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"Enough about you, let's talk about me : clinicians' use of self-disclosure and (un)conscious awareness of race, sexuality, and gender

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CHAPTER ONE

INTRODUCTION

Therapists disclose themselves in everything they say and do; simultaneously clients form a picture or perception of the therapist from these disclosures. The dilemma is how much disclosure, particularly verbal disclosure of specific personal information and experiences, especially those not related to the therapy or the therapy relationship that the therapist should engage in. Therapist self-disclosure should be done for the benefit of the client, not for himself or herself. Self-disclosure can be especially beneficial when working with oppressed groups like racial minorities or sexual minorities (Constantine and Kwan 2003; Hanson 2003).

The term self-disclosure in psychoanalytic discourse has a very technical feel to it. In general it refers to a range of presentation within the field of everyday experience that could be described as, revealing something of oneself, or sharing information about one's past, commenting on the relationship, interaction within the therapeutic dyad etc. There will be a more detailed explanation within the literature review.

Self-disclosure has been a fairly acceptable psychotherapeutic technique since the 1970's (Hanson 2003; Kernberg 1994). Much of the discussion has been around issues of neutrality and maintaining the asymmetry of the therapeutic relationship (Barglow 2005; Hanson 2003; Constantine and Kwan 2003; Patterson 1985). Unfortunately, most of the research on the topic of self-disclosure makes no mention of race or sexual orientation. It is this lack of information that motivates the focus of this study. Both clients of color and GLBT clients may be distrustful of their therapist due to the discrimination and oppression that they meet in their everyday lives. Griner and Smith

(2006) talk about three major factors contributing to this distrust. The first is that historically, counseling and psychotherapy have focused predominantly on the therapeutic needs of upper and middle-class European-Americans; second, clients of color are sometimes mistrustful of mental health services because of historic racial disparities and a scarcity of therapists from their own ethnic background who speak the same native language and third, there is a lack of mental health services available in many communities where people of color reside. These factors prevent clients of color from both seeking treatment and staying in treatment. In order to effectively help these populations we must examine psychotherapeutic techniques and mold them into cross-culturally effective practices, otherwise we are just perpetuating injustice and inequality.

I will attempt to further the examination of self-disclosure by surveying therapists of multiple backgrounds who work with a diverse range of clients. I will be asking them to help me answer questions regarding, how we as therapists and professionals define self-disclosure, use self-disclosure, and whether or not it is in fact a therapeutic technique. By asking open-ended questions regarding disclosure I hope to find out more about the motivations behind self-disclosure--highlighting the ways dominant culture may be affecting our choices. This information will be of use to clinicians because we live within a world effected and influenced by systemic heterosexism, homophobia, racism and sexism. Since it is our duty to keep those influences out of our practice(s) we must be able to acknowledge them when they are present.

As social workers we have a responsibility to serve the underserved and fight for justice and equal rights. If our practices are Euro-centric, heteronormative and patriarchal, than by nature we are both fighting ourselves, and being hypocritical.

Researching, theorizing and practicing ways to better serve communities of color, and sexual minorities, are ways to make this happen. This question and analysis is an attempt to further balance the ways that mental health care is provided, received and used with marginalized and oppressed populations.

CHAPTER TWO

LITERATURE REVIEW

The therapist's choice whether or not to self-disclose is an important one. With a definite "no" we may be missing out on effective and very human interventions. With a definite "yes" we may just be indulging our own narcissistic needs as clinicians rather than keeping the clients' interests before our own. The usefulness of self-disclosure as a therapeutic technique, its effect on the client, the theoretical rationale, the timing, content, and certainly, whether or not it is a therapeutic technique (as opposed to a therapeutic mistake) are still in dispute. Being part of an oppressed group makes it more difficult to trust the clinician (Griner and Smith 2006, Marger 2002, Sue and Sue 2003, S. Sue 1988). In order to best serve these clients we must find ways to gain their trust and display empathy. The following analysis will attempt to understand both the pros and cons of disclosure in general and more specifically with diverse groups. There will be a discussion about therapist neutrality and the different types of disclosure that therapists may partake in; as well as a brief historical account of self-disclosure, therapy and the changes in perception and judgment around this practice. This discussion will primarily focus on two major competing theories: Classical psychoanalytic theory (one-person psychology) and the more contemporary relational (field) theories.

The issue of self-disclosure in psychoanalysis has undergone a paradigm shift. It seems that as the ideal of the "neutral" therapist fades so does the negative stigma around self-disclosure from the therapists within the analytic setting. There is no such thing as neutrality when we live in a world full of unequal power relations; it could be said that remaining "neutral" and in the company of the "other" is impossible. The analyst's

neutrality or subjectivity is bound in dynamics of culturally dominant and subordinate constructs of masculinity, femininity, sexuality, race and class (Gerson 1996; Layton and Bertone 1998). When thinking about self-disclosure we must be aware of our place and our clients' places within these hierarchies.

Self-Disclosure: A Classical Psychoanalytic Point of View

Many therapists believe that the best way to pursue and clarify the patient's experience is to keep the therapist's experience out of the room (Wachtel 1993, Bowles 1999). Historically, classical psychodynamic drive theory has situated the therapist in an objective role as a "blank screen" so that the inner-world of the client is not disturbed (Bowles 1999). Freud made recommendations regarding various ground rules of psychoanalytic treatment that laid the groundwork for today's clinicians. Included among these ground rules are that the therapist remain relatively anonymous to the patient and neutral regarding the patient's particular life problems. Under his original methodology, the clinician was expected to control all conscious countertransference in order to refrain from influencing and/or disrupting the client's transference relationship (Gerson, 2004). On the subject of self-disclosure Freud stated that confiding in one's patients,

... achieves nothing towards the discovery of the patient's unconscious; it makes him less able than ever to overcome the deeper resistances, and in the more severe cases it invariably fails on account of the insatiability it rouses in the patient, who then tries to reverse the situation, finding the analysis of the physician more interesting than his own... The [analyst] should be impenetrable to the patient and like a mirror, reflect nothing but what is shown to him. (1912, p118)

Freud's ideas rested on a foundation constructed by his medical predecessors. A powerful model for boundaries was aseptic surgery, in which protective barriers between the

physician and the patient prevented the transmission of infection. The cultural values and social norms of the time reinforced and sometimes extended the scientific view that it was paramount to observe the inner workings of the patient's mind without letting the act of observation alter the subject (Willott, 2007, Mallow 1998). Self-disclosure was thought of as a contamination of the process--the “surgical detachment” that Freud (1912/1913) spoke of.

In addition, therapist self-disclosure comes with the risk that the subject of inquiry will shift from the patient to the clinician. The psychoanalytic guideline of nondisclosure was intended to allow the patient's projections to be more readily identified and analyzed in the transference. Hence rigid prohibitions against self-disclosure in analytic work emerged, culminating in the psychoanalytic concepts of anonymity, abstinence, and neutrality. The therapist became responsible for maintaining nondisclosure and protecting the boundary between the patient and the therapist (Hundert & Applebaum 1992).

Neutrality and Classical Psychoanalysis

Avoiding the imposition of values upon the patient is an accepted aspect of psychoanalytic neutrality. The analyst's neutrality is intended to facilitate the development, recognition and interpretation of the transference neurosis and to minimize distortions that might be introduced if he or she attempts to educate, advise, or impose values upon that patient based on the analysts countertransference (Bornstein, 1983).

Many modern analysts maintain that strict adherence to the rules of neutrality and unresponsiveness are necessary to protect the purity of the transference and the analysis itself (Couch, 1995). The writings and work of Sigmund Freud—the cornerstone of psychoanalytic thought suggest otherwise. In fact, Freud himself used the term neutrality

rarely. It first appears in the context of advice to analysts about how to handle patient's declarations of love (Greenberg, 1986). Responding in kind, whether encouragingly or discouragingly, will defeat the analysis, Freud warns, and he goes on to say "... we ought not to give up the neutrality toward the patient, which we have acquired through keeping the counter-transference in check" (1915, p. 164). Freud went no further in spelling out what he intended neutrality to mean. A formal definition of neutrality did not appear until Anna Freud suggested one in 1936 (Greenberg 1986). In *The Ego and the Mechanisms of Defense* Anna Freud wrote:

It is the task of the analyst to bring into consciousness that which is unconscious, no matter to which psychic institution it belongs. He directs his attention equally and objectively to the unconscious elements in all three institutions. To put it in another way, when he sets about the work of enlightenment, he takes his stand at a point equidistant from the id, the ego, and the superego (1936, p. 28).

A more modern and encompassing psychoanalytic definition can be found in Moore and Fine's psychoanalytic dictionary,

The stance of the analyst generally recommended for fostering the psychoanalytic process. Central to psychoanalytic neutrality are keeping the countertransference in check, avoiding the imposition of one's own values upon the patient, and taking the patient's capacities rather than one's own desires as a guide. In structural terms, neutrality is described as taking a position equidistant from the demands of the id, ego and superego.

Though Freud made recommendations regarding the embodiment of a blank slate he did not apply neutrality to every component of treatment (Thompson 1996).

Moreover, it has been argued that Freud was misunderstood and he himself was discontented by how his recommendations were applied by some of his students (Gill 1983, Wachtel 1993). Gill quotes in this context from a letter Freud wrote where he

reflects, “the human propensity to take precepts literally or exaggerate them” and goes on to say that “in the manner of analytic passivity that is what some of my pupils do”

An Intersubjective Perspective on Self-Disclosure

Intersubjectivity is a relational two-person psychology where the relationship between the client and the clinician becomes the central focus of therapy, rather than the classical focus that remains entirely on the client. Intersubjective theory has grown from a philosophical shift from the objective, neutral role of the therapist to recognition of their subjective involvement within the therapeutic dyad. Intersubjectivity rests on the acknowledgment of the inevitable meeting of subjectivities within the psychological field (Darwin 1999). Understanding the inevitable subjectivity of the clinician, intersubjective theory incorporates the clinician’s subjective influence into a greater understanding of the client. In acknowledging the centrality of the two subjective individuals within the therapeutic dyad, one way to employ and explore this central focus on relationship is through attention to the clinician’s countertransference and disclosure of countertransference. Within the therapeutic frame, self-disclosure is a method of acknowledging what the clinician holds, acknowledging what is part of the relationship and utilizing this knowledge for therapeutic means (Davis, 2002). In its broadest sense, intersubjectivity is described as a theory that:

Focuses on the interaction between the therapist’s subjective experience and the client’s subjective experience, emphasizing their reciprocal, mutual influences on the clinical relationship and treatment process. The therapist and client co-construct a shared reality in which each participates (Bowles, 1999, p. 365).

The perspective of self-disclosure as a technique encourages clinicians to disclose in their practices. In order for the therapist to acknowledge her own subjectivity she may

chose to reveal something not only about their relationship but also about herself. This study hypothesizes that clinicians practicing under more relational models of therapy (such as intersubjectivity) self-disclose more than the more traditional psychoanalytically oriented clinicians.

