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**Do clinicians perceive a connection between their personal and professional habits of self-disclosure? : a study exploring self-disclosure on social networking sites and in therapy**

Marie H. Desloge  
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Marie Desloge  
Do Clinicians Perceive a Connection  
between their Personal and  
Professional Habits of Self-  
Disclosure? A Study Exploring Self-  
Disclosure on Social Networking  
Sites and in Therapy

## **ABSTRACT**

This qualitative, exploratory study used an interview method to understand if clinicians believed there was any connection between their online self-disclosure on social networking sites (SNS) and offline self-disclosure with clients. Twelve clinicians were asked a myriad of questions to address the perceptions of their disclosures in each arena and any potential relationship between their comfort and frequency to self-disclose online and in therapy. Using a relational theory lens to understand therapeutic self-disclosure, this research adds a new component to current clinical literature on the topic by comparing it to self-disclosure on social networking sites like Facebook. As a whole, clinicians in the study did not perceive a connection between their personal use of social networking sites and how often they self-disclosed with clients. Half the participants believed that their comfort to disclose in both places was related based on being limited and cautious with disclosures while the other half did not see the two categories as related. No one in this study indicated that increased comfort or frequency to self-disclose online led to increased self-disclosures with clients. These results suggest that clinicians perceive online SNS self-disclosure in a different light than therapeutic self-disclosure and that they can engage in online social networking habits and professional roles simultaneously without blurring therapeutic boundaries. Participant demographics are addressed and discussion is offered in terms of the strengths and weaknesses of this research, the study's implications, and suggestions for future exploration on this topic.

**DO CLINICIANS PERCEIVE A CONNECTION BETWEEN THEIR PERSONAL AND  
PROFESSIONAL HABITS OF SELF-DISCLOSURE?  
A STUDY EXPLORING SELF-DISCLOSURE  
ON SOCIAL NETWORKING SITES  
AND IN THERAPY**

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

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2013

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## **CHAPTER I**

### **Introduction**

Imagine a therapist who spends her personal, free time outside of work (or perhaps even at work while on her lunch break) engaging in online social networking through Facebook and Twitter. This therapist finds herself posting pictures online of her recent vacation, she Tweets her political views and religious beliefs on Twitter regarding a local law that was recently passed, and she also writes comments about her hobbies and weekend plans on her Facebook page. Additionally, the therapist utilizes these online social networking sites to share her experiences and advice about living with a family member who struggles with a lifelong illness. Across her Twitter and Facebook accounts she offers her insight, links to articles, and other resources. For her, online social networking represents a space to share her personal journey, views, and thoughts with those who care to read them. As a result, through her online actions and interactions, the therapist takes many opportunities to communicate her private life with others.

As she transitions back into her role as a clinician, it becomes unclear whether or not she believes her social networking habits of disclosing personal information will filter into the professional environment she has with her clients. Does she think she is more apt to share her religious or political views in a therapy session as a result of sharing them online? Does the clinician feel more comfortable self-disclosing personal information (perhaps about her recent vacation or ill family member) after engaging in online self-disclosure about these topics? Will she hesitate less to answer a question from a client that evokes self-disclosure because she's used

to “voicing” her beliefs online? Is the therapist more open to sharing personal information with her client because the material is fresh on her mind?

These questions may not be as far-fetched as we imagine. Social networking sites (SNS) may indeed play a vital personal and indirectly, a professional role for many people in today’s society including professionals in the field of social work. Due to the impact that online social networking has for many people today, it’s questionable if clinicians who utilize social networking sites feel that their online social presence plays a role in their professional technique of self-disclosure. In this qualitative study, I examine the following question: Do therapists believe that their personal, non-work related use of social networking sites (i.e. outside a therapy session, on their own time, and not associated with their professional duties) is related in any way to their views and behaviors of self-disclosure as it applies to their clinical practice with clients? I hope to demonstrate clinicians’ perceptions as to whether they believe there is any connection between their online social networking habits and views of self-disclosure as compared to their clinical practice of this technique with clients in therapy.

The ever-growing, popularity of online social networking has become a phenomenon in today’s society verified by staggering statistics about its use (Bennett, 2012; Brown, 2012; Bullas, 2012). Many Internet social networking websites such as Facebook and Twitter are geared towards social networking (or in simplest terms, *connecting*) with others in an online forum. These sites, which have become increasingly common over the years as technology has boomed, include various avenues to utilize self-disclosure by sharing personal information, beliefs, opinions, pictures and more. In fact, as of 2012 there were a reported 850 million monthly, active users of Facebook and more than 465 million Twitter accounts world-wide (InfographicLabs.com, 2012, as cited by Bullas, 2012). These impressive numbers demonstrate



that many people are using social networking sites on a regular basis and have many opportunities to engage publically, which in many ways, is an online form of self-disclosure.

In psychotherapy literature, the use of self-disclosure, the term used to indicate providing personal information about oneself to a client, has been a profuse topic and seems to be a subject that continues to evolve for researchers and clinical therapists (Barnett, 2011; Barrett & Berman, 2001; Hanson, 2005; Myers & Hayes, 2006; Simone, McCarthy, & Skay, 1998). Self-disclosure has been defined as a nuanced technique (Roberts, 2012) that should be delivered with purpose and timing. As a therapeutic tool and when used effectively, it serves various functions such as enhancing overall treatment (Barrett & Berman, 2001) as well as acting as a meaningful technique when a client feels a positive connection to their therapist (Hanson, 2005; Myers & Hayes, 2006). These, and other related components of self-disclosure, will be discussed in more detail in this study. Given the role social media plays in individuals' lives, especially today's generation of both clients and therapists, gathering a greater sense of what drives a clinician to self-disclose with a client seems not only relevant to the field of clinical social work practice, but an important step in understanding if there are other layers connected to the use of self-disclosure. Consequently, it is the intent of this study to explore any such possible connections from the clinicians' perspective.

After surveying much of the recent literature related to self-disclosure in therapy and online social networking, it appears this topic has yet to be directly researched. Studies and articles focus on various factors of this study: self-disclosure as it relates to therapy with clients (Barrett & Berman, 2001; Bridges, 2001; Gutheil, 2010; Myers and Hayes, 2006); social networking sites in general (Boyd & Ellison, 2007; Hargittai, 2008; Marche, 2012); the overlap between SNS and self-disclosure (Attrill, 2012; Joinson, 2001; Treppe & Reinecke, 2012); and

the comparison between online vs. offline disclosure habits (not relating to the clinical profession of therapy) (Nguyen, Bin, & Campell, 2012). This qualitative study may offer additional insight into how or even if social media in the form of social networking sites affects the therapeutic process from the view of the clinician. It is also meaningful to the field of social work to research self-disclosure in relation to online habits, especially as younger clinicians (many of whom have grown up using social networking sites) enter the field. This study will explore any potential generational differences or perceived differences with regards to social networking use and therapeutic self-disclosure among participants. Since self-disclosure has been identified as a positive therapeutic intervention for clients when used effectively (e.g., Barrett & Berman, 2001), it is important to explore all possible avenues that may impact a clinician's decision to use this technique.

In the following chapter, I present a literature review of self-disclosure in a clinical setting, social networking sites as a phenomenon, and the overlap between self-disclosure and online social networking. The chapter will also examine relational theory as the main theoretical framework that underlies my study. Since a relational perspective focuses on the self, the other, and the in-between space in the therapist-client relationship (Mitchell, 1988, as cited in Berzoff, Flanagan, & Hertz, 2008), it serves as a significant framework when exploring the therapeutic dynamic and the choice point involved with a clinician's application of self-disclosure with a client. This qualitative, exploratory study was designed to allow participants to be as open and candid as possible when reflecting on their personal disclosures both in therapy with clients and on SNS. This research will address both the practical and theoretical components of self-disclosure as an empathic, nuanced technique that therapists use with clients. In doing so, it will

create an opportunity to gather information about any possible trends or patterns of clinicians' approaches to self-disclosure as they relate it to SNS and psychotherapy.

## **CHAPTER II**

### **Literature Review**

This qualitative exploratory study focuses on clinicians' perceptions around their behaviors and views of self-disclosure as a therapeutic technique alongside their personal use of social networking sites outside of the professional field. The main hypothesis is concerned with whether clinicians ultimately perceive any connection between their professional and personal habits of self-disclosure with social networking use. A review of the current literature related to this phenomenon will be presented in this chapter in order to assess empirical findings that are relevant to the present topic, in addition to clarifying the rationale for this study. The focus will be on self-disclosure and social networking sites in recent research. In this literature review I will concentrate on the following topics: 1) self-disclosure as a therapeutic technique; 2) the phenomenon of social networking sites; 3) the intersection between self-disclosure and social networking sites; and 4) relational theory as the theoretical framework for the foundation of this research. It is my hope that this study will generate a greater understanding as to what drives a clinician to utilize self-disclosure with clients, especially considering the lack of literature on this specific topic.

#### **Self-Disclosure as a Therapeutic Technique**

**Definition, types, and application of self-disclosure:** Self-disclosure has been defined as the “interactions in which the therapist reveals personal information about him/herself (self-revealing) and/or reveals reactions and responses to the client as they arise in session (self-

involving)” (Knox, Hess, Petersen, & Hill, 1997, p. 275, as cited in Hanson, 2005, p. 96). For the sake of this proposed study, the term *self-disclosure* will refer solely to the self-revealing component in the above definition. Examples may include sharing a personal preference with a client (political affiliation, moral view, or favorite food for example), sharing with a client a past or current personal situation (being a cancer survivor, having gone through substance abuse rehab, or currently coping with a family member’s illness), or offering details that inform a client of personal topics (such as relationship status, living situation, or religious beliefs). Much of the literature discussed below, however, incorporates both the self-revealing and self-involving aspects of this technique which illuminates how it functions in the therapeutic setting.

The use of self-disclosure is an abundant topic in psychotherapy literature. It has been widely researched in relation to clinical work with clients and continues to be explored for the complexity and nuance involved with this therapeutic technique (Barnett, 2011; Barrett & Berman, 2001; Hanson, 2005; Myers & Hayes, 2006; Roberts, 2012; Simone, McCarthy, & Skay, 1998). In Barnett’s (2011) study on self-disclosure he emphasizes that it is the procedure of sharing personal rather than professional information to a client. The article asserts that self-disclosure may be a valuable and influential intervention by a psychotherapist, depending upon how, when, and why the self-disclosure takes place. Barnett reviewed the various types of self-disclosure that exist in clinical work which include deliberate, unavoidable, and accidental or inadvertent disclosures (Zur, 2009, as cited in Barnett, 2011). Boundaries and violations of boundaries are also discussed to convey how self-disclosure is a technique that should be used judiciously and consciously.

Janine Roberts, an educator who trains therapists and runs clinical workshops worldwide, acknowledges that therapists “share personal information to strengthen the therapeutic

alliance, demystify therapy, and reduce the power differential between themselves and their clients” (2012, para. 7). She also states that “with the informality of U.S. culture, both therapist and clients are likelier to step across previous professional guidelines” (para. 9). Though she does not allude to social networking sites as part of this informality, her article allows the reader to question what aspects of our society play a role in the formality vs. informality of a clinical setting which may impact the use of self-disclosure with clients. She asserts the following on how to effectively apply self-disclosure:

So in the discussion about self-disclosure, we need to move beyond either/or frame, as in “yes, do it” (often the stance of feminist therapist), or “no, keep tight boundaries” (often the position of traditional psychoanalysts). A both/and frame – which looks at when, where, and how revelations by therapist support the therapeutic process and when they get in the way – establishes a more realistic place from which to analyze and understand the possibilities and dangers inherent in disclosure. Focusing on timing and process of disclosures can move us out of an “it’s good” or “it’s bad” position. The ways we disclose, read cues from clients, and ask questions and discuss what’s been divulged provide safeguards for our clients and opportunities to advance their therapeutic goals. (Roberts, 2012, The Elephant in the Room section, para. 6)

Using a case example to prove her point, Roberts (2012) shares the importance of emotional control (being able to control what one discloses to a client), ensuring that the client is being attended to, and not portraying that the therapist needs a certain reaction in return as other key components of considering when and how to use self-disclosure. Certain vital questions should be in a therapist’s mind when contemplating the use of self-disclosure: “In what ways might this disclosure be helpful to my clients? How can I reveal something briefly and then turn the conversations back to their concerns? What viewpoints are embedded within this disclosure? How might different clients respond?” (Roberts, 2012, Too Much Information section, para. 4). These questions offer meaningful insight into how clinicians should come to make the choice to offer personal information to their clients.

A recent academic study conducted at Harvard University illuminates why self-disclosure is so appealing to humans (Tamir & Mitchell, 2012). The neuroscientists who conducted the research address why people like to talk about themselves through their findings which show that sharing one's thoughts triggers the brain's reward system into action. The study uncovered that information sharing is more often than not associated with personal gains (Tamir & Mitchell, 2012, as cited in Rose, 2012). In their research the authors "suggest that humans so willingly self-disclose because doing so represents an event with intrinsic value, in the same way as with primary rewards such as food and sex" (Tamir & Mitchell, 2012, p. 8041). They utilized fMRIs to analyze the process behind participants' self-disclosure by looking at its two components, that of *self* and *sharing*. Results showed that the aspects of both thinking of oneself and knowing that such information is being shared with others, each contribute to a system of rewards in the brain that triggers elevated neurochemicals such as dopamine. The study helps clarify why people in general are more prone to engage in self-disclosure and is therefore, relevant to the current research.

In her study concerning the therapeutic impact of self-disclosure and non-disclosure on clients, Hanson (2005) utilized audiotape interviews of client participants to establish their perceptions of these two techniques (i.e. the presence and absence of self-disclosure). Data from the interviews revealed that participants in that study were more apt to report clinician disclosures to be helpful, whereas they were likely to find non-disclosures unhelpful in the therapeutic process. The effects of various types of helpful and unhelpful disclosures and non-disclosures were also analyzed. Outcomes showed that the therapeutic alliance was the predominant factor in how a client perceived disclosure or non-disclosure. In its most general sense, the *therapeutic alliance* is a term that relates to the connection or bond that is present

between a client and the provider. The findings from Hanson (2005) were persuasive and the author successfully highlighted various limitations of the study including the potential for researcher bias and the decreased generalizability of the findings as a result of the limited sample population. Even though these limitations exist, it's valuable to keep in mind that no matter what technique is used in therapy, the therapeutic alliance is a key indicator of a client's positive therapeutic experience, including one's perception of self-disclosure (Hanson, 2005).

Myers and Hayes (2006) conducted another similar study which looked at the interaction of two types of self-disclosure--general and countertransference self-disclosure versus no disclosure and how participant outcomes differed based on whether the therapeutic alliance was seen as positive or negative. For the purpose of their study, the authors "conceive of countertransference as therapists' internal and overt reactions to clients that are rooted in therapists' unresolved intrapsychic conflicts" (Gelso & Carter, 1985; Gelso & Hayes, 1998 as cited in Myers & Hayes, 2006, p. 173). General self-disclosures, on the other hand, were represented by "anecdotal, empathic" (Myers & Hayes, 2006, p. 173) therapist disclosures that are contextual and non-countertransferential in nature. Results indicated that when the alliance was positive, participants rated the sessions more positively when the therapists employed general disclosure. However, when the therapeutic alliance was negative, the sessions were rated more negatively when therapists utilized disclosures that were either general or countertransferential as opposed to no disclosure at all.

This may indicate that no matter how or when self-disclosure is used, if the alliance between a therapist and client is poor, the technique of self-disclosure may be ineffective (Myers & Hayes, 2006). It also suggests that general self-disclosure which is not rooted in a therapist's personal internal struggles may be more of a meaningful therapeutic tool as opposed to



countertransference self-disclosure (Myers & Hayes, 2006). Understanding the complexity of self-disclosure in this literature review will help clarify why gaining an even more in-depth evaluation of what could potentially impact self-disclosure is a valuable step in a clinical field like social work. If self-disclosure is perceived as a positive intervention when the alliance is good, it would be worthwhile to understand what components impact a clinician to use self-disclosure with a client that may therefore add to or deter from the therapeutic alliance.

A different yet equally relevant article on the use of self-disclosure in clinical work is written by Barrett and Berman (2001) whose study explored the effectiveness of when a therapist discloses personal information in psychotherapy. Using an outpatient clinic as their research setting and manipulating the experimental environment to either increase or limit the use of the therapists' self-disclosure among clients, findings revealed that the more a therapist disclosed, the more positive the outcome of treatment was for the client. This finding held true not only with regards to reporting reductions in symptoms, but also in reference to expressing greater attachment for the therapist.

