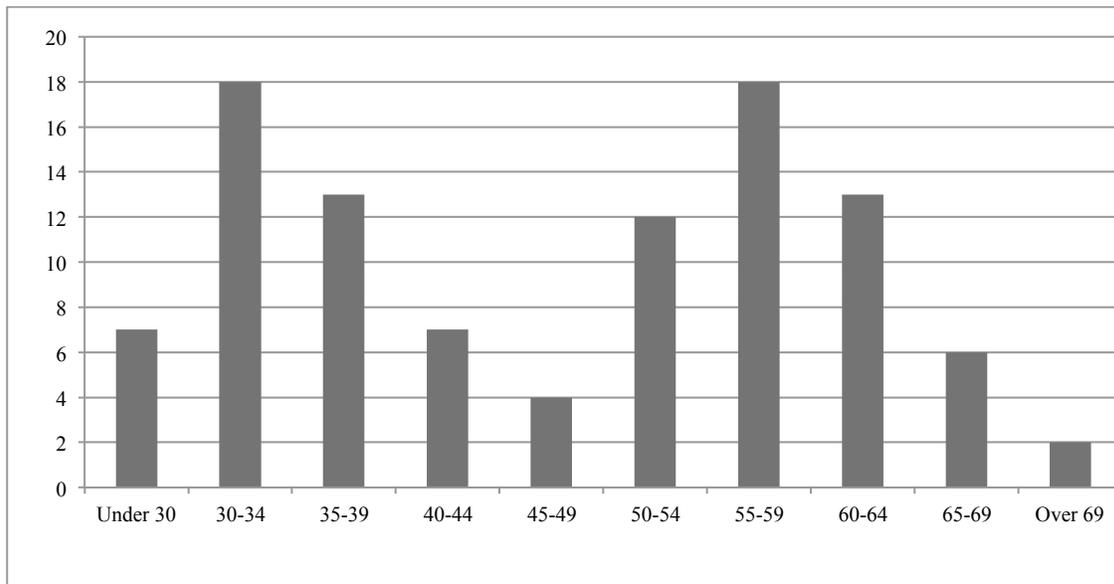


Figure 1. Frequency distribution of respondents' ages

Clinical practice demographics. The vast majority (87.13%; n=88) of respondents identified Minnesota as the location of their clinical practice. The remaining responses cited Indiana (4.95%; n=5), Wisconsin (2.97%; n=3), Illinois (0.99%; n=1), and Virginia (0.99%; n=1) as their practice locations while three people (2.97%) chose not to respond to the question. Although the practice settings of study participants showed some diversity, the vast majority of respondents worked either in private practice (44.55%; n=45) or in an outpatient mental health clinic (39.60%; n=40). Other common practice settings included hospitals (12.87%; n=13), schools (9.90%; n=10), and day treatment (8.91%; n=9).

Clinician demographics. Given the qualifications required for participation in this study, the sample showed a balanced distribution of educational disciplines, educational degrees, and

professional licenses. The data concerning educational disciplines suggest that the majority of respondents were trained as psychologists (43.56%; n=44) or social workers (40.59%; n=41) with a smaller representation of marriage and family therapists (16.83%; 17), chemical dependency counselors (9.90%; n=10) and professional counselors (6.93%; n=7). Two respondents wrote in educational disciplines other than the options provided. These disciplines were “public health” and “mental health nursing.” Not surprisingly, the data regarding clinical licensure is very congruent with these findings. Again, most respondents (74.26%; n=75) hold licenses in the fields of social work and/or psychology with fewer respondents licensed as marriage and family therapists, chemical dependency counselors, and professional counselors. While nearly 21% (n=21) had earned a doctorate in their fields, most held a Master’s degree (73.27%; n=74) and some held a Bachelor’s degree (24.75%; n=25).

The least experienced psychotherapists in this study reported having been in practice for less than one year while those with the most experience have been practicing for up to 40 years. The average amount of time respondents reported being in practice was 15.44 years with a standard deviation of 11.92 years. Like respondents’ ages, years of experience were also distilled into five-year groupings. Over a quarter of respondents (26.7%; n=27) reported being in practice for fewer than five years. Although this statistic does not fit the bimodal pattern that emerged in distributing respondents’ ages, the remaining data show a slight replication of two modal peaks – the first in 10-14 years of practice (13.9%; n=14) and the second in 20-24 years in practice (12.9%; n=13).

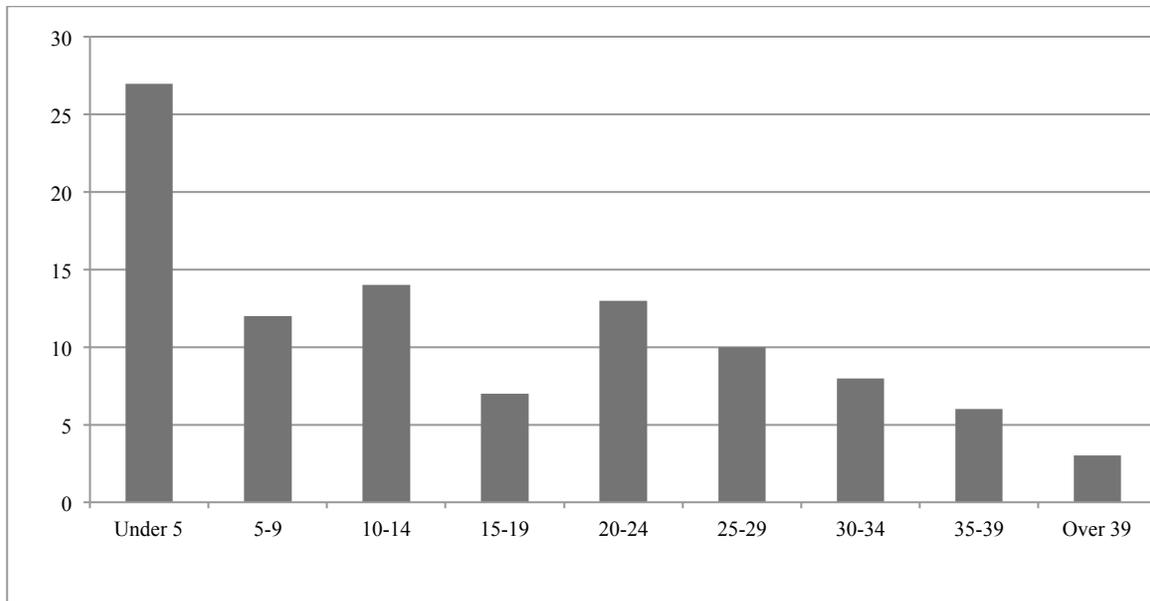


Figure 2. Frequency distribution of respondents' years in practice

Theoretical orientation. As previously mentioned, respondents were asked to rank five theoretical categories *as defined by the researcher* by the degree to which they resonated with each approach. The resulting data were structured and analyzed in a variety of ways. First, results were reviewed by examining each rank level. This analysis revealed that the humanistic/person-centered approach was the most frequent response for both first (34.65%; n=35) and second level (27.72%; n=28) in rank ordering. With 32.67% (n=33) for the first rank and 21.78% (n=22) for the second, the cognitive-behavioral approach was the second most frequent response at both levels. In fact, 33.66% of respondents ranked a combination of these two orientations in first and second positions.

Very few respondents (1.98%; n=2) reported a pure identification with only one theoretical orientation. Those that did so identified solely with cognitive-behavioral theory. Of the respondents who identified with only two theoretical orientations (6.93%; n=7), cognitive-behavioral was one of those two orientations for all but a single respondent. Despite instructions

to omit any theoretical categories with which they were unfamiliar or by which they had not been influenced, the majority of respondents (62.38%; n=63) ranked all five orientations.

Using this same data, each theoretical orientation was given a score to represent its relative degree of importance within the collective sample (see Table 7). This score was calculated by reverse scoring each rank value and then finding the sum of all rank scores for each orientation. Scores ranged from 353 (humanistic/person-centered) to 179 (experiential/somatic).

Table 7

Respondents' Theoretical Orientation Profiles

Theoretical Orientation								
	Rank	1	2	3	4	5	Count	Score*
Psychoanalytic/Psychodynamic		12	12	15	13	23	75	202
Person-centered/Humanistic		35	28	16	9	-	88	353
Cognitive-behavioral		33	22	6	13	12	86	309
Systemic		9	14	28	21	6	78	233
Experiential/Somatic		3	14	18	16	22	73	179
Total		92	90	83	72	63		

*Score = sum of reverse scored rank levels

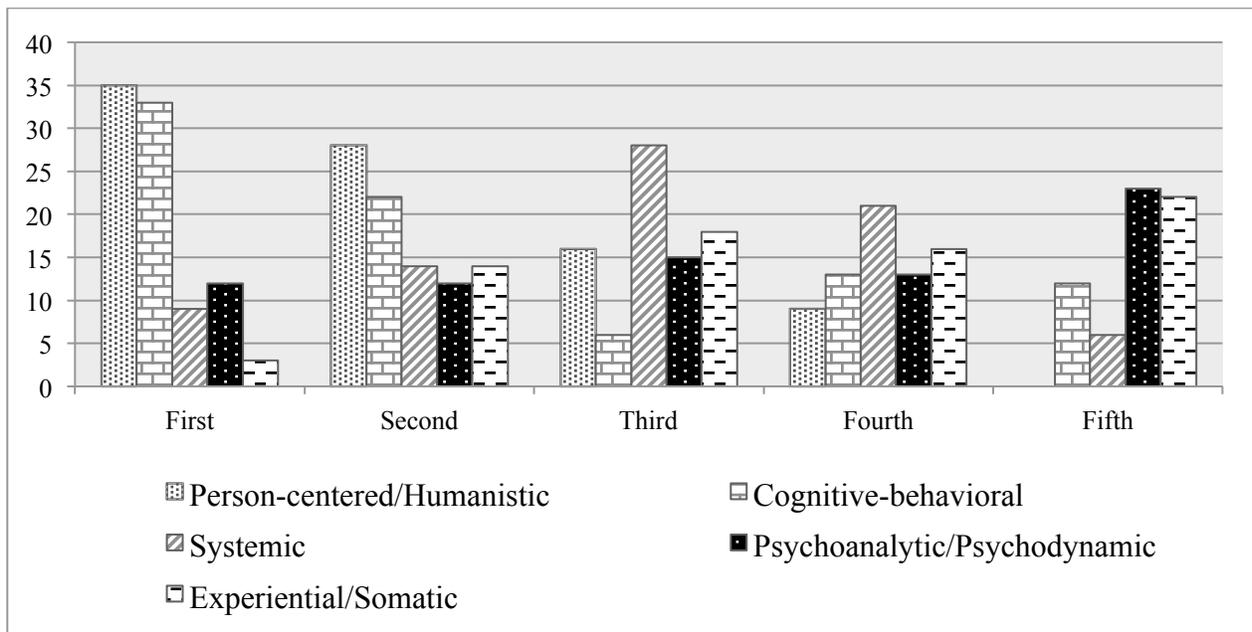


Figure 3. Distribution of respondents' theoretical preferences

Finally, in an effort to discover any potential trends or patterns in the sample's theoretical preferences, a coding system was developed that assigned a theoretical profile to each respondent. This profile – essentially a codified representation of each participant's endorsement and ranking of the five theoretical orientations – made more granular comparisons between participants' theoretical influences possible. Rather than exposing trends or patterns within the theoretical orientation of respondents, the resulting profiles exposed profound diversity.

In the profile coding process, a single letter was used to represent each of the five theoretical categories (P=Psychoanalytic/psychodynamic; H=Person-centered/humanistic; C=Cognitive-behavioral; S=Systemic; E=Experiential/somatic). The profile code itself could be as few as a single letter (i.e. the respondent endorsed only one theoretical category) and as many as five letters (i.e. the respondent endorsed and ranked all five categories). If two respondents endorsed the same categories and ranked them in the same order, their theoretical profiles would be identical. With five rank positions, five orientations, and the acceptance of a null value in the positions following the last-ranked orientation, there were 325 potential profile permutations. As shown in Table 8, the 93 (out of a total sample of 101) respondents who answered this question represented 63 of these potential profiles. Of the 93 respondents, 40 individuals (43.01%) had a profile that was not shared by any other individual in the sample. Additionally, looking only at the profiles that were shared by two or more respondents, no discernible patterns emerged. In fact, the remaining 53 respondents shared 23 different profiles. The mode of the distribution was three (i.e. three respondents with the identical profile) and that mode occurred in six different profiles. The 17 remained profiles each occurred twice.