This shift from a one-person psychology to a two-person psychology has dissolved the once assumed clear line of separation between observer and observed or subject and object, thus expanding the central focus of therapy to often include the relationship rather than simply the client (Berzoff & Mattei, 1999; Safran & Muran, 2000). Maroda, (1999) writes that self-disclosure is “very compatible, if not *most* compatible with intersubjective theory,” (p. 487). Burke and Tansey (1991) write about the use of countertransference disclosure in order to increase the intersubjective discourse which, “Allows for an eventual discovery of disavowed aspects of the patient with which the therapist has identified. In such instances, explicit disclosure helps to illuminate what has occurred,” (p. 377).

Intersubjectivity makes a distinction between the analysts “self” and her “subjectivity” (Cooper, 1998b; Teicholz, 2001; Stolorow et al., 1987; Atwood and Stolorow, 1984). Stolorow et al. believed that the term “subjectivity” would express more fluidity of experience than the term “self.” Subjectivity includes both the conscious and unconscious patterns of organizing experience. Since these experiences are happening simultaneously the clinician must work hard to expand awareness of her own subjective experience so that it becomes visible and the possible focus of analytic inquiry (Stolorow et. al., 1987; Teicholz, 2001). Self-disclosure is one way to acknowledge the clinician’s subjectivity (as it is already present in the room). Instead of simply being

aware of her subjectivity it is recommended that analyst becomes more open with self-expression and self-disclosure (Aron, 1991; Hoffman, 1998; Renik 1998). The basis for this recommendation is that it is far better to bring a mutual perception concerning both subjectivities into the open conversation rather than to allow the patient's perceptions of the analyst's experience remain unanalyzed (Teicholz, 2001).

The intersubjective perspective claims that the clinician's subjectivity is brought into the room through questions and interpretation and plays a role in all aspects of the therapy regardless of disclosure. The disclosure is seen as an opportunity for mutual participation that may actually assist the clinician in either making an interpretation or establishing an environment where an interpretation can occur (Cooper, 1998b). This slight change in language from self to subjectivity helps to frame the idea that self-disclosure is no more revealing of one's self than other analytic interventions. Self-disclosures are made purposefully with the intent to reveal a perspective of the self of the patient that he or she has not been aware of or fully explored.

Because of the multitude of definitions and lack of clarity around its implications self-disclosure is a notion that needs to be explored. What is really being practiced behind closed doors? This researcher expects a high rate of self-disclosure. The once rigid cautions against disclosure have transformed the idea from a mistake to a possible intervention and it is expected that the sample reflect these modern applications of self.

An Intersubjective Perspective on Neutrality

One argument against the use of self-disclosure is that it takes the therapist away from a neutral position. This is not the case when looking through the lens of intersubjectivity. According to Stolorow and Orange (1998),

Neither disclosure nor withholding is neutral; each has a particular meaning in the context of a particular psychoanalytic treatment. Our primary concern, if we work with an intersubjective perspective, must be to understand with the patient the meaning of whatever is going on.

Some intersubjective theorists see compatibility in neutrality and self-disclosure.

Neutrality is an essential foundation for discerning whether or not self-disclosure is therapeutically advantageous (Gerson, 2002; Meissner, 2002). To some intersubjectivists, neutrality is a perspective, a goal, not a set of behaviors that can be generalized to all clients. Myerson (1981) states this clearly when he says,

...unlike personal revelation, neutrality should not be thought of as behavioral concept at all. Silence, anonymity, advice giving and other terms refer to possible behaviors of the analyst. Neutrality, on the other hand, is a way of talking about a particular therapeutic form.

Some would go even further and claim that there is no such thing as neutrality in an intersubjective view of treatment. Stolorow and Atwood (1997) argue that once the therapeutic relationship is recognized as an intersubjective system of mutual influence, the concept of neutrality is revealed to be an illusion.

Though it is difficult to find an “intersubjective” definition of neutrality, there are intersubjectivists who believe that neutrality is in fact real, and is co-created. Gill (1994) addresses the clinical construct of neutrality and redefines it:

the analyst is always influencing the patient, and the patient is always influencing the analyst. The mutual influence cannot be avoided; it can only be interpreted. It is the analyst’s awareness of this unremitting influence of patient and analyst on each other and his attempt to make that influence as explicit as possible that constitute his “neutrality” (p50).

Rather than avoiding or denying the mutual influence to create neutrality, the clinician does the opposite--she acknowledges the space created between them and by recognizing both sides neutrality is created. Thus neutrality is something that is a mutual

achievement of both the client and clinician. Neutrality is a co-created informant about how therapists can best use themselves, or their subjectivity. Neutrality may include the use of self-disclosure if it is consistent with the facilitation of the therapeutic process.

Self-Disclosure: What does it Look Like?

Therapist self-disclosure generally refers to behaviors, either verbal or non-verbal that reveal personal information about therapists themselves to their clients. Some of this communication is inescapable (messages associated with physical appearance), inadvertent (tone of voice that goes along with certain emotions) and deliberate (Barnett 1998; Barret and Berman 2001; Constantine and Kwan 2003; Hanson 2003; Knox, Hess, Petersen and Hill 1997). Information about the therapists' personal styles, tastes and interests may be consciously or unconsciously available to clients through manner of dress (culturally symbolic apparel, hairstyles, or wedding rings,) physical appearance (race, age, pregnancy) and manner of decorating the office (diplomas, photos, art), (Barnett 1998; Constantine and Kwan 2003).

According to the literature, disclosure can be classified into three basic groups,

1. Self-revealing statements: statements that reveal factual and personal information about therapists. (Barrett and Berman 2001; Constantine and Kwan 2003; Hanson 2005; Hill, Mahalik and Thompson 1989; Knox et al. 1997; Patterson 1985).
2. Self-involving statements: statements reveal therapist's reactions, thoughts or emotions about their clients during the therapeutic encounter (Barrett and Berman 2001; Constantine and Kwan 2003; Hanson 2005; Hill et al. 1989; Knox et al. 1997; Patterson 1985).
3. Unintentional/non-verbal disclosures: information about therapists' personality styles, tastes, and interests may be consciously or unconsciously available to clients through dress (e.g. culturally symbolic apparel, hairstyles, or wearing engagement or wedding rings), physical appearance (e.g. race, pregnancy, or age), and manner of decoration of the therapeutic space (e.g. diplomas, family photos,

or personal mementos; (Barnett, 1998; Constantine and Kwan 2003; Mahalik, Van Ormer, and Simi, 2000).

For the purposes of this study I will be excluding non-verbal/unintentional disclosures (including body language) from the definition of “self-disclosure.” Instead the focus will be on occasions when the therapist verbally reveals information about him or herself—self-revealing or self-involving statements.

Self-Disclosure in Relation to Clients of Color

There are three basic themes regarding the benefits self-disclosure has when working with clients of color. Many people of color have experienced prejudice and discrimination in their contact with European Americans at individual, and institutional levels and accordingly may be distrustful of future contacts (Burkard, Knox, Groen and Perez 2006, Constantine and Kwan 2003, Sue and Sue, 2003). In counseling, these past experiences may cause clients of color to approach European American counselors with caution. In these instances, self-disclosure may be critical to demonstrating that the counselor is culturally sensitive, thus increasing her credibility and gaining the trust of the culturally different client (Burkard et al. 2006; Helms & Cook, 1999; Sue & Sue, 2003). For example, it may be critical to clients of color that therapists, especially European Americans, acknowledge and discuss racial and cultural similarities and differences and be willing to self-disclose their own experiences (LaRoche & Maxie, 2003; Thompson & Jenal, 1994; Thompson, Worthington, & Atkinson, 1994). Second, some theorists (Burkard et al. 2006; Helms & Cook, 1999; Sue & Sue, 2003) have suggested that clients of color may require that their therapists be able or willing to demonstrate their sensitivity concerning cultural and racial issues in therapy. For

example, Thompson and Jenal's (1994) research suggests that African American women became more frustrated with therapists who withdrew from discussions of racial issues. Furthermore, clients of color with therapists who were more responsive to cultural issues than not responsive were more likely themselves to self-disclose in therapy (Thompson, Worthington and Atkinson 1994). Within these therapeutic contexts, therapists' self-disclosures are believed to be important interventions used to convey therapists' understanding of client frustration with oppression and racism (Burkard et al. 2006; Constantine and Kwan, 2003). Third, disclosure may also function as a model for clients of color particularly for those clients who are of international origin (Constantine and Kwan, 2003). Some clients may come from cultures where psychotherapeutic processes are foreign, or may hold cultural values that stigmatize help-seeking behavior for psychological difficulties. In these cases, self-disclosure may be a way for therapists to model appropriate in-session behavior and to help form a productive working alliance (Burkard et al. 2006, Constantine and Kwan, 2003). Constantine and Kwan (2003) give us a perspective from clients of color that reiterates these points,

Psychotherapy may be a foreign and strange experience for many clients of color. Cultural-mistrust attitudes towards Whites, a fear of exposure to culturally insensitive mental health professionals, and feelings of discomfort with the fundamental values and goals of Western psychotherapy may prevent some people of color from accessing formal mental health treatment (Constantine, 2002; Nickerson, Helms and Terrell, 1994). Along with the educating role it might serve, therapist self-disclosure may provide a modeling function to help demystify the therapeutic process for many of these clients and to encourage client self-disclosure. Congruent and reciprocal self-disclosure also might help contribute to the perceptions of clients of color that their therapists are genuine, caring, and similar (Barrett and Berman, 2001; Knox et al. 1997). (p. 587)

Although it may be assumed that it is less necessary, self-disclosure can also be used when the therapist is part of the same social group, race or ethnicity as the client,

depending on both of their racial identities. Even though a client of color is matched with a same-race or same-ethnic therapist, the client may still view the therapist as a member of a larger oppressive system that may not be sensitive to his or her concerns or issues.

Constantine and Kwan (2003) comment:

In the case of same-race dyads, for example, Black clients with high immersion-emersion Black racial identity attitudes, which are characterized by an idealization of one's racial or ethnic group and an acute sensitivity towards racial issues (see Helms & Cook, 1999), may likewise test Black American therapists who may be perceived as being assimilated to the dominant culture (Thompson and Jenal 1994). (p. 582)

Self-disclosure can be useful, but there are dangers involved as well.

Indiscriminant self-disclosure may be counterproductive. Therapists may unintentionally shift psychotherapy techniques towards themselves and their own race-related difficulties. Therapists need to be aware of their racial countertransference so they are not disclosing for reasons that benefit them (e.g.: an attempt to show cultural competence) or operating from stereotypes they may hold regarding the clients racial group or social group (Constantine and Kwan 2003).