Despite being published in 2001, two articles (Bishop & Lane, 2001; Bridges, 2001) were groundbreaking in their research on self-disclosure and made a solid case for the importance of studying this phenomenon in psychotherapy. Both sets of authors shed light on the value of learning more about self-disclosure as a technique in the therapy setting. In a meta-analysis, Nancy Bridges (2001) cites close to fifty authors in her comprehensive literature review. Drawing on the impact that relational psychotherapy has had on the influence of self-disclosure, the author uses clinical vignettes to demonstrate examples of when and where intentional self-disclosure may be applied to enhance the goals of psychotherapy. Since the current research is also interested in exploring self-disclosure through a relational lens as it relates to the therapist-

client dyad, Bridges (2001) understanding of self-disclosure is important to reflect upon here. She summates that “the negotiation of connection and disconnection in the therapeutic relationship becomes central to the therapeutic process” (Bridges, 2001, p. 21). This follows the theme of previously conducted studies (Hanson, 2005; Myers & Hayes, 2006). When examining the risks involved in divulging information to a client, Bridges (2001) also comes to understand that therapists are wary of extreme disclosures that alter the focus from the patient and distract from the necessary assessment of the therapeutic techniques and treatment process. Being aware of the risks involved seems crucial since self-disclosure appears to be an intervention that can be inappropriately used and abused.

Bridges (2001) offers important guidelines regarding the application of self-disclosure and reports that many clinicians value “the clinical intuition, timing, and sensitivity that inform the decision to disclose in any treatment dyad” (p. 23). Additionally, the article suggests that therapists who choose to disclose “remain patient-focused, rely upon the patient’s resources and expertise, model emotional honesty, and share their view of the clinical situation at hand” (Bridges, 2001, p. 23). Sharing insight into perspectives of the self, disclosure as a form of countertransference, and the potential for the therapist’s vulnerability in the disclosure transaction, therapists who read her article gain valuable knowledge about how personal self-disclosure can and should be applied from the author’s perspective. Years later, Bridges (2001) evaluation of this relational tool for therapy continues to be relevant in a therapeutic culture that is still using the tactic of self-disclosure.

With regards to self-disclosure, Bishop and Lane (2001) reviewed how the therapeutic frame or structure has shifted significantly over time since the traditional Freudian form of therapy in the early 1900’s. The authors discuss how self-disclosure is more accepted today as a

subjective, expressive means of displaying a genuine understanding with clients as opposed to the ways of conventional psychoanalytic theory. However, they warn newer clinicians within the field of psychotherapy to be conscious of their self-disclosure by practicing a more traditional stance when first beginning therapy in order to build a basic framework. When looking into the conventional perspective that was taken in classical psychoanalysis, the article assesses how neutrality and anonymity were once considered critical components to the therapeutic process. Together, these two concepts work towards creating the space for increased focus on the client and ensuring that the therapist's personal stance is minimized and not interfering with treatment (Bishop & Lane, 2001).

With the introduction of relational and intersubjective theoretical frames, Bishop and Lane (2001) argued that the psychoanalytic strategies of Freud were limiting in being effective and authentic with clients. With this shift comes the notion that anonymity and refusing to utilize self-disclosure can actually have a detrimental impact on certain clients (Bishop & Lane, 2001). While recognizing this perspective, the authors encourage new clinicians to self-disclose with clients. The concept of the "blank screen" is something that was considered a major component of psychoanalysis. This view contributed to the creation of what was supposed to be a neutral therapist who did not provide personal information or self-disclose to a client, thus serving as a *blank screen*. As will be discussed in more detail below, relational theory sees the therapist-client relationship as a dynamic, working dyadic bond in which self-disclosure can actually be used as a tool for treatment and building an alliance.

**Ethical factors of self-disclosure:** Since ethics play a large role across clinical work with clients, it is pertinent to evaluate some of the literature that target core ethical components of self-disclosure with clients (Barnett, 2011; Gutheil, 2010; Reamer, 2011). Because ethics or

ethical dilemmas may have an impact on clinicians' use of self-disclosure with their clients, I will focus on the ethical features associated with this therapeutic technique. Gutheil (2010), a professor of psychiatry at Harvard Medical School succinctly labels three significant principles that are pertinent to all mental health practitioners who abide by ethical standards: "beneficence (doing good for the patient), nonmaleficence (doing no harm), and the fiduciary relationship between clinician and patient, where the interests and welfare of the patient always predominate" (Relevant Ethical Principles section, para. 1). Gutheil further outlines that disclosures which are extreme, sexual, oppressive, or egotistic are always unethical and violate a therapist's ethical right. According to the article, since self-disclosures appear to come in many different forms, keeping the context in mind is vital. He clarifies that a clinician's clinical training may have a particular outlook on self-disclosure usage, a therapist's incentive and intent to disclose helps establish the goal of the disclosure, and the patient's diagnosis and phase of therapy may lead to diverse application of this therapeutic technique (Gutheil, 2010). It's possible that the exploratory nature of the current study may add yet another framework or context of therapeutic self-disclosure that has yet to be investigated.

Reamer (2011) explores the complexity involved with self-disclosure, the nature of how self-disclosures comes about in social work, and additional key principles for all therapists to keep in mind when considering personal disclosures with clients. Though it overlaps much of the information addressed in Gutheil's (2010) article, it offers useful examples of common questions posed from clients to most therapists that often evoke self-disclosure. These can include: "Are you married?" "Do you have children?" "How old are you?" "Where do you live?" "Are you in Recovery?" (Reamer, 2011, Self-Disclosure in Social Work section, para. 1). The pros and cons of self-disclosure are addressed in a clear, concise manner throughout the literature where the

author emphasizes the complicated issues involved in this technique. Special attention is paid to boundary violations in the therapeutic relationship and the negative potential impacts of self-disclosure. Self-disclosure could lead to boundaries being blurred, counter-transference and transference arising, trust issues forming, and the therapist taking away the attention from the client.

In order to concentrate on the more positive applications of the technique rather than its pitfalls, Reamer (2011) shares that “social workers’ management of self-disclosure should take into consideration three key issues: the content of self-disclosure, the degree of intimacy of the disclosure, and the duration of the self-disclosure” (Ethical Considerations section, para. 2). Insightful suggestions and caution for clinicians are offered with regards to specific content, intimacy, and how often self-disclosure should occur. The complexity and nuance of this therapeutic technique is evident in Reamer’s article (2011) when he asserts “self-disclosure is among the most challenging boundary issues in social work” (Duration of Self-Disclosure section, para. 9).

### **Social Networking Sites (SNS) as a Phenomenon**

**Definition, types, and statistics of SNS:** For the purpose of the present study, social media and more specifically, social networking sites (SNS) will now be discussed in more detail. Considering social networking sites are constantly evolving and are relatively new to the field of social work and psychotherapy, much of the current information addressed below comes from news articles, web-blogs, and other relevant online information sources. Analyzing what has been researched and written in regards to general SNS will put some context behind why the current study is important.

Unlike the term *social media* which has been broadly defined by Merriam-Webster Dictionary online (2013) as “forms of electronic communication (as Web sites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (as videos)” (para. 1), the term *social networking sites* is more specific. Though Boyd and Ellison (2007) choose to use the label *social network sites* (SNSs) instead, they recognize that the terms social networking sites and social network sites are used conversely across the public. The authors define these sites as:

Web-based services that allow individuals to (1) construct a public or semi-public profile within a bounded system, (2) articulate a list of other users with whom they share a connection, and (3) view and traverse their list of connections and those made by others within the system (Boyd & Ellison, 2007, "Social Network Sites," para. 1).

Serving as one of the categories of social media, SNSs relates to websites used for the sake of connecting with others and establishing and sharing a network (i.e. a group of people one associates with) (Boyd & Ellison, 2007). The current research utilizes this general definition and incorporates examples such as the websites, Facebook and Twitter into the study. The emphasis does not have to be and is not always based on creating new networks with strangers but can also include communication within a pre-established social network (Boyd & Ellison, 2007). When referring to a variety of social networking sites like Facebook, Twitter, MySpace, and LinkedIn, Griffin (2009) shares that overall, members associated with a specific SNS tend to have common interests with others. Social networking sites are also described as being “based upon a simple, but powerful purpose: To help a person identify his or her extended social network and facilitate his or her contact with other individuals who are connected to that network” (Boyd & Ellison, 2007, as cited in Griffin, 2009, What is Social Networking section, para. 1).

Though social networking sites have been considered an aspect of *computer mediated communication* (CMC), they should not be considered in the same way. CMC is a broader

category that includes the more general definition of any “communication that takes place through, or facilitated by, computers” (Dictionary.com, 2013, para. 1). This can include a variety of Internet technology such as email, online videos, live chat, and more (e.g., Dictionary.com, 2013). For the sake of this research, it is necessary to remember that social networking sites are the confluence of social media and computer-mediated communication that is being evaluated and it is beyond the scope of this study to look any deeper or into certain SNS in particular.

Social network sites can include the opportunity to have a personal profile, be in communication with friends, post pictures, video, and blogs, make visible comments online, instant message with people and much more (Boyd & Ellison, 2007). It is said that the first social network site began back in 1997 and examples include popular sites such as Facebook, Twitter, and MySpace in addition to others like Bebo, Cyworld, Friendster, LiveJournal, LinkedIn, BlackPlanet and many more (Boyd & Ellison, 2007). Boyd and Ellison (2007) also state the following:

There are hundreds of SNSs, with various technological affordances, supporting a wide range of interests and practices. While their key technological features are fairly consistent, the cultures that emerge around SNSs are varied. Most sites support the maintenance of pre-existing social networks, but others help strangers connect based on shared interests, political views, or activities. Some sites cater to diverse audiences, while others attract people based on common language or shared racial, sexual, religious, or nationality-based identities. Sites also vary in the extent to which they incorporate new information and communication tools, such as mobile connectivity, blogging, and photo/video-sharing (Introduction section, para. 1).

Boyd and Ellison (2007) do not specifically address the definition of self-disclosure and how it relates to SNSs, but they write about dimensions of different websites that incorporate personal blogging, sharing pictures, posting statuses and other forms of disclosure that incorporate personal information about oneself. These are evidence of the variety of avenues in which people

who engage in social networking can choose to self-disclose with others. The overlap between social networking sites and self-disclosure will be addressed in more depth later in this chapter.

In terms of other relevant information around SNS use, one blog writer reports that statistically, 750 “Tweets” are made on Twitter every second and over 350 million consumers struggle with “Facebook Addiction Syndrome” (original source unknown as cited in Brown, 2012). Another site shares that over one million new accounts per day are created on Twitter (InfographicsLabs.com, 2012, as cited by Bullas, 2012). Additional figures indicates that males and females are split evenly with their SNS use and that networks like Twitter, LinkedIn, and Pinterest are on the rise whereas sites like MySpace, Bebo, and Friendster are becoming less popular (Social Ignite Media, n.d., as cited in Bennett, 2012).

Researcher Hargittai (2008) explored those who utilize SNS in order to establish if there are certain predictors of usage. The researcher discovered that even though a collective analysis of those who use SNS was not associated with particular demographic traits, individual social networking sites show greater similarity across users. Various characteristics were explored including but not limited to participants’ age, gender, race and ethnicity, parents’ education and living situation. It appears that a general look into demographic traits does not predict social networking site use, but that when examining trends of specific sites, it was evident that participants’ diverse backgrounds played a role in who accessed certain SNS. This study does not address the precise research question of the proposed study but it sparks the question of whether or not clinicians’ background information and demographic traits might impact what social media sites they utilize on their personal time and if there is a difference between particular sites and use of self-disclosure.



**Generational/age factors of social networking use:** Some have made the point that the trend in social networking is more generational in nature. A psychologist and university professor who writes about teens and technology shares her thoughts about the Internet generation, stating that “they are growing up in an environment, in a culture where you can get constant feedback from others on yourself in ways that we never did” (Young, n.d., as cited in Kornblum, 2007, para. 7) and that “the private self and public self become intertwined in a way that we (older folks) can’t possible understand” (para. 8). This article portrays how the Internet (or Web) generation, described as 35 years or younger at the time it was written (age 40 or younger at this point in time) (Jones, n.d., as cited in Kornblum, 2007), are more comfortable than their older counterparts at sharing personal information and therefore being less private over the Internet. The concept of why and when online self-disclosure became so popular has also been linked to the confessional trends of reality TV which began to saturate our society (Goodstein, n.d., as cited in Kornblum, 2007) and eventually spread to the online world. As technology and entertainment evolve over time, it appears that more and more self-disclosure and sharing information about oneself is at the core of our popular culture.

A recent article gave astonishing facts as to how pervasive SNS have actually become, declaring that Facebook has 845 million users and made \$3.7 billion in profits last year (Marche, 2012). It also shares that “recent estimates put the company’s potential value at \$100 billion, which would make it larger than the global coffee industry – one addiction preparing to surpass the other” (para. 4). The following list of statistics give an even more concrete look at the undeniable breadth and depth of social networking sites like Facebook:

What’s staggering about Facebook usage is not its volume – 750 million photographs uploaded over a single weekend – but the constancy of the performance it demands. More than half its users – and one of every 13 people on the Earth is a Facebook user – log on

every day. Among 10 to 34 year-olds, nearly half check Facebook minutes after waking up, and 28% do so before getting out of bed (Marche, 2012, para. 39).

Additionally, considering about 30% to 40% of average conversation entails people sharing personal information whereas 80% of online updates on sites like Twitter and Facebook are based on self-disclosure (Rose, 2012), it's reasonable to question if the trend towards having a social networking presence and employing self-disclosure online will drift towards one's self-disclosure in clinical practice. If it has been shown that thinking about oneself and sharing that information with others rewards our systems as was shown in Tamir and Mitchell (2012), as social networking sites become more and more rampant, it's useful to explore if people are self-disclosing more in general.

Taylor, McMinn, Bufford, and Chang (2010) who used a large sample comprised mainly of psychology graduate students and a small group of established psychologists, found results that also indicate age factors with social networking use. The researchers assessed participants' attitudes and ethical concerns around their current use of social networking web sites (SNWs) (a different abbreviation but same concept and definition as social networking sites (SNS)) to evaluate how participants' SNWs activity may be viewed online by clients as a form of unintended self-disclosure. The researchers discovered that unlike the practicing psychologists, the graduate students who were younger in age reported using SNWs more often than the practicing clinicians. As a result, there was a negative correlation associated with age since the younger participants were more apt to utilize SNWs compared to the older respondents. This suggests that the incoming professionals are more current to the trend of social networking, a concept that will be explored further in this study by seeking a diverse sample across clinical disciplines, generations, and number of years in practice.

Findings also showed that the younger participants were more likely to encourage the American Psychological Association to set clear standards for psychologists' use of SNWs. This indicates that younger professional in the field or who are about to enter clinical work, are aware of the influence associated with the Internet and how it may play a role in their profession. In order to understand if generational differences play a role in the current research, all participants will be asked their age. The study by Taylor et al. (2010) does not go into details about what types of *clear standards* should be set but it supports the notion behind this thesis which aims to gain a greater perspective of how SNS may (or may not) be associated with one's clinical use of self-disclosure. The authors claimed that participants who access SNWs appear to have insight behind the clinical and ethical aspects of their online activities and it appears that SNWs use increases the likelihood of unintentionally self-disclosing information to clients (Taylor et al. 2010). They also emphasized that psychologists should reflect on the potential risks of accessing SNWs, take measures to protect their privacy, and that graduate programs should incorporate a discussion of SNWs into ethics training. As increased numbers of people engage in social networking online and professionals, not just psychologists, use SNWs for pleasure, the current research will explore from a social networking lens how Internet usage may (or may not) be identified as a contributing factor to applying self-disclosure with clients.

Though many young people today are accessing and growing up with social networking sites at their fingertips (literally), it cannot be ignored that older generations like the Baby Boomers are also finding pleasure and use in SNS as indicated below. It seems that those who believe social networking sites are *only* used by the youth and Internet generation, are incorrect in their assumption. One source states the following:

Currently, 16.5 million adults ages 55 and older engage in social networking, according to Internet monitoring site comScore. Facebook is seeing the most growth among users

age 30 and older. MySpace, with 130 million users, is enjoying a surge among the 55-plus set, who total 6.9 million users and spend an average 204 minutes a month on the site. And in just one year since AARP.org unveiled its social networking platform, about 350,000 users have created 1,700 groups celebrating everything from gardening to social activism (Della Cava, 2009, para. 14).

These facts portray that SNS activity to some extent extends beyond those who grew up or are growing up with the Internet and social networking capabilities.