Table 8

Theoretical Orientation Profiles of Respondents

Theoretical Profiles of Respondents (n=93) [organized by number of theories ranked]				
One Theory	Two Theories	Three Theories	Four Theories	Five Theories
<i>C</i> ^ψ	CH ^φ CS HC PH	<i>CHS</i> ^ψ EHS HCE <i>HCP</i> ^ψ <i>HCS</i> ^ψ HPC HSE PHS	CEHS CHPS CHSE CPEH <i>HCPS</i> ^ψ HPSE PHEC SHEP SHPC	CEHSP ^φ CESHP CHEPS CHPES <i>CHPSE</i> ^ψ CHSEP ^φ <i>CHSPE</i> ^ψ <i>CPHSE</i> ^ψ CPSHE CSEHP CSHEP ^φ ECSHP ESHCP <i>HCESP</i> ^ψ HCPES HCPSE ^φ HCSEP HCSPE ^φ HEPCS <i>HESCP</i> ^ψ <i>HESPC</i> ^ψ <i>HPECS</i> ^ψ <i>HPESC</i> ^ψ HPSCE <i>HSCPE</i> ^ψ <i>HSECP</i> ^ψ PCSHE PEHSC PESH PHSEC <i>PSCHE</i> ^ψ PSEHC PSHEC SCHPE SEHCP <i>SHCEP</i> ^ψ SHEPC SHPCE SHPEC SPHCE
2 respondents; 1 profile	6 respondents; 4 profiles	11 respondents; 8 profiles	10 respondents; 9 profiles	64 respondents; 41 profiles

Note: ^φ signifies three respondents share the profile and ^ψ indicates two respondents share the profile. All other profiles are unique to the individual respondent.

In summary, the three analyses of theoretical orientations indicate that most respondents take an eclectic approach to psychotherapy. Despite the diversity inherent in eclecticism, humanistic/person-centered and cognitive-behavioral approaches were the most dominant theoretical influences.

Personal Therapy

Amount and incidence of personal therapy. Despite the fact that only therapists who have had personal therapy were eligible to participate in this study, respondents showed significant diversity with respect to the age at which they first sought therapy, the amount of therapy they experienced, and the temporal proximity of their most recent therapy session.

First introduction to therapy. Respondents reported participating in their first personal therapy at the mean age of 27.82. Once again, the standard deviation on this statistic is relatively large (11.71 years) and the ages range from a minimum of 11 to a maximum of 61. What is most significant in the distribution of ages of first therapy is the pronounced mode of age 24 (11.88%;

n=12). The age of 28, the second most frequent response, was identified by only 7.92% (n=8) of respondents. It is also worth noting data pertaining to the age of first therapy are likely distorted by the fact that nearly half (48.51%; n=49) of the respondents in this study are under the age of 45.

Amount of therapy. Respondents were asked to identify whether they had participated in one course of therapy, more than one course of therapy, or in relatively continuous therapy. A course of therapy was defined as “two or more sessions scheduled at relatively consistent intervals with no interval exceeding one year.” The majority of respondents (71.29%; n=72) reported having had more than one course of therapy while nearly equal numbers of respondents reported having had one course of therapy (13.86%; n=14) and having therapy that has been largely continuous (14.85%; n=15). Of the 72 respondents who reported multiple courses of therapy, 63 reported having between two and five courses of therapy.

Temporal proximity of therapy. Nearly half (42.57%; n=43) of all respondents reported having participated in personal therapy within the past year. An additional 40 respondents (39.60%) identified their most recent therapy session having occurred between one and 10 years ago. The final 18 respondents (17.82%) described not having participated in personal therapy for over 10 years.

Presenting issues. On the survey, commonly reported presenting issues were listed within overarching thematic categories and respondents were asked to identify all the issues for which they have sought therapy. The vast majority of respondents stated that they sought therapy for both social/relational concerns (96.04%; n=97) and identity/intrapersonal concerns (92.08%; n=93). Most respondents (81.19%; n=82) also indicated having sought therapy to address a mental health diagnosis. A smaller percentage of respondents identified seeking therapy for

trauma issues (44.55%; n=45), behavioral issues (42.57%; n=43), and professional concerns (40.59%; n=41).

In examining the individual items endorsed in these six categories, seven specific concerns were reported most frequently. These items include life adjustments/transitions (69.31%; n=70), depression (62.38%; n=63), partner relationships (61.39%; n=62), family relationships (60.40%; n=61), self-esteem (49.50%; n=50), anxiety (43.56%; n=44), and life decisions/discernment (39.60%; n=40). The item most frequently endorsed in the profession concerns category was that of professional identity (18.81%; n=19).

Impact of personal therapy. In the first question measuring the harmfulness or helpfulness of personal therapy, respondents rated the impact of their own therapy on their personal lives using a 7-point Likert scale (values were: 1="Very harmful," 4="Neither harmful nor helpful," and 7="Very helpful"). Data reveal that respondents found their own therapy very helpful to them. Responses ranged from a minimum of 3 to a maximum of 7, but the mean for the group was 6.2 with a standard deviation less than 1 Likert point (.932). Using the same Likert scale, respondents rated how helpful or harmful their own therapy has been to their professional development as therapists. These results mirrored those for the previous question with a very small decrease in values and increase in variance. Again, responses ranged from 3 to 7, but the mean showed a very small decrease (6.09) and the standard deviation suggested slightly more variance (1.083).

Influence of personal therapy. In the first of two items measuring the professional influence of personal therapy, respondents rated the degree to which they believed their own therapy has influenced their professional practice on a 7-point Likert scale (values were: 1="No influence," 4="Moderate influence," and 7="Strong influence"). Responses to this item spread

across the entire scale, ranging from 1 to 7. The mean response was 5.43 with a standard deviation of 1.45. Using the same Likert scale, respondents rated the degree to which they believe their personal therapy influenced their professional theoretical orientation. These responses also ranged from 1 to 7, but the mean was slightly lower (4.52) than for the previous item and the standard deviation slightly higher (1.76).

Overall, participants found their personal therapy experiences very helpful in terms of their personal lives. Although they found therapy only slightly less valuable and influential in their professional practices, the nature of their therapeutic involvement was clearly personal rather than professional.

Therapist Self-Disclosure

Operational definitions and measurements. This study measured the impact of two distinct types of therapist self-disclosure on therapist-clients. For purposes of comparison between these two types, an identical measurement instrument (changes in semantics only) was administered for both types. At the beginning of each section, the disclosure type was defined for the respondents and examples of the type were provided (see Table 2).

Disclosure event. Following the section's preface, respondents were asked if they had ever experienced a disclosure like this from their therapist in their own therapy (see Tables 3 & 4). Their answer to this initial question – also called the qualifying question – determined which additional questions they would be given. If they answered “no,” respondents were not shown the next three questions but were sent to the fourth and final question in the section. If they answered “yes,” they were asked to consider one such significant disclosure experience (positive, negative, both, or neutral) while responding to three additional questions.

Fewer than three-quarters of participants (70.30%; n=71) reported having experienced such an emotional disclosure while slightly over three-quarters of participants (77.23%; n=78) reported having experienced personal disclosures. Given the emotional transparency intrinsic to many therapeutic approaches, this finding was unexpected. It is quite possible that emotional disclosures as defined by this study are so ubiquitous in many therapies that respondents did not recognize such experiences as incidents of disclosure. Unlike personal disclosures which make a distinct departure from the “here and now” content of the session, emotional disclosures are closely related to the emotional content of the session and may be identified as empathy as opposed to disclosure by some respondents. In essence, emotional transparency may be understood as a stance – a way of “being” – rather than as an event or incident. Responses to the qualifying question in the emotional disclosure section point to the possibility that the participants shown the next three questions regarding emotional disclosures were not fully representative of the study’s sample.

Subjective experience. The first of these questions was a checklist of 23 descriptions of their possible subjective experience of the disclosure. Respondents were instructed to check all statements that described their experience of the disclosure. Ten of the options were negative responses and 13 were positive responses (see Table 9). Respondents could also choose to write in a description not already listed.

Table 9

Positive and Negative Subjective Experience Statements from the Survey

Subjective Experience Statements	
Positive Statements	Negative Statements
It felt validating.	It shifted the focus of the session from me to the therapist.
It deepened my insight.	It did not feel relevant.
It strengthened our therapeutic relationship.	It felt intrusive.
It helped me understand my impact on others.	I felt angry.
I felt honored.	The disclosure scared me.
I felt trusted.	The disclosure made me feel uncomfortable.
It deepened my trust in my therapist.	It diminished my respect for my therapist.
It made me feel like I was special to my therapist.	It diminished my trust in my therapist.
It reduced my sense of isolation.	I felt nervous.
It normalized my experience.	The disclosure felt inappropriate.
It elevated my respect for my therapist.	
I felt more comfortable disclosing my own emotions.	
The disclosure resonated with me.	

Endorsed statements. The number and value of the statements respondents endorsed in describing their disclosure experiences reveal striking similarities between the two disclosure types. First, respondents had far more positive than negative descriptions of both types of disclosures. The last column of Table 10 shows that while emotional disclosures elicited far more positive comments than negative comments (17.9:1) compared to personal disclosures (10.9:1), respondents for both types endorsed far more favorable than unfavorable statements. Additionally, the four most commonly cited descriptions for each disclosure type – “It felt validating,” “It normalized my experience,” “It strengthened our relationship,” and “It deepened my trust in my therapist” – were shared between the two types, albeit in a slightly different order (see Table 11). Similarly, the statements “It shifted the focus of the session from me to the therapist” and “The disclosure made me feel uncomfortable” were two of the three highest-ranked negative statements for both disclosure types.

Table 10

Incidence of Emotional and Personal Disclosures to Respondents

Disclosure type	N	Positive responses		Negative responses		Total responses		
		Avg.	Total	Avg.	Total	Avg.	Total	Ratio
Emotional disclosures	71	5.296	376	.296	21	5.592	397	17.9:1
Personal disclosures	78	3.910	305	.359	28	4.269	333	10.9:1

Despite these commonalities, emotional disclosures elicited more positive responses from the respondents (see Tables 10 & 11). In fact, the four highest-ranked descriptions of emotional disclosures were endorsed by over half of all respondents (52.11%-69.01%). In contrast, only the highest-ranking description of personal disclosures – “It normalized my experience” – received endorsement from over half of the respondents (61.54%). An opposite pattern emerged in the analysis of negative responses. In describing their experiences with personal disclosures, respondents were more likely to endorse negative statements than when describing emotional disclosures. For example, the three highest-ranked negative descriptions of personal disclosures were “It did not feel relevant,” “It shifted the focus of the session from me to the therapist,” and “The disclosure made me feel uncomfortable.” The percentage of respondents who endorsed these descriptions was 11.54%, 10.26%, and 6.41%, respectively. In contrast, the highest-ranked negative description of emotional disclosures – “The disclosure made me feel uncomfortable” – was endorsed by only 7.04% of respondents.

Perhaps the most fascinating finding regarding respondents’ descriptions of these two types of disclosures pertains to the negative items highly endorsed for one type that remain completely unendorsed in the second type. As shown in Table 11, the second and third most frequently endorsed negative comments regarding emotional disclosures (“The disclosure scared me” and “I felt nervous”) were not endorsed at all when describing personal disclosures. This is

particularly significant since, as previously mentioned, the latter set of respondents endorsed more negative statements overall. This phenomenon occurs in the opposite direction as well. The highest-ranking negative statement regarding personal disclosures (“It did not feel relevant”) remains unendorsed in describing emotional disclosures.