Self-Disclosure in Relation to GLBT Clients

I hope to find more literature on the use of self-disclosure within the therapeutic dyad when there is a difference in sexual orientation. For now, I have found some research that speaks to the dangers of enactment and how internalized homophobia can influence our interpretation, acceptance, or denial of homoerotic countertransferential feelings. The lack of discussion of homoerotic feelings shows just how threatening it can be for many analysts to acknowledge loving and passionate desires for patients of the same gender. In fact, Person (1985) and Bollas (1994) both go so far as to suggest that

sexual feelings seldom occur in heterosexual male analyst–patient dyads. This denial is refuted in more recent literature. When talking about the denial or fear of homoerotic countertransference, Sherman (2002) states:

Having longings for same-sex patients can open a Pandora’s box of uneasy questions about the analyst’s sexual identity and sense of masculinity or femininity. It can bring up particularly intense fears of prejudice or censure by colleagues. Male analysts and patients may unconsciously recoil from the fantasy of being physically and emotionally penetrated, such a fantasy being equated with passivity, weakness, and lack of control. (p. 652)

If this countertransference is denied or feared than self- involving disclosures may become muddled and tainted by fear and homophobia or simply avoided. There is a fair amount of research that talks about the use of self-disclosure (regarding erotic countertransference) to further therapy within an opposite gendered heterosexual dyad—almost exclusively between a male analyst and female client, (Davies 1994; Gabbard 1996; Hoffman 1998; Newirth 2005;Rabin 2003). Homoerotic countertransference and self-disclosure has been mostly ignored in the literature, even by gay authors with a few exceptions (Gabbard 1996; Rosiello 2000; Sherman 2002). Sherman (2002) highlights the need for awareness around these issues well when he says:

Finally, as a profession, we need to more openly talk about, write about, debate about the kind of sexually charged feelings we all face in treatment. Growing up in a heterosexual society, we all have biases about sex and intimacy between two men or two women, as well as about specific sexual activities. The more we can allow ourselves to feel our full range of sexual feelings—including uncertainty and discomfort—the more likely we are to create a safe atmosphere for our patients to do the same. (p. 665)

Since sexual minorities often face similar obstacles, discrimination and oppression that people of color do it is probable that self-disclosure on the part of the therapist can serve similar functions for the GLBT client as the client of color. More

specifically, (as stated earlier for clients of color) self-disclosure can be used to convey sensitivity to cultural (Burkard et al. 2006; LaRoche and Maxie 2003; Thompson and Jenal 1994; Sue and Sue 2003) and heterosexist issues which may result in an increase of trust, greater perception of therapist credibility and improved relationship with people of diverse sexual orientations.

Summary

Disciplined and reflective self-disclosure is one more tool at the analyst's disposal to deepen the analytic process. It has the merit of moving the analyst from the position of the watcher and scientific observer to the position of a reflexive human being (Broucek and Ricci 1998) who is totally engaged in the co-creation of a more egalitarian system of communicating.

Self-disclosure has the potential to normalize client struggles, illuminate effective coping strategies, provide clients with feedback on how they interpersonally affect others, and can model the process of self-disclosure itself (Burkard et al. 2006; Helms & Cook, 1999; Sue & Sue, 2003). Specific to clients who live with discrimination and oppression self-disclosure can be used to convey the therapists' sensitivity to cultural issues, racial issues (Constantine and Kwan 2003; Burkard et al. 2006; Helms & Cook, 1999; Sue & Sue, 2003) and issues of sexism and homophobia which may increase trust, strengthen the therapeutic relationship as well as the perception of the therapists credibility.

CHAPTER THREE

METHODOLOGY

The purpose of this study is to answer the following question: How and why do clinicians choose to self-disclose (with particular attention paid to race, sexual orientation and gender)? In order to answer this question a mixed-method, deductive, exploratory study was conducted. Though self-disclosure is not a new concept, its application cross-culturally is new phenomenological territory. Deduction was used because there was enough existing literature to hypothesize about clinicians who use self-disclosure and their potential reasoning and intention.

Based on the literature review it is this researcher's hypothesis that expected findings for this study are as follows: Though they are warned against it, clinicians use self-disclosure often in their practices, they use self-disclosure in an effort to show empathy and build trust and they use self-disclosure in an effort to alleviate either their own or the client's anxiety. This researcher also hypothesizes that the respondents provide definitions of self-disclosure that mirror the definitions found in the literature review.

Sampling

Participants for this study were mental health professionals from any discipline who have earned a master's level degree or higher. The sample includes social workers, psychologists, psychoanalysts and marriage family therapists. These professionals were recruited via email. Lists of mental health professionals were obtained through the Sanville Institute for Clinical Social Work, Oakland Children's Hospital and Research Center, the San Francisco Center of Psychoanalysis as well as the Northern California

Society of Psychoanalytic Psychology. In an effort to generate a diverse sample population Pink Therapy, which provides therapy services for and by the GLBT community as well as the National Association of Black Social Workers were contacted.

A short recruitment letter (See Appendix A) describing the research topic and the nature of participation was sent out to individuals within these agencies and schools. In order to participate they continued on to the SurveyMonkey website where they read the Informed Consent letter, benefits and risks of the survey.

Data Collection

The self-report survey created contains four categories: demographics; clinical vignettes; open and closed-ended questions regarding their practice and theoretical understanding regarding self-disclosure and their conscious awareness of whether race, sexuality or gender plays a role in their choice to self-disclose (see Appendix C). The Human Subjects Review Board at Smith College School approved the data design for Social Work (see Appendix E).

The study was comprised of a mixed-method survey, in three distinct sections. The first section is composed of demographic questions. The next section of the survey includes both open-ended and fixed answer questions about the subject's use, attitudes, and perceptions regarding therapist self-disclosure. The open-ended questions were designed to elicit more intimate, qualitative information about the subject's beliefs about and experience with self-disclosure. Finally, there was a section of vignettes illustrating four distinct forms of self-disclosure. Participants were asked to describe the vignettes using a limited number of choices (taken directly out of the research presented in Chapter 2) in an effort to match the participant's beliefs with the literature.

The multiple methods were used in an effort to ground the respondents' answers in "real life" circumstances as well as explore their theoretical understandings of self-disclosure. The various techniques in questioning were an attempt to find the link or inconsistencies between respondents' beliefs and their actions.

Data Analysis

Descriptive and inferential statistics were used in order to analyze the 64 survey responses. Descriptive statistics were used to analyze the data received from the demographics portion of the survey. Using descriptive statistics for this instrument allowed me to compare the subjects in terms of numerous variables (i.e. gender, age, and amount of time in the field) and then summarize that data within in a comprehensive frequency table. A chi-square test was used to compare the answers of the different groups (Men v. Women; People of Color v. Whites and GLBT v. Heterosexual) regarding their responses to the vignettes and fixed-answer questions.

Ethics and Safeguards

The subjects were only required to read the informed consent disclosure (See Appendix B) and not sign it thus they were guaranteed anonymity. Although Survey Monkey includes a privacy disclaimer explaining their process for collecting IP addresses, they explain it is only for recording means, and the user's personal information isn't connected to their IP address (See Appendix D). To further protect the confidentiality of the study's participants, their responses were coded. Demographic data was not used to describe each individual; rather, it was combined to describe the subject pool in the aggregate.

Data will be kept in an external hard-drive within a locked box for three years, as required by Federal Policy. After three years the information will be destroyed by compromising the physical integrity of said external hard drive (by drilling numerous holes in it) and throwing it away.

CHAPTER FOUR

FINDINGS

Demographics

This section includes sub-sections on age, gender, race/ethnicity, sexual orientation, professional degree and theoretical orientation. Of the 64 respondents 3 chose only to fill out the demographics portion of the survey whereas approximately half of the respondents filled out the fixed and narrative portions of the survey. The following demographic data can be found in Tables 1-5, below.

The 64 subjects in the study were broken down into 4 age group categories. 62 of the 64 subjects (96.9%) responded to the demographic questions of age. The majority of the subjects fell in the age range of 41-54 (n=19, 29.7%) followed by both 27-40 and 55-64, which were equivalent (n=15, 23.4%), leaving the minority of respondents as the 65+ age range (n= 13, 20.3%).

Table 1. Age Distribution

Age	Frequency	Valid Percent
No response	2	3.1%
27-40 yrs	15	23.4%
41-54 yrs	19	29.7%
55-64 yrs	15	23.4%
65+ yrs	13	20.3%
Total	64	100.0%

All of the 64 respondents answered the demographic question regarding gender. The sample was primarily comprised of female respondents, (n=52, 81.3%) leaving male respondents as the minority, (n=12, 18.8%).

Table 2. Gender Distribution

Gender	Frequency	Valid Percent
Male	12	18.8%
Female	52	81.3%
Total	64	100.0%

For the purposes of the study race was broken up into two distinct categories POC (people of color) and whites. Within the category of POC there were 4 African American respondents and 4 Hispanic respondents, totaling 12.5%. The majority of the respondents were white (n=54, 84.4%) and 2 responded as “other”.

Table 3. Racial/Ethnic Distribution

Race/Ethnicity	Frequency	Valid Percent
Other	2	3.1%
White	54	84.4%
People of Color	8	12.5%
Total	64	100.0%

Sexual Orientation was also broken up into two groups, heterosexual and GLBT (gay, lesbian, bisexual and transgendered). All but one of the respondents answered the question of sexual orientation with a majority (n=49, 76.6%) being heterosexual and the

minority (n=14, 21.9%) being GLBT. Of the 14, 9 specifically identified as gay or lesbian while 3 identified as bi-sexual.

Table 4. Sexual Orientation Distribution

Sexual Orientation	Frequency	Valid Percent
No response	1	1.6%
GLBT	14	21.9%
Heterosexual	49	76.6%
Total	64	100.0%

There was a clear majority of clinicians with a Masters in Social Work that participated in the survey (n=56, 87.5%). There were also Marriage Family Therapists (n=3, 4.7%), Psychologists (n= 4, 6.3%) and a Psychoanalyst (1.6%).

Table 5. Educational Degree Distribution

Degree	Frequency	Valid Percent
MSW	56	87.5%
MFT	4	6.3%
Psychology	3	4.7%
Psychoanalysis	1	1.6%
Total	64	100.0%

The final demographic question regarded theoretical orientation. The respondents were asked to identify their theoretical orientations in an open-ended form so their answers often mixed more than one orientation together. Due to the open-ended nature of the question the answers were then split up into psychodynamic or psychoanalytically

oriented clinicians and relationally based clinicians however; answers included: Psychodynamic; solution focused; strength based; relational; attachment; narrative; cognitive psychodynamics; integral; object-relations; self-psychology; interpersonal-relational; psychodynamic; Freudian; and psychoanalytic.