### **The Intersection between Self-Disclosure and Social Networking Sites**

In order to provide a more concrete example of how self-disclosure is associated with social networking sites, I will focus specifically on Facebook. Those who have Facebook have what is called a *profile* which allows one to share personal information including but not limited to one's relationship status, religion, hometown, area of residence, phone number, email, hobbies, current and past jobs, and favorite movies, books, and songs. A *status update* can also be written on one's profile *wall* (a live forum that allows the person and their connections to share comments and information) in order to communicate what one is doing at the moment, the thoughts on their mind, personal opinions, political beliefs and many other example of self-disclosure. Some limits based on inappropriate material are placed around what a person is allowed to share and write, but the freedom to self-disclose so long as it is within such boundaries is abundant. People with their own unique profiles can add, delete, or alter whatever information they feel comfortable sharing with the public, the semi-public, and/or their friends and can personalize specific *privacy settings*. However, regardless of the safety measures to protect one's privacy and control those who can and cannot see the personal information they share, people who are active on SNS like Facebook can utilize self-disclosure regularly or read information about what others choose to disclose.

**Ethical considerations in SNS:** Similar to the ethical components of Taylor, McMinn, Bufford, and Chang's study (2010) mentioned above, Chernack (2010) tackled the sensitive subject of boundaries in relation to social networking, a concept that is often confusing for therapists in an era when social networking is being introduced into practice. The author clarifies that "boundaries provide the framework for the social work relationship. The blurring of boundaries can create confusion and misconceptions for the client about our roles and the expectations for the services we provide" (Chernack, 2010, para. 1). Considering self-disclosure is a therapeutic technique that requires the therapist share something personal, it's vital to examine both boundaries and ethics in this research. The article succinctly reviews the National Association of Social Workers (NASW) Code of Ethics (as cited in Chernack, 2010) for readers to understand that "in general, when using technology in its various forms, social workers need to adhere to ethical, legal, and regulatory standards in areas such as privacy, confidentiality, client records, and informed consent" (para. 5). The notion that is most relevant to this thesis however, is the condition regarding Private Conduct, Standard 4.03 which states that "Social workers should not permit their private conduct to interfere with their ability to fill their professional duties" (NASW, 2008, p. 13, as cited in Chernack, 2010, para. 11). If a therapist's "private" business entails self-disclosing information on SNS like Facebook or Twitter after they leave their professional setting, it's rational to wonder if they bring their self-disclosing behaviors and views of its use online back into their work. This study attempts to explore this question in order to understand any potential links.

**Online vs. offline self-disclosure – The current debate:** Various measures have been taken by researchers to assess how self-disclosures function over computer-mediated arenas (Attrill, 2012, Joinson, 2001, Trepte & Reinecke, 2012) and others have compared online vs.

offline self-disclosures (Nguyen, Bin, & Campell, 2012). To be clear, what has *not* been researched and the emphasis behind the current study is the notion of understanding online vs. offline self-disclosures *in relation to clinical work* with clients in psychotherapy. Trepte and Reinecke (2012) discovered reciprocal effects in terms of those who utilize SNS and those who apply online self-disclosure. Results of their study indicated that the use of SNS manipulates disclosing information online and vice versa.

Joinson's (2001) research included three sub-studies to gain a greater understanding of how computer-mediated communication (CMC) vs. face-to-face interaction impacts self-disclosure and to establish how self-awareness and visual anonymity may play a role in disclosing information online. The results of the studies show that not only was self-disclosure more prevalent across computer-mediated forums instead of in-person circumstances, but that self-awareness and visual anonymity did indeed factor into how often people self-disclosed online. Findings showed that those who remain visually anonymous on CMC self-disclose more information than people who are not anonymous. It also identified that "the interaction between anonymity (i.e. reduced public self-awareness) and heightened private self-awareness" (Joinson, 2012, p. 188) supports increased online disclosure. Since social networking sites are a sub-category of CMC, this information seems pertinent for the current research because it suggests that online self-disclosures should happen more frequently than offline disclosures and that specific factors should project people's decision to disclose personal information over the Internet.

One might presume, however, that the above information is counter-intuitive to the present study since the goal is to explore whether people's self-disclosures via SNS are related to and potentially augment their use of the technique offline. The article by Nguyen, Bin, and

Campell (2012) is worth evaluating in order to clarify the complexities and indecisive results involved within the research. The authors acknowledge current beliefs that self-disclosures typically happen more often online as opposed to offline interactions but clarify that this postulation is challenged both in theory and in research (Nguyen, Bin, & Campell, 2012). By conducting a methodical review of related literature assessing online and offline self-disclosures from dyadic communications, the authors discovered surprising results. After locating 15 articles that evaluated this topic in which self-disclosure was identified as the dependent variable, the results appeared conflicting in nature (Nguyen, Bin, & Campell, 2012, as cited in Attrill, 2012). A third of the articles conveyed higher levels of self-disclosure online, another third displayed that there was no significant distinction between online and offline disclosures, and the final third resulted in increased measures of offline rather than online self-disclosure.

At first glance, the findings suggest that online disclosures were not actually greater than offline disclosures, but after accounting for the fact that studies within the meta-analysis did not reliably measure the *breadth* and *depth* of the disclosures, it is hard to make concrete interpretations out of the results (Nguyen, Bin, & Campell, 2012, as cited in Attrill, 2012). Evidently, comparing online and offline disclosures is an area that needs to be researched further in order to understand how exactly the two intersect. The current study will add to the online vs. offline debate in the literature by exploring an avenue that has yet to be evaluated; the types and amounts of self-disclosures that occur over social networking sites will be explored in comparison to face-to-face disclosures that occur with clients in therapy.

When exploring how self-disclosure may play a part in social networking sites, another interesting study by Bateman, Pike, and Butler (2010) found “perceived “publicness” or “public exposure” of SNS negatively influences users’ intention to self-disclose, both in terms of the

amount and depth of their self-disclosures” (p. 88). In other words, participants (from a sample population of undergraduate and graduate SNS users from business school) who believed that the personal information they placed online was more apt to be viewed by the public and therefore less private, were more resistant to self-disclosure and disclosed less information. The amount of participants’ offline self-disclosure was used as one of the study’s control variables and researchers found that it forecasted the amount and depth of self-disclosure that participants made on SNS. Through the completion of a meta-analysis, the authors presented convincing correlations in their findings by reviewing a variety of previous applicable literature, establishing clear, concise, testable hypotheses, and establishing internal consistency and validity in their measures. Furthermore, the researchers noted their limited ability to generalize their findings to other groups, as their sample consisted mainly of young, male participants.

This data may provide insight that people self-disclose information online that they might not want everyone to see and that the quantity of offline self-disclosure projects online self-disclosure (Bateman, Pike, & Butler, 2010). However, the study does not address if the types and amounts of online self-disclosure also predict offline disclosures. Though participants disclosed less information when concerned that the public would see, it was not assessed whether the self-disclosures participants’ engage in during more private online networking are associated with their applications of the technique in an offline setting. It remains questionable that those who are more apt to engage in self-disclosure online and comfortable doing so bring this technique with them more readily in offline arenas. This would have been valuable information to assess in order to further understand the directionality of online vs. offline disclosures. Since we live in a society that continues to access and utilize SNS such as Twitter and Facebook on a regular basis, Batemen, Pike, and Butler’s (2010) study provokes questions as to how people are using social



networking sites today and whether they continue to remain cautious about what personal information they share with others.

### **Relational Theory**

Relational theory is a relevant theoretical framework to utilize in exploring the choice behind a clinicians' application of self-disclosure in the therapeutic setting and to analyze the dynamic between therapist and client. Considering self-disclosure has been explored and cited across a variety of avenues including but not limited to its various advantages and disadvantages, the nuances of the technique, and its potential use as validation of a client's experience, a source of modeling, or during a therapeutic impasse (Wachtel, 2011), this theory will serve as the main theoretical perspective for the current research. The understanding of how self-disclosure is used to augment the therapeutic relationship or to bring about a sense of change will be elicited within this research through participants' responses. Clinicians who use a relational lens to treat their clients may find that self-disclosure helps create a tight holding environment or safe space within a session, especially with clients who desire some background information about their therapist (Turner, 2011). Though the present study is not solely focused on practitioners who define themselves as relational theorists or clinicians, relational theory can still be utilized as a framework to understand why clinicians choose to share personal information with their clients. Since self-disclosure can be used as an empathic approach to connect with the client and relational theory aims to "recognize the complexity of empathic attunement with a range of clients" (Turner, 2011, p. 407), it seems not only relevant but essential to use this theoretical framework as the predominant theoretical basis for this thesis.

At its most basic level, the definition of relational theory adheres to three components of the relationship that are always present – the self, the other, and the in-between space (Mitchell,

1988, as cited in Berzoff, Flanagan, & Hertz, 2008). Because a clinician's subjectivity plays a central role in psychotherapeutic process and serves as part of the dynamics that occur between both parties, relational theory is useful in exploring when a clinician's self-disclosure is a meaningful, appropriate tool for therapy (Berzoff, Flanagan, & Hertz, 2008). When applying a relational lens to self-disclosure it is valuable to note that the therapist can hold the right whether or not to divulge personal information (Wachtel, 2011). What is being questioned within this study is not whether clinicians' find themselves withholding information from clients, but rather, if they notice or recognize if their views and trends of self-disclosure may be associated and perhaps augmented by their tendency to utilize self-disclosure in other forms such as online social networking.

As many of the above studies indicate, self-disclosure is not merely an act that occurs where only one party in the therapeutic relationship is involved. Instead, when self-disclosure takes place in therapy, both therapist and client play a role in the interaction – how it is shared, how it is perceived, how it may change the view of the therapeutic process and so forth. Therefore, it's necessary to emphasize that relational theory is focused on the therapeutic *relationship* as a large component of change in the therapy process. The process can be seen as a fluid dynamic in which the self is influenced by the *interaction* that occurs between client and therapist (Turner, 2011). Over the last 50 years, relational theory has evolved from a variety of theoretical frameworks including object relations theory, self psychology, self-in-relation theory, intersubjective theory, and infant research and has moved away from the traditional Freudian, psychoanalytic perspective over time (Turner, 2011). Historically, it has transitioned from a 'one-person psychology' where the self is influenced by a supportive other to a 'two-person psychology' that stresses the dynamic relationship and shared interactions between two people

(Goldstein, Miehl, & Ringel, 2009, as cited in Turner, 2011). When describing the clinical relationship, Turner (2011) also clarifies that relational theory uses the words ‘*mutuality*’ and ‘*co-creates*’ to reiterate the interactions going on between therapist and client. Additionally, relational theory is rooted in the social context of an interaction so that the relatedness which occurs between two persons is not a fixed connection but instead, is altered by the interpersonal and background influences at play (Hadley, 2008, as cited in Turner, 2011).

Relational theory is highly relevant to clinical social work practice. Indeed, social work has been referred to as “relational at its core” (Turner, 2011, p. 403), especially when supported by the fact that the NASW Code of Ethics highlights the value of human connections, empowerment, genuineness, and respect for all individuals (NASW Code of Ethics, 2008, as cited in Turner, 2011). Turner (2011) shares that a client and therapist can be equal contributors and have agency over the therapeutic process which creates a unique aspect of relational theory that breeds a general concept of empowerment. This sense of authenticity is a central theme for relational theory and allows space for self-disclosure to have a place in the therapeutic process (Turner, 2011). However, it’s necessary to note that “this does not imply that an “anything goes” approach is endorsed by relational theory; self-disclosure is used to understand the rich dynamic between the two so that clients can between themselves understand the complexity of their inner world and/or facilitate change” (Turner, 2011, p. 404).

According to Turner (2011) self-disclosure as utilized by the relational clinician often falls into three general categories. The first type of disclosure tends to relate to personal “feelings, attitudes, values, life experiences, and factual information about themselves or others in their life” (Turner, 2011, p. 408). Clinicians may also choose a second type which discloses their thoughts and feelings associated with the treatment process including discussion around

certain interventions or dilemmas within the dynamic relationship. Finally, the third type of self-disclosure from a relationally-oriented clinician would incorporate the acknowledgement with a client around a counter-transference response. As indicated throughout this literature review and for the purpose of this study, the self-revealing components of self-disclosure serve as the main focus of this research.

### **Summary**

As the concept of self-disclosure continues to be discussed in the clinical realm (Bishop & Lane, 2001; Bridges, 2001; Hanson, 2005; Roberts, 2012) and statistics indicate that social networking use is a prevalent phenomenon (Bullas, 2012; Della Cava, 2009; Marche, 2012), the main effort of this research is to explore whether or not clinicians believe that their self-disclosure online through social networking sites may be connected to offline, clinical use of the technique. By researching this issue through qualitative analysis, the goal is to understand if clinicians perceive that there may be another layer of this tool for therapy that has not yet been researched. The current research addressed above appears to be unclear and inconclusive with regards to how exactly online vs. offline self-disclosure are related. No studies were found which explored the topic being proposed in this research. Therefore, the exploratory nature of this study will allow clinicians to reflect on their own use of self-disclosure online through SNS *and* in the therapy room to see if they believe that their views and behaviors of online vs. offline self-disclosure are at all related.

Finally, relational theory is examined as a means to understand a clinician's choice to apply self-disclosure with a client within the therapeutic dyad and to delve deeper into their beliefs and behaviors of this therapeutic technique. In order to assess how I will explore if clinicians believe their online social networking is at all connected to the self-disclosure they use

with clients, the methodology of this study will be discussed in the following chapter to outline the process by which my research was conducted.

## **CHAPTER III**

### **Methodology**

The purpose of this study is to explore whether clinicians' believe that their behaviors and views about self-disclosure as a therapeutic technique are related to their personal use of social networking sites outside of the professional clinical field. This exploratory, qualitative study utilized a structured interview with open-ended questions on clinicians' use of self-disclosure. A total of twelve clinicians were recruited from a variety of different disciplines that included Clinical Social Work, Marriage and Family Therapy, Psychology, Psychiatry, and Mental Health Counseling. In terms of qualifying criteria, each participant had to currently practice psychotherapy *and* utilize a social networking site(s) (SNS) for personal, non-work related purposes. I chose to conduct a qualitative study in order to provide participants the opportunity to share their thoughts discursively and reflect upon their choice to self-disclose with clients and online through SNS. The snowball method of recruitment was utilized to garner participants. Sample size, data collection, and data analysis will be reviewed with more specifics below.

### **Sample**

In order to participate, individuals had to be a Licensed Clinical Social Worker (LCSW or LICSW), Psychologist (either Ph.D or Psy.D), Psychiatrist (M.D.), Marriage and Family Therapist (MFT), or a Mental Health Counselor who was over eighteen years of age and currently practiced psychotherapy in the U.S. They also had to be able to read and speak English

and agree to the informed consent for participation. Furthermore, all research participants were required to be social networking website consumers by having an active account on Facebook and/or Twitter. Because these are two common SNS to date, they served as the basis of the study and were advertised in the recruitment process. People who used other social networking sites on top of Facebook and/or Twitter were also included. Those who did not fit these inclusion criteria were excluded from the study. Participants were given the opportunity during the interview process to provide additional details about their current discipline and were asked to indicate their primary practice setting and years of experience. Once participants met the minimal criteria for participation in the study, they were requested to answer a series of demographic questions during the interview in order to provide supplementary information about any patterns or trends in the sample. Demographic questions helped identify different types of professional and personal diversity expected in my sample. Once I reached an N of twelve participants, I stopped the recruitment process. Additional people contacted me expressing interest in my study but due to either ineligibility or timing constraints for the recruitment period (which will be described in more detail in Chapter Five), only twelve people were included. Interviews were conducted over the phone and in person depending upon participant preference and feasibility.

### **Recruitment**

Participants were recruited for my study through a nonprobability sampling technique known as snowballing sampling. I chose this technique for my study with the understanding that it “is appropriate when the members of a special population are difficult to locate” (Rubin and Babbie, 2013, p. 173). I chose this method due to being unfamiliar with where I could recruit clinicians for my study other than from a variety of friends, colleagues, and professional contacts that could refer others to this research study. Recruitment occurred between February and March

2013 and all interviews were completed by the end of March 2013. The snowball method entailed sending out a recruitment email to friends, close associates, and professional colleagues to request help in securing participants for the study (see Appendix A). It clarified that I could not utilize people I personally knew within my study and therefore requested that recipients of the email pass along information about my study to prospective participants and other contacts. More specifically, it asked people to forward a recruitment email for prospective participants (see Appendix B) and a list of inclusion criteria (see Appendix C) which were outlined in separate email attachments to potentially eligible participants they knew who could spread the word further about my study. The recruitment email for prospective participants stated the purpose of the research, presented the eligibility requirements, provided a brief outline of the interview process, explained the informed consent process, and indicated how to participate in this study. Prospective participants interested in the study were asked to fill out and send back a list of inclusion criteria via email to ensure eligibility.