Clearly, respondents’ descriptions of both types of disclosure were largely positive and shared characterological similarities. Their negative descriptions, while few, were far less similar. Two common critiques of therapist self-disclosure ranked in the top negative descriptions for both types (“It shifted the focus of the session from me to the therapist” and “The disclosure made me feel uncomfortable”). However, the remaining high-ranking negative descriptions for each type reveal important qualitative information about the inherent dangers of each. While both types of disclosures have the potential to be experienced as intrusive, uncomfortable, and/or irrelevant, emotional disclosures have a greater risk of producing feelings of nervousness, fear, and mistrust in the client.

Table 11

Subjective Experiences of Emotional and Personal Disclosures

Emotional disclosures		Personal disclosures	
Top positive statements (rank)	% (n=71)	Top positive statements (rank)	% (n=78)
It felt validating. (1)	69.01% (49)	It normalized my experience. (1)	61.54% (48)
It normalized my experience. (2)	64.79% (46)	It felt validating. (2 tied)	47.44% (37)
It strengthened our therapeutic relationship. (3)	63.38% (45)	It strengthened our therapeutic relationship. (2 tied)	47.44% (37)
It deepened my trust in my therapist. (4)	52.11% (37)	It deepened my trust in my therapist. (4)	37.18% (29)
The disclosure resonated with me. (5)	40.85% (29)	It reduced my sense of isolation. (5)	34.62% (27)
Top negative statements (rank)	% (n=71)	Top negative statements (rank)	% (n=78)
The disclosure made me feel uncomfortable. (14)	7.04% (5)	It did not feel relevant. (13)	11.54% (9)
I felt nervous. (15)	5.63% (4)	It shifted the focus of the session from me to the therapist. (14)	10.26% (8)
The disclosure scared me. (16 tied)	4.23% (3)	The disclosure made me feel uncomfortable. (15)	6.41% (5)
It shifted the focus of the session from me to the therapist. (16 tied)	4.23% (3)		
Unendorsed items		Unendorsed items	
It did not feel relevant.		I felt nervous.	
		The disclosure scared me.	
		It diminished my trust in my therapist.	
Write-in responses (n=1)	(+/-)	Write-in responses (n=6)	(+/-)
Alarmed at the emotional impact I could have on my therapist which helped me be more compassionate with myself.	+	I learned more about my therapist's attitudes that were relevant to the issue.	?
		It humanized my therapist in my eyes.	+
		It surprised me since it was years into our relationship	?
		It confronted a projection I had made about my therapist.	+
		It helped me know what to do	+
		It did not affect me.	null

Scale scores. For each disclosure type, positive and negative scale scores were calculated by counting the total number of positive and negative descriptions endorsed by the respondent. However, because there were 13 positive options and only 10 negative options, the negative score (count of all negative items) was multiplied by 1.3 to give it parity with the positive scale score. Finally, a cumulative scale score was calculated by subtracting the negative scale score

from the positive scale score. This single score could be either a positive number (indicating a largely positive impact) or a negative number (indicating a largely negative impact). A cumulative score at or near zero might indicate either a negligible impact or one that was subjectively diverse. Although this score is only a crude estimation of the respondents' subjective experiences with disclosure, it is only one of a number of variables used to answer the research questions.

The scale scores calculated to measure the overall favorable or unfavorable impact of therapist self-disclosures corroborate the findings that respondents experienced both types of disclosures as being far more positive than negative. As Table 12 indicates, these scores align with previous data (see Table 10), which show that respondents endorsed more positive statements regarding emotional disclosures than they did regarding personal disclosures. Conversely, respondents endorsed more negative statements regarding personal disclosures than they did regarding emotional disclosures. Unsurprisingly, given the high positive-to-negative ratio for both types of disclosures, the cumulative scale scores for both types were positive. However, emotional disclosures had a higher mean ($M=4.897$; $SD=3.567$) than that of personal disclosures ($M=3.418$; $SD=3.273$).

These data indicate that emotional disclosures seemed to produce a more positive impact on respondents than did personal disclosures. Furthermore, the data suggest that the positive impact of emotional disclosures consisted of a broader range of subjective experiences than for personal disclosures. It is also important to reiterate – as previously noted regarding data gathered from the qualifying question for emotional disclosures – that there is a strong possibility that the incidence of emotional disclosures was under-reported or unrecognized by study

participants. If so, the overall validity of findings related to emotional disclosures and comparisons between those findings and those of personal disclosures is problematic.

These scales scores, while clearly unsophisticated in their measurement, do assist in illuminating one key finding that might otherwise go undetected. While the negative scale score mean is higher for personal disclosures, the maximum point of that scale's range is substantially higher for emotional disclosures than for personal disclosures (see Table 12). In other words, a comparison of means suggests that respondents generally endorsed more negative statements about personal disclosures than about emotional disclosures. However, based on the range and standard deviation of the negative scale scores, those respondents who experienced disclosures negatively reported a much greater – though less common – negative impact from emotional disclosures than from personal disclosures. This suggests that while the risk of negative outcomes for emotional disclosures may be relatively small, the *degree* to which the disclosure might negatively impact therapy is greater.

Table 12

Subjective Experience Scale Scores for Emotional and Personal Disclosures

Disclosure type	Positive Scale Score			Negative Scale Score			Cumulative Scale Score		
	Range	M	SD	Range	M	SD	Range	M	SD
Emotional disclosures	0-12	5.282	3.057	0-7.8	.3845	1.171	(-6.8)-12	4.897	3.567
Personal disclosures	0-13	3.880	3.291	0-3.9	.4667	.9126	(-3.9)-13	3.418	3.273

Perceived impact and influence. The last two items shown to qualifying respondents measured their perceptions of the impact of therapist self-disclosure on their personal therapy and its influence on their professional practice. To understand its overall helpfulness or harmfulness in personal therapy, respondents were asked to identify the personal impact of this disclosure on a 7-point Likert scale (values: 1=“Very harmful,” 4=“Neither harmful nor helpful,” and 7=“Very helpful”). Consistent with the previous data, respondents reported that both types of

disclosures were significantly helpful to their personal therapy. Table 13 shows that responses ranged from two to seven with a mean of 5.68 (SD=1.079) for emotionally-transparent disclosures and ranged from two to seven with a mean of 5.12 (SD=1.181) for disclosures of personal information.

Table 13

Therapeutic Impact (Harmful/Helpful) of Emotional and Personal Disclosures

How would you rate the impact of this disclosure?									
Disclosure type	Very harmful		Neither harmful/helpful			Very helpful		Mean	SD
	1	2	3	4	5	6	7		
Emotional disclosures	-	1	2	3	25	22	18	5.68	1.079
Personal disclosures	-	1	6	16	23	22	9	5.12	1.181

Respondents also rated the influence of the recalled disclosure incident and others like it on their own use of disclosure in their professional psychotherapy practice. Respondents were asked to finish the sentence, “This experience as a client makes me” by choosing one of five options ranging from 1 (much less likely to use this type of disclosure with clients) to 5 (much more likely to use this type of disclosure with clients), with option 3 signifying that the disclosure had no influence on the likelihood of making similar disclosures with clients in their professional practices. Results in Table 14 indicate that experiences of both types of disclosure made respondents only slightly more likely to utilize disclosures of the same type with therapy clients. In both cases, scores covered the entire range from a minimum of one to a maximum of five. For emotionally-transparent disclosures, the mean score was 3.96 (SD=.818) compared to a mean of 3.49 (SD=.931) for disclosures of personal information.

Table 14

Influence of Disclosure Experiences on Disclosing Behaviors

For emotional disclosures: This experience makes me [value] likely to disclose session-related emotions to clients.							
For personal disclosures: This experience makes me [value] likely to disclose relevant personal information to clients.							
	Much less 1	Slightly less 2	No more or less 3	Slightly more 4	Much more 5	Mean	SD
Emotional disclosures	1	1	16	35	18	3.96	.818
Personal disclosures	1	12	20	35	8	3.49	.931

Self-reported use of disclosures. All respondents, regardless of how they answered the qualifying question, were asked to respond to one final item regarding each disclosure type in an effort to understand their use of therapist self-disclosure in their professional psychotherapy practice. Respondents were presented with a continuum ranging from zero (“I rarely or never allow clients to know my emotional responses to the content of the therapy session” or “I never share information about my life outside of the therapeutic session with clients”) on the left to ten (“I frequently allow clients to know my emotional responses to the content of the therapy session” or “I frequently share information about my life outside of the therapeutic session with clients”) on the right. Respondents were asked to position themselves as psychotherapists on this continuum. Responses ranged from one to nine in relation to respondents’ reported use of emotional disclosures with a mean of 6.158 (SD=1.820). Responses to the same item regarding personal disclosures ranged from zero to eight on the scale with a mean of 5.209 (SD=2.002), indicating a slightly lower utilization of this disclosure type.

Statistical Relationship between Personal Therapy and Therapist Self-Disclosure

The first research question in this study examined whether there is a relationship between therapists’ experiences of therapist self-disclosure in their own personal therapy and their use of

therapist self-disclosure with their clients. A number of correlations (Spearman's rho) were run in answering this question. For each disclosure type, the professional use of disclosure and the disclosure likelihood variables (two measures) were used to measure therapists' use of self-disclosure. The experience of having been the client-recipient of therapist self-disclosures was measured using the disclosure impact variable as well as the positive, negative, and cumulative experience scale scores (three measures).

The research hypothesis for each disclosure type was: There is a relationship between respondents' experiences of (emotional/personal) disclosures as therapist-clients and their use of (emotional/personal) disclosures as therapists. The null hypothesis was: There is no relationship between respondents' experiences of (emotional/personal) disclosures as therapist-clients and their use of (emotional/personal) disclosures as therapists. For both types of disclosures, as shown in Table 15, a moderate positive relationship existed between respondents' increased likelihood of using disclosures with clients and how favorably they viewed their experiences of such disclosures. In keeping with these results, there was a weak negative relationship between the same likelihood variable and the overall negative evaluation of the disclosure experience. These correlations were all statistically significant with p-values below .05.

Comparing the likelihood/impact correlation to the likelihood/cumulative scale score correlation suggests that the impact and cumulative scale score variables may be quantifying the disclosure experience as intended. Results from running an additional Spearman's rho correlation between the likelihood and use variables indicate a significant moderate positive relationship for both emotional disclosures ($r_s=.439$, $p<.001$) and personal disclosures ($r_s=.447$, $p<.001$), again suggesting some consistency between these measures.

Table 15

Correlations between Disclosure Experiences and Disclosure Behaviors

Inferential Statistics						
	<i>r_s-value</i>	<i>p-value</i>	<i>Reject H₀</i>	<i>r_s-value</i>	<i>p-value</i>	<i>Reject H₀</i>
Emotional disclosures	Likelihood			Professional Use		
Impact	.510	<.001	Yes	.295	.013	Yes
Positive experience scale	.412	<.001	Yes	.289	.015	Yes
Negative experience scale	-.260	.028	Yes	-.218	.070	Yes
Cumulative scale	.418	<.001	Yes	.439	<.001	Yes
Personal disclosures	Likelihood			Professional Use		
Impact	.722	<.001	Yes	.385	.002	Yes
Positive experience scale	.706	<.001	Yes	.322	.005	Yes
Negative experience scale	-.699	<.001	Yes	-.349	.002	Yes
Cumulative scale	.4722	<.001	Yes	.322	.006	Yes

Qualitative Analysis of Disclosure Experiences and Use of Self-Disclosure

This exploratory study asked participants to share any thoughts or reflections on their experiences – both as clients and as therapists – with self-disclosure. The instructions for this open text box on the survey read as follows: “Please provide any additional comments that you believe might be helpful in my research as I explore therapist self-disclosure and how it is impacted by experiences in personal therapy and by theoretical orientation. You may also use this space to clarify any of your prior responses or to share your own insights about therapist self-disclosure.”

While some participants chose to reflect on the impact of the experiences they had as therapy clients, many chose to respond based on their experiences as therapists. The most frequent responses for both groups addressed the potential benefits and/or risks inherent to self-disclosure and, interestingly, there was significant agreement between these two perspectives about both benefits and risks.