Vignettes

The vignettes were designed to gain another perspective of how respondents viewed certain types of disclosures. Each case had a different type of disclosure, ranging from erotic countertransference to the disclosure of physical appearance previous to the initial session. These vignettes had a limited amount of responses designed to match up with data gathered in the literature review. Their answers were broken down by race, gender and sexual orientation and a chi-square test was used to compare the different groups responses. Unfortunately, once the respondents were broken down into separate groups there were not enough responses to gather any statistically significant data.

Clinicians Perspectives on Self-Disclosure

The following will be an analysis blending both statistical data with narratives written in response to open ended questions. The blending is an attempt to compare and contrast the clinician's theoretical understandings with the practical application of these understandings in their day-to-day practices.

The qualitative segment focused on narrative questions that were presented throughout the survey. The questions read as follows:

- How do you define therapist self-disclosure?
- What does your theoretical orientation teach you about the use of self-disclosure?
- If you have disclosed in the past what were you trying to achieve or gain?
- Why do you use self-disclosure in your practice?

- When making decisions about self-disclosing is race/gender/sexuality a factor? How and why does it come into play?
- The fixed questions were of a similar nature, and read as follows:
- Is self-disclosure a therapeutic technique?
- Do you use self-disclosure in your practice?
- When making decisions about self-disclosing is race, gender or sexuality a factor? How and why does it come into play?

How do you Define Therapist Self-Disclosure?

Respondents were asked, “How do you define therapist self-disclosure” and of the 64 respondents 51.5% (n=33) answered the question. This portion of the analysis was examined using the aggregate data, there was no analysis done regarding sameness or difference of definition depending on identity. As a whole there was one major theme in the definitions given by the respondents. The most common theme, mentioned by 18 out of the 33 respondents was that self-disclosure is the revelation or sharing of “personal” information. There was little description of how this information is revealed and shared but it was acknowledged by many that the disclosure could be made both consciously and unconsciously.

Many respondents did not define self-disclosure but instead described how and if it should be used. The question of definition seemed to put some of the respondents on the defensive, their answers immediately taking the stance of caution. The quotes below speak to this sense of caution and highlight both how nebulous the issue of self-disclosure is and how potentially anxiety provoking the subject can be for clinicians.

I think therapist self-disclosure can be useful but must not be self-serving in the slightest and needs to be balanced with the needs of the client. In other words, is there a different way to get at the same conclusion or is the only way to "get the client there" to use self? A therapist should never infer, imply, insinuate or hint at being attracted to a client regardless of the issue the client presents. This is a boundary that is not appropriate to cross, in my view. Use of self can frequently be helpful to gain trust, model in session behavior, etc. If clients want to know

my sexual orientation I will generally explore with them why they want to know before I disclose. And often I am not satisfied that it is clinically relevant and so I do not disclose.

Therapist self-disclosure should be used as a tool to help the client in their understanding of the problem, to help form a rapport with the client, or to show the client that the therapist can understand what the person is feeling. But should never be self-serving for the therapist and there are certain things that one would not disclose to a client. Self-disclosure should be something that happens rarely, if at all.

What Does Your Theoretical Orientation Teach You About Self-Disclosure?

53% (n=34) of the respondents answered the question regarding what their theoretical orientation teaches them about self-disclosure. These answers varied depending on orientation but there was one major thread and that was to proceed only with caution. 14 of the 34 had responses pointing to their orientations warning against disclosure evidenced by using the words: caution, abstain, judiciously, careful or referred to self-disclosure as a narcissistic indulgence. Psychodynamically oriented clinicians dominated these respondents.

According to my sample most therapists use self-disclosure. When asked, “Do you use self-disclosure in you practice?” 91.1% (n=41) of the 45 respondents who answered were answering positively. This majority crosses all of the identities that were surveyed. The reasoning behind the disclosures is explained in the following section.

Self-Disclosure and (Un)Conscious Intent

Statistically 88.9% (n=40) of the 45 respondents who answered, “is self-disclosure a therapeutic technique?” answered positively. This is evidence that clinicians believe disclosure to be a tool rather than a blunder. The chart below delineates how different identities chose to answer; the majority for all was “yes.”

The themes behind the therapist's intentions when disclosing were very similar to what the literature suggests.

- Builds trust
- Displays empathy
- Creates Rapport
- Strengthens the therapeutic alliance
- Equalizes the power differential
- Models behavior
- Bring more humanness to the relationship
- Relieves client's anxiety
- Fulfills narcissistic needs of the therapist

It seems that most clinicians are aware of the fact they are either going against the traditional theoretical "grain" when they use self-disclosure or following the more modern theoretical framework of relational theories such as intersubjective theory when they use it in an effort to benefit the client or relationship. This is explained well by one of the respondents,

Regardless of what I learned in my training, I have learned that use of self-disclosure is a very effective tool in developing trust, rapport and credibility with a patient. I am careful to be sure that I am doing this in the best interest of my patient and not for my own purposes.

The disclosures that were motivated less by client need and more by the clinicians conscious and unconscious needs had a lot to do with anxiety. The anxiety of the therapist seems to be a catalyst for disclosure. Respondents gave examples of where this anxiety comes from:

- Were asked a direct question by the client
- Were worried about how he or she was being perceived.
- Wanted to be seen as "real"
- Felt compelled to comfort the client

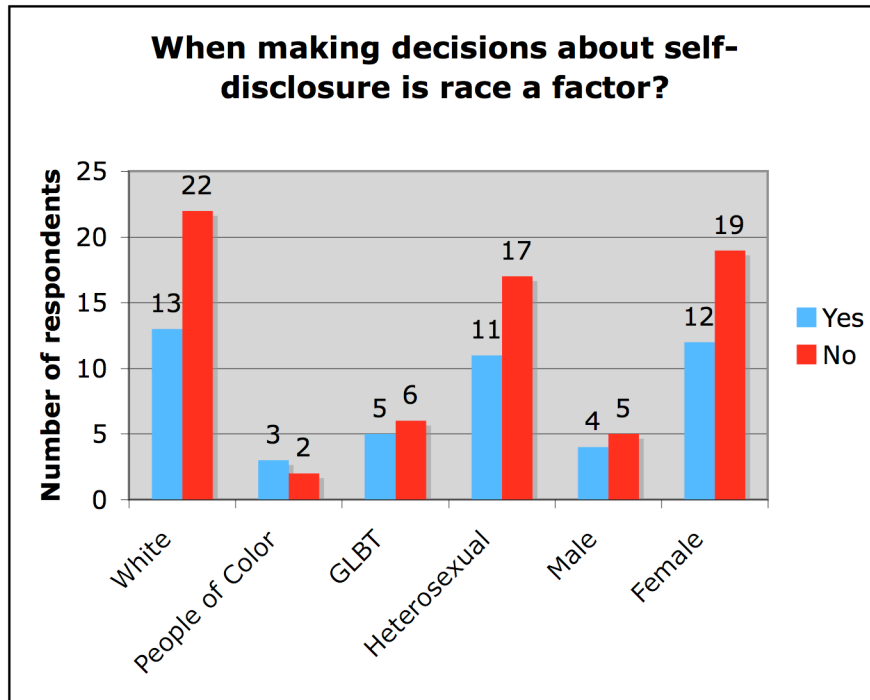
These answers were ascertained when respondents were asked "Are there any patterns that you can think of that prompt your use of self-disclosure?"

The equalization of power differentials regarding identity was mentioned generally by seven respondents, “I use it to acknowledge that one-way disclosure leaves persons seeking help more vulnerable and leave space for a discussion of power relations”. There was no specific mention of how it is specifically used for marginalized populations. There was a response that spoke to relating to a client who may be cynical or have a distrustful attitude of healthcare workers. “I find it helps the client see me as a person looking to help them, not a worker from “the department.” Two other clinicians who work with teenagers mirrored this sentiment. One of those clinicians explained she disclosed more often with teenagers because, “The issue is that some teenagers can be difficult to engage and they feel that adults really don’t understand what it’s like to be a teen.” The following is a breakdown concerning how respondents replied to questions regarding taking race, gender and sexuality into account when self-disclosing.

When Making Decisions About Self-Disclosure is Race a Factor?

Statistically, a 60% (n=24) majority of the 40 respondents replied “no” to the question of race playing a part in their disclosure. When looking at Figure 1 below it is clear that most identities share that point of view. It is notable, but not statistically significant that more people of color see race as a factor when making decisions about self-disclosure.

Figure 1.



The open-ended portion of this question yielded 28 responses displaying a broad spectrum of answers. Some answers were focused on disclosing information specifically regarding either the race of the client or the therapist, “First of all racial differences are noticeable. There is little to disclose about ones race.” There were other respondents who omitted disclosure due to a belief that race is separate from culture “No, because I don’t look at the patient due to their race although one must be considerate of ones culture.” Only white respondents took the stance that race either should not or does not influence their disclosures, exemplified by comments such as, “has never been pertinent,” “I rarely think about race unless the patient raises the issue” or “I hope that it would not.”

The next theme is of the opposite nature—race is always in the room and therefore must be taken into account. One of the quotes mentioned above expresses that due to the visibility of race it does not need to be mentioned, other respondents who felt

differently addressed this omission. They feel that not disclosing or acknowledging the racialized identities in the room perpetuates power differentials both within the therapeutic dyad as well as in the world outside the therapy room. The following quotes speak to the perceived responsibility of clinicians to acknowledge the racial identities in the room:

In this society, White people are encouraged not to acknowledge impact of racism. It is up to me as a white person to make sure I am not participating in silencing or denying.

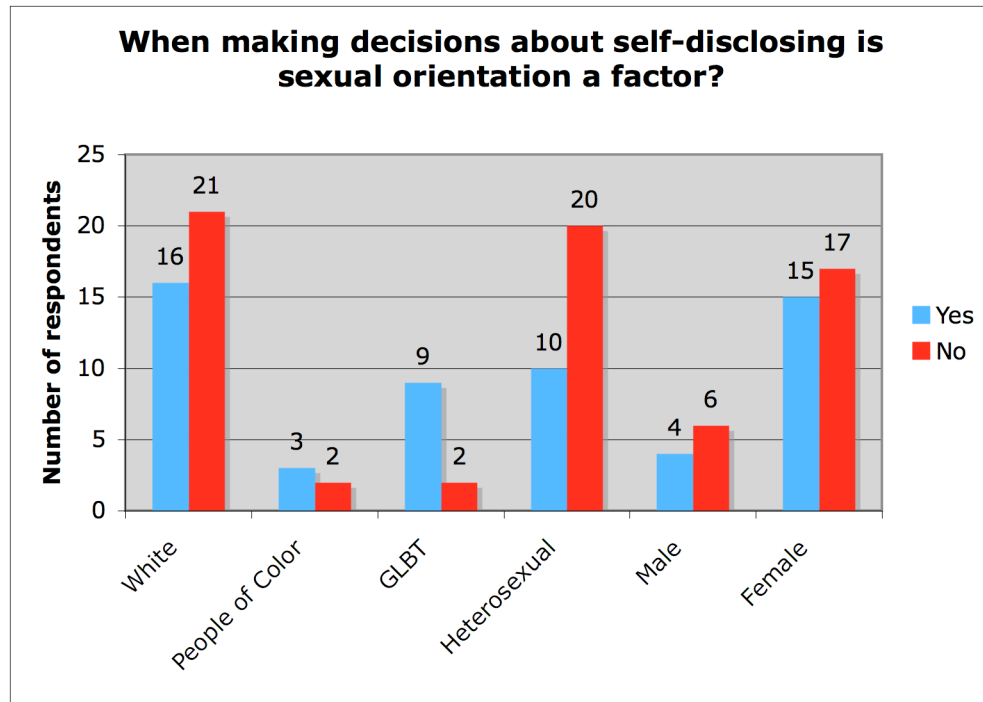
The final major theme in the narratives regarding race is linked to the idea of breaking silences. Disclosure can be used in an effort to break stereotypes and broaden the client's perspective.