Participants who were eligible based on the inclusion criteria were sent a confirmation email (see Appendix D). This indicating their eligibility for the study, gave instructions to read, electronically sign, print out a copy for their own records, and asked people to send back the informed consent form (see Appendix E). Some participants indicated that they fit the inclusion criteria without sending back the attachment or simply indicated their interest in the study without reference to their eligibility. I responded to participants' email accordingly in order to confirm receipt of their desire to participate and to indicate the next steps for participation (e.g. ensuring they were eligible by asking them to fill out the inclusion criteria and read and sign the informed consent). As a result, emails with potential participants and eligible participants were slightly varied, though they each touched upon similar content and every participant filled out



the list of inclusion criteria and originally signed and dated the informed consent. Those who did not meet the inclusion criteria for the study were thanked for their interest in the current research and sent an email with a statement indicating their ineligibility (see Appendix F). This writer communicated with participants via email or phone (based on their preference) in order to set up a time and date to conduct the interview. The informed consent disqualification statement email (see Appendix G) was not necessary for the completion of this research because all participants were willing and agreed to sign the informed consent.

The final stream of recruitment entailed a Facebook post on my private Wall asking my Facebook Friends to help recruit referrals for my study (see Appendix H). The post was a similar, condensed version of the recruitment email to friends, personal associates, and professional colleagues. It asked people to contact me directly via Facebook or my Smith College email address if they thought they knew people who would like to participate. When Facebook Friends contacted me after reading the post, I sent them a copy of the email recruitment for prospective participants and the list of inclusion criteria to be forwarded to potential referrals for my study. I uploaded the Facebook post once to my Wall followed by two reminders about my study, asking people to refer to my recent recruitment post. This approach served as an attempt to reach out to people as best as possible during the recruitment period. It is possible that there could be bias in my sample given the fact that I recruited from a pool of people with whom I may have a mutual connection. I will discuss this potential bias further in Chapter Five.

Two shifts were made during the recruitment that will be discussed in more detail in Chapter Five. These shifts did not alter the major recruitment aspects of my study which entailed recruiting via email and Facebook. After realizing that the friends, personal contacts, and

colleagues who received the recruitment email and Facebook Friends who read my initial Facebook post may not know potentially eligible participants for my study, I added a brief addition to these recruitment avenues by asking people to also forward the information about my study to a minimum of five contacts. Those friends, personal contacts, and colleagues who had already received the recruitment email without this addition were contacted again indicating this request and my second Facebook post to Friends reminding them about the study also noted this component. Additionally, after receiving inquiries about whether my recruitment email to prospective participants could be posted on an online forum for therapists, I confirmed with those who asked and also specified above my recruitment email to professional colleagues that it would be helpful if they could share it in this avenue as well.

**Risks of participation:** The current study presented low risk to participants. However, because participants were asked to reflect on the use of self-disclosure with their clients, it is possible that participation in the study triggered discomfort and feelings of regret or embarrassment. Participants were informed prior to beginning the interview that they had the right to refuse to answer any question(s) and could decide to end the interview at any time. Participants were given the opportunity to request to withdraw from the study up to two weeks after the date of participation however this did not occur within my research. They were also informed that if they disclosed identifiable information about themselves or their clients, this information would be deleted or changed to maintain appropriate confidentiality.

**Benefits of participation:** Personal benefits of participating in this study included having the opportunity to share one's experience as a clinician working in this field. Participants may have also benefited from the interview by using it to reflect upon and evaluate their own practice in terms of self-disclosure and social networking usage. They may have chosen to use

this research to become more aware of how, when, and why they apply self-disclosure in their practice and in doing so, may have gained a new perspective on this technique as a result of their participation. No financial compensation was offered for participation.

### **Data Collection**

Once the informed consent process was completed and participants and I set up a time and date to complete the interview, this researcher interviewed each participant (see Appendix I). All interviews were conducted from February through March 2013. Two interviews occurred in person and the remaining ten interviews were conducted over the phone. All interviews were audio recorded using a digital recording device. Though an audio tape recorder was initially going to be used for the study, the decision was made before the data collection process began to use a digital recording device for ease and feasibility purposes. After discovering that the digital recording device was more portable, required less parts (e.g. no tapes were necessary) and it could be connected to a computer using a USB drive to transcribe the interviews afterwards, this appeared to be the most efficient system to collect data.

Participants were asked to answer a set of twelve questions which addressed their personal use of social networking sites, the application of self-disclosure in their practice setting, what they believed influenced their views and use of self-disclosure, and other similar questions that aimed to address the research question. Demographic information was also collected in the beginning of the interview in the form of seven relevant questions addressing participants' professional domain, years of practice in their respective field, age, gender, race and/or ethnicity, the type of social networking interface(s) they use for personal use, and how often they spend on indicated SNS. All demographic data except for age and years of practice was measured

nominally or ordinally and will be presented in the subsequent Findings chapter using descriptive statistics.

Interview questions were thoughtfully worded to target the validity of the chosen measure. Since this is an exploratory study, content validity was achieved by gaining approval from Smith College School for Social Work Human Subject Review (HSR) committee (see Appendix J) in February 2013 for the use of my interview questions prior to conducting the research. Reliability of the interview process was also addressed as a means to create consistency within the data collected: interview questions were asked in the same order to each participant and a conscious effort was made to ask questions using a similar tone of voice. Outside distractions during the interviews were minimized on the researcher's part to work towards researcher reliability. Because it was impossible to control for distractions that could occur with participants over the phone, I provided them the flexibility to choose a time for the interview that worked best for them and fit into their schedule. For the interviews that occurred in person, efforts were made to conduct it in a place that was not too busy or loud.

Some variation occurred within and between interviews as a result of this researcher asking clarifying unstructured follow-up questions or reframes to certain responses in addition to sharing reflections and/or acknowledgment of participants' answers. Particular questions sometimes required expansion or a reframe for purposes of clarification. Sometimes participants covered a question ahead of time by providing thorough responses so they were informed that if they felt they had already answered a question sufficiently, they could indicate so and the interview would move to the following question. Double-barreled questions which have been defined as "asking for a single answer to a question that really contains multiple questions" (Rubin & Babbie, 2013, p. 367) were consciously minimized within the interview questions to

increase reliability of the study. However, these questions were not completely avoided altogether. A further evaluation of the interview process and the potential impact of any double-barrel questions and the variations described above will be explored in more depth within Chapter Five. The actual interview (not including the time it took to fill out the inclusion criteria, read and complete the informed consent, and set up the interview) took about forty-five minutes. However, depending upon participants' responses and how much they chose to share, the shortest interview lasted about thirty-five minutes while the longest one lasted approximately an hour.

**Ethics and safeguards:** Specific measures were taken to remove any identifying information provided during the interview and/or during the communication process before the interview took place to protect confidentiality of participants and their responses. Because I communicated with participants via email and/or phone and met some of them in person for the interview, it was not possible for the respondents to remain anonymous because I received personal information about them. However, I took the necessary precautions to ensure that the material they discussed and offered in the interview, among their emails and phone calls, and within the inclusion criteria and informed consent forms remained confidential and secure. Data was only viewed by this researcher and my research advisor. My research advisor saw data only after names and identifying information had been removed. Participants were informed within the consent form that if they mentioned any personal information that could potentially identify them or a client, this data would be deleted or altered in order to maintain confidentiality.

Interviews were gathered through the use of audio-recording in order to analyze the data. Per federal regulations for research studies, the data collected during the interview was stored in a locked cabinet and will be kept for a minimum of three years. After this time period, the data

will be destroyed so long as it is no longer needed for research purposes. Individual's data was only used in combination with all other data and any quotes provided during the interview were appropriately disguised. Collected participant emails and all corresponding attachments including the inclusion criteria responses and informed consent forms were stored on my Smith College email account which is a secure, password-protected, encrypted website. The inclusion criteria and consent forms that were received as hard copies were also appropriately and safely secured. These recruitment measures will be destroyed when no longer needed after the completion of the study. If this study is used for publication or presentation, participants and their responses will remain confidential.

### **Data Analysis**

All interviews were audio-recorded, transcribed manually by this researcher, and then coded. I listened to individual participant's verbal responses carefully and slowly in order to transcribe the data accurately. All interviews were transcribed by early April 2013 and were coded soon after the interview took place. The material gathered from transcription was then analyzed using content analysis so this researcher could identify relevant, major topics that surfaced and any potential resemblance or variations within the data. More specifically, a grounded theory approach of content analysis was applied in order to analyze data within each interview individually (intra-transcript analysis) and then between interviews as a group (inter-transcript analysis) (Glaser & Strauss, 1967, as cited in Steinberg, 2004). Transcriptions were carried out using a program called RCA Digital Voice Manager which allowed this researcher to slow down the voices of participants to type along, pause and rewind as necessary. Each transcription was transferred into a Microsoft Word document, saved, printed out, read through

various times, and highlighted for findings. As required, all transcriptions will be destroyed after the completion of the study. The results of this study will be presented in the following chapter.

## **CHAPTER IV**

### **Findings**

The purpose of this study was to explore clinicians' perceptions of their personal, non-professional use of social networking sites and their application and views of self-disclosure in their clinical practice with clients. Consequently, this research aimed to show if participants believed that their online social networking habits and outlook of self-disclosure was at all related to the direct use of this technique with clients in therapy. Through interviews, participants' online and offline self-disclosures were explored in terms of what people believed influenced their disclosures, the types of self-disclosures they engaged in, the comfort level to self-disclose on SNS and within a therapeutic setting and the amounts of self-disclosure that occur in both places. Participants were also asked to reflect upon any possible generational divides for newer clinicians entering the field in the context of social networking usage and to consider if a social networking policy is necessary to have with clients.

A total of twelve interviews were collected and assessed. This chapter will review the findings from these interviews and present the data obtained from the group of clinicians who participated in the study. It will begin with an outline of the key findings from the study and the demographic diversity of research participants, followed by a summarization of the themes that surfaced after coding each interview using content analysis. These themes, both in terms of similarities and differences among participants' responses, will be covered below and include the following five categories: motives to self-disclose with clients and on SNS, types and amounts of



self-disclosures in therapy and online, comfort and frequency to self-disclose on SNS vs. with clients, generational divides, and online boundaries with clients.

### **Key Findings**

Clinicians' motives to self-disclose with clients and on SNS varied depending upon the context of the disclosure and one's comfort to provide personal information. The range of types and amounts of disclosures offered professionally in therapy and via social networking sites were also diverse and appeared to be linked to the motive behind the self-disclosure and the comfort level in sharing personal material. Though research participants fluctuated around seeing a connection in self-disclosure use on SNS affecting their use in therapy, most of the sample did *not* see that their personal use of social networking sites was associated to the frequency they disclosed with clients.

*All participants indicated they would not engage in SNS with clients.* Additionally, when asked to envision if a generational divide may be present for younger clinicians who grew up with SNS in relation to their self-disclosure in therapy, the majority of the sample believed there was a generational difference *but not everybody felt this had to do with self-disclosure.* Many interviewees also reported having general online boundaries such as not engaging in SNS with clients and creating privacy settings on their social networking sites as factors in the divide to self-disclose. Most people did not perceive that a written policy was a necessary step to take but instead, was an aspect to be dealt with as it came up in therapy. These key findings which have been divided into the aforementioned five themes will be expanded upon below. Quotes offered throughout this chapter serve as examples of the particular findings. They are presented verbatim unless there was a need to screen confidential information, to shorten the response for brevity purposes, or to paraphrase for clarification purposes.

## Sample Demographics

The sample of twelve participants was diverse in terms of professional domain and years of practice. Research participants included five Licensed Clinical Social Workers, four Clinical Psychologists, one Psychiatrist, one Marriage and Family Therapist, and one Mental Health Counselor (see Figure 1). Participants' ranged from having about three years to fifty years of practice within their respective fields. There was also a wide variety in terms of age considering multiple generations were represented in the sample: the youngest participants were in their low 30s while the eldest person was in their mid 70s (see Figure 2). The sample was not as diverse in terms of gender or race. Ten out of the twelve people identified as female while two people identified as male and eleven people identified as either White or Caucasian, while one person identified as Asian-American. Some participants also spoke to their ethnicity and three people identified as Jewish; one person noted Hispanic heritage; another person shared being Taiwanese-American; someone indicated having South Texan roots, and another participant stated a European background.

In regards to the types of social networking for non-clinical use that people reported using and how often they spent on these sites, all participants had an active Facebook account and therefore, *Facebook served as the main focus of most participants' responses*. Only one person had a Twitter account but clarified that "(I) almost never use it." When asked to indicate how long they spend on social networking sites, participants responses ranged anywhere from "several hours a day" or "two hours per day" to "less than an hour per week" or "at least once a week". A fourth of participants noted spending less than a half an hour per day, another fourth of responses were in the thirty minutes to an hour daily category, and two other people indicated using SNS different times weekly, but not every day. When comparing these responses, it

appears that the majority of participants (n=8) spend at least some time on social networking sites daily though the amount of this time varies greatly. There was no obvious division between the amount that people used SNS and their age. While four of the five in the youngest category reported using it to some extent daily, two people in the 50-59 grouping also reported this frequency, while one person in the 60-69 age range and the only person in the eldest category indicated this as well. These findings point out that clinicians across a wide range of generations, not solely the youngest group, access and utilize social networking sites on a regular basis.

### **Motives to Self-Disclose with Clients and on SNS**

**Motives to self-disclose with clients:** Before exploring how participants perceived their comfort and frequency to self-disclose with clients in relation to their SNS use, a review of the assorted motives, types and amounts of self-disclosure in therapy and online will be presented in order to provide examples of clinicians' behaviors and views of self-disclosure in each category. Clinicians' motives to disclose are offered first. This category portrays the variety of reasons indicated by the sample in regards to their therapeutic use of self-disclosure and includes how clinicians deemed the relevance of disclosures to clients and treatment, how clinicians remained focused on the client, clinicians' comfort in presenting disclosures, and the impact of Google.

***Relevance to the client and treatment:*** A major pattern that surfaced for clinicians was the notion that offering or providing self-disclosure in the therapy room was an effort to help the client in a way that was relevant to them and their treatment. This appeared to also embrace the ideas of normalizing experiences with clients, illustrating important points in order to be supportive, providing reassurance, and building the therapeutic alliance. While people varied in how often they applied self-disclosure, a concept discussed later in this chapter, the quotes below indicate that no matter how much the following participants used self-disclosure, it was a

purposeful, therapeutic technique as it related to the client (and within the therapists' own comfort) rather than using it loosely.

When someone asks you a question about yourself, clinically asks you a question about yourself, it's helpful to think if your response would be helpful...I try to think about whether it would be helpful for them in their therapeutic work if I were to answer the question and if I feel comfortable with that information being out to them.

I'm very cautious, always in the service of the therapy if it feels clinically useful, if it feels that the client is struggling with some shame and feels sort of isolates, I sometimes will use self-disclosure sort of as a normalizing experience.

This next response is more specific in terms of self-disclosure when working within substance abuse treatment. Multiple people in the study who also spoke to being in recovery indicated that using their own recovery as self-disclosure was something they were comfortable doing so long as it applied to the therapy.

Because I'm working with people for whom that kind of information has an impact. It says, I've been there. I've done what you've done, and I've found a way out. And basically, you know, you can too. I'm very open and it's just the way I've always worked... Any time I think a personal experience is relevant, I never have a problem sharing, I'm like way end of that continuum.

Some female participants pondered the idea of what would be considered relevant to a client and his/her treatment in terms of sharing one's sexual orientation as a lesbian. Despite the differences in their perceptions, each participant showed they had thought about this concept *before* making their disclosure with the understanding that they were thinking about how it would or wouldn't help their clients.

I identify as lesbian and there are lots of people that would come into the clinic who identify as gay whether male or female. And for some reason, I wouldn't necessarily feel that it would be helpful to that person... who knows, would it be more helpful to a client to have that connection or would be more helpful to have the person not know anything about my orientation and just feel accepted straight out.

I do tell people so they can feel comfortable that I am a queer clinician. However, unless I am sure that information is going to be useful for the therapy, like I think it's actually helpful for GLBT folks to know the sexual orientation of their therapist, given that if they

know they don't have to reinvent the wheel when it comes to homophobia for example or queer experience generally.