Potential benefits of therapist self-disclosure. From both the therapist and client perspectives, the most significant potential benefit of therapist self-disclosure had to do with

enhancing the therapeutic alliance. Two additional themes emerged from the data suggesting that both perspectives valued the ways in which therapist self-disclosure might serve to normalize or validate a client's experiences as well as model compassion, emotion, and the client's impact on others.

Improved therapeutic alliance. Speaking from a therapist's perspective, a number of respondents suggested that some therapist disclosure is essential to building an alliance with clients. The following comments reflect this belief:

"...[research] supports the efficacy of a strong therapeutic alliance with clients. Part of that alliance is built from genuine, client-centered self-disclosures by the therapist."

[In referencing work with children] "...it seems to at times be almost necessary for a) building a therapeutic, trusting relationship and b) to help normalize experiences."

More frequently, however, respondents noted how self-disclosures enhance specific qualities of a good therapeutic alliance.

Authenticity, vulnerability, and trust. When responding as therapists, participants clearly saw authenticity as essential to building trust in the therapeutic alliance. This value had stronger implications for the use of emotional disclosures than for personal disclosures. As one respondent noted, "...I believe that being an authentic and sincere human being is first and foremost the most healing gift I can bring." Another respondent indicated that to withhold her authentic emotional reaction to the client would have been inauthentic to the degree that it might have ruptured the alliance:

I have made some spontaneous emotional expressions to a client when I have been so moved that it would have been dishonest and improper to withhold my feelings. I think the client would have been aware if I had tried to do so and that would have damaged the relationship.

From the client perspective, respondents identified authenticity with a therapist's willingness to be vulnerable, real, and emotionally present with clients. They described being "more comfortable with therapists who used self-disclosure" and feeling "more comfortable in my vulnerability of being a client." Another respondent suggested that "when therapists would use self-disclosure, I felt that they were relating to me much more subjectively."

Connecting through the human condition. Using disclosure to build human connection and equalize power in the therapeutic alliance was also supported by both client and therapist perspectives. Closely related to the vulnerability described above, this humanizing aspect of disclosure allowed therapists and clients to connect around the struggles inherent in the human condition. In both perspectives, respondents felt that disclosure could be used effectively to expose the humanness of the therapist in ways that allow for deeper connections and reduced isolation. One respondent, from a therapist perspective, noted, "I believe that we can only help by disclosing SOME of our humanness." Another, speaking from her experience as a client, indicated that her therapist's disclosures "helped to humanize the therapeutic experience and made me feel more connected with the clinician." Other respondents suggested that therapist disclosures can also be instrumental in equalizing the power differential between therapist and client. One respondent identified this as a primary motivation for disclosing to clients: "...some [of my disclosures] are intended to even out the felt power differential between me and the client if necessary."

A normalizing, validating tool. Self-disclosure's capacity for normalizing or validating client experience was the second major benefit of therapist self-disclosure to emerge from respondents' comments. Interestingly, when speaking from a therapist perspective, most respondents described this benefit using the term "normalizing" while those speaking from a

client perspective referred to a similar experience as “validating.” In wanting to communicate to clients that their experiences or emotions are normal, therapists are motivated to use disclosure with clients:

“Most of my disclosures are intended to normalize the client’s experience.”

“I use intentional self-disclosure as part of the DBT approach to validation.”

In reflecting on disclosures intended to normalize their experiences, respondents speaking from a client perspective identify that such disclosures “made me feel validated” or “felt very validating.” Additionally, one therapist in a medical setting noted that self-disclosure can help make therapy accessible to individuals who do not identify as having mental health issues: “I find that self-disclosure normalizes the experience and allows them to consider participating in therapy.”

The role of modeling. Therapists’ ability to model impact, compassion, and emotion through self-disclosure was the third benefit to emerge from these responses. Again, participants responding from both client and therapist perspectives endorsed this benefit. One respondent noted that modeling felt particularly important in emotional disclosures and that her personal story became less relevant.

I think what did become more relevant was expressing my feelings about what I heard the client say, or if I noticed a physical sensation in my body and could connect it to a feeling. I think role modeling expressing and identifying feelings can be valuable.

Another respondent reported the impact emotional disclosures often have as the therapist and client model and practice honest, caring communication in the therapeutic relationship:

It is my experience that when I share my emotional experience of a client or situation with a client, that it raises the therapy to a new level, we are able to use the ‘here and now’ situation to effect change, which can then be generalized in the client’s life. It

tends to enrich and deepen the therapeutic relationship and facilitate client growth when I am closely attuned to the client's need and my disclosure is based on the needs of the client or, more rarely, my own limits as a therapist and I need to disclose my experience in order to stay in the therapeutic relationship. In those situations it is important for me to not judge or be critical, but to acknowledge the truth in both of our experiences, and come to a synthesis that works for both of us.

Such emotional transparency proved to be very pivotal in one respondent's personal therapy and went on to deeply influence that respondent's professional use of emotional disclosures:

At the time in therapy in which I was the most suicidal, my therapist, who normally provided few transparent emotional disclosures, welled up with tears in her eyes. That was a critical moment in my therapy. Before, I didn't understand that my therapist (or perhaps anyone) really cared about me - I thought I was just paying her bills. It also conveyed to me how sad and wasteful it would be if I were to suicide. Seeing my therapist's tears gave me compassion for myself. I remembered her face when I thought about suicide after that, and no longer considered it an option. Because of that experience, I am not afraid of my own tears showing up in sessions with my clients.

Potential dangers of therapist self-disclosure. Respondents also shared a number of criticisms about the use of therapist self-disclosure. These criticisms were identified through therapists' negative experiences as recipients of disclosure in the course of their personal therapy as well as through complaints clients made to them about frustrations with prior therapists. These risks of disclosing are congruent with the subjective experience statements respondents endorsed earlier in the survey. Responses identified potential dangers of disclosure as shifting the focus from client to therapist and having the disclosure be perceived by the client as intrusive, annoying, or self-serving on the part of the therapist. One respondent indicated that

understanding clients' prior therapy experiences sheds light onto how therapist self-disclosure is frequently experienced:

At intake sessions, if a new client has had therapy before, I ask them if they can tell me what was helpful in past therapy and what was not helpful. Sounds to me like many patients interpret and experience overdone therapist-self-disclosure as 'therapy being too much about them' or 'felt more like friendship than therapy' – things like that.

Potential dangers of therapist nondisclosure. Although the survey did not inquire about whether there are dangers associated with not utilizing personal and emotional disclosures in therapy, a surprising number of respondents addressed this issue directly. Essentially, these comments were focused entirely on the potential damage that nondisclosures – particularly emotional nondisclosures – can have on the therapeutic relationship. Whereas respondents found that emotional disclosures benefited the therapeutic relationship by increasing authenticity, trust, vulnerability, and human connection, they found that emotional nondisclosures risked being perceived as robotic, disrespectful, impersonal, one-sided, and dishonest. The following statements provide a sense of the potential harmfulness of a lack of emotional transparency:

A past therapist who never used self-disclosure and adhered to a mechanical, structured approach to therapy made my wife and I feel as if we were objects and he would be using the same approach in the same way regardless of who we were as individuals. It resulted in a cold therapeutic dynamic and we quickly terminated our sessions with him and moved toward an emotion-focused, experiential practitioner.

I had a short-term experience with a more psychoanalytic therapist ... that was characterized by a very closed, non-self-revealing style that I found very unhelpful. So in my own view, not sharing at all (either types of self-disclosure) seems robotic and even disrespectful. With clients I have seen who have reported previous less-than-satisfying therapy experiences, it is not at all uncommon that their dissatisfaction

stemmed from this adherence to a style that is non-engaging, and perceived as one-sided.

Additional findings from the therapist perspective. Those respondents commenting from a therapist perspective provided three additional types of comments. They reflected on how they make the decision to disclose and what they have noticed about their own disclosing behaviors. They also offered a number of suggestions about how to use disclosure most effectively.

The decision to disclose. Having a clear, therapeutic reason for disclosing emerged as the strongest theme regarding the appropriateness of therapist disclosure. Many respondents talked about how they ask themselves questions that help to clarify their reasons for wanting to disclose. Such questions included understanding who would benefit, what benefit was likely to be experienced, what was motivating the disclosure, how much time would it take, and how might the client perceive the benefit and/or motivation of the disclosure. One respondent stated that:

Any time I decide to disclose something personal, it is always with a purpose that is relevant to the client's current state/condition/problem, etc. I always ask myself before: 'Why do I feel the need to disclose? What purpose would it serve?' If it's because I want to appear a certain way to the client, or feels more like a 'tit-for-tat' sort of disclosure, I abstain because it serves no therapeutic purpose.

A number of other respondents indicated that their decision about whether and how to use self-disclosure was dictated by the treatment modality they were using. Using self-disclosure as part of the DBT treatment model came up repeatedly, as evidenced by the following comment: "I believe it depends on the mode of therapy you're doing. In DBT, self-disclosure is part of the model, so when doing DBT, I disclose often. Not so with other models of therapy."

Disclosure behaviors. A few respondents reflected on what they have observed about their own disclosure behaviors. Multiple therapists indicated that they find themselves disclosing less frequently now than early in their practice. Therapists also noted that they were more inclined to use disclosure with some clients than with others. The differences in disclosing behaviors were dictated by the demographic differences (such as working with children rather than adults) and by sensing and assessing each client's particular needs in the therapeutic relationship:

I have found over the years that I try to use humor or everyday disclosures (e.g., common parenting stressors or challenges) more with some people than others. I try to be mindful about sensing, or even asking, who seems to want to know me more as a person in order to help them open up, or who seems to be distracted or annoyed by any attempt I might make to allow them to get to know me (a good portion of people just don't want that).

Disclosure techniques. Some therapists offered suggestions for using disclosures in the most beneficial way. One respondent suggested that personal stories might be better given as third-person illustrations. Based on personal therapy experience, another respondent reflected on the timing of disclosures in the session:

From my own therapy experience as a client, I have found that it is very disorientating for a therapist to do that in the middle of a session, but during a wrap-up part of the end of a session I think it has a greater chance to be more helpful to a client and less distracting.

Additionally, a number of therapists suggested negotiating disclosures with clients by asking them if they would find a disclosure helpful:

If it is a very specific disclosure that I would consider 'big' (like disclosing a family member of mine going through a medical trauma and I am sharing that experience in order to give the client information that helped me get through it), then I have learned

always to ask permission first to give that type of disclosure, 'Would it be helpful to you if I shared a personal experience related to that topic?'

Lessons learned from personal therapy. A number of respondents reflected on the significant lessons they learned about disclosures and boundaries in their personal therapy. One respondent indicated that her therapist's use of disclosure modeled attunement and flexibility:

It was evident that the self-disclosure of the therapist was well thought out depending upon my relationship/history with her as well as her ability to ascertain what my needs were. Her self-disclosure taught me about boundaries and their fluidity instead of black and white.

Another respondent noted that therapist disclosure that was beneficial early in the therapeutic relationship could later become detrimental if the boundaries around disclosures are not maintained:

I had a great therapist who told me about her boat and money concerns, which was great and we were really close. At first I felt like, wow - she likes me and trusts me. After awhile, I felt like, I don't really care I just want you to help me get over my problems.

Other observations. The other responses in this portion of the survey focused primarily on the survey construction itself. Although one respondent stated "some of the perspectives I noticed here seemed somewhat clinical/sterile," the other comments about the survey focused on the broad categorization of theoretical orientation. Describing himself as an integrationist, one person suggested that the "therapeutic categorizations are limiting." Another respondent offered substantial concern about how these broad theoretical definitions might distort the study's conclusions:

I worry that your very generic and inclusive definitions for the various theoretical orientations may lead you to make erroneous conclusions about the relationship between

therapist self-disclosure and theoretical orientation. ... Without a greater ability to discriminate, your conclusions could lead a reader to believe something about theoretical orientation that might not hold-up under greater scrutiny.

This same respondent also had concerns about how the study might draw erroneous conclusions about self-disclosure based on the lack of context for the client's subjective experience.