Race plays a role in any and everything that you do in the workplace. As a young, Black, male social worker who works with predominately Black and Latino clients in a residential drug and alcohol facility where many clients are court mandated I find that my clients presume that because I dress "professionally" and speak without using slang that even though I'm Black I cannot identify with them...I also find that I use myself as an example. For example if a client makes a remark that indicates that it was his or her race or community that forced them to become involved with the legal system I may gently remind them that I am a person of color who grew up in the same (or a similar) community and did not have the same outcome.

When Making Decisions About Self-Disclosure is Sexual Orientation a Factor?

Statistically, of the 42 respondents 54.8% (n=23) answered "no" to the question of sexual orientation influencing the decision to self-disclose. Similar to the numbers in the race category (with a heavier majority) the GLBT respondents believed that their decisions regarding disclosure are affected by sexual orientation, as seen on the following page in figure 2.

Figure 2.



As was the case when asked about race, this question was often interpreted by respondents as whether or not one should disclose their sexual orientation to a client and a broad range of narratives were shared by the 31 respondents who chose to answer. There were those who denied sexual orientation playing a role in disclosing, “the decision is more about the character structure of a person than their sexual orientation” and those who were unaware of its existence, “Not sure.”

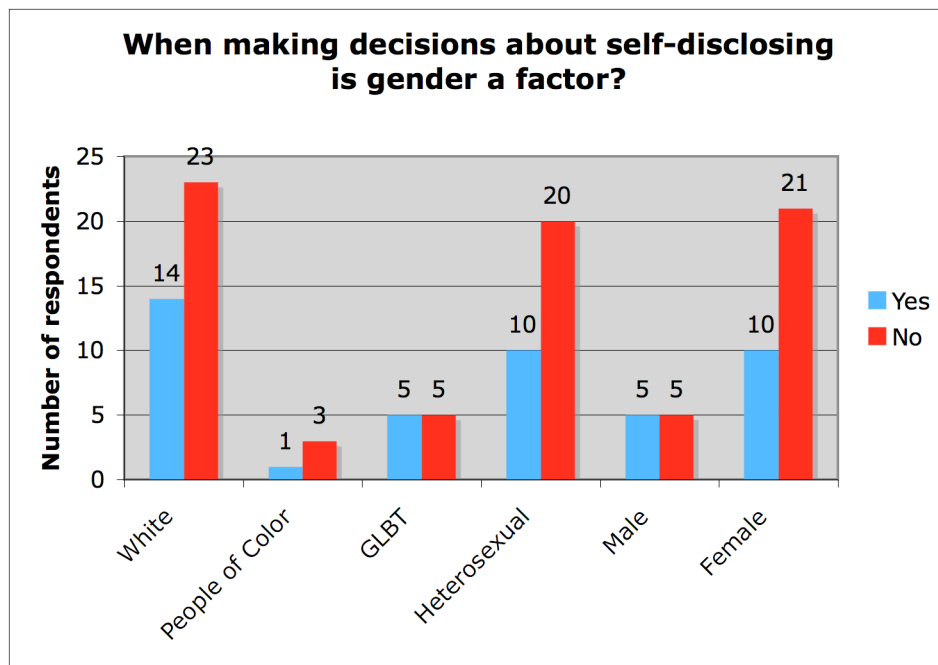
Combating stereotypes and offering new perspectives were referenced several times as a reason for disclosing--just as it did when race was the focus. It is important to note that more often than not the disclosure was a disclosure of sexual orientation generally made by a GLBT clinician. The following quote is an illustration of these points. It also speaks to the use of self-disclosure in an effort to break silences.

The world assumes that everyone is straight. I "look straight." It is important for clients in same sex relationships and/or those that identify as queer to know that they are being treated by a queer therapist. By telling them that I am gay, it brings down a wall. They know then that I am not judging them or thinking that "all gays" are like them. I also disclose to gay clients that I am in a successful happy 12-year relationship. I do this because often I am the only person that they know in a long-term gay relationship. There is a view that homosexual relationships aren't as stable as straight ones-gays can internalize this viewpoint and believe that their relationships won't work out in the long term.

When Making Decisions About Self-Disclosure is Gender a Factor?

Out of the 41 respondents 63.4% (n=26) answered “no” to the question, “When making decisions about self-disclosing is gender a factor?” When looking at specific identities all but the male and the GLBT clinicians had a majority of “no” answers.

Figure 3.



There were 24 respondents who chose to answer the open-ended question regarding gender's relationship to self-disclosure. Just as in the case of race and sexuality there were many respondents who did not recognize gender as a factor when choosing to self-disclose, "I have never thought of it being a factor."

The themes regarding gender were different than those found with race and sexuality. The main themes when it came to gender had to do with miscommunication and boundaries.

This is probably the area I pay most attention to. For some reason, in my experience, cross gender (male therapist with female pt) tends to be more prone to misinterpretation. I find myself exploring much more the pros and cons of making a disclosure.

The men answering the survey were very aware of gender affecting their decisions; specifically when working with female clients, "I definitely am more aware of male clients responses/reactions to me and am more hyper-vigilant about boundaries when working with the opposite sex. This was the case for the minority identities for race and gender as well. Although typically males are thought of as having more social power than women, as clinicians they are in the minority. With that in mind it is congruent for them to be more aware of their identity and how it affects their choices, just as it was for the identities mentioned above.

Summary

This mixed method study explored therapists' use of self-disclosure. The themes presented in this chapter were not exhaustive, however they did address prominent trends in the data. Information from the interviews was grouped into themes that addressed the intentions behind disclosure and the definition of disclosure itself. These intentions were

also examined with particular attention being paid to race, gender and sexuality. The intent behind disclosure was both conscious and unconscious and included: building trust; displaying empathy; strengthening the therapeutic alliance, breaking silences and stereotypes, equalizing the power differential, modeling behavior and relieving the client's anxiety. The next section compares and contrasts these results with the literature review that was presented in Chapter II.

CHAPTER FIVE

DISCUSSION

The purpose of this study was to answer the following question: How and why do clinicians choose to self-disclose (with a focus on race, sexual orientation and gender)?

There are two factors that motivated this question:

1. Most of the research on the topic of self-disclosure makes no mention of race or sexual orientation.
2. The possible discrepancy between what the literature says about self-disclosure and what clinicians are actually doing within their practices.

As clinicians we are constantly using our “selves” to heal, communicate and challenge—this study was an effort to better understand if self-disclosure is a technique used by clinicians within the boundaries of social work ethics and professionalism. If so, is it a technique that can be used to better reach communities of people that have been, or continue to be oppressed?

Findings

91.1% of respondents in the survey use self-disclosure in their practices and 88.9% believe that self-disclosure is a therapeutic technique. These numbers cross the boundaries of race, gender, sexuality, and years of experience. Most of the theories in the literature review either condemn self-disclosure or insist on its judicious use for the sole benefit of the client rather than the narcissistic indulgences of the therapist. The recommendation to censure self-disclosure was not reflected in the study where 91.1% of the sample uses self-disclosure in their practices. The majority of the clinicians surveyed were psychodynamically trained and cautioned about the use and misuse of self-

disclosure. In some cases this caution was heard and refuted by clinicians, as said in Chapter four:

Regardless of what I learned in my training, I have learned that use of self-disclosure is a very effective tool in developing trust, rapport and credibility with a patient. I am careful to be sure that I am doing this in the best interest of my patient and not for my own purposes.

Participants were in agreement that self-disclosure should not be for the clinician's "own purpose" on the other hand classical psychoanalytic theorists would argue that by nature, self-disclosure is a self-serving action. This study does not counter that point; however, the high percentages in favor of the use of self disclosure do show that clinicians are going against the recommendations made by their theoretical orientations and are making use of self-disclosure. They are using self-disclosure and they believe that it is benefiting their clients.

Not all of the respondents were able to speak specifically on the issues of race, sexuality or gender though using self-disclosure as a bridge between the clinician and the client was brought up by some (n=7) of the respondents. The difficulty of or hesitancy to speak specifically about issues of identity and privilege displays how necessary it is for clinicians to have tools and methods to engage clients in conversations around these issues.

These seven clinicians mentioned above did find ways to talk about self-disclosure as a method to connect with "cynical" or "distrustful" clients such as teenagers, or clients who are mandated to therapy. The use of self-disclosure to gain the trust of a teenager because they feel misunderstood or stereotyped can also be seen as a basis to use disclosure when working with marginalized populations such as people of

color, women and the GLBT community. Interestingly, there was a lack of exploration when it came to answering the questions specifically geared to gender, race and sexuality. It may have been easier to refer to teens (as mentioned earlier) as opposed to the marginalized populations mentioned above. Treating clients differently based on sexual orientation, gender and race was not something that most respondents acknowledged as a motivation.

Race

Most (63%) white respondents did not believe that race is a factor when they make decisions about self-disclosure; in fact (in the narrative responses) only White respondents took the stance that their racial identity should not or does not influence their decisions. Perhaps in this case their race influenced the omission of self-disclosure rather than it's use. Perhaps the white clinicians racial privilege lends to the notion that race is not important or should be ignored in an effort to see everyone as equal. They may not be as aware (as clinicians of color) of how race affects the daily lives of their clients and themselves.

There were three major ideas regarding the benefits of self-disclosure when working with clients of color: Gaining their trust; demonstration of cultural sensitivity displayed by a willingness to talk about issues of race and culture and modeling the therapeutic process for those that may be unfamiliar or uncomfortable due to stigma or lack of exposure to the process.