While the next interviewee uses the word *irrelevant* to describe how some of her self-disclosures deviate away from the actual material covered in therapy, it appears this participant uses self-disclosure in a conscious, purposeful and therefore relevant manner to reassure particular populations that may benefit from its use. The notion that self-disclosure can be used in a variety of different approaches clarifies the nuances of this technique and the dynamics it entails.

I have worked with people who have really serious schizophrenia, even paranoid schizophrenia and so, with those people I am more inclined to answer a question than to ask them to explain to me why they want to know just because the people that are in that category very often will get extremely uncomfortable if you're not about to answer a question, cause they think you're hiding something that is somehow relevant to them. So as a way of reassuring people sometimes you answer a question that is completely irrelevant to the therapy.

Various participants shared similar views of using self-disclosure as a tool to build the therapeutic alliance. This concept included joining with the client and building a sense of rapport between clinician and therapist. While some responses were more general and others were in reference to a particular type of self-disclosure, the evidence presented in the following examples displays beliefs that the therapeutic alliance and connecting with the client is an important aspect of therapy and utilization of self-disclosure. One person stated "I'm going to stay within their comfort zone because my focus is therapeutic alliance, 'cause all I have to do is turn them off and we might as well kiss it all goodbye." Others shared the following:

It's much more of an intentional disclosure because I think in some way it will help with the treatment and with them. Whether that be in building the relationship or rapport or in the actual treatment.

I don't hide my support of all the social justice stuff they're talking about if I feel like that might be a good sort of connection between us because I think that the therapeutic alliance is one of the stronger pieces of therapy anyway, so that is an area where we can bond.

If it's something a little less loaded, and it might help them to see me as real human being who has my own life and I can relate to them, then I would probably lean towards answering the question.

***The session is about the client, not the clinician:*** Many participants spoke to their beliefs that sessions should be about the clients rather than the provider and how this factored into their viewpoints around using self-disclosure. Those who indicated this as a reason for how they chose to apply the tool in therapy were clear that they did not use self-disclosure as a way to attract attention to themselves. Instead, the responses illustrated here show perspective on beliefs around the importance of maintaining focus on the client. Though clinicians in this study did not speak specifically towards their theoretical orientation(s), the concept that many participants used aspects of themselves to relate to and preserve the focus on clients ties into the client-therapist relationship involved with relational theory. One participant noted that “if you’re answering it because you want the patient to like you more, so it would be helpful for you in that way, then it might not be a good idea to answer it” while another reiterated that “it’s very careful, my information is not the focus. It’s what would be helpful to the client. They’re the ones who are paying.” Additional responses included similar perceptions like “it’s not like I made the sessions about me, but if it’s pertinent I don’t have a problem sharing it” as well as “I obviously let the client take the lead and I don’t actually necessarily speak my views out loud, but I might be right in their corner or really support them for the kind of thing they are doing.” Through such responses it’s evident that these therapists were mindful of the balance between sharing personal information as a tactic while not sharing so much so that the center shifted away from the client. Furthermore, unlike the traditional psychoanalytic perspective in which the therapist serves as a *blank-screen* by not offering self-disclosure, the examples shown above indicate more of a

relational stance by clarifying how clinicians in this study used parts of themselves in order to relate to their clients.

Linked with this notion that the client is the primary vehicle for self-disclosure is the aspect of *intention*. Consequently, nobody in this study stated or hinted at being reckless with this therapeutic intervention. Examples that shows participants being thoughtful about self-disclosure and using it appropriately came across when someone mentioned “it’s a very tender and nuanced... kind of thing” and “we outta [sic] try to be really thoughtful about our use of self-disclosure and if we notice we’re wanting to do it, we should check to make sure whose interest will it help. And the answer should always be the client.” Multiple participants also spoke to the component of intention by indicating the uniqueness of their self-disclosures as it related to particular circumstances and how their disclosures were not all universal. For instance, one shared “I’m a divorced woman and have been a lesbian for about half my life and I don’t always disclose that to my clients. I disclose it to some clients and not to others” and another person mentioned “so if it’s just factoids... I tend to answer those but again it varies a little bit client to client.” The idea that self-disclosures reported in this study are extremely diverse and variable depending upon differences in the therapy and the intention to self-disclose is not surprising and confirms the many layers and complexities involved with this technique.

***Personal comfort:*** Another prevalent trend under clinicians’ motives to self-disclose with clients had to do with their comfort level to offer information. When asked to reflect on the kinds of disclosures that were more common as opposed to those they felt were “off-limits” to their clients, participants had distinctive viewpoints on what types of material they felt comfortable sharing or not sharing in a therapeutic context. A couple trends surfaced across different interviewees, however, with regards to not providing specifics about where they live, details

about family life, and intimate disclosures around relationships or sexual habits. While particular clinicians felt comfortable sharing information that others were not, some of these differences appeared linked to the type of work they were doing with clients. More details around the specific types of self-disclosures with clients will be elaborated upon in the next major theme of this chapter, but it's important to note that all clinicians acknowledged in some respect or another the limits to their disclosures. Some of these limitations are presented below.

Some people shared wanting to keep their relationship status or family life private by saying "I would never tell somebody that I was dating...that feels like too personal, I can't think of a clinical relevance for that" and "I would never talk in any way about personal relationship issues, my own relationship issues...I would never talk about family dynamics...family of origin stuff, nothing like that." Another participant felt comfortable talking about sexual practices if it related the work being done with clients but said "one of things I don't disclose is I'm a nudist. It's not relevant to almost anything else. But I do a lot of work with sex, they are not intertwined, they are not the same thing." In contrast, the following person stated "I would deflect sex, I don't mind sexuality, like gay, straight, whatever, but I'm gonna deflect questions if they get too personal about my sex life, or my extra-curricular activities, how I live, where I live." In reference to more things than not being off-limits to clients, an interviewee shared "absolutely. Of course. Most of my life." Some people spoke to not answering questions related to past experiences such as drug or alcohol history and another person hinted at similar notions by explaining "certain types of history questions that (are) pretty specific. Have you ever, do you, or have you ever experienced this? I typically don't answer." As evident from these numerous examples, the diversity of clinicians' comfort to self-disclosure with clients has some overlapping similarity among participants but is quite variable in nature.



*The impact of Google:* Finally, a mixture of the sample also spoke to the nature of Google and how they are aware their clients can simply look up information about them on the Internet. People expressed the notion that certain self-disclosures can be found publicly online by simply Googling their name and therefore, they are conscious of this added aspect of disclosure and how they choose to share personal components with clients. A couple responses that elaborate upon this motive to self-disclose are offered here. One person claimed that “if you don’t answer... it’s such a simple question that they could get the answer if they just Googled me. That it would be like I was just trying to hide something from them, like what’s the point.” Another shared a comparable viewpoint in terms of sharing the “little, the factual details that I don’t think say very much about me but help connect” by realizing that “the truth is that a lot of that information if you use Google, you can find out about me.” In reference to her marital status a different clinician felt that her divorce was a self-disclosure she would share if people asked with the understanding that “it’s like public information in the Internet.” These findings reiterate how various clinicians recognize that certain information and disclosures are easily accessible online and therefore play a role in how they apply certain disclosures about themselves.

**Motives to self-disclose on SNS:** The motives to self-disclose on social networking sites as compared to in therapy were very different according to research outcome. Though there was still some variation in why people disclosed personal information online and what they believed influenced their decisions to do so, these motives were unlike the reasons that people self-disclosed with clients and in turn, less diverse. Participants’ responses appeared linked to using social networking for its intended purposes of connecting with others in some capacity: communicating with friends and family, staying in touch with those that live far away, displaying beliefs, indicating their current status, posting interesting articles, links, or websites, receiving

positive feedback, informing others of events, and what one person labeled as promoting “transparency”. While some people shared they posted status updates on their personal Facebook Wall, others clarified they did not participate in this behavior. This was also the trend for posting pictures or commenting on other people’s Wall. While the following illustrations are each unique, they all highlight the mutual pattern of connecting with others.

People complained and said you know it's one way we have to stay in touch, we don't see you for a whole year and we really want to know more about what you're doing and what your likes and dislikes are and who you're spending time with and so forth. And so I have used it that way, if I go to a concert, I put something on there about it. If I listen to some music that I think is wonderful I'll put that on. If there is a political action that is going to happen that I think is important I put that on.

Yeh, I think it’s mostly that if something important to me has happened that I want my friends to know about it and it’s kind of an easier way to do it than call them. I have fellow friends that live overseas as well so that’s the main way that I stay in touch with people. And then there’s also that if there’s an article or a website that is compelling in some way that I feel other people would like as well or should read or something, I’ll post that.

I'm on it because of connecting with especially people who don't live close to me. Although I also have a lot of local friends on it. I guess I put the political things up because I do like to advertise certain things. I've also used it to advertise events.

A handful of clinicians felt that their basis to disclose online were for privacy-related reasons with an understanding that there is the potential for clients to see such information or material becoming public. One person said she would “not share anything unless I'm ready for it to be on the move” while other people stated:

I think that it's, one I think that anything could be public. Even though I have my private Facebook...I wouldn't post any photo or comment that if it did somehow make it onto Google that it would be problematic for me. So that influences it...I don't have a desire to keep it too real, so to speak. Like major events and fun stuff, but I don't have a desire for it to be a real time line of my life versus just a time line of ideas or quips or something like that.

Most of the self-disclosures come through status updates. I limit whose page I comment on depending on how many privacy they have on their pages. So I check with my friends

and find out what kind of privacy settings they have, because if I comment on somebody's page and they don't have a lot of controls, my clients could (see).

Though the next participant also recognized the risks of privacy involved with social networking sites, she felt it was important to stay in contact with others regardless.

I've sorta of decided that connecting with others and being able to share views and hear news about others, is more important to me than the very real possibility that you could be putting yourself at risk by showing pictures of yourself or your kids on Facebook. So it's not that I deny that that's possibly a problem but it's more important for me to be able to connect with people from my past who live on the other coast or in another country who I realistically wouldn't communicate with.

Different participants acknowledged their restricted, if any at all, self-disclosure on Facebook and indicated they used it predominately for supporting others. The former example refers to using the "Like" button that can be clicked to show personal support for someone else, while the latter quote emphasizes sharing positive comments.

So I basically do it to be nice to people, I mean I don't know. It doesn't matter to me, it seems like one of those co-dependent things, like I'll be a good friend. It has very little to do with anything, any gain for me personally...I'm not interested in informing or sharing beliefs or whatever. I would really much rather have a phone conversation or a face-to-face conversation with somebody.

So if I actually am reminded by Facebook to go check it out, I'll do (that) and then I'll look through it a little bit and... to be supportive than anything else. It's like a "way to go" "nice job"... something like that.

On the opposite spectrum, a different responder believed that being transparent was the main influence for his online self-disclosures. Unlike many of the participants above who shared a sense of caution to some of their disclosures, this person felt he could afford to be more open and revealing on the Internet.

What principally motivates me, is that I'm a big promoter of transparency...In general, more transparency, more honesty is better than less. Being strategic about that. I don't have to be strategic about that because I am pseudo-retired... There's no one out there that can really fire me.

## **Types and Amounts of Self-Disclosures in Therapy and on SNS**

**Types and amounts of self-disclosure in therapy:** The different types of self-disclosure that clinicians reported applying in therapy seemed connected to the various motives listed above. Consequently, depending upon the circumstance of the disclosure, their own personal comfort to provide information, and the type of therapy they were doing (i.e. substance abuse treatment, couples work, life transitioning and adjustment therapy, child and adolescent treatment, adult and elder treatment, etc.), a wide range of responses surfaced in the findings. The first part of this section will address the variability across the types of self-disclosures that clinicians noted while the different amounts of self-disclosures they engaged in will be explored next. Though there was some variation on when or if participants would share certain kinds of disclosures, how they saw self-disclosure applicable to the treatment they did with clients, and what was within their own comfort, the following topics of self-disclosures surfaced at some point or other across the data: relationship/marital status, parenting strategies, having or not having kids, sexual orientation, political views/social justice lens (without pushing views on clients in a isolating way), dealing with grief, sharing coping strategies, family history components, cultural background, religious or spiritual beliefs, health related disclosures, recovery status from substance use, having pets, hobbies or interests, past or future plans, being a grandparent, and general (not specific) area of residency.

To clarify, clinicians tended to be open to different types of self-disclosures with the consideration that they had a therapeutic motive or reason to provide such information to clients and it was within their comfort zone to disclose such information. There were assorted disclosures that people felt were “off limits” as noted above, but again this seemed to vary depending upon clinician’s comfort to self-disclose particular matters and how they saw it

applicable to the therapy. Though some people acknowledged that some self-disclosures came across unintentionally, it's important to reiterate that no one in the study indicated that they would purposely or actively toss a self-disclosure into the room without having a therapeutic context to do so.

In regards to the amounts of disclosures clinicians used with clients, there was also an array of how often people reported they spoke to personal topics in therapy. Some people felt like they used self-disclosure often in their practice as a meaningful therapeutic tool while others indicated using it less often. However, all participants spoke to self-disclosure as something that they have used with clients and therefore, no one said that they had never used this technique before. The subsequent examples provide glimpses into the mixed responses that people gave in reference to how much they disclosed with clients. Those who mentioned using it more made statements like "I use self-disclosure as a tool frequently in my office. And I find it really effective" in addition to the following:

I probably err on more self-disclosing side because I work with children and adolescents and I feel like families need kind of more of a real human being there with them... because sometimes they're just looking for you know, you as a kind of role model, like what do these adult people do.

Most of the time (when) someone asks me a direct question, I'll answer it. I feel like I can tell when a client is seeking information to strengthen the therapeutic connection, like they want to know I'm human vs. someone is seeking personal information in a more self-serving capacity.

Conversely, others spoke to using the technique of self-disclosure less often. One clinician mentioned that "generally I use it very sparingly and when I do, it's very mindful and intentional with a therapeutic motive to it" while someone else said "my general idea is less is better. And only, I self-disclose when I think what I self disclose will be helpful to the patient. On an as-needed basis, I guess." An additional response in this category conveyed:

I use limited self-disclosure, mostly around parenting issues...I would say either with kids and teenagers and young adults, less self-disclosure. So I don't have a purely psychoanalytic stance of having boundaries like the wall of China, I do share sometimes, but not extensively.

Finally, a variety of clinicians mentioned they were more general with their disclosures rather than providing many details which also touches upon amounts of self-disclosure. This came across when people made comments such as "I disclose vaguely... I don't get specific and say, oh this is my story" and "usually my disclosures are more general." Since the types and amounts of therapeutic self-disclosures were just covered, the different types and amounts of online disclosures will be explored next.

**Types and amount of self-disclosure on SNS:** Comparable to the variety of types of self-disclosures that clinicians felt comfortable offering (and not offering) to clients in therapy, people who partook in this research had different behaviors for the types of self-disclosures they presented or withheld on social networking sites. Though some of the different types of self-disclosures were already mentioned in the above section, a more comprehensive list will be covered here. This list represents the self-disclosures that were brought forth at some point across the twelve interviews with the acknowledgment that SNS self-disclosures, like therapeutic self-disclosures, depended upon people's motive to disclose and what information they wanted or did not want to share. While a select few noted "I don't share anything" or "I don't share much at all", the majority of people spoke to at least some type of personal self-disclosure. These online self-disclosures included posting pictures, articles, or links to websites, sharing hobbies and preferences, informing others of their plans, major events, or accomplishments, making announcements, sharing "fun playful stuff" or "funny things and cute things and comments", writing status updates, indicating beliefs or leanings (i.e. political or social justice topics), and providing information about relationship status, where one lives (generally), and educational

background. Additional discussion about the self-disclosing nature of social networking sites like Facebook will be presented in the concluding Discussion chapter.

Whether or not participants reported engaging in self-disclosure on SNS, all participants in this study noted that there were limits to their online disclosures to some degree. The fact that numerous participants reported being limited with their personal disclosures as evidenced below, suggests that as a whole, clinicians in this study did not engage in copious amounts of online self-disclosures. Just as participants' had their own views on what types of information they would disclose on SNS, people's responses varied in regards to what they would not self-disclose in this arena. Despite these differences, all touched upon some type of limitation to how much they disclosed. Cases that were predominately narrow in their approach shared what was "off-limits" for them.

I guess I'd say the majority, almost everything. I'm probably not likely to post something about myself. I feel like I don't want to be a bragger and I know that's not how people see FB posts, but that's how it would feel to me which is partly why I don't ever post my own stuff.

