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Beyond the office doors : the relationship between psychotherapists' disclosures of personal life events and their professional identity

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ABSTRACT

Psychotherapist use of self-disclosure is a topic that has been under-researched to date.

Stemming from classic psychoanalytic training, the belief that clinicians should strive to be

"blank slates" influences many psychotherapists' negative perceptions of their own self-

disclosure. Within this study 12 psychotherapists were interviewed regarding their experiences

disclosing personal life events to their clients in order to ascertain what influence, if any, these

disclosure experiences had upon their professional identities. Of the personal life events that

were described, some were inevitable and unavoidable while others were more intentional in

nature; the main types of personal life events that emerged through the interviews pertained to:

pregnancy, medical issues, marriage and divorce, and death of family members. The findings

from the interviews overwhelmingly demonstrated that the psychotherapists' self-disclosures had

a profound influence on them both professionally and personally. This study ultimately strives

to reframe the classical notion that clinician self-disclosure is something to be avoided by using

relational theory to show that psychotherapists' disclosure of their personal life events can, in

fact, be a useful and professional clinical tool.

BEYOND THE OFFICE DOOR: THE RELATIONSHIP BETWEEN

PSYCHOTHERAPISTS' DISCLOSURES OF PERSONAL LIFE EVENTS AND THEIR

PROFESSIONAL IDENTITY

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

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CHAPTER I

Introduction

Psychotherapists' use of self-disclosure within the therapeutic setting has been a much-debated issue for theorists and practitioners throughout the history of psychoanalysis and psychotherapy. Questions as to whether it is a benefit or a detriment for clients to learn about their therapist's personal life and experiences or personal reactions to the therapy sessions often arise in the discussion of clinical self-disclosure; very rarely, though, is consideration given to how the disclosure affects the therapist. The question at the heart of these discussions is: should psychotherapists self-disclose to their clients? As can be seen in this question, the commonly accepted usage of the term self-disclosure refers to disclosures that psychotherapists choose to make. This sort of intentional self-disclosure may include sharing a personal reaction to something a client has just said or providing an explanation for needing to cancel session. However, there exist other forms of self-disclosure over which psychotherapists have no control; Goldstein, Miehls, and Ringel (2009) termed this sort of disclosure, "strange encounters of the extra therapeutic kind." When a therapist experiences a major personal life event and the subsequent disclosure of this event to clients, it often influences his or her professional life and professional identity. The focus of this study will be on this issue: the influence of therapists' disclosure of personal life events on their professional identities and abilities.

For the purpose of this study, "personal life events" will be defined as choices psychotherapists make and occurrences that take place within the psychotherapists' lives outside

of their office. Examples of "personal life events" include: marriage, divorce, pregnancy,

illnesses that can be physically perceived, and deaths of loved ones. The disclosures may be

either intentional, such as when a psychotherapist explains the reason for an unexpected absence,

or unintentional, as would be the case with pregnancy or other visible physical changes.

"Professional identity" will be defined within this study as the psychotherapist's conception of

psychotherapists in general as well as his or her own professional sense of self, his or her sense

of belonging to the clinical community, and his or her confidence in his or her ability to practice

clinically. Throughout this study the terms "psychotherapist," "therapist," and "clinician" will

be used interchangeably.

Despite the recent surge of literature encouraging analysts and mental health

professionals to develop a "human demeanor" as opposed to "rigid hyper formality" (Renik,

1995), there still exists within the profession an often unspoken expectation that clinicians ought

to uphold a level of near-perfection within the therapy room. In a sense, clinicians who have

devoted their lives' work to encouraging others to express their weaknesses and vulnerabilities

within sessions are often unwilling to do the same for themselves. Whether this negation of

therapist imperfection stems from patient expectations of the therapist or the therapists' self-

idealization is unclear but each undoubtedly reinforces the other.

This dynamic was perfectly illustrated in a graduate class when a professor who was also

a practicing psychotherapist disclosed to this researcher's class that he had been divorced;

flabbergasted, a student in the class blurted, "Divorced? Aren't therapists supposed to have their

lives more together than that?" Caught off guard, the professor, in turn, sputtered something

about having made mistakes but understanding himself and relationships better now. In this

instance, the student projected her expectation for therapists to be super-human and free of

imperfections onto the professor and rather than challenge this, he accepted them and tried to prove that he was upholding them.

Denying one's humanity is not always possible for clinicians, though; in cases of major life events such as illness, loss, and pregnancy, it is often inevitable that clients will see another side of their clinician that may shatter their idealized view. Gerson (1996) reflects on the discomforting experience clients may have upon discovering their clinician's humanity: "I have thought about how jarring it was to many of my patients to discover how closely we inhabit the same worlds—of dirty dishes, unrealized dreams, grief, and struggle" (p. 67). Likewise, the revelation of a clinician's humanity can be equally deregulating for the therapist who may feel suddenly vulnerable and exposed.

It is this researcher's assumption that the occurrence of personal life events that become known to a therapist's clients is nearly inevitable throughout the course of a therapist's professional life. Yet, despite the fact that most, if not all, psychotherapists will face the collision of their personal and professional lives at some point in their careers, very little is written about the issue. Although much has been written anecdotally about therapists' experiences of disclosing life events to clients, there is a clear gap in the empirical research regarding how disclosing these aspects of their personal lives affects psychotherapists' professional identities. As such, the research question behind this study is: What influence does the disclosure of a therapist's personal life event within session have upon the therapist's professional identity?

The intended research would be useful to the general population of psychotherapists and especially to those who are in the midst of the disclosure of a personal life event or see the potential for one. This researcher's hope is that not only could this study be referenced by

clinicians when they encounter an unintentional self-disclosure, but also that this study could be

elaborated upon and turned into further research in the subject area.

CHAPTER II

Literature Review

Traditional Views on Clinician Self-disclosure

As the father of psychoanalysis, Freud is responsible for hypothesizing and developing numerous tenets upon which the current field of mental health is founded. While the theoreticians who succeeded Freud have altered the way his theories are to be utilized in practice and also developed theories of their own, it cannot be denied that tenets of this Freudian Classical Psychoanalysis still influence the mental health field today. Not least of these influential concepts is that of the therapist as a blank slate. Within Classical Psychoanalysis, the analyst is expected to remain rigidly neutral, or blank, so as to keep from influencing the analysand's thoughts and fantasies. Renik (1995) elucidates this expectation stating, "…we are directed by theory to subtract our personalities from the analytic situation as much as we can in order to leave our patients the blankest screen available upon which to project their fantasies" (A misleading ideal section, Para. 3). Goldstein, Miehls, and Ringel (2009) add, "In more traditional psychodynamic models, self-disclosure was rigorously avoided because of the belief that it violated the notion of therapist's neutrality and objectivity" (p. 45). In addition to the possibly deleterious effect a disclosure may have on the therapist's neutrality, traditional analysts also believe that personal responses or disclosures detract from the patient's experience (Maroda, 1999) and should, therefore, be avoided.

This apprehension about disclosure is compounded when disclosing causes the clinician to feel vulnerable. Garfield (1987) addresses the vulnerability that is an inherent part of disclosing personal reactions within session, "By sharing his personal reactions with the family, whether these be positive, negative or ambivalent, he risks exposing himself to their rejection or criticism" (Garfield, 1987, p. 60). Saakvitne (2002) further explains why this feeling of vulnerability is undesirable: "When our vulnerability is both perceived by our patients and experienced by us, often we feel deskilled and sometimes guilty or ashamed" (p. 444). Silverman (2007) reiterates this sentiment and notes that when the analyst feels vulnerable and ashamed she may dissociate those feelings of shame and locate them in the patient. If a clinician is not properly aware of his "fragile wounded places" (Silverman, 2007) and the way the revelation of these places to clients may influence his professional self, the therapeutic treatment can be deleteriously affected.

Saakvitne (2002) suggests that this negative influence on treatment stems from Freudian ideals: "Our unrealistic expectations for ourselves and each other about professional detachment and "neutrality" can create a barrier of shame that prevents the honest disclosure of the pain and anxiety of the work" (p. 446). When practitioners hold themselves to this unrealistic standard the human connection between clinician and client, the very basis for a strong therapeutic alliance, is compromised.

Relational Views on Clinician Self-disclosure

In Contemporary Psychoanalysis, Relational theorists have made the argument that it is not only unnecessary for the analyst to remain inscrutable, but also entirely impossible to do so (Maroda, 1999; Renik, 1995). Accordingly, Renik (1995) describes what develops when

analysts attempt to achieve the "blank slate" as a "pretense of anonymity" (Anonymity and Idealization of the Analyst section, Para. 1), which allows both patient and analyst to disavow the analyst's inherent subjectivity and also cultivates idealization of the analyst as authority. By closing their minds off to the possibility of an analyst's subjectivity, analyst and analysand alike are unable to recognize when that subjectivity may be influencing the treatment. Greenberg (1986) also argues that inscrutability or neutrality is not possible for clinicians. He explains that many clinicians adopt a stance of "inactivity," mistakenly believing that being inactive will lead to their impartiality but he argues that it is not possible for a therapist to truly be inactive: "…even if inactivity is possible politically, as the dictionary suggests, it is never possible interpersonally" (Greenberg, 1986, p. 137).

Though it runs counter to conventional theorists' disavowal of all clinician self-disclosure, Relational Theorists advocate for the judicious use of self-disclosure within therapy, recognizing that it can be beneficial and, in some instances, essential to the therapeutic work. Contemporary psychoanalytic relational theory emphasizes "the mutual interaction between client and clinician as two open and authentic human beings" (Goldstein, Miehls, & Ringel, 2009, p. 37) and, therefore, differs from traditional psychodynamic theories in that it calls for clinicians to actively and authentically participate in the therapy. This 'active participation' includes contributing one's subjectivity, personal thoughts, countertransference, interpretations, and emotions to the clinical discussion (Aron, 1992; Ehrenberg, 1995; Goldstein, Miehls, & Ringel, 2009; Maroda, 1999). Through disclosing these aspects of their personal selves, relational theorists posit that clinicians are better able to form strong therapeutic bonds with their clients, demystify the therapeutic process, and access data about their clients that would otherwise remain elusive (Ehrenberg, 1995; Goldstein, Miehls, & Ringel, 2009). In her paper

discussing countertransference disclosures, Ehrenberg (1999) notes that a clinician's willingness to disclose to a client can be an effective analytic tool that allows for exploration of a key part of the client-clinician relationship that may not otherwise be acknowledged or addressed.

Beyond noting the potential benefits of clinician self-disclosure, most relational theorists recognize that the alternative to disclosure—silence or refusal to respond—can be far more detrimental to the therapeutic work than actually disclosing something about oneself. Ferenczi (1933) noted that his patients observed a great deal about him and conjectured that to deny those observations would be to repeat a major trauma of childhood in which the parents deny disturbing aspects of what their children notice about what is going on around them. Along these same lines, Goldstein, Miehls and Ringel (2009) state that, "Therapists may retraumatize their clients by repeating previous experiences of rejection, invalidation, and emotional withdrawal by not responding to their clients' impressions and perceptions of them" (p. 45). Ehrenberg (1995) suggests that the notion that not answering a client's direct question is the 'safer' response is, in fact, a fallacy because not answering can reflect a form of enactment on the part of the clinician even if he or she is unaware of it being so. Rather than risk engaging in an enactment with the client or retraumatizing him or her through further rejection, relational theorists suggest the use of self-disclosure in an attuned fashion.