The respondents did not specifically mention using self-disclosure as a method to gain the trust of the client. Issues of cultural sensitivity were a major motivator for clinicians' self-disclosure. Acknowledging what they do *not* know about their client's

culture was one way for clinicians to practice their cultural sensitivity as well as willingness to engage in conversations about race and culture. Modeling was also mentioned by some of the respondents:

There are subtleties and complex issues around discrimination that I think it is to know that a clinician either understands on a theoretical level or has experienced first hand. Racism is such a powerful social construct and can have so many levels of consequences for an individual suffering from it....so the open and honest approach is the healthier one in my view because of the very nature and subtleties. It is also important for a client to feel they are viewed in a culturally competent way and for the clinician to check in to see if they are hitting the mark in terms of understanding and hearing the issues of the client.

The clinicians of color often referenced same race dyads as an opportunity to disclose in an effort to broaden perspective or model for their clients. In this case they did not intend to model expected behavior in session but a healthy and successful lifestyle as another person of color. White respondents answered this question as if they were working with a client who was a different race from them. There was no mention of conversation around race when working with white clients. Clinicians of color are using disclosure with clients of color in an effort to combat internalized racism and break stereotypes. It is important for White clinicians to take this into consideration and look at the possible benefits of disclosure and conversation around race within their same race dyads.

A major theme in the participants explanations for self-disclosing was to break the silence that is often surrounding issues of race, racism and privilege. This issue was not talked about in the literature, and was also not mentioned by the clinicians of color. This may be because the issues of silence mostly reside in the white community. Clinicians made statement such as, "It is up to me as a White person to make sure I am not

participating in silence or denying.” And “a frank and honest conversation is a good model for the client because people don’t want to talk about these kinds of things.”

Sexual Orientation

Although 54.8% of the respondents answered “no” to the question of sexual orientation influencing the decision to self-disclose (which reflects the heterosexual population of the study) 81% of the GLBT population of the study answered “yes.” The literature warned us that clinicians often deny their homoerotic countertransferential feelings possibly leading to an avoidance of disclosure, or a muddled disclosure. This homophobia may lead to anxiety for heterosexual clinicians and an avoidance of conversation around sex and sexuality in reference to themselves as well as their clients. This denial leads to the silence that some of the clinicians who use self-disclosure are trying to combat.

In a society that often sends the message “don’t ask don’t tell” where GLBT people face harassment and discrimination from the world around them it serves a great purpose to display acceptance in the therapeutic dyad. The open dialogue that can be created through the use of self-disclosure translates to acceptance of the client and will work to build trust in the therapeutic relationship. If the client is distrustful of the “other” and believes that they will be treated with disrespect or ignored due to their lifestyle it is a powerful experience for them to receive the opposite treatment in therapy—especially from the “other” which in this case means heterosexuals.

Some clinicians explained that this type of disclosure not only breaks silence, but also has a normalizing effect. The therapist is not only encouraging and normalizing conversation around sexuality, but is also encouraging and normalizing the lifestyle itself.

This may be helpful to clients who are bombarded by social messages that they are somehow deviant or “less than” their heterosexual counterparts. Just as in the case of the client of color with the clinician of color, GLBT clinicians often disclose to their GLBT clients to offer them a healthy mirror of what their life can be. They offer a picture that is not commonly portrayed in society today.

Gender

Unlike race and sexual orientation breaking silence and stereotypes were not a part of the discussion regarding gender. This may be because it is less taboo to discuss power relations regarding gender than sexual orientation or race. Rather than focusing on how self-disclosure could be helpful to the therapeutic relationship many of the narrative responses focused on the differences between communication styles with men and women. It seemed that gender influenced the choice to be extremely cautious regarding self-disclosure for fear that there will be a great misunderstanding. One clinician expressed this difference by saying; “the differences between the thought and emotional processes of men and women are often mysterious.”

It is notable that there was less exploration of the effects gender has on clinicians’ choices regarding self-disclosure. The majority (63.4%) of the respondents did not believe that it played a role in their decisions, and a fewer percentage of women (32.2%) than men (50%) believed that gender influenced their disclosures. According to the DSM-IV-TR (4th ed., rev., 2000) 70% of the clinical client population is female. This statistic tells us that men are working across gender much more often than women; and this may influence their awareness of gender more than their female counterparts who are working within their own gender more often.

In this very unique situation (the clinical population) men are the minority, and that may account for the fact that they were more aware of their identities effects on their use of self-disclosure than women.

Strengths and Limitations

It is impossible to discern what caused some clinicians to fully participate in the study while others participated in particular sections, or not at all. Such “volunteer bias” cannot be calculated, nor can its impact be determined (Anastas, 1999, p. 286). In the case of a study on self-disclosure, there is a possibility that the participants were individuals who are generally more willing to self reflect, or may simply have had the extra half-an-hour to spend on such a survey.

The survey was composed of several sections containing questions around attitude and use of self-disclosure, demographic questions and case examples. The demographic survey allowed a comparison of the sub-samples and a look at possible variables other than attitude, which may have influenced the use of self-disclosure. Unfortunately due to the limited sample size many of these sub-samples were too small to generate significant findings. The survey format on the other hand was strength, as it allowed participants to answer questions, which may have been potentially threatening or difficult to honestly answer. With the survey, participants could honestly answer questions about practices that are discouraged and may be seen as taboo. Another strength in this study was the use of the open-ended questions. These questions provided an extremely rich source of data around participants training, beliefs, and motivations that helped to supplement the numerical data that was gathered in the rest of the survey.

The section of the survey that generated the least amount of discernable data was the vignette section. The vignettes were lengthy and that may have deterred respondents from answering them—the majority of respondents skipped this section leaving very little information to work with. Two respondents shared that they chose not to respond to the vignettes due to the limited number of responses available.

The vignettes would have been more effective if each possible response had an opposing response. For example, if there was a response marked “disclosure was ethical” there should be the contrasting response marked, “disclosure was unethical.” These conflicting responses would have allowed the chi-square test to be run in order to analyze the differences between the groups in this study. Unfortunately, the limited number of responses that respondents were unhappy with is an inevitable part of quantifying the research and was necessary in this instance.

Future Studies

There were flaws in the design of the study that probably acted as a deterrent for some potential respondents. The survey could have been more concise; there were questions that collected data that was outside the focus of the study. These questions included but were not limited to:

- What percentage of your caseload is a different gender/race/sexual orientation from you?
- What is your geographical location?
- Can you think of a time when disclosing something to a patient hindered your relationship?

The vignette section played a big part in the extent of time that it took to complete the survey. Nearly half of the respondents left this section blank, and with the omission

of this time consuming section it is possible that more respondents would have participated in the survey.

None of the chi-square tests yielded statistically significant results due to the small sample size. In addition to shortening the length of the survey other measures could have helped increase the sample size of this study. The sample was primarily taken from psychodynamically trained professionals from the West Coast. More Colleges and Universities from all over the country could have been contacted to not only amplify the number of respondents but also create a more diverse sample as far as educational and theoretical backgrounds. Though efforts were made to reach out to clinicians of color the effort could have been stronger. HBC's (Historically Black Colleges) could have been contacted as a resource as well as various Internet listing sites such as DiversityTherapists.com.

Implications for Practice and Recommendations

The common use of self-disclosure without training illustrates a need for the inclusion of more training around the understanding and use of self-disclosure and related issues. Additionally, an exploration of the purpose and fluidity of boundaries within both intersubjectivity theory and more traditional theories is recommended. It is concerning that while so many clinicians have similar positive (yet cautious) attitudes on the subject of self-disclosure they did not mention any professional training around its use. It is probable in that case that therapists may be cultivating their beliefs around self-disclosure through experiences in supervision, discussions with peers, and patterns in their own practice. These are conscious interventions being made by professionals, but where are they being trained to do this work?

According to this study clinicians believe that they can use self-disclosure to help end silences around privilege—both racial and heterosexual in an effort to work towards equality both within the therapeutic dyad as well as in the outside world. In anticipation of growing numbers of therapists who may self-disclose, as well as a population of people that grows more diverse every day it is important to discuss issues such as boundaries and power dynamics in training. Institutions and training programs can do this by embracing theoretical frameworks that foster self-disclosure, such as intersubjectivity theory.

The theoretical transitions, which have occurred over time and practice, have resulted in a more positive attitude toward the use of clinician self-disclosure, but it is still complicated and potentially dangerous territory and that is why additional training and conversation around this issue is so vital.

Summary

Regardless of the therapeutic warnings concerning self-disclosure clinicians are using it. The majority of the clinicians surveyed not only use self-disclosure in their practices they believe that it is a therapeutic tool that can help build trust, model appropriate in session behavior, equalize the power difference in the room and break silences regarding both sexuality and race.

It is important to acknowledge that the findings of this study are all broad generalities about the potential uses and motivations of self-disclosure. Within the group identity (as well as the individual) there will be difference and subtlety regarding the effects of clinician self-disclosure on the therapeutic relationship.

For both Clinicians of Color and GLBT Clinicians their identities play a part in their choices regarding self-disclosure; this is not the case for those living with dominant identities, with the exception of men. The variance when it came to men, who were split in half may be attributed to the fact that they so frequently work across gender and are in the minority in the “clinical” world. It may be that when you are a person in a “minority” your identity is at the forefront of your choices and experience whether you are making clinical/professional choices or personal choices. Persons in the majority may also be enjoying the privilege of not acknowledging that their identities play a role in their decisions, and possibly denying it’s influence.

Though the narrative portion of the survey did not tell us who is disclosing more often it did tell us that identity plays a part in our choices whether or not to disclose. It also told us that people with minority identities are more aware of how those identities affect their choices regarding self-disclosure.

This study did not prove or disprove the efficacy of self-disclosure. It did prove that regardless of how or if we clinicians chose to reveal ourselves in the room we are there. It is awareness of our identities and their intersection with the identities of our clients that will create understanding and subsequent growth. The clinicians surveyed supported the notion that self-disclosure is potentially burdensome and if used should be an intentional intervention.

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Appendix A

Recruitment Letter

Friends and colleagues,

My name is Sarah Barnett-Parker and I'm a second year graduate student at Smith College School for Social Work. I have contacted you in the interest of a research study. The data that will be collected in this survey will be used for my Masters in Social Work thesis. Please read the following and click on the link below if you are interested in participating.

What is the purpose of the research?

This research will examine mental health providers' use or non-use of self-disclosure in their practices, particularly as it relates to issues of race and sexual orientation.

Who can participate?

All mental health providers who have earned a Master's level degree or higher.

What does participation involve?

Participation will involve an anonymous online survey. The survey contains both multiple-choice and open-ended questions. Depending on the length of your answers the survey may take up to twenty-five minutes ...it's up to you!!

http://www.surveymonkey.com/s.aspx?sm=9hauX6SKqdNUGBIZpbexNg_3d_3d

Please forward this email to any friends or colleagues who may be interested in participating. Thank you for your time and assistance!

Sarah Barnett-Parker
MSW Candidate 2008
Smith School for Social Work
sbarnett@email.smith.edu

Appendix B

Electronic Informed Consent

My name is Sarah Barnett-Parker, and I am a graduate student at Smith College School for Social Work. I am gathering research regarding when and how clinicians use self-disclosure. The research obtained in this study will be used in my master's thesis and will be used for possible presentation and publication.