I don't share anything. I mean I just don't... I suppose it feels like a very different kind of self-disclosure. I'm really not interested in whoever the world is out there knowing my business...I'm not really interested in whoever these people, you know all these 40 billion people who are on Facebook, knowing anything about me.

Aside from perhaps one of my children's birthdays or maybe an accomplishment, about one of my kids, I don't post much else about my daily life... I don't post much about myself personally...I comment a lot on other people's stuff. There's not much content to it though, if I think about it.

Others shared the limits to what they posted as it related to topics such as protecting their families, avoiding marketing ploys, and keeping certain things such as feelings, struggles, relationship components, and sexual habits to themselves. The variety of responses demonstrates how differently people utilize social networking sites based on what information they don't want on SNS.

I wouldn't criticize my kids or my husband online... I would protect my family's feelings over needing to connect with others... how I'm feeling on the inside and kind of exposing myself that way, up til' now that kind of feels off limits to me.

The things that I don't want to share online are the things that will target me for marketing. I do not want to get email offers of whatever new herb. Or another gadget. Anything that goes on the internet, especially Facebook, is being probed by hundreds of marketers and marketing companies who then resell them.

I would never ever talk about my sexual life... I tend to not post if I'm having a tough time or something. Or if I'm struggling with something...Not necessarily anything really really personal.

I'm not really going to espouse my relationship status...I don't share my political views actually. I mean they know them, but I'm not like posting some article and saying oh my god did you read this.

Other confinements to self-disclosures were associated with some people wanting to share certain information in a more intimate, private setting as opposed to the larger, online world.

This was evident when participants noted comments similar to “there are things that you know, you'd only tell close friends in one-on-one conversations. I wouldn't post anything that I wouldn't say to a big group at a cocktail party, you know.”

### **Comfort and Frequency to Self-Disclose on SNS vs. in Therapy**

**Comfort to self-disclose on SNS vs. in therapy:** After taking into consideration the variety of motives, types, and amounts of self-disclosure both therapeutically and within an online social networking context, clinicians' perceptions indicated mixed results around whether or not they believed there was a connection between their comfort levels to disclose online in relation to their offline disclosures in therapy. Some participants expressed seeing or identifying a relationship between their comfort levels in both places while others saw the two avenues completely separate from one another. The former category will be address first. This participant offered her perceptions of being limited and cautious in both arenas as a result of skepticism around privacy related issues:



Interesting, 'cause I am actually limited with Facebook obviously. And with my clients, I'm also limited. Huh, so you have a little correlation there. So, yeh...I'm cagey. What goes into Facebook, I'm very cagey 'cause I know that everything can and will be brought up at some point in the future. Yeh, with clients too. They have their own, you know I could say something that might sound pretty and an innocuous tone and later, oh, this has some great meaning. So again, I'm very particular.

Similar to the notion of “cagey” mentioned above, the awareness of being “protective” surfaced in the following response when another person commented, “I'm probably a little more protective on networking sites because I don't want anything to filter through to any clients or potential clients. And whether it affects my disclosure in therapy, I think that I'm a little cautious about each one.” While this next participant also noted a connection based upon filtering information online and offline, she was more comfortable sharing pieces of personal information such as her favorite drinks, pictures of herself, details about her vacation, and specific future plans on Facebook rather than in therapy. Like another respondent above and others in this study, it appeared thinking about a possible connection between online and offline disclosure was a new idea that evoked discovery.

I think I just discovered it in our conversation I actually filter the same things... the differences would be like my drinking preferences... like the pictures that I post of me, you know I wouldn't be talking with clients about my vacation that I'm taking or what I did while I was on vacation, that I'm thinking of buying a house. And I would disclose that on Facebook.

Half of the participants (n=6), however, saw things differently. Five of these people did not perceive any relationship between their online comfort levels to disclose as it related to their self-disclosure with clients, while one of the six conveyed some ambivalence around the topic. Those who declared no connection shared insight as to why they perceived such differences between SNS and therapy.

I don't know, I feel like it's really two different worlds for me. If there's any overlap though, it's probably all really unconscious because I'm trying to think about it now... and it feels like two very different worlds to me that don't really related to one another... I

guess because when I'm with a client and it's one on one and there's no other audience, I would actually be more likely to disclose a feeling of my own to a client, probably, than on Facebook. But then on Facebook I would disclose personal information that I would probably be a lot less likely to disclose to a client... I voluntarily share that stuff on Facebook before anybody asks me, I just share it 'cause I want people to know about me and my life. That's such different situation then the therapy room where it's about their life, it's about them.

Different people indicated that "(on) the basis of transparency, I'm willing to share almost anything. Within the context of the room, I'm not, unless it is very relevant to the client" and "the rest of the world is gone as far as I'm concerned when I'm in the room with a client... so I don't think outside influences are affecting me, I make those decisions in the room." These illustrations quoted above and below show how views and behaviors of self-disclosure vary based upon the setting of the self-disclosure. Another person offered additional insight:

I feel much more comfortable self-disclosing in therapy with clients because...I have visuals, I can see how they're responding. I can do damage control if I overstep the mark. I can in the moment handle feelings that they may have. I can address any sort of issues that come up as a result. With self-disclosure online I have none of that ability to be watchful of that part of my client and all they would have is text information and text is renowned for, it's so easy to project onto it your own thoughts and feelings whereas if somebody is sitting in front of you saying no that isn't exactly what I meant, I can explain a little better. It's a whole other ball game. I think that, other than the fact that I'm private about my life, I also feel protective of my clients. Way different levels.

One more participant shared similar sentiments about being more comfortable to self-disclose offline with clients rather than on SNS but initially portrayed some ambivalence about whether the comfort in each arena was at all linked. Part of the response also alluded to the pattern addressed earlier in the findings that Internet privacy is no longer seen as a guarantee which factored into the comfort to disclose information.

I'm a little less than the middle of how much I self-disclose, I'm not really sure. But I'd say that on Facebook, I'm definitely on the less end...I'm not sure if the two influence each other or are connected or not um, but there seems to be a relationship there...I've been getting more comfortable with self-disclosing with clients and less comfortable with self-disclosing online. So, in some ways they are going in opposite directions. And I'm not sure, I think that's related to just sort of the privacy on the Internet is pretty

questionable and um, as I get more comfortable as a clinician I get more comfortable knowing where my boundary is, where before I probably, I didn't quite know where that was so I was a little more careful about it.

Despite these mixed findings around perceived comfort levels, it's important to highlight that no one in this study mentioned beliefs that self-disclosing online made them feel *more* comfortable to disclose with clients.

**Frequency to self-disclose on SNS vs. in therapy:** While the sample varied in regards to whether or not they believed their comfort levels to disclose online and offline were related, the majority of the sample (n=10) *did not* believe that their personal use of social networking sites was associated with the amount they disclosed in therapy. Therefore, most people did not feel that the frequency of their online self-disclosure was related to how often they shared with clients. Despite this general consensus that the amounts of disclosure between the two settings were unrelated to one another, some participants' responses differed around where they felt they disclosed more information, either on SNS or with clients.

A majority of different participants shared their beliefs around the lack of connection between the amount of online vs. professional offline disclosures with statements such as "I don't think it does, but I may be fooling myself", "no, I don't think they are related at all. I don't think about Facebook much", and "no, I don't think there is a connection. The frequency which I disclose information on Facebook is much more than what I disclose in therapy." The following interviewee expanded upon the reason he believed there was no connection with the acknowledgement that other aspects play a role in his therapeutic disclosure beyond SNS:

I don't think so. I think that there are a lot of other influences related to just why or how often I use Facebook, part of it is that I find it kind of boring. So I feel like there are a lot of other factors and as I've developed as a professional, I don't think that that how much I disclose in therapy is influenced by social network use at all.

While agreeing that the categories were unrelated, in contrast to a participant above who disclosed more online rather than in therapy, someone else offered the opposite perspective:

I don't think so. I think I'm way more self-disclosing with clients face to face. I mean they know nothing about what I'm doing online. I don't think there is a connection, I could be wrong. I see the two things so very different. With Facebook, I have it so wrapped up it's pretty much happening behind closed doors. So it would be like do I feel like anything that ever happens at my house has anything to do with how I self disclose with clients? No. I sort of see it in the same vein. It's so tightly wrapped that it would be pretty hard for people to figure out. I feel pretty confident in my ability to control that.

Two participants did not initially perceive any type of connection between how much they disclosed on SNS and with clients because they felt the goals of disclosure were vastly different. They later added some similarity, however, but these connections were based on being mindful and limited about their disclosures rather than disclosing a lot in both places. One of these examples is presented here:

I'm not sure I can see a connection because... first of all, there's this huge difference; one is that on the social networking, again on Facebook, I only communicate with my friends... So in therapy, first of all, it's not my friend, it's not a friend. And so the purpose of the self-disclosure is completely different. In terms of frequency, I almost say that in a certain way I do it more in therapy than I do on the social networking sites but I can't really, I have to say it's completely different because the audience is so different. Even the online network, my comments certainly on other people's posts are read by anyone they are friends with, so it can be people I don't know. So I guess to some ways, maybe it's similar. It's not sort of all the time in either one.

While the majority of the sample did not perceive a relationship between the frequencies of their online and offline disclosure (including the two people mentioned above who conveyed multiple perspectives), only one-sixth of the sample (n=2) felt that the frequency they disclosed via SNS and the amount they disclosed with their clients were connected. They clarified that this link was based on their minimal disclosures in each setting. One stated, "yeh, I don't do it that often, and I don't self-disclose that often," while another shared:

Wow, um, yeh. Because it's not much. I think I'm comparing myself to people who I think use it all the time, because when I go on, I see people who are posting all the time.

So for me, it's an occasional thing that I'll disclose something and similarly in therapy, it's an occasional thing that I'll disclose, certainly not all the time, it's occasional. Yeh, so I think it is related.

Altogether, these findings convey that no one in the current research felt that increased amounts of disclosure online was connected to increased disclosure in therapy with clients.

### **Generational Differences**

When participants were asked if they believed a generational divide was present for clinicians who grew up with social networking sites as it related to their clinical self-disclosure, most interviewees felt there was indeed a generational difference of some nature but not everybody thought this was necessarily in relation to self-disclosure. Diverse responses included discussion around issues of privacy, boundaries, information-sharing, and the influence of education in the clinical field. Someone in the youngest age category stated, "I haven't thought enough about how, but I think that there will definitely be a difference in the sense one way or the other of disclosing more or less based on an experience of growing up with that technology and it just being so omni-present." In terms of privacy, or really the lack thereof, a few people felt this played a crucial role in the generational dynamic. One 50-59 year old shared "yeh, there's no such thing as privacy anymore. It's out there for the world to see... It kind of takes away from any sense of firm boundaries. I just thought of that." Another participant almost twenty years younger agreed:

I would bet yes 'cause I think that the idea that you can't be as private anymore. You know, I feel like anyone who is growing up in middle school, high school, and college now is having a lot of stuff they're putting out on the Internet that some of them might stick with them, some of it might not, but they are also getting used to the idea that their lives are not as private. And so I think that it might influence either, how they will self-disclose in therapy or how they worry about what's out in the world in social networks and what their patients can find. I'm not sure if it will influence how much they disclose in therapy, but I definitely think it will influence how comfortable they are with the idea that their information is out in the world or they can post this on Facebook and it's possible it could get to a client.

Additional participants, the first in eldest category and the other in the 60-69 range offered reactions regarding the large generational divide in terms of SNS use. While they did not indicate clear notions if self-disclosure will change as a result of this divide, they each alluded to possible consequences for the younger, Internet generation of clinicians. The former indicated that “our beliefs are very driven by our environment. I think that it's going to be much more open.

Whether that's good or bad is another question,” while the latter felt the following:

I do believe that very strongly...as part of your graduate education there needs to be, you know, an ethics conversations to talk about this very thing. ‘Cause I have a sense at times, certainly from my own clients, that people use social networking very inappropriately at times, in ways that it is very harmful... In my generation, there wasn't such a thing. You either talked on the phone or you spoke in person or you sent a letter... now there are so many different possibilities and I do really think that younger clinicians...might take it more for granted and use it more as sort of unintentionally get in trouble with it. Not that they would be stupid about it but that they would just not realize that it had the potential to blow up in their face.

Examples from others who saw that self-disclosure would increase involved replies such as “my guess would be a little bit more open to it or sort of primed to self-disclose because their increased use of social networking that way” and how boundaries have decreased and self-disclosure has become more normalized over the years:

I'm gonna bet that's it's going to increase the amount of self-disclosure in therapy because you know, the younger generation have less boundaries cause of the social media, I think. It pushes the boundaries... But I also think there's going to be a parallel because what they teach us in graduate school, I think over the years they've gotten more lax. I remember when I first started school, the notion of no self-disclosure, no no no. And over the years of treatment...there is a certain amount of self-disclosure that strengthens the relationship and you have to know the difference between why are they soliciting the information. But I think that the younger generation...are gonna be much more comfortable with information sharing with their clients. Hopefully, not too comfortable. That's always a fine line.

The concept of boundaries also came up with a participant closer to sixty years of age. Unlike those that felt self-disclosure would increase, this person perceived the opposite to be true:

I think that there is so much more conversation happening about Internet use, I'm hoping that clinicians who are coming up behind us, behind me and my cohort groups, are being mindful of that too. And sort of like being attentive to not blurring those boundaries... I'm hoping that, god, I've never even thought about this, but I'm hoping that graduate schools are addressing this with clinicians and God knows there's nothing when I went through graduate school... there was nothing to address, there wasn't Facebook.

Someone else who also believed in the influence of SNS but felt differences around self-disclosure were not purely generational, shared her thoughts:

I can't help but wonder if people see the world differently when their sharing so much information on the Internet...there are a lot of people who are so concerned about online privacy and then there's a whole generation, well not just the younger generation... who started just putting all kinds of information out there that a lot of people have been trying to make private. But then all kinds of generations, including people up into their 70s that I know are following suit. So, I don't know...I think it's likely that being really comfortable self-disclosing to the entire planet in addition to way more over-disclosing to your friends and family and people that you might normally speak to as acquaintances but who are also getting all of your statuses, that can't help but influence what you do sort of in your entire life.

Conversely, two people in the youngest category were hesitant around how or if SNS would impact self-disclosure in therapy. The youngest participant felt potential for some type of shift (which is left unclear) but not in regards to self-disclosure by stating, "I think that it would impact them in some way. However, I still think the use of self-disclosure therapeutically is, I don't know, I think that that will kind of stay." The third to youngest person in the study thought that social media may enter the therapeutic picture beyond the therapy room, but not actually change one's impact as a therapist. As she continued speaking her perceptions shifted slightly, albeit remaining unsure how related generational differences were to self-disclosure:

I think they're probably more comfortable using social media with their patients than the older clinicians are. But I don't think in the therapy room they are necessarily going to be very different because people, I think...people that are growing up in the social media age are actually, if anything, a little more socially inept in person...it might be even harder for those persons to connect because they are so used to doing it without eye contact...this is unrelated to the comment I just gave you, but maybe they would be more likely to self-disclose facts about themselves because they know it is so easy for the

patient to look it up anyways...But, other than that it's hard for me to imagine it being very related.

The variety of responses revealed throughout this section indicate that people within this study have different thoughts around how generational differences may be at play and whether or not this would factor into how younger clinicians view and use self-disclosure. Regardless of these variations, most clinicians either perceived a generational divide or if they didn't, they noted some type of difference for those that accessed SNS as compared to those that do not.

### **Online Boundaries with Clients**

**Social networking policy beliefs:** Five participants noted that clients had contacted them on social networking sites to make a connection (e.g. asked to be "Friends" on Facebook), four people said this has never happened to them, and three people did not comment on the subject. Regardless of whether or not they had been asked to engage in online social networking with a client(s), all twelve participants clarified that they would *not* engage in this behavior with current clients. Participants' responses differed around the reasons as to why this was the case but included concepts such as boundary violations, privacy matters, and confidentiality concerns. One individual felt that "I can't because it'd be considered a boundary issue" while another spoke to "because of confidentiality and just privacy, I'm not friends with people I work with on Facebook." The following participant understood the sense of normalcy behind a client's want to be connected with a therapist:

It's probably the most normal thing in the world too for that person, from that person's perspective. You know, they do it with everybody and anyone in their life and so, why not you, you're a dear person to them...If people have more and more views, used to being just out there on the Internet, being out there friends with everybody and very little experience being a client, they wouldn't even know that, oh maybe that doesn't work here.