Anecdotal Descriptions of Specific Clinician Self-disclosures

Clinicians who attempt to remain neutral or inactive maintain the ideal of the "analyst as authority" (Renik, 1995) which reinforces the belief that analysts are somehow above, or better than, their patients and, therefore, less fallible. Given the expansive lives clinicians lead outside of the therapy room, it is incomprehensible to think that they too would not falter on occasion or

suffer many of the same hardships as their clients. Goldstein, Miehls, and Ringel (2009) note

this inevitability stating, "clinicians possess their own personal history, inner conflicts, and

opinions and bring these to their clinical practice" (p. 38). Most often these personal experiences

within clinician lives remain apart from their professional work, but in some cases this separation

is not possible. Clinicians and analysts alike have written accounts of major events within their

personal lives and the ways in which these events have influenced or interfered with their clinical

practice (Cole, 1980; Cullington-Roberts, 2004; Engels, 2001; Fuller, 1987; Gerson, 1996;

Henry, 2009; King & Botsford, 2009; LaPorte, Sweifach, & Linzer, 2010; Lewis & stokes, 1996;

Morrison, 1996; Pollak, 2000). Life events such as pregnancy, illness, and loss are the ones most

frequently portrayed, however, some clinicians (Silverman, 2007) write on less discrete subjects

such as the influence of a clinician's personal or familial history on their ability to treat particular

clients.

  Pregnancy as well as numerous illnesses cause dramatic physical changes to the person

experiencing them; as such, when clinicians become either pregnant or perceptibly ill their

personal condition becomes an unavoidable part of treatment. When a client witnesses a

physical change in his or her clinician due to one of these conditions, they quickly begin making

associations and assumptions on the basis of this information. Fenster, Phillips & Rapoport

(1986) postulate that a therapist's pregnancy is undeniable proof of her heterosexuality; though it

is no longer the case in our modern world that only heterosexual, married women become

pregnant, clients continue to make assumptions about the pregnant clinician's sexual orientation,

relationship status, as well as beliefs about family and parenting. Clients may hold positive or

negative associations with each of these assumptions, thus encouraging the development of

transference and altering the preexisting therapeutic relationship. Additionally, clients'

assumptions resulting from a clinician's pregnancy are often incorrect and can, accordingly, create a countertransferential dilemma for the clinician. Silverman (2001) describes such a dilemma that developed when she, a lesbian therapist, became pregnant and many of her clients took her pregnancy as an indication of heterosexuality. Silverman (2001) describes her internal struggle about whether or not to disclose her sexual orientation to clients; she explains that a sudden disclosure of her sexuality didn't seem appropriate, but not saying anything at all made her increasingly uneasy which, in turn, caused her affect to be inhibited. When Silverman was confronted with the inevitable disclosure of this personal life event, her professional identity was compromised due to her feelings of anxiety and vulnerability (p. 54). Silverman questioned if she could be an effective therapist even if her clients no longer identified with her or if they disapproved of her sexuality or her decision to become pregnant.

From Silverman's account it is clear that while much has been written about the influence a clinician's pregnancy has on clients, this life event also has a substantial effect on the clinician's own professional identity as a therapist. Gerson (1996) describes reacting more intensely to patients and being more susceptible to transferences, distortions and patients' reactions during her pregnancy. Cole (1980), citing Nadelson et al. (1974), writes about the need for therapists to recognize their own anxieties and increased vulnerability during pregnancy. When a woman becomes pregnant, it is not uncommon for her to feel suddenly aware of the innumerable dangers in the world that could harm her unborn child; upon this realization, the maternal instinct is to protect the baby above all else. For a therapist whose primary preoccupation has been the well being of her clients up to that point, it could be dysregulating to begin to perceive them as a threat against which she needs to protect her unborn baby. Cullington-Roberts (2004) explains that patients' hostility is greatly increased with the evidence

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of the therapist's pregnancy, perhaps because pregnancy is an indication that the client has been excluded from a sexual relationship with the clinician or because they wish to be the clinician's only, best baby. The therapist must be able to tolerate and explore the patients' verbal and symbolic attacks on her and her growing baby in order for the therapy to move forward.

An additional professional obstacle arises when a female therapist's pregnancy becomes complicated or results in miscarriage. In this instance, the clinician's anxiety about endangering her baby becomes a reality and could, accordingly, leave her feeling resentment or anger toward those clients who reacted with hostility to her pregnancy. "The therapist has to deal with her own response to the event, but also to countertransference issues specifically aroused by the patient. The therapeutic task is considerably complicated" (Cullington-Roberts, 2004, p. 101). Countertransferential responses regarding blame for the pregnancy complications are not the only issue that arises when a clinician's pregnancy becomes compromised, the therapist's newly undeniable weakness and vulnerability also drastically impact the therapeutic dynamic. Cullington-Roberts (2004), states that the realization of his or her therapist's vulnerability can be traumatic for the client. Gerson (1996) realized the influence upon treatment of her apparent vulnerability when she noticed that her patients attempted to go easy with her and not bother her with their most serious problems after her miscarriage.

In the wake of his wife's death, Morrison (1996) echoes this sentiment regarding the influence of his own vulnerability when he notes that his patients no longer had the freedom to pursue their own associations and inner processes but, instead, had to respond to the concerns regarding his external reality. McWilliams (2004) describes the response of her colleague Albert Shire who experienced a similar professional quandary when his wife was the tragic victim of a freak accident:

…in addition to dealing with his grief, he had to contend with clients who felt guilty

about taking up any of his emotional energy. Understandably, they wanted to take care

of him and not add to his pain, but their consequent inhibitions against talking about their

own problems were also functioning as a resistance to the therapy work. Eventually, he

said to those who were particularly tongue-tied, "Want to take care of me? Let me do my

job." (McWilliams, 2004, pp. 181)

The accounts of these two widowers illustrate how difficult it can be for grieving practitioners to

maintain their professional identity when their clients become aware of their personal tragedy.

Albert Shire's statement to his clients also exemplifies the way in which, for many clinicians,

returning to work is a necessary part of the healing process. Chasen (1996) describes in great

detail the resumption of sessions after her twelve-year-old son was killed; while she initially

questioned whether she had anything to give to her clients at that time, she ultimately found that

her work offered her an escape from "the horror of what [her] life had become" (p. 7). In the

wake of a tragedy, or any major life event, our perspective on the world and of ourselves shifts;

not surprisingly, the professional identity of clinical practitioners is not spared from this change.

Empirical Studies on Clinician Self-disclosure

While there is a wealth of anecdotal evidence regarding the influence clinicians' personal

experiences have on their professional identities and abilities, the subject has not been

extensively researched. Within the empirical studies that have been conducted (Audet & Everall,

2010; Burkard, Knox, Groen, Perez, & Hess, 2006; Carew, 2009; Jeffrey & Austin, 2007

Simone, McCarthy, & Skay, 1998; Wells, 1994), self-disclosure is almost exclusively defined as

the voluntary or intentional admission of information from the clinician to the client; rarely do

the studies account for disclosures of major life events that cannot be concealed from the client. Additionally, within these studies the question being researched is almost exclusively what effect clinician self-disclosure has upon clients rather than what effect it has upon the clinician's professional identity.

Summary

From the literature researched, it appears that a psychoanalytic relational theoretical perspective best supports the current study as this perspective recognizes that the clinician is an active participant in the therapy and is, as such, undoubtedly influenced by all that occurs in the room, including things that both the client and therapist may disclose. Within the above literature is evident that personal life events have a profound effect on the lives of psychotherapists and often, too, influence how they practice professionally. It is upon this finding that the current study is based; accordingly, this researcher's hypothesis is that psychotherapist's disclosure of personal life events within sessions influences their professional identities. From the literature alone, it is not clear whether this influence upon professional identity is positive, negative, or if it varies depending upon each individual situation. This study hopes to explore and shed some light on this question.

CHAPTER III

Methodology

The purpose of this study is to explore the topic of psychotherapist self-disclosure within session and the influence self-disclosure has upon psychotherapists themselves. More specifically, the study will examine the relationship between psychotherapists' in-session disclosures of personal life events and their professional identity. Within this study, "personal life events" are defined as choices psychotherapists make and occurrences that take place within the psychotherapists' lives outside of their office. Examples of "personal life events" include: marriage, divorce, pregnancy, illnesses that can be physically perceived, and deaths of loved ones. The disclosures may be either intentional, such as when a psychotherapist explains the reason for an unexpected absence, or unintentional, as would be the case with pregnancy or other visible physical changes. "Professional identity" is defined within this study as the psychotherapist's conception of psychotherapists in general as well as his or her own professional sense of self, his or her sense of belonging to the clinical community, and his or her confidence in his or her ability to practice clinically.

Much of the current research and literature focuses on the influence psychotherapists' self-disclosures have upon the clients or the therapeutic relationship between psychotherapist and client. To this author's knowledge, there are few, if any, documented studies focusing on the impact self-disclosures have upon psychotherapists in general or, more specifically, upon their professional identity.

Research Type, Method, and Design

This study is qualitative, cross-sectional and exploratory in nature. This researcher used qualitative methods to conduct in-person interviews with research participants. This method is most conducive to researching this subject because it is open-ended, flexible and more subject-oriented than other methods. In an interview, the participants are not constrained by particular questions or multiple-choice answers, as they would be with a quantitative survey, thus, allowing a richer narrative to unfold. Also, by holding individual interviews I maintained the phenomenological concentration as the focus was on the clinician's subjective experience and was not colored by his or her reaction to others' experiences as it may be in a focus group.

The interviews within this study were conducted using a standardized, open-ended interviewing style. An interview guide of twelve open-ended questions (see Appendix C) pertaining to the psychotherapist's thoughts about and experiences of self-disclosure as well as their professional identity formed the foundation for each interview. Additionally, nine demographic questions, including questions regarding the participant's professional background and current clinical setting, were asked at the start of each interview. The data collected from this set of questions allowed the researcher to make observations and connections between the participants' background experience and the themes that emerged across interviews. The interviews were held in the participants' personal offices or a location of their choice; they lasted between 30 and 60 minutes.

Interviews were documented through the use of a recording device as well as through interviewer notes and observations. The recording data was then transcribed onto a secure word processing program for the purpose of analysis.

Data Analysis

Interviews were transcribed completely for the purposes of accuracy and to minimize potential interviewer bias. Upon transcription, the researcher assigned each interview response a code name so as to maintain the confidentiality of the participants' identities.

Once transcribed, the interviews were coded using an "open coding" format (Rubin & Babbie, 2010) to highlight areas of potential significance and recurring themes. Through this inductive approach, it became clear that disclosing a personal life event within therapy had three primary impacts: upon the therapeutic relationship between clinician and client, upon the clinician personally, and upon the clinician professionally. Data from the interviews was then categorized accordingly under these three thematic headings and then further subcategorized as more nuanced themes began to emerge. The findings from this data analysis will be addressed more extensively in the following chapter.

Characteristics of Participants

This researcher relied on purposive, snowball sampling to recruit participants for this study. Clinicians in this researcher's professional network were contacted via email and encouraged to participate if they had been in practice for at least two years and had disclosed, either intentionally or unintentionally, a personal life event to an adult client in therapy. If the clinicians did not meet eligibility criteria or were not interested in participating, they were encouraged to forward the recruitment email to colleagues who may be.