Your participation is requested because you are a mental health professional. If you are interested in participating in this study, you must be a mental health practitioner with a masters level degree or higher. If you choose to participate in this online survey, you will be asked to share demographics as well as your experience, thoughts, and theoretical understanding of self-disclosure. This survey will be the one and only time that I contact you for information. The survey contains both multiple choice and open-ended questions and may take up to 25 minutes.

This is a low-risk study; the questionnaire will ask about your demographic information and whether you have engaged in conversations about race or sexuality in therapy. This may cause you to experience some discomfort, but you have the right to *not* answer any question on the questionnaire.

The benefits of participating in this study are that you have the opportunity to contribute to a new area of research, and to convey the need for MSW programs to prepare their students for work with oppressed populations. You also have the opportunity to explore issues in your own practice that you may not have otherwise. Unfortunately, I cannot compensate you for your participation.

SurveyMonkey employs a firewall system that will prevent me from obtaining any identifying information about participants. Your information will be kept in secure electronic server and will be destroyed after three years have passed. In the written thesis, I will not use demographic information to describe each individual; rather I will combine the demographic data to reflect the subject pool in the aggregate. In this way, participants will not be identifiable in the written work.

Participation in this study is completely voluntary. You may refuse to answer any interview question(s), and you may withdraw from the study at any time during the survey, but once it is submitted there is no way to identify and then withdraw your individual survey. If you have any questions or concerns feel free to email me at srbp11@gmail.com.

CLICKING ON THE LINK BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. IF YOU ARE NOT INTERESTED IN PARTICIPATING PLEASE CLICK ON 'EXIT THIS SURVEY' TO LEAVE SURVEYMONKEY.

Participants may contact the Chair of the HSR Committee at (413) 585-7974 if they have any concerns about any aspect of the study. Thank you for your time, and I greatly look forward to having you as a participant in my study.

Please print out a copy of this consent for your records.

Sincerely,

Sarah Barnett-Parker

Appendix C

Survey

Demographic Information

1. What is your gender?

- A. M
- B. F
- C. Z

2. What is your racial/ethnic identity?

- A. Multi-racial
- B. Black/African-American
- C. Asian
- D. Hispanic
- E. White
- F. Other: _____

3. What is your sexual orientation?

- A. Gay/Lesbian
- B. Bi-sexual
- C. Heterosexual
- D. Other (please specify)

4. What is your age?

5. What is your professional discipline and degree? (i.e. Psychology/Social Work, MSW, Ph.D. etc.)

6. How long have you been in practice?

Type of practice: _____

7. What is your geographic location?

- A. Urban
- B. Suburban
- C. Rural
- D. Other

8. What percentage of your caseload is a different race or ethnicity from you?

- A. 0-10%
- B. 11-20%
- C. 21-30%
- D. 31-40%
- E. 41-50%

- F. 51-60%
- G. 61-70%
- H. 71-80%
- I. 81-90%
- J. 91-100%

9. What percentage of your caseload is a different gender from you?

- A. 0-10%
- B. 11-20%
- C. 21-30%
- D. 31-40%
- E. 41-50%
- F. 51-60%
- G. 61-70%
- H. 71-80%
- I. 81-90%
- J. 91-100%

10. What percentage of your caseload is a different sexual orientation from you?

- A. 0-10%
- B. 11-20%
- C. 21-30%
- D. 31-40%
- E. 41-50%
- F. 51-60%
- G. 61-70%
- H. 71-80%
- I. 81-90%
- J. 91-100%

Clinical Vignettes: Each of these vignettes includes a form of therapist self-disclosure. Below each vignette please give your professional opinion(s) regarding the therapist's choices. Having your input on each vignette is ideal, but if you have time constraints please feel free to read and comment on one or two of them and move on. Thanks.

1. Sarah, a health care worker in her 40s, had recently moved to New York City from the Midwest in order to break away from her very disturbed and enmeshed family. Anxiety and depression over such a huge physical and psychic separation led her to seek psychotherapy. She worked with an experienced female colleague, at first quite effectively. However, she gradually developed an intense negative maternal transference that culminated in a suicide attempt. After a short hospitalization, it was decided to refer her to a man for outpatient treatment, and she came to see me. Initially, the treatment was primarily supportive, given her suicide attempt and her high levels of anxiety and

depression (which were also being treated by medication). After we had worked out some of the meanings of her suicide attempt, Sarah got “down to business” (her phrase). Her primary goal in therapy was to become a full person. She had spent much of her adult years taking care of the disturbed members of her family and working. She wanted to date men and be able to live with and/or marry someone. Having been raised in a fundamentalist Protestant denomination, Sarah had very self-punitive feelings about her sexual desires; she had masturbated (with immense guilt) but had never been sexually involved with another person.

I liked Sarah—especially her determination to move ahead and her genuine consideration for others. I am sure that she sensed that. She had developed an idealizing transference toward me as a kindly and yet firm good father. She had been making considerable progress in feeling more and more comfortable with her sexual self and starting to dress in a reasonably attractive way instead of in her customary asexual manner. She was beginning to feel her sexual and loving attraction toward men; she struggled to behaviorally express these desires but could not act on them as yet. One day, Sarah came into my office, attractively dressed and looking very alive. She was excited about her intentions to initiate contact with a man in her office whom she liked and was detailing to me her seductive fantasies. Then, in a sudden shift, I heard in a painful, moanful voice, “But how could any man find me attractive!” Spontaneously, and feeling very moved by her pain and by my bodily sexual reactions, I replied, “Sarah, I am feeling very attracted to you right now!” She asked, “Do you really mean that?” “I certainly do!” I replied. Her tears now slowing down and relaxation showing in her body, Sarah said, “I feel you do . . . you have always been honest with me . . . Maybe I am pretty and sexy enough for men to desire me.” In the next session, Sarah, with a warm smile, said, “I felt so good that you found me womanly, that I started to flirt.” She was referring to the man in her office that she liked.

The disclosure:

- Shows clinician's empathy
- Is sexist
- Demonstrates cultural sensitivity
- Is self-serving
- Models appropriate "in-session"
- Behavior for the client
- Is racist
- Is ethical
- Is unethical
- Attempts to show competency
- Is homophobic
- Helps create trust
- Is unprofessional
- Is professional

2. Donna was a 27 year-old single white female with bipolar I disorder. She had been referred as a frankly narcissistic female whose self-esteem was closely aligned with her evaluation of those around and near her. Therefore, before accepting the case, I advised the referring clinician to inform Donna that I am “overweight and not very attractive.” This is both an accurate self-appraisal as well as a ploy intended to make the client aware that I could not and would not attempt to feed her narcissistic idealism. Donna accepted the referral and during the first session disclosed that the man with whom she lived was a drug addict and dealer. She also hated the menial, temporary work, which she did for a living.

At the end of the assessment session, Donna had put on her coat and suddenly asked, “Are you a lesbian?” A classic response might have been “Are you apprehensive that I may not be able to help you if I am a lesbian?” Acutely aware of Donna’s narcissism, however, this response may have backfired. Not knowing her well enough to ascertain how she would respond, I replied, “Yes, I am.” Donna smiled and said, “Cool!” She went on to explain that she had known several lesbians, “but I never felt comfortable enough with them to talk about it.” In his case it seemed that the client was expressing a small measure of comfort interacting with me and wanted to know how I would respond when discussing issues of human sexuality. Donna never questioned or discussed my sexual orientation again. However, she frequently raised questions about her own sexuality and sexual attractiveness. For example, she occasionally questioned whether her preference for sexually passive males reflected a latent homosexuality. We used these occasions as an opportunity to explore what it would mean to her to have a same-sex sexual relationship.

Although Donna’s identity as a heterosexual did not change during therapy, she appeared to become more cognizant of and comfortable with her occasional sexual attraction to women.

The disclosure:

- Shows clinician's empathy
- Is sexist
- Demonstrates cultural sensitivity
- Is self-serving
- Models appropriate "in-session"
- Behavior for the client
- Is racist
- Is ethical
- Is unethical
- Attempts to show competency
- Is homophobic
- Helps create trust
- Is unprofessional
- Is professional

3. Jessica was a 20-year old Black female junior majoring in engineering at a large, predominantly white west-coast state university. Prior to this Jessica had attended racially and ethnically diverse schools and was considered to be bright and hardworking by her teachers, parents, and peers. She presented to psychotherapy to address feelings of lethargy, lack of motivation, anxiety, social isolation, and racial and gender discrimination. Jessica requested a female therapist and was assigned a White female therapist by the agency.

Jessica stated that she was frustrated about several things in her academic department. She reported that her academic advisor, the one female faculty advisor in the department had not been granted tenure at the university and was leaving at the end of the semester. Jessica reported that her advisor had “shielded” her from a lot of politics in the department and had served as a supportive role model to her. In response to her leaving, Jessica indicated feeling increasingly depressed anxious and withdrawn. In particular she wondered how she would cope with the “blatant racism and sexism” in her department at the hands of many male faculty and students once her advisor leaves.

Early in her therapy session, she stated that Blacks and Whites tended to think and communicate differently, and that we’re “just different.” She often made such statements followed by uncharacteristically long pauses. Sensing that she hesitated to describe her frustrations further with her therapist. Jessica was directly asked how she felt about discussing her feelings and perspectives with a non-Black therapist. Jessica appeared surprised by this question and stated that she expected her therapist to listen to her without “really getting it.” She also reported that she had been hesitant to discuss or elaborate on this issue because of the therapists’ race. Jessica then asked her therapist whether she had personally ever been discriminated against. Her psychotherapist, who had experienced similar sexist treatment in her graduate program nearly 30 years ago said, “I know that feeling discriminated against must be difficult for you.” Jessica became frustrated by her therapist’s response and stated, “I asked you the question because I wanted to know if you really understand how I feel. Based on your answer, I don’t know that you do, so I’m not sure I can trust telling you more at this point.” Jessica’s therapist considered the pros and cons of directly answering Jessica’s question and then stated, “I’m sorry I was evasive. I knew what you were needing from me at the time you asked that question, but I guess I didn’t want my response to deter you from your own issues and progress. I would have to honestly report that I have also experienced sexism and it is painful. However, an additional element you are currently experiencing is racism, and I am wondering how you’re feeling about having to deal with these two issues concurrently?”

The disclosure:

- Shows clinician's empathy
- Is sexist
- Demonstrates cultural sensitivity
- Is self-serving
- Models appropriate "in-session"
- Behavior for the client
- Is racist

- Is ethical
- Is unethical
- Attempts to show competency
- Is homophobic
- Helps create trust
- Is unprofessional
- Is professional

4. George is a thirty-five-year-old obstetrician in analysis for severe depression. Although he is married and the father of three, he feels he has no satisfying relationship in his life. Over the past two years, we have explored the ways that his religious upbringing resulted in a judgmental and moralistic overlay to his sexual feelings and fantasies, about which he is riddled with shame. Neglect by his distracted, concrete, intermittently seductive mother and ridicule from his successful businessman father were experienced in an emotional vacuum, as a result of which George developed profound self-loathing.