Relationship between Theoretical Orientation and Therapist Self-Disclosure

The final research question sought to determine whether there is a relationship between therapists' theoretical orientation and their use of therapist self-disclosure with their clients. To make this determination, non-parametric Mann-Whitney U tests were run on all of the variables for both disclosure types as well as the variable measuring the reported influence of personal therapy on the respondents' theoretical orientation. The Mann-Whitney U test measures whether the distribution of means for each variable is the same between two groups of the sample. In teasing out the significance of theoretical orientation, two categorical comparisons were created for each of the five theoretical categories (P=psychoanalytic/psychodynamic; H=Person-centered/humanistic; C=Cognitive-behavioral; S=Systemic; E=Experiential/Somatic). The first comparison for each orientation (1) tested the variable means of those who ranked that orientation first against the variable means of the rest of the sample. The second comparison (2) tested the variable means of those who ranked that orientation first or second against the variable means of the rest of the sample. For each of the 130 Mann-Whitney tests, the research hypothesis was that the distribution of scores for [selected variable] is significantly different for the [selected category] than it is for the rest of the sample. Similarly, each test had a null hypothesis that the distribution of scores for [selected variable] is not significantly different for the [selected category] than it is for the rest of the sample. If a test had a p-value of less than .05, the null hypothesis was rejected with confidence.

For example, the p-value (.080) for the first of these 130 tests is displayed in the first data cell in Table 16. This p-value refers to the statistical significance of the test run on the scores of the variable measuring the influence of personal therapy on a therapist's theoretical orientation. This variable was operationalized in the personal therapy section by the item: "To what degree do you believe that your personal therapy has influenced your theoretical orientation as a therapist?" The values listed for this 7-point Likert scale ranged from 1 ("No influence") to 7 ("Strong influence") with a center value of 4 ("Moderate influence"). The Mann-Whitney U test compared the distribution of this variable's score between two groups. The category column – in this case, P1 – identifies the criteria for dividing the study sample into two groups. Based on the definition of P1, the first group contained all respondents who identified psychoanalytic/psychodynamic (P) theory as their top-ranked theory. The second group contained all other respondents in the sample. In this particular test, the research hypothesis was that the distribution of scores for the variable (influence of personal therapy on theoretical orientation) is *significantly different* for the respondents who ranked psychoanalytic/psychodynamic theory first than it is for all other respondents in the sample. The null hypothesis was that the distribution of scores for the variable (influence of personal therapy on theoretical orientation) is *not significantly different* for the respondents who ranked psychoanalytic/psychodynamic theory first than it is for all other respondents in the sample. Given that the resulting p-value (.080) was greater than .05, the null hypothesis could not be rejected. In other words, chance could not be ruled out as the cause for any differences in the distribution of this variable's scores between the two defined groups of respondents.

The data cell to the right of this first cell displays the p-value of the exact same test with one variation. In this case, the sample was divided into two groups using the category P2 rather

than P1. Consequently, the first group included all respondents who ranked psychoanalytic/psychodynamic theory first OR second while the second group contained all other respondents. Because the p-value for this test was less than .050 (.015), the null hypothesis for this test was rejected.

As shown in Table 16, only two of these tests indicated statistically significant differences between the test group and the rest of the sample on the variable score distribution. In both cases, the test group consisted of the respondents who identified psychoanalytic/psychodynamic as one of their top two preferred theoretical orientations. These respondents had a statistically different distribution of responses to the questions regarding the influence of personal therapy on their theoretical orientation ($p=.015$) and the overall harmfulness/helpfulness of emotional disclosures ($p=.044$). Interestingly, however, test results were just shy of the significance level when the test groups were defined as respondents with psychoanalytic/psychodynamic ranked first (personal therapy: $p=.080$; emotional disclosure impact: $p=.066$) and the rest of the sample. It is also worth noting that the difference in p-values for the two types of disclosures between groups favoring psychoanalytic/psychodynamic theory (P1 and P2) and the rest of the sample. While the distribution of responses regarding the impact of emotional disclosures differed at a statistically significant level between P2 and the rest of the sample ($p=.044$) and at a nearly significant level between P1 and the rest of the sample ($p=.066$), no such differences were even marginally detected by the same tests run on personal disclosures.

Table 16

Significance of Mann-Whitney U Tests across Theoretical Orientations

Mann-Whitney U Test p-values										
<i>Variables</i>	<i>Categories*</i>									
	<i>P1</i>	<i>P2</i>	<i>H1</i>	<i>H2</i>	<i>C1</i>	<i>C2</i>	<i>S1</i>	<i>S2</i>	<i>E1</i>	<i>E2</i>
Influence of personal therapy on theory	.080	.015	.174	.526	.061	.263	.611	.170	.391	.740
Emotional disclosures										
Impact	.066	.044	.076	.124	.437	.890	.146	.180	.925	.272
Likelihood	.624	.954	.715	.519	.256	.737	.097	.849	.468	.385
Professional use	.223	.798	.203	.975	.975	.249	.146	.142	.417	.812
Positive scale	.457	.437	.947	.537	.671	.398	.587	.242	.503	.560
Negative scale	.801	.549	.553	.848	.422	.735	.327	.364	.655	.897
Cumulative scale	.732	.586	.790	.550	.893	.467	.862	.328	.434	.571
Personal disclosures										
Impact	.462	.737	.183	.406	.295	.657	.750	.575	.411	.238
Likelihood	.550	.806	.581	.737	.270	.486	.821	.898	.340	.125
Professional use	.462	.908	.657	.561	.552	.436	.219	.648	.859	.184
Positive scale	.750	.872	.628	.757	.858	.634	.974	.216	.788	.071
Negative scale	.232	.855	.256	.934	.391	.804	.405	.846	.486	.052
Cumulative scale	.614	.922	.534	.798	.832	.636	.960	.236	.807	.078

**P*=psychoanalytic/psychodynamic; *H*=Person-centered/humanistic; *C*=Cognitive-behavioral; *S*=Systemic; *E*=Experiential/Somatic

Discussion

The current study was designed to explore the relationship between respondents' experiences of therapist self-disclosure in their personal therapy and their use of self-disclosure as practicing therapists. While the topics of personal therapy and self-disclosure have each been the focus of substantial research, little is known about the relationship, if one exists, between therapists' experiences as client recipients of therapist self-disclosure and their subsequent self-disclosing behaviors as therapists. Consequently, this study investigated whether such a relationship exists and whether that relationship might be a viable focus for future study. Because of the historical influence of theoretical orientation on utilization of personal therapy and on the advisability of therapist self-disclosure as a therapeutic technique, this study also sought to identify if/how an individual's theoretical orientation might be a mediating factor in the relationship between personal therapy experiences and the use of therapist self-disclosure.

Experience of Personal Therapy

Participants in this study were extremely positive about the personal helpfulness of their own therapy experiences. This finding is consistent with the majority of recent research conducted on therapist ratings of their personal therapy effectiveness. In summarizing the last three decades of this research, Orlinsky, Norcross, Rønnestad, and Wiseman found that 90-99% of therapists rated their personal therapy as effective (2005, p. 215). Similarly, the current study found that the issues that prompted participants to seek therapy were congruent with the motivations identified in prior research. As Norcross (2005) noted when reflecting on his comprehensive meta-analysis of research studies on personal therapy, “Before, during, or after training, the results are clear: Psychotherapists largely enter psychotherapy to deal with ‘personal stuff’” (p. 844). In fact, when therapists were asked to indicate all their reasons for seeking therapy (rather than only their primary motivation), fewer than half of the respondents identified training or professional issues as a goal of therapy. This was true in the current study – 40.59% identified professional issues – as well as in previous studies in which 46% identified professional training (Orlinsky, Norcross, et al., 2005).

Despite the fact that training or professional development was not typically the primary motivation for seeking therapy, participants overwhelmingly identified their personal therapy as helpful in their professional development and influential in their professional practice. Again, these results are consistent with those from Orlinsky, Norcross, Rønnestad, and Wiseman’s secondary data analysis (2005).

This study asked participants to characterize their theoretical orientation and encouraged them to identify the degree to which their personal therapy influenced their theoretical orientation as a therapist. However, due to the profound theoretical eclecticism of the

respondents, it was impossible to draw meaningful conclusions about the association between personal therapy and theoretical orientation. Interestingly, existing research identifies a strong relationship between therapists' theoretical orientation and participation in personal therapy as well as between their orientation and the orientation of their personal therapists (Norcross, 2005). The vast heterogeneity of theoretical orientations revealed in the current study's sample raised important questions about the role of theoretical orientation in existing and future research on the topics of personal therapy and therapist self-disclosure. Given the relatively small sample size and the nonprobability sampling methods of the current study, it is quite possible that this study's sample is not at all representative of the larger population of therapists. However, it is also possible that when theoretical orientation is defined by therapists' top theoretical preference alone, any resulting conclusions drawn about the influence of theory on therapists' behaviors or practices may be misleading, simplistic, or erroneous. If the current study's sample is any indication, the vast majority of therapists function as theoretical integrationists. In the current study, only two of 93 respondents identified as practicing therapy from a single theoretical stance, while over three-quarters of the respondents ($n=74$; 79.57%) indicated that their practice is informed by four or more theories of psychotherapy. It is possible that the diversity of theoretical influences endorsed by each therapist may reveal as much or more about the therapist's behaviors and practices than can be identified through primary theoretical orientation alone.

The fact that study participants identified their personal therapy as being both personally effective and professionally influential aligns closely with the concept of "apprenticeship of observation" used as a framework for this study (Lortie, 1975). If therapists judge their own therapy as having been effective and acknowledge the influence of their personal therapy

experiences on their professional development, it is somewhat predictable that they would incorporate the therapeutic techniques they experienced as most helpful into their own practices and would exclude those that were least helpful or harmful from their therapeutic repertoire. This study's findings about therapists' use of self-disclosure supports this assumption.

Therapist Self-Disclosure in Personal Therapy

When compared to existing research, one of this study's most incongruous findings was the incidence of emotional disclosure events in respondents' personal therapy. Despite the fact that nearly all prior studies found that therapists make far more emotional disclosures than personal disclosures, this sample reported the opposite to be true in their therapy experiences (Knight, 2012; Pope, Tabachnick, & Keith-Spiegel, 1987; Edwards & Murdoch, 1994). Although it is possible that this indicates a departure from prior research, it more likely reflects a lack of clarity in the survey's operational definition of emotional disclosure. While emotional disclosures and empathy are not synonymous, the differences between them are subtle and may not have been adequately communicated in the survey instructions.

Participants in this study reported both types of therapist self-disclosure as being far more positive/helpful than negative/harmful in their personal therapy experience. These findings are difficult to compare to prior research for two primary reasons. First, since existing research lacks consensus about what constitutes self-disclosure, results are contradictory and confusing. In addition, the vast majority of prior studies queried therapists about their perceptions of the usefulness of their disclosures rather than asking clients about their experience of the disclosures.

Nevertheless, Henretty and Levitt's (2010) qualitative analysis of the last 40 years of research on this topic found a number of significant and reliable results. In terms of client perceptions of the therapist, their primary finding was that the characteristic of warmth was the

only variable reliably and consistently impacted (in this case, positively) by therapist self-disclosures. Similarly, they found that clients had a more favorable response to therapists who used self-disclosure and felt a stronger connection with them. The current study's findings, reflected in the subjective descriptions endorsed by participants and by the comments they shared at the end of the survey, were largely consistent with these conclusions. For both types of disclosures, participants reported the disclosure experience as far more helpful than harmful and clearly more helpful than neutral. Also consistent with Henretty and Levitt's (2010) findings, participants responded more positively to emotional disclosures than to personal disclosures. However, the findings of this study hint at a new hypothesis regarding the risks intrinsic to different types of therapist self-disclosure. This hypothesis posits that – although emotional disclosures may result in negative outcomes less frequently than personal disclosures – the potential for those outcomes to inflict serious harm on the therapeutic alliance may be substantially greater for emotional disclosures than for personal disclosures.

Professional Impact of Disclosure Experiences

This study's findings suggest that the “apprenticeship of observation” concept plays an active role in the clinical practices of therapists who have participated in personal therapy. Specifically, this research supports the idea that therapists who have positive experiences with therapist self-disclosure are: 1) more likely to use self-disclosure professionally and 2) identify themselves as more self-disclosing. Conversely, those with negative experiences with therapist self-disclosure are: 1) less likely to use self-disclosure professionally and 2) identify themselves as less self-disclosing.