Initially, this researcher received affirmative responses from 18 clinicians; of those 18, 12 returned the informed consent forms and agreed to be interviewed. The ultimate sample size of 12 included eight licensed clinical social workers (LCSW), three advanced practice registered nurses (APRN), and one licensed professional counselor (LPC) who also held a certification as a

registered art therapist. Participants practiced in an array of settings including hospital-based

outpatient clinics, private offices, and agencies that provide community-based or in-home

psychotherapy. The participants had been in practice from three years to 40 years and carried

caseloads of varying sizes: from eight to 150 clients. Participants ranged in age from 28 to 69.

All of the participants identified themselves as Caucasian and only two out of the twenty

identified as male while the remaining 10 identified as female.

Limitations of the Study

This study was limited by the temporal, financial and logistical confines resulting from

the researcher's Master of Social Work program. Ideally, this study would have taken place over

a period of time longer than the nine months allotted by the program thereby allowing the

researcher to recruit and interview more participants. Additionally, had this researcher had

additional time and financial resources it would have been possible to interview clinicians from

various locations within the country; as it was, the participants within this study were all

recruited from states along the East Coast that were within driving distance from this

researcher's Connecticut home. Additionally, to expedite the recruitment process, emails were

initially only sent to individuals within this researcher's professional network; accordingly, many

of the participants knew the researcher, at least peripherally, which may have influenced their

willingness to participate and disclose information about themselves honestly within the

interviews.

In addition to being small and geographically limited, the sample size was limited in that

it was not representative of the entire population of clinicians. All of the participants identified

as Caucasian though according to a 2004 study of licensed social workers in the United States,

the percentage of Caucasian social workers was slightly lower at 86% (Center for Workforce Studies, 2004). Additionally, the ages of the participants within this study were not representative of the age distribution among the general population of social workers according to the same 2004 study. In the general population of social workers, only 5% are over the age of 65 (Center for Workforce Studies, 2004) but in this study 33% of participants reported being 65 or older. Additionally, the largest percentage of social workers (33%) falls between the ages of 45 and 54 (Center for Workforce Studies, 2004), but within this study only one participant (8% of the total participants) fell within that bracket.

Finally, this study was limited in that participants were encouraged to describe any personal life event that they had disclosed during their clinical practice so there was not a preponderance of any one type of disclosure. In future studies of this topic, it would be preferable to interview a larger sample of people within each type of disclosure (pregnancy, illness, death in the family etc.) and compare the data results across types of disclosures to determine if the type of disclosure influences the effect it has upon clinicians.

Ethical Considerations

Ethical concerns specific to this study include issues of confidentiality, risk of distress to participants and potential biases of both the interviewer and the participants.

Within the general issue of confidentiality there was concern for the confidentiality of participants' identities as well as the identities of the clients about whom they talked during the interviews. To ensure the identities of participants remained known only to the interviewer, only the informed consent forms noted their full names—in all other documentation they were assigned a code name. At the outset of each interview, participants were encouraged to disguise

any identifying information about the clients they described so as to maintain the anonymity of the clients as best as possible.

In addition to keeping their identities confidential, other efforts were made to protect participants from any undue distress as a result of their participation. This researcher submitted a proposal to the Smith College School for Social Work Human Subjects Review Board (See Appendix A for letter of approval) to ensure that the study met all federal regulations and expectations for research with individuals. Additionally, each participant signed and agreed to an informed consent form (See Appendix B) outlining the potential risks and benefits of participation and the voluntary nature of participation.

The final ethical consideration of potential interviewer and participant biases was not as easily addressed as the former issues. As mentioned earlier in the "Limitations of the Study" section, the researcher knew many of the participants in some capacity; accordingly, both the researcher and the participants may have engaged in the interview process with some form of bias due to the prior relationship with or knowledge of the other person. Participants were encouraged to speak freely with this researcher and were assured that their identities would be known only to the researcher and not shared with other colleagues or peers, but this, presumably, did not eliminate all potential bias on either side.

CHAPTER IV

Findings

Overview of the Study

The purpose of this study was to examine the potential influence disclosing a major personal life event to a client within session has upon a psychotherapist's professional identity; accordingly, the psychotherapists interviewed were asked to describe the disclosure of a particular personal life event and then were asked questions about their professional sense of self and feeling of "belonging" within the professional community. Additionally, the participants were asked about their beliefs and perceptions of general psychotherapist self-disclosure apart from the particular instance that they described.

Within this chapter the reader will first find a review of the demographics of the study sample as well as a summary of the responses regarding general clinician self-disclosure followed by a summary of the types of particular life events that participants disclosed. From there the reader will find an analysis of the collected data, organized thematically according to influence. The main findings of this study were that disclosing a personal life event to a client within therapy influences the psychotherapist's professional identity, the way in which the psychotherapist experiences the life event personally, and the client-therapist dynamic/relationship. Given that the original purpose of this study was to explore the influence of the disclosure upon the psychotherapist's professional identity, the findings within this area will be presented first. Though it should be noted that the findings pertaining to the influence upon the clinician's personal experience of the life event and the client-therapist relationship

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were more salient even though these areas of research were not explicitly set forth at the

inception of the study. Finally, this researcher will briefly present findings regarding the

evolution of participants' perspective on and use of clinician self-disclosure within therapy.

Sample Demographics

In addition to the demographic data about the participants of this study presented within

the Methodology chapter, a summary of their educational backgrounds and theoretical

orientations is of note as these characteristics may influence the responses that participants gave

within the interviews.

As noted in Methodology, the majority of the participants within this study were trained

as Clinical Social Workers (8 out of the 12 total); of the 8 social workers, 6 were

psychodynamically trained while 2 received more generalist training. 2 of the 6

psychodynamically trained social workers also received specialized post-Masters training in

psychoanalysis from an Institute for Psychoanalysis. Of the remaining 4 participants who did

not identify as social workers, 3 were Advanced Practice Registered Nurses (APRN) and the last

was a Licensed Professional Counselor with a specialization in art therapy.

Nearly all of the clinicians interviewed (10 out of 12) practiced in an outpatient setting

though 7 of them worked within a hospital or nonprofit setting while the other three were in

private practice. Of the two clinicians who were not based in an outpatient setting, one worked

at a residential in-patient program within a hospital and the other a supportive housing agency

providing therapy to clients within their homes.

Though it was specified in the eligibility criteria that participants must have experienced

disclosing something about their personal life to an adult client, only 7 of the participants

exclusively worked with adults. The remaining 5 participants provided therapy to both children

and adults; these participants were encouraged to describe their experience of disclosing to their

adult clients within the interview but did occasionally mention the responses of their child clients

too.

General Views on Clinician Self-Disclosure

The responses from participants regarding their general thoughts on clinician self-

disclosure ranged from strong advocacy for its use within clinical work: "I think that self-

disclosure in many ways is a positive thing and I think far preferable to the blank screen refusal

to disclose any personal information that has been part of the tradition" to strong opposition: "I

lean more toward the non-disclosure in thinking that it's better not to disclose than to disclose."

Overall, there were four main themes that emerged within the conversation about general self-

disclosure: Self-disclosure is *inevitable,* self-disclosure *enhances the therapeutic relationship*

and the clinical work, self-disclosure *humanizes the therapist,* and self-disclosure should only be

used if it will *benefit the client*.

Inevitable.

Multiple participants remarked on the inevitability of clinician self-disclosure saying

things such as, "I try to limit it, although sometimes I feel that it's inevitable." One participant in

particular shared that she had learned over the years that she was constantly disclosing things

about herself just by coming to work and going about her regular activities:

The reality is that you're disclosing all the time. You know? I mean when you, someone,

when you're driving in to work if someone sees you driving they see what car you're

driving or they see how you're dressed or they see you on your cell phone or they see an

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expression on your face and there's so many kinds of self-disclosure that aren't this

intentional.

Recognizing that though all clinicians disclose things about themselves unintentionally, one

participant noted that self-disclosure is especially inevitable in the milieu setting where she

worked:

I think there's always self-disclosure whether you are intending to self-disclose or not,

there's always sort of an element of self-disclosure. [It's especially true] in the milieu

because in the milieu it's a different way of being, it's a different way of working with

people…like I go down to get my lunch out of the refrigerator and there's my client who

just had a Cognitive Processing Therapy session getting their lunch out of the fridge

[too], and so it's like oh ok, I'm having tuna fish.

Enhances the therapeutic relationship and clinical work.

Of the participants who endorsed the benefits of the use of clinician self-disclosure within

the clinical work, most reasoned that it could enhance the therapy or the therapeutic relationship

between client and therapist in some way. One participant stated of self-disclosure, "It's very

discriminate and it's based on serving some useful purpose for the advancement of the

psychotherapy." Another participant recognized that she could best advance the psychotherapy

by sharing some of her own experiences, "I think that it's positive to be able to use my pain as a

tool to help the patients move forward and understand their own issues, their own pain."

A number of other participants endorsed a strong therapeutic relationship as the primary

factor that determines the success of therapy and proposed that clinician self-disclosures can

enhance the development of that relationship. One participant stated of self-disclosure, "I think

it contributes to the close and trusting connection between therapist and patient" while another

postulated, "For a lot of them, we're the only normal relationship, healthy relationship they have, so I think a lot of times too it's healthy for them to know that we too struggle and that we persevere."

Humanizes the therapist.

Underlying all of the reflections from participants about the potential of self-disclosure to enrich the therapeutic relationship was a sense that disclosing things about one self leads the client to see the therapist in a more realistic light—as a whole human being rather than just a therapist. One participant conveyed the significance of being seen as a whole person while working with the severely mentally ill population when she stated,

> It was very important for me to just be a person as well as a therapist, I mean of course we are people, but that was an important piece for [this population]; in addition to being a therapist to them I needed to be a person and so I would, just without lots of detail, would just talk about the process [of adopting a child].

The ability of self-disclosure to humanize a therapist was captured by one participant when she described an exchange between herself and a client,

> "I can't believe it," he goes, "I thought you had all the answers, I didn't think all of you had problems, I don't understand." He just couldn't get his head around the fact that therapists could be struggling too and I said we're human beings, it's the human experience. You know, we're not perfect.

Exposing their own imperfections seems to be one way that therapists are able to become real and knowable to their clients, traits that one participant feels are fundamental in a successful therapist:

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Therapy provides in some way, often a completely new experience for people who have

been used to being disparaged or un-listened to, or unheard and I think part of giving that

experience is that they are in the presence of another real person who understands them

or seeks to understand them, means well by them. I think that the little bits of self-

revelation can further that, certainly, but the wall that's put up by traditional practice can

sort of damage that.

Additionally, another participant noted that exposure to the challenges that therapists too

experience can develop greater compassion and concern for others within clients:

I feel that the commonality between us as human beings is underscored through this

unguarded, honest approach…This occurred for me as I began to welcome myself into

the human race: each one of us possessing an element of human frailty. I share this view

with clients always…seeing each of us in our own personal challenge develops

compassion, heightened understanding, genuine concern, and caring.

With the intention of being as 'real' as possible so as to generate trust between the therapist and

client, one participant described the transparent way in which he responds to clients'

observations of him,

[Therapy] can sort of generate a whole new set of neurological circuits that have to do

with experiencing trust and a kind of openness and relationship that can be attuned and so

if people ask me, say, "you look really tired tonight" I'll say "I am a little tired" if I am.

Finally, one participant candidly summarized the advantage of using self-disclosure to humanize

the therapist when she stated, "it's positive for [clients] to see you as a human being with all the

messiness that goes along with being a human being."

Benefit the client.