Interestingly, when asked during the interview to reflect upon having a social networking policy with clients, most people felt that having a written policy was not a necessary step to take



up-front with clients. Only one person reported having a written social networking policy and this unique response said “we put it right into our intake paperwork. It says something like, in the interest of client privacy and confidentiality clinicians...will not “friend” or “link” to clients in the center.” However, the majority of participants shared that some type of discussion with clients or a policy would be a consideration if it came up. More to this point and the significance of clinical social networking policies will be spoken to in the Discussion chapter. The following examples reflect clinicians’ perceptions on what such a policy would mean for them and their practice:

I suppose one could make a statement to be clear that I do not friend my clients nor will I accept a request to be your friend online. I suppose I could do that, it's never come up. But certainly could. If I really continue the work til I'm 90... by then I'll have to be doing that. I've never thought about it but...I would certainly consider it if it ever became an issue.

Yeh, I think that it would be kind of like a set policy in my head, I don't think that I would necessarily need to spell that out in the beginning or on a website for example, but I think it would, if it came up case by case basis then we would need to have a conversation about those boundaries. That it would be me communicating that I would not engage with that person online.

I think in this day and age of social networking I think it's really useful to have thought about it, on my own, and then I still think it probably makes the most sense to talk about it if it comes up.

**Online privacy:** As shown above clinicians in this study were clear about the boundaries they would set with clients by not engaging in SNS activity with them in order not to blur the client-therapist relationship. Another online boundary that clinicians reported was in reference to SNS privacy settings. While two people did not speak to the subject of privacy settings and another two were not positive if their pages were private, two-thirds of the sample (n=8) indicated their privacy settings. Out of these eight, a range of people identified high privacy settings by sharing “my Facebook page has every single privacy control you can possible put on”

and “my profile is on lock down and nobody in the public could actually find me.” Someone else clarified that their SNS is “private, very, very, private” and another who had an anonymous page stated “I went into Facebook and disabled all the things so that no one could know anything about me. I only put in information that I absolutely had to give to have an account.” These illustrations are evidence that clinicians as a whole were aware of the importance of maintaining a distinction between their public/professional and private lives and therefore identified the value in having privacy settings on their SNS.

### **Summary**

The many different motives, types and amounts of self-disclosures reported by clinicians during therapy and on SNS show that this therapeutic technique and component of online networking is not so clear cut and predictable. Self-disclosures in each arena appear to vary depending on the motive for the clinician to offer personal information, the context in which the disclosure is being made, and clinicians’ comfort level to share particular aspects about themselves. After reflecting upon the aforementioned five themes and findings from the data, the results of this study reveal mixed conclusions as to whether clinicians believe that their views and behaviors of self-disclosure are related when comparing the therapeutic setting and SNS.

More specifically, the findings show that while some clinicians viewed their comfort levels to disclose in offline and online arenas were connected, others did not perceive this relationship. Some clinicians identified that they were cautious or limited in both avenues although no one in the study indicated that an increased comfort to disclose on SNS meant they were more comfortable to disclose with clients. In terms of frequency of disclosures, there was popular agreement that there was not a connection between the amount of disclosures online and offline. However, some of the interviewees had different views regarding where they self-

disclosed more. A few people observed that they did not disclose a lot on either SNS or in therapy but nobody in the study identified that self-disclosing more online led to increased self-disclosure with clients.

The reality that various participants appeared mindful about what privacy settings they utilized and had considered the potential for information to be seen by clients or becoming public offered insight into how clinicians were protecting their personal matters. While only one person reported having a written social networking policy, all participants would not engage in online social networking with current clients. Many interviewees felt that they would address this phenomenon if it became necessary. Finally, the diverse range of ages in this study from those in their thirties, forties, fifties, sixties, and seventies provided data from people across multiple generations. Overall, those who participated in this study believed that the presence of social networking sites will impact younger clinicians in some manner (not necessarily in regards to self-disclosure) who recently entered the clinical field or will enter it soon. A couple of people did not associate the impact of SNS to only those in the younger generation by acknowledging that older generations use online social networking as well. Further examination and reflection of these results as they apply to previously conducted research, relational theory, and the field of social work will be covered in more detail in the subsequent and final Discussion chapter.

## **CHAPTER V**

### **Discussion**

This study was created in order to research whether clinicians identified a relationship between their therapeutic use and views of self-disclosure and their online disclosure through social networking sites. As reported in the previous chapter, the findings indicate that clinicians engage in self-disclosure both professionally in therapy and personally online. While an assortment of and at times similar types of self-disclosures emerged in each arena, disclosures with clients and on SNS differed based upon the motive to self-disclose, the context of the disclosure, and clinicians' comfort to provide personal information. The majority of participants did not perceive there was a relationship between the frequencies to self-disclose online versus offline, and some clinicians identified that their comfort to self-disclose on SNS and in therapy were related based on limited disclosures in both places while others saw no such connection. The results of this study imply that therapists perceive the utilization of self-disclosure on social networking sites and in therapy differently and therefore, their views and behaviors of sharing personal information online and offline vary. This chapter will delve into these findings, as they relate to previous research and relational theory, followed by an outline of the strengths and limitations of the study and the implications of the outcomes in terms of social work practice and further research.

## Therapeutic Self-Disclosure

Clinicians in this study recognized the nuance and complexities involved in therapeutic self-disclosure with regards to a variety of components such as remaining relevant and client-focused, maintaining or building the therapeutic alliance, reflecting upon the intent of the disclosure, and acknowledging how self-disclosure varies from client-to-client. These findings support Barnett's (2011) acknowledgment that contextual factors should play a role when considering self-disclosure, that the clinical relevance of the disclosure is important, and that clinicians should understand "the nature of self-disclosure as a boundary issue in psychotherapy, its implications for the psychotherapy relationship and process, and how to decide when and how to use this potentially important psychotherapeutic technique" (p. 315). The notion that a range of participants were aware that the therapeutic alliance contributed to their motive to apply self-disclosure also connects to former research (Bridges, 2001; Hanson, 2005; Myers and Hayes, 2006) which highlights the impact of the client-therapist relationship in terms of the function of this technique and aspects of the therapy.

All clinicians, regardless of their background, spoke to some type of self-disclosure that they engaged in with clients. Consequently, none of them indicated feeling they needed to serve as a *blank screen*, a concept that Bishop and Lane (2001) reviewed in reference to the traditional Freudian perspective of withholding self-disclosure in therapy. Instead, the results indicate that the sample was open to offer (at least to some extent) self-disclosure as a meaningful, therapeutic tool when applicable and useful to their clients. While participants did not speak directly to their specific theoretical orientation(s), the fact that they reported using self-disclosure as a mechanism to help their clients, contribute to their treatment, and relate to them in some way supports Bishop and Lane's (2001) recognition that over time and with the impact of relational

and intersubjective lenses, self-disclosure has become an acceptable, authentic therapeutic tactic. Further, additional connections to relational theory were evident when participants spoke to their understanding that the use of themselves through self-disclosure could be applied to normalize an experience or reassure their clients, display a sense of genuineness, to join with clients in a supportive manner, and as Wachtel (2011) noted, have the ability to make the choice whether or not to share personal information during sessions. Since clinicians did not state they applied self-disclosure in a reckless, inappropriate manner it was evident that they were attentive to how self-disclosure plays an important relational component with their clients.

### **Social Networking Sites Use**

All participants in this study were required to have an active Facebook and/or Twitter account and therefore, all twelve people in this research utilized SNS. The fact that two-thirds of the sample reported some type of daily Facebook use supports the statistic that over half its consumers log on daily (Marche, 2012). Participants in this sample also represented a wide range of generations and it appeared that it was not just the youngest cohort (those in their 30s) that used social networking sites on a regular basis. Though this study only included licensed professionals rather than clinicians in training, unlike Taylor et al. (2010) who discovered that younger, graduate students reported using SNS more often than older, practicing clinicians, these research results did *not* indicate a noteworthy difference in age and SNS usage. Though this sample cannot be generalized to a larger population of clinicians due to its small size, a concept discussed in more depth below, the findings from this study clarify that a diverse range of ages access and make use of online social networking.

Furthermore, while the inclusion criteria did not require that people *had* to self-disclose on their SNS or make use of the "status update" option on Facebook, most people shared that

they engaged in some type of online self-disclosure such as posting pictures, commenting on other people's pages, and/or posting their statuses. As mentioned in the literature review, considering 80% of people's updates on SNS sites like Twitter and Facebook are based on self-disclosure (Rose, 2012), it is not surprising that therapists who use social networking sites also report self-disclosure in this realm. This study purposely incorporated sites like Facebook and Twitter because of the self-disclosing character they entail, as opposed to other SNS like LinkedIn which are geared towards social networking in a professional rather than personal regard. Numerous participants in this studied also acknowledged the possibility for clients to find information about them online in some form. These findings reiterate Chaernack's (2010) claim that "in the electronic environment, the potential for blurring the boundaries between our private lives and professional lives is great" (para. 16). Consequently, many people referenced online boundaries for their SNS page by noting privacy settings which limit others' access, such as the public, to their personal information. When also considering the sense of awareness that a variety of clinicians mentioned in terms of monitoring their online self-disclosures, these findings support Bateman, Pike, and Butler's (2010) research which found that people who thought their personal information online is less private remained hesitant to self-disclose.

### **Online vs. Offline Self-Disclosure**

Taking into account that the current research was the first of its kind and therefore no one prior has looked into self-disclosure on SNS *as it relates to therapeutic self-disclosure*, there aren't any preceding studies to compare the results around this *exact* topic. However, in reflecting upon Nguyen, Bin, and Campell's (2012, as cited by Atrill, 2012) recent meta-analysis which compared online to offline self-disclosure and found mixed results regarding self-disclosures within the two arenas, it's important to restate the researchers' understanding of their varied

findings. The researchers believed that the studies within their meta-analysis did not always measure the breadth and depth of self-disclosures and therefore, the results were difficult to firmly interpret. Efforts were taken within the current study to assess the nature of online and offline disclosure from clinicians' viewpoint to address components of this dilemma, but it remains *unclear* if the context of therapeutic disclosures can be placed under the same category as non-therapeutic offline disclosures which studies have measured to date. Keeping this important point in mind, the present research also showed mixed findings with regards to therapists' beliefs when comparing online to offline self-disclosures. Participants in this study did *not* generally perceive a connection between how often they self-disclosed online as it related to their therapeutic use of the technique, though some people had different views on where they believed they were more self-disclosing.

Despite the fact that there was some overlapping similarities in the kinds of self-disclosures that occur both online and with clients, the motives to disclose in therapy appear extremely different than the motives to disclose online. Therefore, participants illustrated that the context of their self-disclosures and their comfort to provide information played a role in how they understood their self-disclosure on SNS and in therapy. In order to more precisely compare the results of this study as it relates to other research that compares online vs. offline disclosures, future research should continue to measure offline disclosure in relation to the therapeutic setting. Additional suggestions for future research will be offered later in this chapter, but as it stands now, clinicians do not see that the amount they disclose online is related to the amount they disclose in therapy unless it deals with being limited in both avenues. Some participants perceived a connection around their comfort levels in each arena, but this also had to do with being restricted rather than profuse with their use of self-disclosure.



## **Strengths and Limitations of the Study**

There are numerous strengths about this study which will be discussed after the study's limitations are addressed. Like many qualitative studies, the findings presented in this research are not generalizable to a larger population due to the small sample size. In addition, the original recruitment design was slower than expected for gathering prospective participants. This may have been a result of the verbosity of the recruitment email to personal contacts and the multiple steps that people were asked to take in order to help recruit. Though the target number and minimum N of twelve participants was achieved, it is possible that if the snowball sampling recruitment process was simplified with fewer steps, clearer wording, and initially designed to recruit from other arenas such as online forums for therapists, participant response rate to join the study may have increased. Even though some people reached out to participate after twelve people joined the study, as a result of the longer course of recruitment it was decided that twelve people would be sufficient and feasible for the completion of the research.

Different biases are also worth noting in this section. While this researcher was only aware of a mutual connection with two out of the twelve participants, there is the potential for partiality based on this fact. Additionally, since this was not an anonymous interview process and personal information was linked to participants' responses, clinicians were notified in the informed consent that once they provide information during the interview that information was known to the researcher and used for data collection purposes. Consequently, there is also the chance for researcher bias as a result of knowing what participants provided which responses. Another form of bias may have been possible during the interview when providing examples for brainstorming purposes (i.e. examples of different types of disclosures and of influences for self-disclosing online) which could have swayed participants' answers. Although participants were

not required to speak to any specific category offered in these examples and could expand or limit their answers as they pleased, sharing prospective topics to respond to could be considered an area of bias if it primed participants to speak to a particular subject.

Variations that occurred within and between interviews are important to acknowledge as well. While these differences were not striking and efforts were made to create similarity and reliability during and among interviews, particular questions required expansion or explanation which led to differences in the interview process. One example refers to the question which asked people to reflect, “Do you believe that your personal use of social networking site(s) is at all related to how often you self-disclose with clients?” It was evident about halfway through the twelve interviews that this question required some clarification. Many participants were therefore informed that the question was hinting at their perceptions between their frequencies of self-disclosure and if they saw a connection between how often they self-disclosed online as it compared to how often they disclosed with clients.

Furthermore, the second interview question (See Appendix I) was an example of a double-barrel question since participants were asked to reflect on "when, how, and/or if you use self-disclosure" which touches upon more than one question at a time. This could have led to non-uniformity in responses if people were unsure which part of this question to address first. Finally, some questions had overlapping components and touched upon similar topics, especially when participants were thorough with their responses. This resulted in some redundancy at times and the need to clarify with different participants that they could signify if they felt they had already accurately covered a question. While the differences mentioned above intended not to alter the content of the questions asked and the overall interview process, it's valuable to recognize that any variation within a study may impact results.

Since this research was unique and had not been conducted previously, the interview questions were distinctive. The measure deliberately targeted a variety of responses from clinicians around their views and behaviors of online and offline self-disclosure. While most interviews lasted around the intended forty-five minute mark, some were longer and others were shorter. Studies in the future may want to identify a measure that is more predictable in terms of timing which accounts for the variability that is likely in qualitative responses. Finally, even though there was more diversity among participants in terms of age, professional domain, and years in practice, the sample was not very diverse in terms of gender and race since ten of twelve people identified as female and eleven of twelve people identified as White or Caucasian. Ideally, the research sample would have represented a more diverse group of people to incorporate greater variety. The following facts, however, point toward the disproportionate breakdown amongst different mental health practitioners. According to a 2004 study, 81% of Licensed Social Workers were female and 84.5% identified as Non-Hispanic White (Center for Health Workforce Studies & NASW Center for Workforce Studies, 2006) and American Psychological Association's 2009 Membership Directory and Employment Update noted that 56% of its members were female and 90% were White (APA Center for Workforce Studies, 2010). Hence, the limited gender and racial diversity in this study does not seem too exceptional.

Considering the aforementioned areas for growth, it's also necessary to recognize the various strengths of the study and its valuable addition to clinical research on self-disclosure. The timing of this study was purposeful and fitting since it took place within a society that is increasingly connected to online social networking. This research enabled the opportunity for clinicians across a wide age-range to reflect upon an avenue of self-disclosure that has *not* been researched previously and therefore, participants were given the space to discuss a *new*

perspective around this technique. As a result, a variety of people began to think for the first time about perceived connections between their SNS habits and views of self-disclosure as it related to their professional work. Clinicians who participated in this research and those who read this study may use the reflections and findings to become more aware of how, why, when, and to what amount they apply self-disclosure both online and with clients.

While the findings indicate that clinicians as a whole do not see a connection between the frequencies they self-disclose online in comparison to in therapy, half the people saw a connection between their comfort level to disclose in either place. This comfort level was in regards to being cautious and limited in both realms as opposed to carelessness and inappropriate use of their disclosures. Through the thorough interview process, clinicians were able to consider how their online and offline use of self-disclosure applies to their personal and professional lives and the value of being judicious with their disclosures. The study also served as an educational avenue for therapists to think over their analytical style and self-awareness. Furthermore, clinicians provided their insight and attitudes around generational differences and social networking policies which are both important arenas to discuss considering today's popularity and impact of SNS. The implications of their insight on these topics are offered in more detail below.