Professional Reflections on Self-Disclosure

Despite these moderate-to-strong correlations between therapists' experiences and practices related to self-disclosure, the comments submitted suggest that the process of determining whether, when, and how to disclose to a client is far more than a knee-jerk reaction to the therapist's personal therapy experiences. These decisions are frequently the culmination of an intentional, reflective process that includes examining the motivation for disclosing, clarifying the intended outcome of the disclosure, assessing the client's needs in the therapeutic process, and seeking congruence with setting and therapeutic modality. Participants commented on techniques for disclosing appropriately and unobtrusively and reflected on changes in their disclosing behaviors over time.

Strengths and Limitations

This study examined the connection between two heavily-researched psychotherapeutic topics – personal therapy and therapist self-disclosure – in an effort to determine how or if the personal therapy experiences impacted professional use of self-disclosure. While this venture into two robust areas of psychotherapy research was at times overly ambitious for such a time-limited study, the rich body of existing literature on both personal therapy and self-disclosure made this exploratory research possible.

Limitations of the study. There were a number of ways in which the veracity of this study's findings was compromised. Key among these limitations was the inherent difficulty of accurately measuring the subjective content of a therapy session. All prior research in both the areas of personal therapy and therapist self-disclosure has been hampered by this problem. Therapy is relational and private by nature and the problems addressed in therapy are subjective. Consequently, it was impossible to accurately standardize measures for either the use or the

impact of self-disclosure that could effectively control for these high levels of subjectivity. The majority of existing research has privileged therapists' perspectives of the use and impact of this technique. Ideally, therapy sessions would be videotaped and reviewed by multiple researchers to establish inter-rater reliability of the disclosure events. Additionally, both the therapist and client would be interviewed separately and those interviews rated by multiple researchers to establish reliability around the impact of disclosures. Without employing this high level of control and invasiveness, measuring the incidence and impact of self-disclosure remained murky, crude, and highly subjective.

The current study was hindered by this subjectivity in a couple critical ways. First, as noted earlier, it was hypothesized that respondents under-reported their use of emotional disclosures due to an operational definition that did not adequately assist them in identifying these disclosures. If this hypothesis is true, all findings related to emotional disclosures were compromised. Not only would this have skewed the number of respondents who reported such disclosures, but also those respondents who reported never having received an emotional disclosure were then excluded from additional items regarding these disclosures. Second, the item measuring therapists' use of self-disclosure was based entirely on the therapists' subjective perception of the frequency of their use. The 11-point use continuum ranged from never using disclosure at one end to frequently using it at the other. Although the concept of "never" is absolute, all other values on the spectrum were extremely subjective and open to interpretation. While one therapist might describe a disclosure usage pattern as "frequent use," another might consider the same pattern to be "infrequent use." Consequently, the meaning of this item's score changed for each respondent. The more accurate item asked therapists to evaluate whether their disclosure experience increased or decreased the likelihood of using disclosures with their

clients. This item viewed the disclosure's impact within each respondent's subjective perception rather than across the multiple perceptions of all respondents.

The homogeneity of the sample also limited the usefulness of this study. In particular, the sample lacked diversity in the areas of race, gender, and geographical location. Additionally, based on the recruitment methods, the sample was probably not reflective of a broad population of therapists and, in turn, results of the study were likely skewed by the ways in which participants were connected.

In general, the size of the sample was quite good given the limited time and funding for this research. However, it was too small to draw any useful conclusions about the role of theoretical orientation in relation to the research topic. This was due to the lack of homogeneity present in participants' theoretical orientations. Based on the results of the survey, most therapists would probably have identified themselves as eclectic if given that option. That option was deliberately not offered in an effort to distinguish between the various theoretical influences in eclecticism. Given the vast number of theories in psychotherapy, the study would have required an extremely large sample in order to draw meaningful conclusions about patterns of behavior based on theoretical orientation. Rather than revealing discernable relationships between therapists' theoretical orientation and disclosure behaviors, this study offered deeper insight into the theoretical diversity and eclecticism of many psychotherapists.

Strengths of the study. A major strength of this study was that it utilized therapists who have been therapy clients to bridge the gap between client and therapist experiences. While both experiences are subjective, evaluating the impact of therapist self-disclosure from the perspective of a person who was both a client and therapist controlled for some perspectival diversity.

With the exception of implications for theoretical orientation, the sample size for a project of this nature was quite good. Additionally, the completion rate of the survey was high and participants were generous with comments and observations about this topic.

Correlations between therapists' experiences of disclosures as clients and their perceptions of those experiences on their professional use of disclosures were mostly in the moderate range and were clearly statistically significant. The strongest correlations existed between the impact and experience of personal disclosures and the resulting likelihood of the respondent to utilize similar disclosures with clients. The unambiguous degree and significance of these correlations counterbalanced some of the ambiguity in the measurement of variables. The clarity of these results suggested that though the correlations may have lacked precision, they clearly existed and thereby warrant more extensive and meticulous study.

Implications for Psychotherapy

As psychotherapy continues to develop its theories, modalities, and intervention techniques, the findings in this study offer some important insights. The formative impact of personal therapy on professional practice in relation to the use of a particular technique emerged as the most significant finding in the study. Data suggested marked correlations between therapists' experiences of self-disclosure as clients and their professional use of self-disclosure as therapists. However, self-disclosure is simply one of many techniques used in therapy. If, as this study suggests, therapists' use of self-disclosure is correlated with their experiences with self-disclosure as clients, the same may be true for many or even most therapeutic techniques and interventions. Although a significant amount of research would be required to substantiate this idea, the findings in this exploratory study are compelling enough to encourage therapists to be reflective about whether or how their personal therapeutic experiences impact their decisions as

clinicians. In this way, the study encouraged therapists to deepen the self-reflective elements of their practice.

Psychotherapists may also find it helpful to consider what this study reveals about the differences between the two types of disclosures and the potential risks and benefits inherent in each. Overwhelmingly, respondents' subjective experiences of both types of disclosures were positive and the disclosures were perceived to deepen the therapeutic relationship. Based on the essential importance of the alliance as a common factor in therapy (Asay & Lambert, 1999), appropriate self-disclosure may be a critical tool for forging a strong alliance. The study suggests that emotional disclosures are experienced more positively and have a deeper influence on the alliance than personal disclosures. In keeping with this, it appeared that therapists utilized emotional disclosures more frequently than personal disclosures.

The most interesting discovery – and the one with the most critical implications for therapists using self-disclosure – concerns the disparity between potential risks inherent in both types of disclosures. As indicated earlier, participants generally experienced emotional disclosures less negatively than they did personal disclosures. This is reflected in the items measuring the harmfulness/helpfulness of the disclosures as well as in the negative and cumulative scale scores. However, a closer look at the subjective descriptions and the negative scale scores for each disclosure type indicate that emotional disclosures – while experienced negatively less frequently than was true of personal disclosures – may actually represent a more serious risk to the alliance and therapy. As evidenced in the negative scale scores, those respondents with a negative experience of emotional disclosures attributed a greater number of negative characteristics to the disclosure event. Additionally, the negative descriptors used appear to represent greater potential for a rupture in the therapeutic alliance. Respondents

indicated that when personal disclosures were not positive in nature, they were typically experienced as disruptive to the focus and flow of the session. For instance, the two most prevalent negative descriptions concentrated on the shift of focus from client to therapist and the lack of relevance to the content of the session. However, when respondents experienced emotional disclosures negatively, the subjective descriptions they endorsed suggested that the disclosure had triggered intrapersonal or interpersonal distress. For emotional disclosures, the top three negative descriptions cited feelings of discomfort, nervousness, and fear. This discovery suggests that emotional disclosures may be more tightly welded to the alliance itself and, consequently, contain both the greatest potential benefit and risk to the therapeutic relationship.

Recommendations for Future Research

This study points toward exciting possibilities for future research. While existing research on personal therapy has resulted in relatively similar findings, research on therapist self-disclosure continues to lack a consensual definition of self-disclosure types as well as any standardized means of measuring its impact. Ideally, future research on therapist self-disclosure would include some of the controls mentioned earlier, such as videotaped client sessions and qualitative interviews with therapists and clients rated by multiple researchers for inter-rater reliability. Many aspects of self-disclosure were not included in the scope of the current study but are integral to understanding its use and impact. These aspects include the amount, content, and frequency of disclosures as well as the client, therapist and practice variables that influence disclosure. These should all be addressed in future studies. Given the current study's findings about emotional disclosure's potential for rupture in the therapeutic alliance, the concepts of how rupture and repair in regards to self-disclosure are addressed within the alliance also warrant attention.

In its broad-stroke, low-cost, exploratory fashion, this study's findings clearly suggest that therapists' experiences of self-disclosure in their personal therapy are correlated with their use of self-disclosure in their practices. This indicates that the intersection of personal therapy and the use of self-disclosure is a viable research area and warrants more extensive, systematized research. With its viability established, future researchers should develop measurement tools with established reliability and validity for measuring client disclosure experiences, the degree of professional disclosure, and the impact of personal therapy experiences on professional disclosure.

Based on the correlations found in this study about personal therapy and self-disclosure, it is also recommended that additional research address how personal therapy experiences may predict how therapists use other therapeutic techniques. Research methodology designed to study this phenomenon would benefit from more controls and standardization as well. One possible method might engage therapists in a longitudinal single-system research design in which therapists' techniques are measured before and after a course of personal therapy. If there is validity to the idea of "the apprenticeship of observation," the influence of that apprenticeship is likely present in the use of a wide variety of interventions.

Conclusion

Despite the continual drive toward using evidence-based interventions, much of the work of psychotherapy remains highly subjective. No two individuals experience psychological suffering in exactly the same way. Similarly, no two individuals share identical experiences in relieving their suffering. The science behind psychotherapy rests on a strong foundation of research into human development, psychology, psychiatry, sociology, neurochemistry, anthropology, and so forth. Yet, even equipped with this research and with the lessons learned

from generations of responding to psychological suffering, a large portion of psychotherapy remains an art form in which the medium is the client's subjective experience of life and the primary artistic implement is the therapeutic relationship. As Asay and Lambert's (1999) study reveals, this therapeutic alliance is the most powerful common determining factor in therapeutic outcomes over which the therapist has any direct control. Based on their findings, the therapeutic alliance has twice the influence of any specific intervention technique or strategy in determining therapeutic outcomes. Consequently, it seems essential that all therapeutic techniques need to be evaluated for not only for their efficacy in terms of treating the presenting issue, but for their impact on the therapeutic relationship as well.

The present study, which focused on the technique of therapist self-disclosure, underscores the importance of the therapeutic relationship. It revealed that this technique's most significant impact – both positive and negative – is focused on the therapeutic relationship. For therapists who are or have been therapy clients, this relational impact extends far beyond their own therapy experience. As they integrate lessons from their personal therapy into their professional practice, their subjective client experiences of the therapeutic alliance help to inform their professional behaviors. As reflective practitioners, therapists would do well to bring awareness and intention to how their “apprenticeship” as clients impacts their professional decisions and attitudes.

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Appendix A: Telephone Recruitment Script

Hello _____,

I am completing my Masters of Social Work degree at University of St. Thomas/St. Catherine University. I am currently working on my final research project that explores therapists' use of self-disclosure in their practice. The specific research I am conducting examines how or if a therapist's use of self-disclosure is impacted by their experiences in their own personal therapy.

As part of this research, I have created an anonymous, online survey that takes fewer than fifteen minutes to complete. I am asking individuals within the field of psychotherapy to consider taking this survey and passing information about this study on to their colleague and therapy contacts.

May I send you an email containing more information about the study, including clarification of participant qualifications, a link to the study, and a link to a customizable email invitation that you might use to inform others about this study?

Appendix B: Recruitment Email

I am a Masters of Social Work student at the University of St. Thomas/St. Catherine University in St. Paul, Minnesota. I am conducting research on therapists' use of self-disclosure with clients and whether therapists' experiences in their own personal therapy impact their use and beliefs about therapist self-disclosure.