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In presenting their thoughts regarding self-disclosure in general, nearly all participants touched upon the necessity of using it judiciously and ensuring it is being done to benefit the client: "[Self-disclosure is] sometimes necessary and beneficial…as long as the client remains the center of the work, like as long as the disclosure is done in a thoughtful way with the client's needs in mind." For one participant, determining the "usefulness" for a client served as the litmus test for whether or not she would disclose something at all,

If the thought is coming to my mind about saying something about myself, usually, what I'm thinking about is whether this would be useful or not and if it's something that I think [might] help the client to know that I perhaps have been through a similar experience, then I go ahead and share it. So I don't necessarily always share those things, but it just depends on whether I think it's going to be helpful.

Similarly, another participant implied that clinicians ought to be thoughtful and judicious in their use of self-disclosure when she noted, "I think, working relationally [self-disclosure] can be an incredible tool, um, but it sort of requires a pretty high level, I think, of insight and awareness and thought and reflection as well." In describing their concerns about using self-disclosure indiscriminately, many participants referred to colleagues or other clinicians who they knew or who they had witnessed disclose things about themselves constantly to the detriment of the therapy. In cautioning against this sort of indiscreet use of disclosure, one participant stated:

I think one has to be careful and monitor one's own use of it, make sure it isn't being used for some sort of subtle self-aggrandizement or isn't shaking off into advice giving or "use me as an example" sort of thing. And isn't something that is likely to touch some deep difficulty or sorrow in the person and in a sense making them feel not heard or recognized.

Participants' Personal Life Events

Within this study participants were asked to describe an instance in which they disclosed, either intentionally or unintentionally, a personal life event to a client to whom they were working therapeutically. Participants were not given suggestions of what may constitute a "personal life event" unless they requested clarification. The descriptions of personal life events that participants shared were wide-ranging and rich but the most-often addressed issues were those of *pregnancy*, *medical issues*, *marriage and divorce*, and *death of family members*.

Pregnancy.

Five of the 12 participants detailed the experience of being pregnant while still providing psychotherapy to their clients. For all of them there was mention of the unavoidable nature of that sort of disclosure: "Because I worked up until the end, people were able to tell that I was pregnant," "You know this kind of disclosure was something new for me because it was something that I couldn't hide, it was very much a part of me. I brought it everywhere I went." Many of these participants also discussed trying to maintain their clinical boundaries while also managing societal expectations of pregnancy,

> …When you think about pregnancy in the world, it's kind of like everybody gets really
> excited; I had neighbors that I'd never met before dropping off packages at my door so of
> course my clients are going to be interested in it and want to talk about it and culturally
> it's really normal for people to reach out and touch you or you know [ask], "is it a boy or
> a girl?" "When's your due date?" all [those] kind of things. So then how do you set those
> limits with your clients?

Another couple of participants described having been pregnant and miscarried or delivered a stillbirth and discussed how their grief then impacted their roles as clinicians.

Medical issues.

A few participants shared what it had been like for them to endure a physical illness or medical issue while continuing to practice. Two of the participants had been diagnosed with cancer and had to take medical leaves of absence in order to have the tumors removed but each individual participant handled disclosing this information to their clients very differently. One participant explained that he allowed the clients to choose how much information they would like to know about his leave of absence:

> I had a, what turned out to be a fairly minor cancer operation 12 years ago, or no, 11. And uh, I was going to be out for recuperation, I was going to have to be out for about 6 weeks and so I said to people that I was going to be out for a health reason and if they wanted to know any further details that I would tell them and some said, "no I don't need to know" and some said "yeah I'd like to know" so I told them I had just the very earliest beginnings of a prostate tumor and was going to have surgery and recuperate for a number of weeks.

The other participant who also shared her experience of having cancer took a much different approach with her clients, letting them come to their own conclusions about why she would be out:

> And it was interesting, I had told them that I would be gone for two months to have surgery, they did not ask one question and, in fact, in thinking about it, during the time I was preparing them about my leaving and coming back, they made assumptions about what kind of surgery I was going to have. It was kind of talk amongst themselves or in

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between the lines about what I was having; it was not even close! I mean what I was

having was so unusual that I don't think people would think that. So I kind of just let it go

and let them think whatever they thought.

A third participant described her experience of developing back trouble after conducting sessions

in a chair that was not ergonomically correct:

I developed back trouble and I just was like really uncomfortable and in pain sitting…so

in my process of seeing different doctors and chiropractors and physical therapists and all

that, I was consulting about what can I do and they all said you have to get a different

chair…so then I had a succession of kind of buying the chair I thought would help and

then it didn't work and then I had to buy another one and finally on the third try I got the

right chair after a lot of research so that was unavoidable because my clients who come in

[would] say, "oh you got a new chair!" and then a month later "oh, you got another new

chair! What's going on there?"…So yeah, I think most people ended up knowing that I

was having back trouble because of all the musical chairs.

Marriage and divorce.

The cultural expectation in the United States is that women wear engagement rings upon

getting engaged and both women and men wear wedding bands once married; as described by a

number of participants, these ring additions were noticeable by clients and thus, became the type

of personal life event they couldn't help but disclose. Participants described their experience of

adding rings to their fingers, "[with the] engagement ring people could tell that I was engaged,"

"I got married and added a wedding band to the engagement ring I had been wearing the whole

time I was working" and "the only other time in my life where I've worn something that was a

disclosure was a wedding ring and that's a choice that I've made." A number of other

participants described the intentional disclosure of marital status as a result of questions from clients:

> A lot of the parents would always ask like, "oh are you married, do you have kids" things like that, so you know I initially started [with a] very clear line on not sharing anything and trying to put the question back to them but that seemed to put them off a little bit so I tried opening up a little bit more and saying, "yes, I am married, yes, I do have kids" that sort of thing.

Upon divorce, individuals may remove their wedding rings thus spurring an unavoidable disclosure, but for the one participant who described her experience of disclosing divorce to a client, the disclosure was much more her own doing even though she did not intend for it to happen:

> With one [client], I don't remember the context of what we were talking about but he said something about you know, "you need a man to shovel your sidewalk"…and I said, "I don't have one" and it just came out because I was newly divorced and it just came out of my mouth and I was like "Ohh! I wish I hadn't said that!" So then he goes, "What?" and I just said, "oh, I'm newly divorced...just a couple of weeks ago."

Death of family members.

A couple of participants disclosed information about the deaths of their loved ones to clients with whom they were working clinically; in describing these disclosure experiences, both participants noted that they were generally more intentional about telling clients this information as a way to foster connection and a sense of understanding:

> My mother passed away last year so when somebody is sharing their loss sometimes I'll say, "this is what happened to me and my mother lived to be 98 ½" and, you know, I'll

share things like that. Like how I cope, what helped me: I went to a recovery group and a

support group which really helped me a lot and that would be something they could think

about [doing too].

The situation I've disclosed more often than other themes has to do with my father's

death and I have had, it's kind of interesting, over the years, I've had probably four or

five clients whose fathers also died when the client was a child…after a while [I] decided

that I would share that I too had lost a parent.

However, one of the participants experienced the death of her mother during the time that she

was in clinical practice and due to the raw, emotional nature of the experience she struggled to

keep the event separate from her clinical work:

Oh, I was grieving so that was on my mind so I probably told everybody, you know,

everybody heard it. To the point that I had to go to a support group, I needed to talk it

out in a support group. It wasn't helpful to talk about it here, or to patients about it

Influence of Disclosure Upon Clinicians' Professional Identity

Within this study, "professional identity" was defined as the psychotherapist's conception

of psychotherapists in general as well as his or her own professional sense of self, his or her

sense of belonging to the clinical community, and his or her confidence in his or her ability to

practice clinically. When responding to the questions regarding the influence the disclosure had

upon their professional identities, participants mostly indicated that the disclosure influenced

their confidence in their clinical abilities either positively or negatively. Additionally,

participants noted that the disclosure had some affect on their sense of belonging to the

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professional community. Within this section the responses will be subdivided into three sections

to illustrate the ways in which the disclosure experiences influenced the clinicians' overall

professional identities: *Decreased Confidence in Clinical Abilities*, *Increased Confidence in

Clinical Abilities*, and *Sense of Belonging to Professional Community*.

Decreased confidence in clinical abilities.

Experiencing and disclosing a personal life event, as a therapist appears to have caused

many participants within this study to question their clinical capabilities. For many of the

participants who expressed losing confidence in their clinical abilities after the disclosure of a

personal life event, it was not so much the disclosure that caused them to waver but the actual

experience of enduring the life event itself and the aftermath caused by the event while

simultaneously trying to balance their clinical duties. For instance, a number of participants

reflected on the internal struggle they had about having to take time off from work as a result of

their personal life event: In response to needing to take a medical leave of absence one

participant stated,

> I am an overachiever worker, I'm always there, I don't cancel, I don't let people go for 8
>
> weeks without having an idea of when the next appointment is, so it did make me much
>
> more vulnerable…[and brought up] an incredible amount of guilt.

Similarly, another participant reflected on how she felt her maternity leave might have negatively

affected her clients:

> I was also on leave for three months and how did that affect my clients? I had one kid
>
> who said, you know I don't think it really affected him, he was really surprised when I
>
> said "I only have two weeks left' he said "wow that went by so fast! I thought it would
>
> take another year or something" and while I was gone he started not going to school and

really kind of fell off of things and I said well what happened? And he said, "I felt

abandoned." And so, what did my pregnancy mean to my clients, because when else do

you leave your clients for three months? You don't.

Beyond taking leaves of absence, a couple of participants remarked that enduring their life event

while continuing to provide therapy made them feel ineffective as a clinician because it directed

their focus away from the client exclusively. In reference to providing therapy while grieving

the loss of her mother one participant stated,

Even the first time I came back, I had to do an interview with somebody for the first

[time] and it was so hard to even listen to it. You're so absorbed in your own

[thing]…How am I gonna help somebody else when I'm not listening myself?

For this same reason, another participant shared that she worried that she "couldn't be a

professional and a mother or pregnant at the same time" because she feared, "I wouldn't be able

to focus on, you know, their needs…my focus would not be on them completely."

Upon disclosing personal life events some participants began to lose confidence in their

clinical abilities because they questioned if self-disclosing to a client was a professional thing to

do. One participant described how she would chastise herself after disclosing that she felt

exhausted because her child had been up all night, "I can see myself saying that and then saying

like, "oh my gosh really? Does a therapist really say that? Is that too personal?" Another

participant turned to her colleagues for advice when she was unsure if she was maintaining

professionalism, "I actually talked about it with you know some of my colleagues you know

cause I wanted to make sure that I was you know maintaining professional boundaries and doing

the right thing for the patient." A third participant who was caring for her ailing mother and

would receive calls from the home-health aides while in session shared the professional concerns she had from this inevitable disclosure,

> I became aware of the time spent discussing my personal life in sessions and became first, self-conscious, second, apprehensive that the patient would hold back to not over-burden me, and third, unsure as to the means of pulling back once the topic was open.

Increased confidence in clinical abilities.

Many participants in this study conveyed an increased confidence in their clinical abilities due to the self-disclosures they made within their clinical work, "I became more relaxed, more true to myself, and more sure that I was helpful as a therapist by being the whole person I am." For a number of the participants, it seemed that working from a relational framework was essential to their work; the self-disclosures they made reinforced the relational quality of the therapy. In regard to the way in which self-disclosures improved the clinical relationship, two participants stated the following:

> Well I think oftentimes [making self-disclosures] sort of confirmed my sense of their rightness in the context of what I was just talking about, that I think therapy, the relationship in therapy is important and it should be one where the person feels a trust, helps to develop a sense of trust that they will be heard and not judged and not devaluated. And I think that the uh, the little, not an all the time thing, but the willingness to disclose things about myself, I can feel that it doesn't damage things that often. I think it increases the sense that this is another real human being and relating to.