He comes to a session worried about having sexual feelings toward a female patient earlier in the day. He imagined her exercising and being sweaty and then having sex with him. He felt ashamed of having these “inappropriate” thoughts, and found himself wondering what I did with my sexual feelings toward patients. Then he decided that was just a “weird way of wondering if you have sexual feelings toward me—of course you couldn't because I'm disgusting.”

With some anxiety, I decide to try a new approach that speaks from my own, necessarily subjective experience. I say, “I don't separate my mind from my body to think about myself or patients. It seems so obvious to me that there's been a rapport between us from the beginning that we both enjoy, that I can't help thinking that your worry and self-criticism about having sexual feelings and about your own attractiveness have to do with something you bring to our relationship. I have in mind the traumatic experience of your mother's lack of desire for you—which may well have resulted from her discomfort with her desire for your bodily self. And the idea that I'm laughing at you reminds me of your having said that you think your father had contempt for you.”

A few sessions later, George says, “I know you have a kindness and a caring for me, but there are times when I confuse it with a tender love.” And I say, “I think it is a tender love. What's the confusion?” He says, “Well, I think I make it into more than it can be—a kind of nurturing that I need so desperately.”

The disclosure:

- Shows clinician's empathy
- Is sexist
- Demonstrates cultural sensitivity
- Is self-serving
- Models appropriate "in-session"
- Behavior for the client
- Is racist

- Is ethical
- Is unethical
- Attempts to show competency
- Is homophobic
- Helps create trust
- Is unprofessional
- Is professional

Disclosure Info: This page will help get a better feel for your theoretical orientation and self-disclosure practices. If you do not have time for the comment boxes please answer the multiple-choice questions. Thanks...you're almost done!

1. How do you define therapist self-disclosure?
2. What do you consider your theoretical orientation?
3. What does your theoretical orientation teach you about the use of self-disclosure?
4. Do you believe the use of self-disclosure is a therapeutic technique?
 - Y
 - N

Why or why not?

5. Do you use self-disclosure in your practice?
 - Y
 - N

Why or why not?

6. If you have self-disclosed in the past what had you been trying to achieve or gain?
7. Are there any patterns that you can think of that prompt your use of self-disclosure?
 - Y
 - N

8. In what instances do you believe that it is inappropriate to self-disclose?

More disclosure info

1. Can you think of a time when disclosing something to a patient hindered your Relationship?

2. When making decisions about self disclosing is race a factor?

- Y
- N

How and why (or why not) does race come in to play?

3. When making decisions about self disclosing is sexual orientation a factor?

- Y
- N

How and why (or why not) does sexual orientation come in to play?

4. When making decisions about self-disclosing is gender a factor?

- Y
- N

How and why (or why not) does gender come in to play?

You have reached the end of the survey.

Thank you for your participation!!

Appendix D

Human Subjects Review Application

Investigator Name: Sarah Barnett-Parker

Project Title: “Enough about you, let’s talk about me”: An analysis of clinician self-disclosure practices with a particular awareness of dominant culture influence in the therapeutic dyad.

Contact Address: 540 63rd St. Oakland, CA 94609

Contact Phone: (207) 939-8377

E-mail Address: srbp11@gmail.com

Project Purpose and Design

Self-disclosure has been a fairly acceptable psychotherapeutic technique since the 1970’s (Hanson 2003; Kernberg 1994) much of the discussion has been around issues of neutrality and maintaining the asymmetry of the therapeutic relationship (Barglow 2005; Hanson 2003; Constantine and Kwan 2003; Patterson 1985). Unfortunately, most of the research on the topic of self-disclosure makes no mention of race or sexual orientation. It is this lack of information that motivates the discussion in this paper. Both clients of color and GLBT clients may be distrustful of their therapist due to the discrimination and oppression that they meet in their everyday lives. Griner and Smith (2006) talk about three major factors contributing to this distrust. The first is, Historically, counseling and psychotherapy have focused predominantly on the therapeutic needs of upper- and middle-class European-Americans; second, clients of color are sometimes mistrustful of mental health services because of historic racial disparities and a scarcity of therapists from their own ethnic background who speak the same native language and third, there is a lack of mental health services available in many communities where people of color reside. These factors prevent specifically clients of color from both seeking treatment and staying in treatment. In order to effectively help these populations we must examine psychotherapeutic techniques and mold them into cross-culturally effective practices, otherwise we are just perpetuating injustice and inequality.

From the research that I have conducted so far I have been able to find a wealth of information regarding clinician self-disclosure. Most of the research makes no mention of sexual orientation, and very little makes reference to race. I have been attempting to stretch the literature regarding race and ethnicity to fit clients living in the sexual minority, but this information gap is part of the motivation behind the topic. The stated information was gathered through my literature review, and all of the research and data gathered will be used for my master’s thesis and possible presentation and publication.

I will attempt to further the examination of self-disclosure by surveying therapists of multiple backgrounds who work with a diverse range of clients. I will be asking them

to help me answer the questions regarding how we as therapists and professionals define self-disclosure, use self-disclosure, and whether or not it is in fact a technique in our practices. By asking open-ended questions regarding disclosure I hope to find out more about the motivations behind self-disclosure highlighting the ways dominant culture may be affecting our choices.

I am hopeful that my findings may add some understanding of clinician self-disclosure especially as it relates to issues of race and sexual orientation. A greater understanding of both the risks and benefits of clinician self-disclosure is useful to mental health professionals because it a choice that we are faced with in our daily practices. It is also important for us to see that there are different beliefs depending on our theoretical orientations and educational backgrounds.

The Characteristics of the Participants

The participants in this study must be mental health professionals with at least a master's level degree. The demographics and characteristics of the sample should reflect the demographics of the profession as a whole. A sample size of fifty would be satisfactory; an attempt will be made to collect as many as possible.

The Recruitment Process

Professionals will be recruited via email. Lists of mental health professionals will be obtained through the Sanville Institute for Clinical Social Work, Children's Hospital Oakland employees (which is where I am currently interning), various past colleagues of this researcher and from the (publicly listed) directories of: the San Francisco Center of Psychoanalysis; the Northern California society of Psychoanalytic Psychology; Division 39; and the National Committee of Psychoanalysis.

I will not have a list of email addresses (outside of my personal contacts). The contact people—Judith Nelson, dean of students at the Sanville Institute and Cherise Northcutt from Children's Hospital will send the letters out on their own. There is a letter of permission from Judith Nelson attached, but in order to use the hospital for research I must clear their IRB (Internal Review Board) to receive permission.

The letters that they send will be the short recruitment letter describing the research topic and the nature of their participation that I have written. If their students and employees choose to participate they will simply need to click on the link to SurveyMonkey found at the bottom of the page. This will take them directly to the survey where they will then read the Informed Consent letter and decide whether or not to participate in the survey.

The Nature of Participation

Participants will partake in an online survey. The website used is called SurveyMonkey, and the data will be gathered and saved through their website. This survey contains several case vignettes (containing different therapist self-disclosure scenarios) that they will read and comment on, there is also a section asking them to

define self-disclosure, talk about their theoretical orientations, and share experiences using self-disclosure in general and specifically with clients of a different gender, sexual orientation or ethnicity from themselves. The conclusion of the survey asks them for some demographic information.

The survey could take anywhere from fifteen to thirty minutes and will be the one and only time the participants are contacted. The reason for the large range of time is that there are several places where the participant is asked to comment, either on vignettes or standard open-ended questions.

Risks of Participation

This is a low-risk study. Some interview questions or vignettes could trigger negative thoughts and feelings surrounding personal experiences of oppression, discrimination or misunderstandings. Participants have the right to *not* answer any question on the questionnaire or during the interview without any repercussions.

Benefits of Participation

The benefits of participating in this study are that they have the opportunity to contribute to a new area of research, and to explore the methods used in their own professional practices. Unfortunately, I am not able to offer participants financial remuneration for participating.

Informed Consent Procedures

My survey will be distributed online, therefore the informed consent will be explained once they enter into the survey website. This introductory email will contain information regarding my topic, the nature of their participation and the inclusion criteria. Since this is an online survey I will not be obtaining participants' signatures, at the bottom of the email there will be a link to the actual survey. The first thing that they will read upon entering the survey is the informed consent. It will explain that by entering the survey they have given consent, and they will be given a choice of exiting at this point as well.

Precautions

Data will be kept in an external hard-drive within a locked box for three years, as required by Federal Policy. After three years the information will be destroyed by compromising the physical integrity of said external hard drive (by drilling numerous holes in it) and throwing it away.

There are several safety features that survey monkey provides. They employ multiple layers of security to make sure that the data remains private and secure. SurveyMonkey employs a third-party firm to conduct daily audits of their security, and data resides behind the latest in firewall and intrusion prevention technology. I have also

added SSL to my account, which guarantees that data is collected in a totally encrypted environment.

The collection of survey responses will be anonymous. An anonymous collector is created through SurveyMonkey and will be programmed not to save IP or email addresses. The specifics of how data is kept safe is as follows (www.surveymonkey.com):

Physical

- * Servers kept in locked cage
- * Entry requires a passcard and biometric recognition
- * Digital surveillance equipment
- * Controls for temperature, humidity and smoke/fire detection
- * Staffed 24/7

Network

- * Multiple independent connections to Tier 1 Internet access providers
- * Fully redundant OC-48 SONET Rings
- * Uptime monitored every 5 minutes, with escalation to SurveyMonkey staff
- * Firewall restricts access to all ports except 80 (http) and 443 (https)\
- * QualysGuard network security audits performed quarterly

Hardware

- * Servers have redundant internal power supplies
- * Data is on RAID 10, operating system on RAID 1
- * Servers are mirrored and can failover in less than one hour

Software

- * Code in ASP, running on SQL Server 2000 and Windows 2000 Server
- * Latest patches applied to all operating system and application files
- * SSL encryption of all billing data
- * Data backed up every hour internally
- * Data backed up every night to centralized backup system, with offsite backups in event of catastrophe

Investigator's Signature: _____

Date: _____

Advisor's Signature: _____

Date: _____

Appendix E

HSR Approval Letter

February 22, 2008

Sarah Barnett-Parker

Dear Sarah,

Your revised materials have been reviewed and you have done a fine job with their amendment. All is in order and we are glad to give final approval to this interesting study.

Please note the following requirements:

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

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

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

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

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

Good luck with your study. I hope you are successful in your recruitment. That is often the hardest part and it is very helpful that the Institute is willing to participate in recruitment.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee
CC: Diana Fuery, Research Advisor