I have created an anonymous, online survey that can be completed in fewer than fifteen minutes. I am hoping to recruit qualified participants from diverse educational, theoretical, professional backgrounds. I am asking for your help in this endeavor. Please consider assisting me in one or both of the following ways:

1. If you meet the qualifications for participating in the study, please consider completing this anonymous survey. Qualified participants meet all of the following requirements:
 - Participant is currently or has been a psychotherapy client.
 - Participant is currently providing or has provided psychotherapy to clients in a practice setting.
 - Participant is currently or was professionally licensed to provide psychotherapy in the state in which she/he practiced.

The survey can be accessed at this link until February 15, 2014: www.survey_url.com

2. Whether or not you personally participate in this study, please consider inviting your professional colleagues to participate in this study by copying the following text into an email:

SURVEY PARTICIPANTS NEEDED

Psychotherapists of all disciplines are needed to complete an anonymous, 15-minute, online survey as part of a graduate research study exploring whether therapists' experiences in their own personal therapy impact their use and beliefs about therapist self-disclosure.

Qualified participants:

- Are or have been psychotherapy clients.
- Are providing or have provided psychotherapy to clients in a practice setting.
- Are or were professionally licensed to provide psychotherapy in the state in which they practice(d).

The survey can be completed until February 15, 2014. For additional information, please visit www.survey_url.com.

Please also consider sending information about this study to professional listservs, email lists, or bulletin boards, or verbally share the survey link in consultation groups, supervision groups, or clinical staff meetings in which you participate. To facilitate this process, I have created a number of customizable resources you may use to invite others, including:

- A short post about the study (including a link to the survey) to be included in email lists, electronic newsletters, blogs, or online bulletin boards
- A customizable email to send to colleagues
- A printable page of informational cards to be distributed at face-to-face meetings
- A printable page with study information and tear-off survey links for posting on bulletin boards

All these informational resources can be accessed at www.resource_url.com.

You can find details concerning the study at the www.survey_url.com. Your participation in this study and in inviting others to the study is completely voluntary and anonymous. However, feel free to contact me if you have questions about the study or survey. I can be reached at email@domain.com.

Thank you for your consideration of this request!

Anne Breckbill

Appendix C: Thank-you/Resource Page

Thank you for your participation in this study! I appreciate your contribution of time and energy into this research topic.

Invite others:

Please consider passing information about this study on to other psychotherapists and inviting them to participate as well. I have included a number of resources on this page that make inviting others to the study simple.

- **Posting:** Consider posting the following text to electronic newsletters, listserves, blogs, or online bulletin boards.

Survey respondents needed for a study on therapists' use of self-disclosure. Psychotherapists of all disciplines are needed to complete an anonymous, 15-minute, online survey as part of a graduate research study exploring whether therapists' experiences in their own personal therapy impact their use and beliefs about therapist self-disclosure. For additional information, please visit www.survey_url.com.

- **Email:** Customize the following email to send to your professional contacts.

I am writing to encourage you to participate in a short survey as part of a graduate research study exploring whether therapists' experiences in their own personal therapy impact their use and beliefs about therapist self-disclosure. The online survey is anonymous and took me fifteen minutes to complete.

The survey is available until February 15, 2014 and psychotherapists of all disciplines, licensure, and theoretical orientations are encouraged to participate. The results of the study will be available later this spring and will add to the existing research on the impact of personal therapy and the use of therapist self-disclosure.

Thank you for considering this investment in psychotherapy research. For more information or to participate in the survey, please visit www.survey_url.com.

- **Link:** Copy this link and include it in an email of your own.

www.survey_url.com

- **Cards:** Print the following document to make informational cards that can be handed to colleagues at meetings, supervision/consultation groups, or educational workshops (see Appendix D).
- **Poster:** Print the following document to post on bulletin boards in places frequented by therapists (see Appendix E).

Learn more about therapist self-disclosure:

Bloomgarden, A., & Mennuti, R. B. (Eds.). (2009). *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy*. New York: Routledge, Taylor & Francis Group.

Henretty, J., & Levitt, H. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*, 63–77.
doi:10.1016/j.cpr.2009.09.004

Learn more about the impact and prevalence of personal therapy among therapists:

Bike, D. H., Norcross, J. C., & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 19-31.
doi:10.1037/a0015139

Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (Eds.). (2005). *The psychotherapist's own psychotherapy: Patient and clinician perspectives*. New York: Oxford University Press.

Norcross, J. C., Bike, D. H., & Evans, K. L. (2009). The therapist's therapist: a replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 32-41. doi: 10.1037/a0015140

Learn more about this study:

- To read the study proposal, [click here](#).
- The completed research project will be available on this site by June 1, 2014.

Appendix D: Printable Recruitment Cards

Recruitment cards (ten per page) can be printed from a Word or PDF document. Each card contains the following information:

Survey respondents needed!

Therapists of all disciplines are needed to complete an anonymous, 15-minute, online survey as part of a graduate research study exploring whether therapists' experiences in their own personal therapy impact their use and beliefs about therapist self-disclosure.

For additional information or to take the survey, please visit www.survey_url.com.

Appendix F: Informed Consent Form**CONSENT FORM
UNIVERSITY OF ST. THOMAS****The Impact of Personal Therapy on the Use of Therapist Self-disclosure**

543552-1

My name is Anne Breckbill and I am conducting a study about therapists' use of self-disclosure in their professional practice and whether therapists' experiences in their own personal therapy impact their attitudes about therapist self-disclosure. I invite you to participate in this research if you:

- Are currently or have been a psychotherapy client
- Are currently providing or have provided psychotherapy to clients in a practice setting
- Are/were professionally licensed to provide psychotherapy in the state in which you practice(d).

This study is completely anonymous and voluntary. Please read this form before agreeing to be in this study. If you have questions about participating in this study, you may contact the researcher at email@domain.com.

Under the advisement of Jessica Toft, Ph.D., I am conducting this study as partial fulfillment of requirements for a Masters of Social Work degree from the University of St. Thomas/St. Catherine University.

Background Information:

The self-referent technique of therapist self-disclosure remains one of the most hotly contested uses of the therapist's self. Opinions and practices about therapist self-disclosure vary from therapist to therapist, often by discipline, theoretical framework, and therapist demographics. Though numerous studies explore the impact of therapist self-disclosure as a therapeutic technique, the majority of such studies base their conclusions about the benefit or harm of using self-disclosure based on the perceptions of therapists rather than clients. Given that an estimated three-quarters of all therapists have participated in their own personal therapy at some point in their lives, these therapists offer a unique opening into understanding the impact of subjective personal experiences on the use of self-disclosure. As current or former therapy clients, they hold personal understandings of how specific therapeutic techniques have been helpful or harmful to them as clients. As current or former therapists, they have their own experiences and perceptions about using self-disclosure with clients. This unique position provides opportunity for them to reflect on how their therapy experiences as clients have impacted their professional work as therapists.

This study focuses primarily on two specific and intentional types of therapist self-disclosure. Transparent disclosures, the first of these two types, are intentional disclosures in which a therapist makes a decision to bring her or his own emotions into the therapeutic session. In such disclosures, what is being disclosed is the emotional impact that the client, the content of the session, or the progress of therapy is having on the therapist. It is the therapist's transparent emotional response to the client, to the therapeutic relationship, or to the content of the client's disclosures. The second type, self-disclosing disclosures, are intentional disclosures in which a therapist makes a decision to introduce relevant personal information about her or his life or experiences outside of the therapy. While this may include emotional disclosures, the emotions disclosed are not in response to the client's experience but to the therapist's experience. *This study's focus is not on inappropriate self-disclosures made primarily to serve the therapist.* Rather, it focuses on disclosures – while revealing something about the therapist's life outside of the therapy session – made for the client's perceived benefit and used to assist the treatment process.

The purpose of this study is to explore how therapists' subjective experiences as client recipients of therapist self-disclosure impact their attitudes about therapist self-disclosure. Additionally, this study will investigate how therapists' personal therapy and theoretical orientation impact the use of self-disclosure.

Procedures:

If you agree to be in this study, I will ask you to participate in an anonymous online survey that can be completed in fewer than fifteen minutes. This survey presents you with questions regarding your experiences as a psychotherapy client, your attitudes and use of therapist self-disclosure in your professional practice as a psychotherapist, and personal/professional demographic information.

Risks and Benefits of Being in the Study:

This study has minimal risks. The questions in the survey explore personal and professional experiences and attitudes that you may seldom share with others. Consequently, some of these questions may seem a bit invasive and it may feel vulnerable to answer them honestly. However, this survey is anonymous and is configured so that the researcher is unable to associate any particular response with a particular respondent. Similarly, the researcher cannot determine whether a specific person participated in the study. You are not under any obligation to participate in the study and, if you choose to participate, you may leave the survey at any time or skip any questions that feel invasive or uncomfortable.

There are no direct benefits for participating in this study.

Confidentiality:

As mentioned above, the data collected in the survey is anonymous. Consequently, the researcher will not be able either to identify whether or not a specific individual has completed the survey or to match specific responses with a specific individual. The anonymous data collected will be stored in a password-protected electronic database. If you make any comments in the survey that

contain information that could potentially identify you, such detailed information will not be included in any public reports or presentations of this study.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Because of the anonymous nature of this survey, I will not know whether or not you participated in the study. Your decision whether or not to participate will have no effect on your current or future relations with me, my research committee, or the University of St. Thomas. If you decide to participate, you are free to leave the survey at any time or to skip any questions you prefer not to answer.

Contacts and Questions

If you have questions about participating in this study, you may contact me at email@domain.com. Jessica Toft, Ph.D. is my research advisor for this study and can be reached at email@domain.com. You may also contact the University of St. Thomas Institutional Review Board at (phone_number) with any questions or concerns.

Statement of Consent:

By clicking the button labeled “Start Survey” below, you are indicating the following is true:

- You have read the above information.
- You consent to participate in the study.
- You are at least 18 years of age.
- You are currently or have been a psychotherapy client
- You are currently providing or have provided psychotherapy to clients in a practice setting
- You are/were professionally licensed to provide psychotherapy in the state in which you practice(d).

Cancel Survey

Start Survey

Appendix G: Survey

Survey Sections and Instructions:

This survey is divided into five short sections. Please complete these sections using each question's specific instructions:

Section I Personal Therapy Experience:

Investigates your utilization of and experiences in personal therapy and explores your perception of its personal and professional impact

Section II Self-involving (transparent) disclosures:

Investigates your personal therapy experience with disclosures of emotional transparency and explores your perception of its personal and professional impact

Section III Self-disclosing disclosures:

Investigates your personal therapy experience with disclosures of non-immediate, personal information and explores your perception of its personal and professional impact

Section IV Personal Demographic Information:

Gathers relevant demographic information for data analysis

Section V Additional comments:

Allows opportunity to provide optional insights or observations about the impact of your personal therapy on your professional use of therapist self-disclosure

Section I: Personal Therapy Experience

Personal therapy refers to the experience of having been a client of therapy services.

At what age did you participate in your first personal therapy session? Age in years: _____

When was your most recent personal therapy session?

- Within the past year 2-5 years ago Over ten years ago
 1-2 years ago 6-10 years ago

How many courses of personal therapy have you had in your life? (*A course of therapy is defined as two or more sessions scheduled at relatively consistent intervals with no breaks exceeding one year.*)

_____ Number of courses My personal therapy has been largely continuous

Please identify the primary issues for which you have sought personal therapy. (*Check all that apply*)

Social/Relational concerns:

- Social relationships
- Partner relationships
- Family relationships
- Divorce/Separation
- Parenting relationships
- Other social concerns

Intrapersonal/Identity concerns:

- Self-esteem
- Grief and loss
- Life adjustments/transitions
- Sexual identity
- Gender identity
- Life decisions/discernment

Trauma and Abuse:

- Partner/domestic abuse
- Adult sexual abuse
- Verbal/emotional abuse
- Childhood sexual abuse
- Childhood physical abuse
- Other interpersonal violence
- Other trauma

Behavioral concerns:

- Anger management
- Self-harm behaviors
- Suicidal risk
- Substance use/abuse
- Gambling behaviors
- Money mgmt./spending
- Sexual behaviors
- Other compulsive behaviors
- Food/eating problems
- Other behavioral concerns

Mental Illness:

- ADD/ADHD
- Autism spectrum disorder
- Depression
- Anxiety
- Bipolar disorder
- Other mood disorder
- Psychotic/thought disorder
- Sleep disorder
- Personality disorder
- Other mental illness

Professional Concerns:

- Professional identity
- Professional conflict
- Ethical issues
- Countertransference issues
- Client boundary problems
- Vicarious trauma
- Specific client concerns
- Grief/Client loss

What impact has your personal therapy had on your personal life?