> Um, I felt like they were able to connect with me a little bit better because I wasn't just a worker, I was a person and there was a, I think it developed a little bit of the relationship

with me…. And even with like the sharing like the parenting and the marriage stuff, I think it gave them the sense that like this guy knows what he's talking about a little bit as opposed to like he's read a book and is now coming to tell us what to do.

For some participants, it seemed that living through their own personal life events increased their clinical confidence in that they then felt better able to relate to their clients' experiences. One participant reflected on her increased confidence in working with parents after she became a mother herself,

> having my own child and understanding that time outs [don't] work for everybody and this doesn't work for everyone and it's not easy and…it's challenging…[I have a] better understanding of what's, um, I feel like I can relate [to clients] going through this.

Another participant used her personal experience of taking antidepressant medication to help reassure a patient:

> I had one patient, we were doing med reconciliation and he said he was feeling down about him self because he's on these meds and he goes, "Do you take medication?" And for a second, I was like, I wanted to say, "Well, why are you asking that?" but it just would've not been healthy for him. And I said, "Actually I do take Bupropion" I said, "You know it helps me, gives me motivation, helps me concentrate." He said, "Ok, thanks for telling me that." For a split second I almost said, "why are you asking that? Why is that important to you?" Yeah, but I knew the answer! I knew why it was important to him. So uh, well I didn't know the answer, but I was making an assumption there…it would've really shut things down if I said that.

A recently married clinician shared that she felt disclosing her marital status gave her more credibility as a clinician:

> I do think being seen as married person by my client was somehow positive for me…I think because I realized I wasn't just a novice anymore. I had arrived, personally and professionally…saying I'm married carries some weight with clients. Maybe they see me as more of a grown-up when they learn that, not just another young social worker new to the field.

In another vein, one participant explained that experiencing the inevitable disclosure of pregnancy increased her confidence in her clinical skills because it served as another learning experience:

> I really thought about it a lot as sort of both a personal kind of challenge and a professional kind of challenge, um because it's there and it's inevitable and it's going to happen and we're going to have to deal with it. And so there's like a dread that comes with doing things with doing things that are uncomfortable but it was also kind of challenging in a good way because it just made the work I think that much more interesting to have something else to think about, how is this influencing the therapy or our relationship. Um so its kind of it was a challenge in that way. But you know if you're into the clinical work and you like being a therapist you get excited about that shit. You know? So it's not, it doesn't always feel good and it's not always, you know, but it's like in that dorky kind of way, like you know what I mean. I want to be a better therapist and so this is kind of a new challenge.

Sense of belonging to professional community.

Within the interview participants were asked if they felt like they belonged to the professional community of their discipline; nearly all participants answered affirmatively. When asked if the experience of self-disclosing to a client influenced their sense of belonging, most participants answered that it did not, but a few did describe the way it affected their feeling within or relation to the community. A couple of participants described the negative response they received from their colleagues when they disclosed their pregnancies: "It was more as if they, like they were like, "oh she's going to be gone, let's take advantage" like, use me as much as they can now until I get back," "We say "I'm pregnant" and it's like "oh shit, we're going to be without a staff for three months and when they come back they're probably not going to be the same" and it's true, you're not."

A couple of other participants described the way in which their disclosure experiences helped them to give back to the professional community by supporting others in similar positions: "It's something I use when I supervise, when I teach, I mean I think in consulting with other colleagues, that have like their own angst about maternity [I use my experience]," "there's somebody that's pregnant [within our community] and I made a point to try to reach out to her because I don't know that it's something that's talked about or always supported here."

Influence of Disclosure Upon Clinicians Personally

A theme that emerged repeatedly throughout the interviews within this study was that disclosing a personal life event to clients affected the way in which the clinician experienced that event him or herself. For some participants, disclosing seemed to enhance their experience of the event, "I mean I felt proud [to tell them] because I was proud and excited [to be pregnant]" but for the majority of participants, the act of disclosing seemed to detract from or negatively

influence their experience of the event. The participants who described their experiences of being pregnant while continuing to practice clinically explained the various ways that having clients be aware of this life event detracted from their experience of it:

> I got really tired of it. I felt like being pregnant for me physically, I was always very aware, especially the bigger that I got, of just the fact that I was pregnant everywhere I went people were acknowledging it so it felt like it was really just all-encompassing so by the end I was really tired of it.

> I did not want to give too much information, so I was very conscious of how I was replying, for example I wouldn't show pictures or wouldn't give [my daughter's] name or anything like that. So it would be like, "how far are you along" "oh I'm not sure yet." I wouldn't give specifics.

> I did, however, worry that my [pregnancy] could lead to complications for clients who either had been unable to conceive or who had experienced the death of their own child. I was also working with children, many of whom had losses regarding mothering, so I was again concerned that a child patient could feel hurt or jealous or resentful of my impending motherhood and the child I would take better care of.

One participant was pregnant at the same time as a client of hers and knew that they would be giving birth around the same time at the same hospital; she described the way in which this knowledge upset her immediately following her son's birth:

> My son actually had to go into the NICU briefly and so he was taken away, I was rolled in there to see him and I'm looking around and there are all these babies in incubators

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and I'm like "oh shit, what if she's in here, this is not the time to see my client" I could

not be a therapist having just given birth. And that was the time where, you know after

holding my baby for about a minute, that was the time for me to make that initial bond

and so, honestly, I was pissed off that I was having to deal with that. Because that was

my time and this was my life event, not hers, and I didn't want her to get in the way.

This same participant went on to explain that her client's baby ultimately died which, in turn,

influenced the way the participant related to the client clinically:

it was really hard to figure out you know what are my limits what are my boundaries

around this? How do I be supportive and at the same time not really hurt myself? And I

also was feeling, you know, what does it mean that I had a child that didn't die and my

kid's ok?...the fact that we had gone through this process in the same time is what made it

feel very close to home. I really, I had to set a limit and say, "I can't hear the details" to

my co-workers. I wasn't working as kind of a one-on-one with this person, it was just in

the group format so I kept it with the group but I didn't want to do anything outside of

there. I didn't go to the hospital to visit the baby, I really you know, I decided that I

would send a card or something but that was it.

A participant who had cancer while in clinical practice endured a similar experience

when one of her clients was in the hospital room next to her; she describes the way in which this

impacted her personal experience of recovering from surgery:

This person knew I was having surgery but not in the room next door. So I didn't come

out of my room. I actually stayed in my room until that person was discharged. I was

supposed to do walks, you know you're supposed to walk after surgery and I basically,

me and my nurses walked in circles around my room because I wouldn't leave the room!

Hahaha! Walking around with a johnny coat and a urine bag and an IV was just not going

to be something my clients were going to see!

This same participant shared that having to disclose her medical condition to her clients caused

her to have to deal with some aspects of the diagnosis that she was not yet prepared to address:

Well it was very difficult because first of all I had to deal with the fact that I had to leave,

myself, which I was in total denial about so that was hard. And thinking about that I was

telling people things that may have them ask questions that I wasn't ready to answer

myself. Um, so thinking about how to deal with this major life event for myself and then

having to take care of my clients and thinking about how they're going to respond to it.

Not wanting them to know the details of why I was leaving yet feeling that they had to

have something to hold onto.

In a similar fashion, another participant explained that disclosing about her father's death to

clients caused her to have to readdress parts of her experience of that event:

Sometimes it was, you know I had to reprocess my emotions once again. Sometimes I

would tear up in talking about the effects on me of my father's death and how I found out

or how I felt… So, yeah, there was that. There was the interpersonal thing and there was

also what was going on within me, "yes, this is one more time I need to process these

feelings."

Influence of Disclosure Upon Clinician-Client Dyad

In discussing the experience of disclosing a personal life event while within their clinical

role, most participants mentioned some sort of effect that the disclosure had on the clinician-

client dyad or the therapeutic relationship between themselves and their clients. The main themes that emerged within this topic were that there was a bit of a *role-reversal* as the power structure shifted and clients became concerned about and care giving toward the therapist, often the disclosure would lead to a *loosening of boundaries*, and on a few occasions the disclosure had a negative influence that led to a *rupture* within the therapeutic relationship.

Role-reversal: Client as caregiver.

Numerous participants described instances in which their clients became concerned about them once they learned about what the clinician was experiencing within their own life and then they detailed the way in which that concern manifested as a sort of role-reversal within the relationship. Participants who had been pregnant around clients described how many clients became more protective of them: A clinician who provided therapy in clients' homes stated, "I think some maybe [became] even more protective, [especially] in some neighborhoods." Another participant described a client's response to her pregnancy, "[I had] this mom who was a caregiver to everybody and so what did it mean that I was pregnant? She tried to become my caregiver." A third participant described an instance in which a client's concern for her due to her pregnancy became overwhelmingly distracting during a group session:

> …Working with the veterans with PTSD there was like a little bit of protectiveness, I remember one day doing a group and I was up at the board and I had boots with heels on and one of the guys was like, "no, no, no, hold on, stop, just stop talking, you're gonna fall. See you're standing right next to the edge of the board and it's sticking out and you have heels on, I can't think of anything else other than like you like falling right now. Could you please stay still?"

This same participant described her reaction to the client's increased protectiveness:

I'm a very sort of independent personal like I like to like carry my groceries and make the

bags as heavy as possible. I do things on my own I'm not like a frail little thing. So you

know…whether it was a veteran being extra protective or my husband being extra

protective, I don't particularly like that.

Conversely, a participant who disclosed his cancer diagnosis to clients thought it was beneficial

for his clients to show concern toward him:

I think that was upsetting to a few people who worried a lot about me, but I'm not sure

that it was bad that they worried about me. And it gave them a chance to be sort of caring

to me in exchange rather than feeling separated off, that I didn't want any concern from

them…I thought one of the effects of that was that it did evoke some sort of caring

responses from them and often people have told me that they like to be able to return the

favor in a sense of doing something caring.

Another participant saw the benefit in the role-reversal between clinician and client when he

became physically ill in front of a client and witnessed his client's unexpected caring response:

I almost fainted and he was, a kind of rough guy, he could be very angry, I mean I knew

there was a bond between him and me but he became this sort of protective, almost

nurse-like person…it showed me a side of him that I really had never experienced and

deepened my sense of his complexity. He was just very kind and I think he enjoyed

being able to have that role in relation to me.

Loosening of boundaries.

Throughout the interviews, a number of participants reflected on the way that self-

disclosing to clients within therapy caused the boundaries between therapist and client to loosen

as the clients felt that they could take more liberties with the therapist as a result of knowing

something about his or her personal life. This seemed to be most true in the instances where clinicians disclosed their pregnancies to clients; upon the disclosure, clients began probing into other aspects of the therapist's pregnancy: "One gave me a present, one um, asked if it was a boy or a girl, the gender…"

> I also made the decision not to say whether I was having a boy or a girl and that turned into a guessing game with some of my clients. They were like "well you're carrying this way so I think it's this or that" in retrospect, I think I might have just said, "It's a boy." And leave it at that. So, it was sort of a way for the clients to engage even further into the discussion instead of just having a limit or answering the question and being done with it.

Another participant noted that once clients became aware of her pregnancy more questions flowed forth on a regular basis as her child was growing up, "Of course, a major part of my life was open for clients' questions, as the topic of my baby and all that goes with being a new mother was a boundary already erased." Often, the responses clients had to the clinicians' pregnancy caused the clinician to feel uncomfortable:

> I could have a session with [a client] and they'd sort of finish and be on their way out and would always say goodbye to me and to like my baby, like my stomach. Like "ok bye, you too little one" you know, so I mean, then there's sort of like this sort of self-disclosure around my discomfort with that which you know how do you kind of respond to that and say, you know, like, like, "please don't do that."

Another participant shared that her clients' constant appraisal of her physical appearance while she was pregnant caused her to feel uncomfortable:

He, on occasion, would touch my stomach and he said that my belly was shaped weird.

So that made me kind of like "is my belly shaped weird?" It felt, I don't want to use the

word creepy, but it was. I did not want him touching me.

Conversely, one participant reflected on the generosity that resulted as her clients became less restrictive with her:

I really felt they were just, "Oh! You're having a baby! I knew you were pregnant."

They seemed excited for me and they actually gave me what looked like a re-gift of

something that they had but for them, I thought it was very thoughtful and they had very

limited means so it was a lot for them to do that.

A final example of how the awareness of the clinician's pregnancy altered the clinical work as a result of loosened boundaries came from a therapist at a Veteran's Administration Hospital:

[the pregnancy] became a lot of the focus of our therapy because he was sort of having

fantasies around how maternal I was as my stomach was getting bigger and that we were

going to, uh, we were going to move to Maine together where I could work at the VA up

there and he could um, have a job in forestry or something like that. You know so like, in

some ways, it like had to enter the therapy.

Rupture.

Though most of the disclosures of clinicians' personal life events seemed to result in positive outcomes, or at least challenged the therapy to move in a new direction, some participants described instances where a disclosure resulted in rupture between the client and clinician. Continuing with the theme of questions and assumptions resulting from the knowledge of a clinician's pregnancy, one participant explained how a client responded to her disclosure regarding the gender of her baby:

There was this one woman who was upset with me for finding out if it was a boy or a girl. I was kind of confused as if, "Did I do something wrong?" I had a feeling she thought I did the amnio and then that's what made her upset because she refused to do that [herself] because it might hurt the baby.

Another participant who had been working with a client who outwardly expressed romantic feelings for her and longing toward her throughout their work together described the negative response elicited by seeing her wearing a wedding band:

In the middle of the time we were working together, I got married and added a wedding band to the engagement ring I had been wearing the whole time I was working with this client. He never mentioned it, until the third to last session before termination (which was determined by the year-long duration of the program). He said, mid-sentence, "You're married?" I said yes, and he asked for how long. I told him it had been married earlier in the year. He said, "I didn't realize. I thought you were just engaged. If I had known…I never would talk to a married woman how I have…" I tried to get him to elaborate, but he pretty much shut down on that topic. That disclosure burst his fantasy of me and I think that he was ashamed of his behavior once he thought of it in the context of reality. He shied away from talking about it in our remaining sessions…. It changed how he saw me. I went from being a fantasy woman to a real woman, with a life in which he at most a peripheral figure, not the central one. I think the disclosure made him feel that his behavior had been inappropriate. He was someone who valued marriage a lot, actually, and I don't think he liked thinking of himself as a man who'd hit on a married woman for months on end!

One participant shared an example in which he told a client in psychoanalysis about his daughter, a disclosure that was very off-putting to the client:

> She told me I think in maybe the second or third session about her two sons of whom she was very proud and she showed me pictures of them and oh I said "well let me show you a picture of my daughter" and that really went against the grain with her because she was expecting a therapist oriented toward a much more bounded analysis. And I think it was a little silly and premature because I didn't really know enough about her to have a sense that that kind of sharing of parenthood experiences wouldn't be a good thing and I didn't really experience her really negative association. And she brought that up not infrequently as something that made her question my seriousness.

In providing her perspective on why ruptures occur when some clients learn about their clinician's personal life, one participant shared something that a client had said to her:

> "I just need you to be my therapist" and she used this kind of gesture, she said, "I need you to be my therapist and not a person, so I don't want to see you as someone driving a car, I don't want to know what kind of car you have or I don't want you to become personal to me like that. I just want you to be someone I can come and talk to and I can say anything I want but I don't want to know about you." And she didn't say it in a hostile way; it was just somehow that's what she needed [me] to be.

Evolution of Use of Clinician Self-Disclosure

"It's sort of evolving; it's always been evolving" said one participant of her view of clinician self-disclosure within therapy. This is one example of a sentiment that came up repeatedly throughout the interviews within this study: experiencing the disclosure of personal

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life events within therapy caused clinicians' views on the use of self-disclosure to evolve. One

participant explained how her experience of being pregnant created a shift in her view of

clinician self-disclosure:

> I think it also, um, having the experience of having been pregnant and doing the work, it
>
> changed the way I think about self-disclosure and changed sort of, I don't want to say my
>
> boundaries around it, but I think sort of the frequency or the, or just my feelings about it I
>
> guess…. Um I think I was much more sort of guarded and restrictive in terms of um self-
>
> disclosing around sort of personal details, I mean we're always disclosing like our
>
> feelings or thoughts or expressions or things like that but I think around sort of talking in
>
> a more personal way, after having gone through my first pregnancy and maternity leave,
>
> coming back, um, I think I definitely started to feel sort of less restrictive around it, and
>
> feel like a little bit more ease, I think, in disclosing… I didn't used to have picture of my
>
> family on my desk, actually I still don't, but I was very sort of guarded in terms of what I
>
> would share and that really changed a lot.

Similarly, disclosure experiences increased another participant's willingness to share information

about herself and caused her to become a more relational therapist:

> I now think of myself as much more of a self-psychological and relational
>
> psychotherapist than I would have said ten years ago…Well, it's hard to know which is
>
> the chicken and which is the egg. Disclosing like that, certainly over the years has made
>
> me feel like a much more interpersonal, relational therapist than I started out being; you
>
> know with the more traditional training that I had had.

Along the same lines, another participant explained that his experiences self-disclosing caused

him to question some of the Classical Freudian training he had received that discouraged any sort

of clinician self-disclosure:

> I remember reading some classical psychoanalytic text from the 40s or 30s by a Freudian
>
> who said that therapy is really a simulated relationship, that you sort of go through the
>
> motions and you discover things about the person through that. It's not really beyond the
>
> office doors, and uh, I don't engage myself except in some occasions with people outside
>
> the office door, but I want it to be a real relationship, a kind of friendship—a therapeutic
>
> friendship. And that, I think, goes along with my sense that it's not, not a terrible thing
>
> that they know something about me. Or that I have a willingness to be open and engaged
>
> with them and not sort of shut the door on them.

In contrast to this, some participants shared that their experiences self-disclosing only reiterated

their sense that self-disclosure was not necessary or useful within the clinical work. One

participant stated that being pregnant actually caused her to become more restrictive in her future

use self-disclosure:

> Having gone through a major life event, where self-disclosure [was inevitable], it was
>
> such a part of me I couldn't hide it, I felt like I really stepped back to day one in many
>
> ways I had to reevaluate my boundaries and what I was willing to say or not say. So it
>
> kind of threw me for a curve.

The participant who chose not to disclose the reason behind her medical leave of absence felt

reassured in the rightness of her decision to share only the minimum necessary:

> I learned a whole lot because I didn't give the specifics about why I left and it has
>
> influenced [my beliefs toward self-disclosure] because I realize that the clients didn't

need to know why I had left. You know, I gave them an anchor of saying I was having

surgery but they didn't need to know the specifics. I really struggled with that: how

much should they know or not know and they really, they didn't need to know much.

They needed to know that I was ok and that I was kind of taking care of things and I think

they needed to have a little bit like I think that telling them "surgery" was ok, but they

didn't need to know more. So I did learn that you don't have to give the whole story.

Both this participant and another explained that, though they often shared similar experiences

with their clients, they did not feel the need to disclose this to the clients:

I have had moments, a lot of moments where I've shared a personal experience with the

veterans and very consciously chosen not to say anything. You know I lost my mom

when I was in my early 20s and I've had a lot of veterans who have dealt with parents

dying and mommy issues and all that kind of stuff and grief and bereavement is one of

the major themes that veterans come in to treatment with, but there's not been one time

where I've, I mean I've felt very connected in terms of like bereavement struggles and

healing and all that and I've had moments where I've wanted to sort of offer, but I

haven't. You know and so I feel like do I have an increased awareness about it, I realize

it happens more, but I also feel like sort of my, um, I don't know, like an intact sense of

you know, I'm not just like oh yeah I talk about my kids so I talk about everything. You

know I think there's still discretion.

CHAPTER V

Discussion

Introduction

This study addressed clinicians' experiences of disclosing personal life events to clients within therapy with the expectation that such experiences would have an influence upon the clinicians' professional identity. Given that the formative training many psychotherapists receive is built upon the foundation of classical Freudian theory in which the analyst is encouraged to remain completely neutral and "blank," it was this researcher's expectation that it may be difficult for clinicians' to maintain confidence in their professional abilities when an aspect of their personal life enters the therapeutic space. Through interviews with psychotherapists who had experienced the disclosure of a personal life event within their therapeutic work it became clear that these experiences did, in fact, have a significant influence upon the clinicians. Additionally, these interviews confirmed that, while clinician self-disclosures can be difficult to navigate and anxiety provoking, they can also be extremely beneficial to the client, the clinician, and the therapeutic work in general. Essentially, the main finding of this study was that, for psychotherapists, the personal could also be professional.

Within this chapter this author will briefly summarize the main results of the study's interviews and will then provide an analysis of the findings through a relational lens, which will help to illustrate how disclosing personal life events still maintains the professional integrity of the therapist. From there, this author will provide a discussion of the study's strengths and

limitations as well as implications this study may have upon social work practice, policy and future research.

Summary of Findings

Perspectives on self-disclosure.

This study researched clinicians' perspectives on their own self-disclosure to clients and the ways in which the experience of disclosing influenced them both personally and professionally; accordingly, in summarizing the findings of this study it is necessary to first present the participants' general views on clinician self-disclosure. As noted in the Findings chapter, there were 4 themes that emerged through the discussion of clinicians' thoughts and beliefs about their own self-disclosure: self-disclosure is inevitable, self-disclosure enhances the therapeutic relationship and clinical work, self-disclosure humanizes the therapist, and self-disclosure benefits the client. The connection between these findings and relational theory will be discussed later in this chapter.

Additionally, a recurring theme throughout the interviews was that clinicians' views of self-disclosure had evolved throughout their years in practice. Generally, the participants conveyed that early in their careers they held the belief that they should not disclose anything personal to their clients, but as time wore on and they began to make some personal disclosures (generally inevitable in nature at first) the participants indicated that they recognized a marked shift in their rigidity upon seeing the utility of self-disclosure.

Specific personal life events.

To be eligible for this study, participants must have experienced at least one disclosure of a personal life event within their therapeutic work. Of the personal life events that they

described, most fell within one of the following 4 categories: pregnancy, medical issues, marriage and divorce, and death and bereavement. These personal life events align with those that other clinicians have written about in prior anecdotal essays (Chasen, 1996; Cole, 1980; Cullington-Roberts, 2004; Engels, 2001; Fuller, 1987; Gerson, 1996; Henry, 2009; McWilliams, 2004; Morrison, 1996; Pollak, 2000; Silverman, 2001).