1 2 3 4 5 6 7

Very harmful/strongly negative Neither harmful nor helpful Very helpful/strongly positive

To what degree do you believe personal therapy has influenced your professional practice as a therapist?

1 2 3 4 5 6 7

No impact Moderate impact Strong impact

What impact has your personal therapy had on your professional development as a therapist?

1 2 3 4 5 6 7

Very harmful/strongly negative Neither harmful nor helpful Very helpful/strongly positive

To what degree do you believe personal therapy has influenced your professional theoretical orientation?

1 2 3 4 5 6 7

No impact Moderate impact Strong impact

Section II: Self-involving (transparent) disclosures

An intentional disclosure in which a therapist makes a decision to bring her or his own emotions into the therapeutic session. In this type of disclosure, what is being disclosed is the emotional impact that the client, the content of the session, or the progress of therapy is having on the therapist. It is the therapist’s transparent emotional response to the client, to the therapeutic relationship, or to the content of the client’s disclosures. For example:

- A therapist is angered by a client’s behavior and allows the client to see that anger.
- A therapist shares his or her own feelings in response to what the client is sharing or doing. (I feel scared for you; I am so happy for you; I am proud of you.)
- A therapist is emotionally transparent nonverbally in a session (i.e. becoming teary, becoming irritated cringing, etc.)

Yes | No In your personal therapy, has a therapist ever self-disclosed his or her emotions regarding the content of your session?

As you answer the following questions, please consider one such disclosure that was significant (either positive or negative) in your experience in therapy.

Please check all the items that describe your experience of this self-involving (transparent) disclosure:

- | | |
|--|--|
| <input type="checkbox"/> It shifted the focus of the session from me to the therapist. | <input type="checkbox"/> It diminished my respect for my therapist. |
| <input type="checkbox"/> It felt validating. | <input type="checkbox"/> It deepened my trust in my therapist. |
| <input type="checkbox"/> It deepened my insight. | <input type="checkbox"/> It diminished my trust in my therapist. |
| <input type="checkbox"/> It did not feel relevant. | <input type="checkbox"/> It assisted me in disclosing my own emotions. |
| <input type="checkbox"/> It strengthened our therapeutic relationship | <input type="checkbox"/> It reduced my sense of isolation. |
| <input type="checkbox"/> It felt intrusive. | <input type="checkbox"/> It normalized my experience. |
| <input type="checkbox"/> I felt angry. | <input type="checkbox"/> It elevated my respect for my therapist. |
| <input type="checkbox"/> The disclosure scared me. | <input type="checkbox"/> I felt scared. |
| <input type="checkbox"/> It helped me understand my impact on others. | <input type="checkbox"/> I felt more comfortable disclosing my own emotions. |
| <input type="checkbox"/> I felt honored. | <input type="checkbox"/> The disclosure resonated with me. |
| <input type="checkbox"/> I felt trusted. | <input type="checkbox"/> The disclosure felt inappropriate. |
| <input type="checkbox"/> The disclosure made me feel uncomfortable. | |

How would you rate the therapeutic impact of this self-involving (transparent) disclosure?

1	2	3	4	5	6	7	
Very harmful/strongly negative			Neither harmful nor helpful		Very helpful/strongly positive		

Rate the influence this experience (and others like it) has on your own use of self-involving (transparent) disclosures in your professional psychotherapy practice.

- My experience as a client makes me:
- Much less likely to disclose emotions to clients
 - Slightly less likely to disclose emotions to clients
 - No more or less likely to disclose emotions to clients
 - Slightly more likely to disclose emotions to clients
 - Much more likely to disclose emotions to clients

Please place yourself as a psychotherapist on a continuum of your use of self-involving (transparent) disclosures.

1	2	3	4	5	6	7	8	9	10
I rarely or never allow clients to know my emotional responses to the content of the therapeutic session						I frequently allow clients to know my emotional response to the content of the therapeutic session.			

Section III: Self-disclosing disclosures

An intentional disclosure in which a therapist makes a decision to introduce relevant personal information about her or his life or experiences outside of the therapy. While this may include emotional disclosures, the emotions disclosed are not in response to the client’s experience but to the therapist’s experience. This study’s focus is not on inappropriate self-disclosures made primarily to serve the therapist. Rather, it focuses on disclosures – while revealing something about the therapist’s life outside of the therapy session – made for the client’s perceived benefit and used to assist the treatment process. For example:

- A therapist reveals to a client that she has also struggled with anxiety, depression, eating, addiction, etc.
- A therapist tells a personal story as an illustration of a concept she is trying to describe.
- A therapist shares a part of her personal identity that she believes will be helpful for the client to know. (I am divorced. I am a lesbian. I have an adopted child. I was raised Catholic.)

Yes | No In your personal therapy, has a therapist ever self-disclosed relevant personal information to you that pertained to his/her life outside of the therapeutic session or relationship?

As you answer the following questions, please consider one such disclosure that was significant (either positive or negative) in your experience in therapy.

Please check all the items that describe your experience of this self-disclosing disclosure:

- | | |
|--|--|
| <input type="checkbox"/> It shifted the focus of the session from me to the therapist. | <input type="checkbox"/> It diminished my respect for my therapist. |
| <input type="checkbox"/> It felt validating. | <input type="checkbox"/> It deepened my trust in my therapist. |
| <input type="checkbox"/> It deepened my insight. | <input type="checkbox"/> It diminished my trust in my therapist. |
| <input type="checkbox"/> It did not feel relevant. | <input type="checkbox"/> It assisted me in disclosing my own emotions. |
| <input type="checkbox"/> It strengthened our therapeutic relationship | <input type="checkbox"/> It reduced my sense of isolation. |
| <input type="checkbox"/> It felt intrusive. | <input type="checkbox"/> It normalized my experience. |
| <input type="checkbox"/> I felt angry. | <input type="checkbox"/> It elevated my respect for my therapist. |
| <input type="checkbox"/> The disclosure scared me. | <input type="checkbox"/> I felt scared. |
| <input type="checkbox"/> It helped me understand my impact on others. | <input type="checkbox"/> I felt more comfortable disclosing my own emotions. |
| <input type="checkbox"/> I felt honored. | <input type="checkbox"/> The disclosure resonated with me. |
| <input type="checkbox"/> I felt trusted. | <input type="checkbox"/> The disclosure felt inappropriate. |
| <input type="checkbox"/> The disclosure made me feel uncomfortable. | |

How would you rate the therapeutic impact of this self-disclosing disclosure?

1	2	3	4	5	6	7
Very harmful/strongly negative			Neither harmful nor helpful	Very helpful/strongly positive		

Rate the influence this experience (and others like it) has on your own use of self-disclosing disclosures in your professional psychotherapy practice.

My experience as a client makes me:

- Much less likely to disclose relevant personal information to clients
- Slightly less likely to disclose relevant personal information to clients
- No more or less likely to disclose relevant personal information to clients
- Slightly more likely to disclose relevant personal information to clients
- Much more likely to disclose relevant personal information to clients

Please place yourself as a psychotherapist on a continuum of your use of self-disclosing disclosures.

1	2	3	4	5	6	7	8	9	10
I never share information about my life outside of the therapeutic session with clients.					I frequently share information about my life outside of the therapeutic session with clients.				

Section IV: Personal Demographic Information	
Please provide the following information about yourself and your professional practice.	
Gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Trans male <input type="checkbox"/> Gender queer <input type="checkbox"/> Female <input type="checkbox"/> Trans female <input type="checkbox"/> Other	
Ethnic/Racial identity: <input type="checkbox"/> African-American <input type="checkbox"/> African-American AND white <input type="checkbox"/> American Indian or Alaskan native <input type="checkbox"/> American Indian or Alaskan native AND white <input type="checkbox"/> Asian <input type="checkbox"/> Asian AND white <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Hispanic or Latino AND white <input type="checkbox"/> White <input type="checkbox"/> Other: _____	
Age in years: _____	Years in clinical practice: _____
Educational discipline(s): <i>(check all that apply)</i> <input type="checkbox"/> Social work <input type="checkbox"/> Marriage and Family <input type="checkbox"/> Professional counseling <input type="checkbox"/> Psychology <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Psychiatry <input type="checkbox"/> Other _____	
Educational degree(s): <i>(check all that apply)</i> <input type="checkbox"/> Associates degree <input type="checkbox"/> Masters degree <input type="checkbox"/> Certificate program <input type="checkbox"/> Bachelors degree <input type="checkbox"/> Doctoral degree <input type="checkbox"/> Other: _____	
Licensure: <i>(check all that apply – note that exact licensure credentials vary from state to state)</i> <input type="checkbox"/> Licensed clinical social worker <input type="checkbox"/> Licensed marriage and family therapist <input type="checkbox"/> Licensed psychologist <input type="checkbox"/> Licensed chemical dependency counselor <input type="checkbox"/> Licensed professional counselor <input type="checkbox"/> Other: _____	
Location of professional practice: State/Province: _____ Country: _____	
Setting of professional practice: <i>(check all that apply)</i> <input type="checkbox"/> Private practice <input type="checkbox"/> Inpatient treatment <input type="checkbox"/> Group practice <input type="checkbox"/> Outpatient clinic <input type="checkbox"/> Day/outpatient treatment <input type="checkbox"/> Joint/Partner practice <input type="checkbox"/> Hospital setting <input type="checkbox"/> Other residential <input type="checkbox"/> School/University setting <input type="checkbox"/> In-home setting <input type="checkbox"/> Other _____	

Theoretical Orientation: *Using the descriptions below, please rank order the following broad categories of theoretical orientations. There is, of course, overlap between these categories in both theory and practice. Given this, please **rank them in the order that best fits the degree to which you resonate with each approach.** (1=most resonant approach; 5=least resonant approach)*

_____ **Psychoanalytic/Psychodynamic:** This category includes classical and contemporary forms of psychoanalysis and psychodynamic psychology as well as other psychologies focused on an individual's internal world, including Jungian analysis, Adlerian psychology, depth psychology, ego psychology, self psychology, etc.

_____ **Person-centered/Humanistic:** This category includes therapies in which the client's unique experiences constitute his or her reality and a warm, empathic, respectful therapeutic relationship is used as the vehicle for growth and change. Therapies include Rogerian, humanistic, existential, and phenomenological, etc.

_____ **Cognitive-Behavioral:** This category includes therapies focused on tracking and changing behaviors and thoughts. Therapies include cognitive-behavioral therapy (CBT), dialectical-behavioral therapy (DBT), rational-emotive therapy (RET), behavioral modification, etc.

_____ **Systemic:** These therapies, many of which utilize some elements of the theories above, understand human behavior as predicated on the context and system in which it occurs. These mostly modern and post-modern therapies endorse multiple realities and suggest that clients' internal psyches, interpersonal relationships, and behaviors/cognitions cannot be viewed independently from their power-laden social contexts. Therapies include structural therapy, feminist therapy, narrative therapy, family therapy, environmental psychology, and systems psychology.

_____ **Experiential/Somatic:** Based on emerging brain research, this category encompasses therapies that focus on the body-brain connection in experiencing and processing significant and often traumatic events. These neurobiologically-informed therapies include Eye Movement Desensitization and Reprocessing (EMDR), Somatic Experiencing, Accelerated Experiential Dynamic Psychotherapy (AEDP), etc.

Section V: Additional Comments

Please provide any additional comments that you believe might be helpful in my research as I explore therapist self-disclosure and how it is impacted by experiences in personal therapy and by theoretical orientation. You may also use this space to clarify any of your prior responses or to share your own insights about therapist self-disclosure. Thank you for your participation in this study and for your generous gift of time.