A secondary line of investigation within this study pertained to the difference between unavoidable disclosures of personal life events and voluntary disclosures that may not otherwise arise without the clinician's intentional presentation. As can be seen by the summary of the life events that participants described disclosing within this study, the overwhelming majority of disclosure experiences were inevitable. For instance, in the cases of both pregnancy and medical issues, often an observable physical change takes place within the clinicians making their disclosure of the life event to their clients inescapable. Similarly, for the clinicians who described the experience of disclosing a change in their marital status, most indicated that the disclosure was prompted by the visible addition or removal of a wedding ring on their left ring fingers. From these findings, it would seem that when a clinician feels as though he or she has less control over the disclosure it is a more memorable and fraught experience than when they voluntarily disclose something to a client. Saakvitne (2002) provides a potential explanation for this when she explains that clinicians often feel deskilled when they feel that their vulnerability is perceived by their clients; it seems likely that inevitable disclosures lead clinicians to feel vulnerable with their clients and, therefore, less confident in their clinical abilities.

In a similar vein, there seemed to be a difference in how the participants reflected on the disclosures of positive events versus more stereotypically negative events. The participants who experienced pregnancy, an event that is generally celebrated within our society, during their

clinical work described their disclosures as joyful occasions in which their clients shared in

congratulating them. Conversely, for the clinicians who had to disclose a more negative

experience such as being diagnosed with a medical condition or losing a loved one, there was a

greater sense of apprehension and anxiety about how the knowledge of their impaired well being

would be received by the client. Again, this distinction in the clinicians' responses to disclosing

positive and negative experiences can likely be accounted for by the increased feeling of

vulnerability that accompanies the negative experiences.

Influence of specific disclosures.

Though the explicit focus of this study was on the way in which self-disclosing a

personal life event to a client influences the clinician's professional identity, through the

interviews it became clear that the disclosure experiences also had a profound impact on the

clinicians personally and on the client-clinician dyad. A thorough examination of the influence

the disclosures had in each of these areas can be found within the Findings chapter of this study.

In general, the effects of disclosing varied from positive to negative but, overwhelmingly, the

clinicians were able to find some benefit in the experience of disclosing even if the initial effect

seemed to be negative.

Findings Through the Lens of Relational Theory

Relational theory rests upon the premise that we are born oriented to and seeking

interaction with others (Hadley, 2008); further, relational theory posits that the individual cannot

be known apart from his or her relationships with others: "The person is comprehensible only

within the tapestry of relationships, past and present" (Mitchell, 1988, p. 3). As such, relational

theorists recognize that the clinician cannot subtract his or her own subjectivity from the

therapeutic equation. From a relational perspective, the clinician and the client mutually

influence one another and together co-construct what emerges within the space between the two

(Hadley, 2008). Clinician self-disclosure is, understandably, perceived very differently under

this theoretical orientation than it is from the classical Freudian stance: within relational theory

clinician self-disclosure is considered not only inevitable (Renik, 1995) but highly beneficial

when used judiciously and in an attuned fashion (Goldstein, Miehls, and Ringel, 2009). As such,

utilizing a relational frame allows one to recognize clinicians' disclosure of personal life events

to clients as wholly professional and aligned with the expectations of their clinical discipline.

This section outlines three of the most prominent aspects of relational theory—the *two-person model*, the *relational matrix* of social and cultural identities, and the recognition of and

reflection upon relational moments and patterns between client and clinician as a means to create

meaningful *therapeutic change*—and utilizes these theoretical cornerstones as a means to

analyze the data collected from this study's interviews.

Two-person model.

Relational theory presents a "two-person" approach to clinical work in which the

therapist and client's subjectivities are understood to influence each other (Hadley, 2008). This

"inherently dyadic" therapeutic situation relies on the development of a relationship between the

client and therapist in order for therapeutic action to take place (Hadley, 2008). In forming this

relationship, relational theorists recognize that it is essential for clinicians to play an active role

in the therapeutic interaction in a way that is authentic, honest, and spontaneous (Goldstein,

Miehls, and Ringel, 2009). One way in which clinicians can actively participate in the therapy in

an authentic way is to self-disclose as clinically indicated.

Within this study's interviews, data emerged that indicated that disclosing personal life events allows clinicians to be more authentic and, therefore, enhances the therapeutic relationship. A number of the participants reflected that they believed their self-disclosures helped them to be seen by their clients as more "real" people and that this sort of authenticity fostered the positive therapeutic relationship. A couple of participants gave specific examples of instances in which they disclosed a difficult aspect of their lives to a client and were met by an incredulous response from the client who found it hard to believe that therapists too struggle and experience hardships. Relational theorists attempt to move away from this idealization of the clinician, promoting instead a "mutual but asymmetrical" (Aron, 1992, p. 483) relationship between client and clinician. One participant who was trained in traditional psychoanalysis but felt more aligned with a relational, self-psychological way of working with clients stated that it is his goal to create a "real relationship, a kind of friendship, a therapeutic friendship" with his clients; for that reason, this participant stated that he did not feel it was a "terrible thing that [clients] know something about me." It would not be possible to imagine developing a friendship or relationship with a peer in general society without sharing anything about oneself; by the same token, it would seem that a real therapeutic relationship cannot develop without a willingness on the clinician's part to share with the client. Further, a couple of participants remarked that they felt that refusal to disclose any personal information was especially problematic because it reiterated the same mistreatment and rejection that patients may have experienced through earlier relationships with others. Of this point one participant remarked,

> …Therapy provides in some way often a completely new experience for people who have
> been used to being disparaged or un-listened to or unheard. I think part of giving that

experience is that they are in the presence of another real person who understands them or seeks to understand them, means well by them.

In creating these "completely new" experiences for clients, participants indicated that they are aiming to correct any negative or traumatic interactional experiences from the client's past and create a new, healthy relational experience. It would seem that this goal could only be accomplished when the therapist is genuinely open to sharing parts of him or herself with the client.

Relational matrix.

Another central component of relational theory is the understanding that, in addition to relationships with others, the larger social and cultural milieus in which individuals are located greatly influence their personal development as well as what they bring to the therapeutic interaction (Hadley, 2008). Mitchell (1988) referred to this concept in combination with the notion of the self being able to exist only through interaction with others as the "relational matrix." Hadley (2008) applies the term "relational matrix" to the clinical encounter stating, "the complexity of a 'relational matrix' with all the issues of gender, race, class, age, ethnicity, culture, and the health care system are present in the room" (p. 224). In considering this postulation, Silverman (2007) asks herself, "How is my history in the room with me when I am with my patients? How do I use that history to inform and expand my thinking?" (p. 288). Clinician self-disclosure is also relevant in light of the relational concept of the "relational matrix" as it allows the clinician to shed light on some of his or her social and cultural identities that address the ways that his or her history may influence the therapy.

Within this study participants described numerous instances in which they disclosed something regarding one of their social or cultural identities that then, in turn, influenced the

therapy. The majority of the clients who disclosed something regarding a social or cultural identity expressed doing so with the intention of bridging a gap between client and clinician or creating some sort of connection through their shared experiences. For instance, a number of the participants who worked with families and children disclosed their own parental status to clients as a way to convey their shared experience and understanding of parenting. Other examples of this sort of disclosure that participants provided were the shared experience of losing a parent, the shared experience of coping with physical illness and the shared experience of taking psychotropic medication for mental illness.

Of course, not all disclosures of a clinician's social or cultural location were done with the express purpose of creating connection with the client; often participants explained that they felt they had to disclose a point of difference between themselves and the client so as to address something that may be hindering or simply influencing the therapy. One participant explained the uncomfortable situation of having to tell a client who had been exhibiting erotic transference toward her that she had recently become married; for this clinician it was important to disclose this point of departure from her unmarried client so that they could both address the potential issues that this new identity of the clinician's may cause within the therapeutic relationship. Similarly, Silverman (2001) writes on the experience of acknowledging her homosexuality with heterosexual clients during her pregnancy. Silverman describes the struggles she had with this disclosure, explaining that when deciding whether to disclose she felt like she was hiding a significant part of herself in not correcting her clients' assumptions about her heterosexuality. This was especially problematic for Silverman because as she notes, "If the therapist is hiding, her affect will be inhibited, causing distance between herself and her patient and limiting the depth of the work" (Silverman, 2001, p. 47). For relational psychotherapists like Silverman, it is

necessary to be honest and genuine with clients so as to maintain the full potential of the clinical work. Silverman (2001) goes on to note that the formation of "close and meaningful relationships" (p. 60) was more possible with an exploration and recognition of both the similarities and differences between the social and cultural locations of client and clinician than with a denial of them.

Therapeutic change.

As with all analytic and clinical theories, the ultimate goal is to create significant and lasting change for the client; this is also true of relational theory, in which the change is seen to take place through a sort of relational remodeling within the therapeutic encounter. By creating a new, genuine relationship with clients, clinicians are able to witness and experience the clients' relational patterns and gain insight about the clients' internal experiences and relations with others (Hadley, 2008). In this regard, a key part of relational practice is being aware of enactments that occur within the therapeutic exchange because it is through these enactments that the "clinician and patient find themselves engaged in relational dynamics that repeat certain familiar patterns from the patient's past" (Hadley, 2008, p. 216). Goldstein, Miehls and Ringel (2009) say of enactments, "It is advisable for clinicians to identify enactments as they are occurring, extricate themselves from being the "old" object, and, in so doing, provide the client with a "new" kind of object or relational experience" (p.142). Clinician self-disclosure often spurs enactments and offers the clinician a new way of seeing the client's interactional pattern.

A number of participants within this study shared anecdotes of enactments that took place upon their disclosure of a personal life event. One of the most salient examples came from a clinician who was pregnant while working in an all-Veteran population: she noted that all of her clients became more caring and concerned about her than they had been in the past but one took

a particular interest in her well-being and began treating her as he might his own wife. When the therapist addressed this change in the client's way of relating to her, the client disclosed an erotic transference that he had been experiencing and was able to connect the fantasies he was having about the clinician to his painful history with women in the past. The disclosure of the clinician's pregnancy may have been inevitable in this instance, but had it not become a part of the therapy the client's transference and personal relationship history may never have emerged. In another instance, a clinician's offer to give a client who had come to the session on foot a ride back to her home incited an angry outburst; this enactment allowed the clinician and client to both analyze the client's need to remain in control and self-sufficient.

Another way that relational theory encourages clinicians to create therapeutic change is through assisting clients in their affective development, which includes their abilities for affect regulation and mentalization. Maroda (1999) posits that clinicians need to express their own emotions to patients in order to facilitate their affective development; in this regard, the disclosure of clinician feelings and emotional responses can be therapeutic for the client. Maroda (1999) explains that in expressing their own emotions openly and honestly with clients, clinicians may be able to compensate for early deficits in the client's ability to "know, feel, name, express, and manage" (p. 123) both basic and more differentiated affects. Aron (1992) has likened the analyst to the parent in a child's development; if this is so, the analyst must display healthy expression of emotion and affect regulation for the client to mirror in his or her outside life.

Goldstein, Miehls, and Ringel (2009) define mentalization as, "the individual's ability to recognize and reflect on his or her own thoughts and feelings, to distinguish inner states from outer reality, to develop empathy and understanding for others, and to become skillful at social

interactions " (p. 102). Of this concept, they note that the therapists' disclosures can help clients improve their interpersonal relationships by allowing them to better understand and empathize with the clinician after learning something about him or her (Goldstein, Miehls, & Ringel, 2009). A participant who disclosed his diagnosis of cancer to his patients noted the truth in this hypothesis when he saw that many of his patients displayed worry, concern, and caring about him upon the disclosure; the therapist stated that many of the clients had before been somewhat "separated off" but that this disclosure increased their ability for an empathic response to him.

One final point regarding the utility of clinician self-disclosure in increasing the likelihood of therapeutic transformation comes from Aron (1992) who likens the analyst's disclosure to, what Winnicott termed, "transitional objects." Knowing a piece of the clinician's personal or internal life can further the clinical work for a client because it allows them to maintain an internal representation of the clinician outside of the office. Aron (1992) explains, "The [analyst's] interpretation may not be useful because it provides new information, but rather because it represents a link with the analyst. The interpretation can be carried around and sucked on when the analyst is away" (p. 485).

Strengths and Limitations

This study was mostly limited by the size and composition of the sample. Due to time and travel constraints, it was not possible for this researcher to access participants far from her own geographic location in the Northeast. Additionally, as recruitment was completed through snowball sampling beginning with former colleagues and acquaintances of this researcher, many of the participants knew this researcher in some capacity; it is possible that knowing this researcher from another context may have influenced the participants' responses. Additionally,

the professional characteristics of the final sample were somewhat different than what this researcher had initially intended and indicated within the eligibility criteria. For instance, within the eligibility criteria, this researcher had not included Advanced Practice Registered Nurses (APRN) within the purview of professions that would be accepted, but once a recruitment email was forwarded to a number of them and a few began expressing interest in participating, this researcher consulted with the study's adviser and determined that APRNs could participate as long as they provided clinical psychotherapy in the same way as the participants of other disciplines. Though this was not originally part of this researcher's plan for the study, it was ultimately very worthwhile to have received responses from a range of disciplines. In the future this author would be interested in researching a larger sample size of clinicians from diverse clinical backgrounds and contrasting their responses alongside one another to determine if the type of clinical training influences the clinician's views on the subject of self-disclosure and professional identity.

Another limitation of the study was that there was not a question about participants' theoretical orientations within the interview guide. At the outset of this study it was not clear that the data would be analyzed through a relational theoretical lens so it did not seem pertinent to ask participants about their theoretical leaning. Now, however, theoretical orientation seems particularly salient; this researcher wonders if the data would have been interpreted differently had the theoretical orientation of each participant been explicitly stated. Perhaps another area of future study could be comparing the responses of clinicians of varying theoretical backgrounds to ascertain if theoretical training alters a clinician's perspective on self-disclosures.

Though the sample could have been improved in various ways, it should not be overlooked that the data sourced from the participants within this study was very rich and

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complex. More clinicians than could be interviewed expressed an interest in participating in this study indicating that this topic is one that psychotherapists are interested in and willing to discuss. Additionally, of the clinicians that did participate, all provided extensive, detailed and fascinating accounts of their own experiences with self-disclosure; though most of the life events could be grouped into one of 4 categories (pregnancy, medical issues, marriage/divorce, and death and bereavement) there were actually a total of 11 unique life events described by the therapists. From this study it is clear that clinicians have a lot to say on the subject of their own self-disclosures; this is promising as the topic has been under-researched to date.

Implications for Social Work Practice, Policy and Research

This study applies to the social work discipline in a variety of ways. Firstly, as seen within the relational research and the interviews, clinician self-disclosures are an inevitable part of practice; as such, most clinical social workers will experience the disclosure of a personal life event at some point within their career. Accordingly, social workers who are in the midst of a personal life event disclosure and potentially feeling unsure of the effect it may have upon their professional identity, may review this study and the responses of the participants within it to reassure themselves that their peers have been in similar situations and to see that personal disclosures can still be professional. Additionally, this postulation, that the personal can be professional, may have implications for social work education in the future. Though social work training programs are increasingly departing from emphasizing classical Freudian theory, they could still benefit from greater relationally oriented discussions about the clinician's role as a therapist and within the client-clinician dyad. Additionally, further discussions, lectures, and

workshops specifically focused on the topic of clinician self-disclosure may help training social workers to better navigate those experiences when they arise within their future practices.

As has been noted earlier in this chapter, the paucity of empirical research on the subject of clinician self-disclosure and the effects of it upon the clinician leaves room for future studies in this subject area. As was evidenced by the numerous clinicians who expressed interest in participating in this study, the subject of clinician self-disclosure is one that clinicians in general and social workers in particular find particularly scintillating and are willing to discuss at length. Judging from this study alone, it seems that an appropriate future study would be on exploring more in depth the specific types of life events that clinicians disclose and analyzing how each type of event influenced their professional identity. For example, it would be of interest to determine if disclosures pertaining to pregnancy versus those around medical issues have a notably different influence on clinicians' professional identity. Further, within this study it became clear that feelings of vulnerability played a large part in how clinicians viewed and responded to their own disclosures; as such, future research could address the topic of clinician vulnerability and look at how it effects their professional identity and practice.

Conclusion

Clinician self-disclosure is a topic that has not been extensively researched; of the studies that have been completed, most have focused on the influence of the disclosures upon the client or the therapeutic alliance as opposed to upon the clinician him or her self. This study aimed to investigate the potential relationship between disclosing personal life events to clients and psychotherapists' professional identity. Within the interviews conducted through this study, clinicians shared numerous instances in which they disclosed a personal life event within their

practice. The personal life events described included experiences of clinician pregnancy, medical issues, marriage and divorce, and loss of loved ones. The interviewed clinicians then shared how the disclosure of these personal life events influenced them either personally or professionally. The resulting data was organized thematically for the purpose of analysis.

Throughout the interviews it became clear that clinicians were influenced by the disclosure of their personal life event in a number of ways; the main themes that emerged were that the disclosures had an effect on the clinician's professional identity, the way in which he or she personally experienced the event, and the client-therapist dynamic or relationship. In each of these categories the psychotherapists described both positive and negative effects of their disclosure experience. Overwhelmingly, though, the interviewed clinicians did not describe the disclosures as a detriment to their clinical work but rather as a benefit or an opportunity for something new to emerge within the work.

Applying a few of the main tenets of relational theory to the responses from participants allowed the researcher to demonstrate the utility of clinician self-disclosure from this theoretical perspective. Within relational theory, psychotherapists are encouraged to be authentic and spontaneous—a clear deviation from the traditional psychoanalytic model—accordingly, self-disclosures are conceptualized as a means for clinicians to connect with their clients and convey their genuine personhood. From this theoretical frame it is clear that clinician self-disclosure is not something that should be avoided or portrayed as un-therapeutic as traditionally psychoanalytic clinicians may have originally been taught; instead, self-disclosure used judiciously can be as much of a valuable clinical tool as anything else.

A great deal of life takes place beyond a psychotherapist's office doors; given the intimate and, sometimes, long-lasting nature of their work with clients in therapy, it is inevitable

that there may be some overlap between a psychotherapist's personal and professional life. The research completed within this study demonstrates that these parts of a psychotherapist's life need not be in competition with one another; with judicious use of self-disclosure and a willingness to work relationally, the personal and the professional can coexist in harmony.

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Appendix A

Human Subjects Review Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

January 11, 2013

Alana DiPesa

Dear Alana,

You have done a nice and complete job in responding to all the Committee's concerns and requests. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

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

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

In addition, these requirements may also be applicable:

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

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

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

Happy New Year and good luck with your study!

Sincerely,

Marsha K. Pruett /Pha

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Joan Lesser, Research Advisor

Appendix B

Informed Consent

Dear Participant,

My name is Alana DiPesa, and I am a graduate student at Smith College School for Social Work. I am conducting research for my Masters thesis, which explores psychotherapists' experiences of disclosing their personal life events to clients in therapy and the way these disclosures influence the psychotherapists' professional identity.

To participate you must be a psychotherapist who has experienced the disclosure of a personal life event such as those described above with an adult client, be currently practicing with a Master's degree, or Doctorate degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Clinical Psychology and have been practicing for at least two years since earning your degree.

This study will be conducted through an interview that should last no longer than forty-five minutes. You will be asked 9 demographic questions (such as gender and professional discipline) and then will respond to a series of interview questions pertaining to the disclosure and the influence it had on you.

Because the interview will include reflections on your own experiences with personal disclosures, some of which may have been painful or upsetting, there is a moderate risk that participation in the study could cause negative emotions to arise. Possible benefits from participating in the study include experiencing participation as informative, having the opportunity to reflect upon your practice, and knowing that your responses could be contributing to the development of knowledge regarding disclosures in clinical work. Unfortunately, no monetary or material compensation for your participation can be provided.

Confidentiality will be maintained throughout this study. Your identity and any identifying information about you will be known only to me and will be kept confidential throughout the course of this study. I will be the only person to view initial data at which point I will de-identify it before making it available to my research advisor, and the volunteer analyst who will assist with coding the interviews. The volunteer analyst will sign a confidentiality pledge prior to receiving any data gathered from the study.

When material from this study is used for future presentation and possible publication, the data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised. All data (including notes, tapes of interviews, transcripts etc.) will be kept in a secure location for a period of three years as required by Federal guidelines; should the researcher need the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed. All electronic data will be stored on a password-protected computer. Also, in the interest of confidentiality, you are asked not to provide any names or identifying information about clients in any of your responses.

Participation in this study is voluntary. You may withdraw from the study at any time during the data collection process and you may refuse to answer any question during the interview. If you choose to withdraw after the interview has been completed, all materials pertaining to you will be immediately destroyed. If you wish to withdraw from the study, you must do so before April 1, 2013. Please contact the researcher at [redacted] should you have any additional questions or if you wish to withdraw.

If you have any concerns about your rights or about any aspect of the study, you should contact the researcher at [redacted]. For further questions or concerns regarding your rights, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE 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.

Signature_____Date_____

Researcher Signature_____Date_____

*Please keep the attached copy of this Informed Consent Letter for your records

Appendix C

Interview Guide

Demographic questions:
1. Under which discipline do you practice? (*Must hold at least a Master's degree in: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Clinical Psychology*)
2. How long have you been in clinical practice?
3. What degree, certification and/or licenses do you hold within your discipline?
4. How would you define your gender?
5. What is your age?
6. How do you define racially/ethnically?
7. In what setting do you practice psychotherapy (i.e. outpatient, hospital, agency etc.)?
8. What is the population that you most often serve within your practice?
9. What is the typical size of your caseload?

Interview questions:
1. What are your thoughts or beliefs about clinician self-disclosure within therapy?
2. Please describe any instances in which you experienced the disclosure of a personal life event within your clinical work.
3. What prompted the disclosures?
4. Describe what you felt or thought upon the disclosure.
5. What was your client's reaction or response to the disclosure to be?
6. In what ways did the disclosure influence the way in which you practiced clinically with the particular client and in general with all clients
7. Did the disclosure of the personal life event influence your view of yourself professionally?
8. Do you feel that you belong to the professional community of your discipline (i.e. the clinical social work community, clinical psychologist community etc.)
9. Did this disclosure experience influence your sense of belonging?
10. Have you ever had a disclosure experience which you felt positively influenced your professional identity? If so, why do you think it was beneficial?
11. Have you ever had a disclosure experience which you felt negatively influenced your professional identity? If so, why do you think it was detrimental?
12. Is there anything else you want to mention about this topic of disclosure and professional identity?