### **Implications for Social Work Practice and Further Research**

This original study opens the door for continued dialogue around how self-disclosure is perceived by clinicians as a therapeutic tool and on their personal time through online social networking sites. When taking into account the uniqueness of the current research, it's essential to reflect upon the meaning of this study and acknowledge the study's implications for the field of clinical social work. The results portray how clinicians believe self-disclosure can serve as an

important technique in therapy when keeping in mind the motives to use it. Online self-disclosure, however, appears to be seen in a different light considering the motives to disclose with personal contacts through SNS are vastly different than connecting with clients in a session. The fact that clinicians in this study were able to reflect upon these differences with self-disclosure between the therapy setting and their online social network is encouraging: it suggests that *therapists can engage in online SNS habits and professional roles simultaneously without blurring therapeutic boundaries*. In other words, based upon participants' perspectives, it is feasible to utilize self-disclosure online and not negatively impact the relational dynamic with clients. Since no one in this study felt like their personal use of social networking sites led to increased frequency and comfort level to self-disclose with clients, this also provides valuable information regarding how these two arenas are perceived differently in terms of self-disclosure.

Though this study cannot be universalized, the majority of the people involved in it, not just the younger clinicians, reported some type of regular SNS use. Future studies should consider expanding the sample size to make it generalizable and to establish if these trends of online social networking are typical for a bigger group of practicing clinicians. Since it is possible that the people who responded to this study represent a sample of therapists who use SNS more often than other people in the clinical field, it would be necessary for future studies to follow-up on this point. If prospective studies surveyed a larger population of social workers and therapists in other fields, they could also evaluate more precisely how often people within different generations access and utilize SNS. On a separate note, other studies could look at potential differences in therapeutic self-disclosure based upon clinicians' theoretical training and professional domain in order to explore how various categories of therapists apply and view this technique.

When reflecting on the fact that participants across a variety of generations perceived that there *would be* a generational difference to some extent for younger clinicians who just entered or will enter the field soon (not necessarily in relation to the impact of self-disclosure per se), these findings imply that clinicians believe the younger populations who grew up using SNS are likely to be impacted by it in some manner. This also concludes that participants in the study acknowledge that SNS use is common in the younger crowd. Considering these points and the current influence of today's online social networking culture, a future study with a larger sample size should continue to evaluate possible intergenerational differences or divides between older and younger clinicians with the purpose of identifying any diversity between age groups, social networking use, and practicing therapy with clients. Graduate programs, clinicians in training, and professors in social work and other clinical fields such as psychology, psychiatry, and mental health counseling can utilize the current research to consider the importance of distinguishing between online and therapeutic offline self-disclosures in order to continue to monitor the use of it in both avenues and ensure that disclosures with clients continue to be applied appropriately and effectively. A longitudinal study following clinicians who just entered their clinical field would be an interesting follow-up to the present research in order to establish if shifts occur in clinicians' perceptions over time as they enhance in their professional roles and carry on as SNS consumers.

On another note, many people in this study acknowledged that a social networking policy would be important if and when it became necessary to discuss with clients. This proposes that clinicians are thinking about the importance of setting *clear boundaries* with clients as it relates to online connections. Whether social workers and other clinicians choose to think ahead of time about a policy or to put it in writing, it will be helpful and arguably, necessary, for clinicians

(and their clients) to be conscious that issues around social networking may surface in therapy. Being prepared to handle requests by clients around this matter could become more of a norm as scores of people sustain routine online social networking use.

In conclusion, it is promising and enlightening to identify that clinicians currently believe they can maintain a division between their personal and professional habits of self-disclosure. This study sheds important light on a subject matter that has not been previously explored. This study offers illuminating and incipient insight into a new arena of social work when considering the perspectives of the clinicians represented in this sample, the study's connection to relational theory, and the multiple implications of the results.

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## Appendix A

### Recruitment Email for Friends, Close Associates, and Professional Colleagues

Dear friends, close associates, and professional colleagues,

As many of you know, I am conducting research for my Masters of Social Work thesis at Smith College. I am investigating whether therapists perceive that their personal use of online social networking is associated with their decision to utilize self-disclosure with clients. Since social networking sites such as Facebook and Twitter incorporate many opportunities for self-disclosure by revealing personal information about oneself, it remains questionable and unclear if this phenomenon carries over to one's views and behaviors of this technique in a therapeutic setting. The data that are collected through my research may be used in a presentation and future publication.

This recruitment email is being sent to you to ask that you **forward the attached recruitment email and list of inclusion criteria to prospective clinicians** who might be eligible for the study. I am looking for participants that I do not personally know, so your help in securing referrals is appreciated.

Participation in the study is voluntary and confidential. The study includes a forty-five minute interview that may be over the phone or in person. In order to be eligible for the study, participants must be a Licensed Clinical Social Worker (LCSW or LICSW), Psychologist (PhD or PsyD), Psychiatrist (MD), Marriage and Family Therapist (MFT), or a Mental Health Counselor who is over eighteen years of age and is currently practicing in the U.S. People must also be able to read English and agree to the informed consent form for participation. Finally, participants must have an active account on Facebook and/or Twitter in order to participate.

If you know individuals that might meet these requirements and would be interested in participating, please forward the attached recruitment email and list of inclusion criteria to these people. You may either copy and paste the recruitment email to prospective participants in the body of an email and attach the list of inclusion criteria, or simply attach both documents to an email with a brief statement indicating their support would be helpful.

If you have any questions about my research, the recruitment process, or the nature of participation, feel free to reply to this email (xxxxx@smith.edu). Thank you for your time and interest in my research topic!

Sincerely,  
Molly Desloge  
MSW Candidate, Smith College School for Social Work

## Appendix B

### Recruitment Email for Prospective Participants

Dear Prospective Participants,

You have been identified as a potential candidate for the present research. My name is Molly Desloge and I am conducting research for my Masters of Social Work thesis at Smith College. I am investigating whether therapists' perceive that their personal use of online social networking is associated with their decision to utilize self-disclosure with clients. Since social networking sites such as Facebook and Twitter incorporate many opportunities for self-disclosure by revealing personal information about oneself, it remains questionable and unclear if this phenomenon carries over to one's views and behaviors of this technique in a therapeutic setting. This study aims to explore this topic. The data that are collected through my research may be used in a presentation and future publication.

This recruitment email is being sent to you so that if you are eligible, you may take part in a forty-five minute interview that may be over the phone or in person based upon your preference. If you are not eligible or do not wish to participate, please also **forward this email** to other clinicians you know who may be eligible for participation in my research.

In order to be eligible for the study, you must be a Licensed Clinical Social Worker (LCSW or LICSW), Psychologist (PhD or PsyD), Psychiatrist (MD), Marriage and Family Therapist (MFT), or a Mental Health Counselor who is over eighteen years of age and is currently practicing in the U.S. You must also be able to read English and agree to the informed consent form for participation. Finally, you must have an active account on Facebook and/or Twitter in order to participate.

Participation in the study is voluntary and confidential. I will ask about your current use of social networking sites, your views about self-disclosure with clients, and what you believe influences your decision to self-disclose. The questions will be presented by this researcher and you will be given time to answer them at your own pace. Questions will also be included to gather information about my sample's diversity. The process requires that you first fill out a list of participatory inclusion criteria attached to this email. If you are eligible and agree to participate, we will set a time to complete the interview which will take about forty-five minutes.

Your contribution to this study is appreciated. Personal benefits will include having the opportunity to share one's experience as a clinician working in this field. You may also benefit from the interview by using it to reflect upon and evaluate your own practice in terms of self-disclosure and social media usage.

\*Please fill out and send back the attached list of inclusion criteria to this email if you are interested in participating in my study.

If you have any questions about my research or the nature of participation, feel free to reply to this email (xxxxx@smith.edu) or contact me in the future. Thank you for your time and interest in my research topic.

Sincerely,  
Molly Desloge  
MSW Candidate, Smith College School for Social Work

## Appendix C

### List of Inclusion Criteria

Please respond to the following list of inclusion criteria by marking an “X” after your response. For example, if you choose to answer “Yes” to a question it should look like the following: Yes: X. Inclusion criteria establish initial eligibility for the interview, followed by the completion of an Informed Consent Form. Please also indicate your contact information so that the researcher can contact you to confirm if you are eligible and send the informed consent form.

1. Do you have a graduate or post-graduate degree, certification, and/or license in one of the following areas: Clinical Social Work (LCSW or LICSW), Marriage and Family Therapist, Psychologist (Ph.D or Psy.D), Psychiatrist (M.D.), and/or Mental Health Counselor?

Yes: \_\_\_\_ No: \_\_\_\_

2. Are you currently practicing your discipline in the United States?

Yes: \_\_\_\_ No: \_\_\_\_

3. Do you have an active account with Facebook and/or Twitter?

Yes: \_\_\_\_ No: \_\_\_\_

4. Can you read and sign an informed consent form in English?

Yes: \_\_\_\_ No: \_\_\_\_

5. Are you over the age of eighteen?

Yes: \_\_\_\_ No: \_\_\_\_

Do you meet these criteria?

Yes: \_\_\_\_

No: \_\_\_\_

\*If you do not meet the criteria above, you are not eligible to participate in this study. I want to thank you for your interest!

#### Contact Information

Required → Participant’s Name: \_\_\_\_\_

Required → Participant’s Email Address: \_\_\_\_\_

Optional → Phone number including area code: \_\_\_\_\_

## **Appendix D**

### **Inclusion Criteria Confirmation Email**

Dear Prospective Participant,

Thank you for your interest in participating in my research. You have successfully completed the inclusion criteria and meet the initial requirements for participating in the current study. The final step before setting up a convenient time for a forty-five minute interview is to read, provide a handwritten signature, and scan or mail back the following informed consent form which is attached to this email. Please also save and/or print a copy for your own record. If you have additional questions regarding participation in this study, please feel free to reply to this email (xxxxx@smith.edu).



**Appendix E**  
**Informed Consent**

Dear Prospective Participant,

My name is Molly Desloge and I am a graduate student at Smith College School for Social Work in Northampton, Massachusetts. I am conducting research for my master's degree thesis to explore possible connections between clinicians' personal use of social networking sites such as Facebook or Twitter and their use of self-disclosure as a therapeutic technique. For the purpose of this study, self-disclosure is defined as providing personal information to clients. The study will be used in a presentation and possible future publications.

In order to participate in this study you must be a Licensed Clinical Social Worker (LCSW or LICSW), Psychologist, Psychiatrist (PhD or PsyD), Marriage and Family Therapist (MFT), Psychiatric Nurse, or a Mental Health Counselor who is over eighteen years of age and is currently practicing in the U.S. You must also be able to read and agree to this consent form for participation.

Participation involves a forty-five minute interview which may occur over the phone or in person based upon your preference and feasibility. Questions will ask about your current use of social networking sites, your application of and views about self-disclosure with clients, and what you believe influences your decision to self-disclose in therapy and online. Questions will be asked about your personal characteristics (age, race, gender, etc.) so I can look at any possible connections between personal characteristics and use of social media. You will have the opportunity to provide any additional comments or opinions during the interview process.

Personal benefits to participating in this research may include the opportunity to reflect upon your current views and application of self-disclosure and share your experience as a

clinician working in this field. Because you will be asked to reflect on your use of self-disclosure with clients, there is a slight risk that participation may trigger uncomfortable feelings.

Unfortunately, it is not possible to provide any financial compensation for your contribution.

Information will be gathered by the researcher through the use of audio-recording and may also be seen by my research advisor only after names and identifying information has been removed. Per federal regulations for research studies, the data collected during the interview will be stored in a locked cabinet and kept for a minimum of three years. After this time period the data will be discarded so long as it is no longer needed for research purposes. Individual's data will only be used in combination with all other data and any quotes provided during the interview will be appropriately disguised. Your responses to the interview will remain confidential and if you mention any personal information that could potentially identify you or a client this data will be deleted or altered in order to maintain confidentiality. All items and information collected for recruitment and scheduling purposes will be stored on Smith College's secure website and deleted by the researcher when they are no longer needed. If this study is used for publication or presentation all potential identifiable information that you provide will be disguised in those, just as in the thesis itself.

Participation in the study is voluntary. You may refuse to answer any question in the interview and may withdraw from the study by communicating this at any time. Your data will be removed for research purposes if you choose to leave the study. However, once you have completed the interview, you will only have two weeks from the date of the interview to indicate that you would like to withdraw your responses if you decide you no longer want to be a part of the study. After this time period your responses will be used as data for the current research. If you should have any concerns about your rights or about any aspect of the study, you are

encouraged to contact me directly at xxxxx@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

**BY PROVIDING A HANDWRITTEN SIGNATURE BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, 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.**

**\*Please print, sign, date, and return this form to the researcher. It can be scanned and emailed back or mailed to the following address:**

Molly Desloge  
xxxxx  
xxxxx

**Thank you for your participation and please keep a copy of this form for your personal records.**

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Appendix F**

### **Disqualification Statement Email**

Unfortunately, you do not meet the eligibility requirements to participate in this study. Thank you for your time and interest in the current research! If you have additional questions regarding participation in this study, please feel free to reply to this email (xxxxxx@smith.edu).

## **Appendix G**

### **Informed Consent Disqualification Statement Email**

Unfortunately, you do not meet the eligibility requirements to participate in this study because informed consent is necessary. Thank you for your time and interest in the current research! If you have additional questions regarding participation in this study, please feel free to reply to this email (xxxxxx@smith.edu).

## Appendix H

### Facebook Recruitment Post

Hi Facebook Friends!

As many of you know, I am conducting research for my Masters of Social Work thesis at Smith College. I'm investigating whether therapists' perceive their personal use of online social networking is associated with their decision to utilize self-disclosure with clients. Since social networking sites such as Facebook and Twitter incorporate many opportunities for self-disclosure, it remains questionable and unclear if this phenomenon carries over to one's views and behaviors of this technique in a therapeutic setting.

If you think you know a clinician that fits the following criteria and might be interested in my study, **please contact me** on Facebook or email (xxxxxx@smith.edu) so I can forward you a recruitment email and list of inclusion criteria to send to prospective participants. I cannot use personal associates for my study, so your help in securing referrals is appreciated.

Participation in the study is voluntary and confidential. The study includes an approximate forty-five minute interview that may occur over the phone or in person. Eligible participants must be a Licensed Clinical Social Worker (LCSW or LICSW), Psychologist (PhD or PsyD), Psychiatrist (MD), Marriage and Family Therapist (MFT), or a Mental Health Counselor who is over eighteen years of age and is currently practicing in the U.S. People must also be able to read English and agree to the informed consent form for participation. Finally, participants must have an active account on Facebook and/or Twitter in order to participate.

If you have any additional questions about how to help recruit participants or the nature of my study, please feel free to contact me!

Thanks for your support,  
Molly

## Appendix I

### Interview Questions

#### Personal Information

Please respond to the following demographic questions. Demographic questions provide details about the diversity of my research sample.

1. What is your professional domain(s)?
2. How long have you worked in your current profession?
3. Please indicate how old you are if you are comfortable sharing your age.
4. How would you define your race and/or ethnicity?
5. How do you identify your gender?
6. What social networking websites do you use?
7. Please indicate how often you spend on social networking sites for personal use (i.e. non-clinical use). Please be as specific as possible such as more than one hour per day, one hour per day, less than an hour per day, a couple times a week, once a week, once a month, etc. .

#### Interview Questions

The following questions are based on your clinical work with clients regarding self-disclosure and your personal disclosure, if any, on social networking site(s). There is no right or wrong answer and please feel free to elaborate or specify your responses as you see fit.

Research has shown that self-disclosure is a nuanced technique within our field and that there are many different types of self-disclosures. The current research is solely focused on the *self-revealing* components of self-disclosure (i.e. sharing personal information with clients such as personal matters, experiences, beliefs, opinions, etc.) rather than self-disclosures that come across in our facial expressions, how we dress, the tone of our voice, etc.

- 1.) Please indicate your general view on the use of personal self-disclosure with your clients, indicating what you believe influences your decision to use this technique with clients, if at all.
- 2.) Specify when, how, and/or if you use self-disclosure in therapy. (If the participant is struggling to answer the question, the researcher will provide some examples of self-disclosure that may include the following: relationship status, political views, religion, hobbies, sexual orientation, living situation, past or future plans, etc.)

- 3.) Please explain any types of self-disclosure that you find you use more and/or less of throughout your practice?
- 4.) Are there certain self-disclosures about your personal life that you would consider “off limits” to your clients, for instance, that you would never consider sharing? Please elaborate if so.
- 5.) Please indicate what type of information you self-disclose and how you choose to disclose it on your social networking site webpage(s), if any. Please specify.
- 6.) Please share what you believe influences your decision to use self-disclosure on your social networking site(s). (If the participant is struggling to answer the question, the researcher will offer examples that may include the following: connecting with others, informing people of your status, sharing your beliefs, knowing that only certain people can see it, etc.)
- 7.) Are there certain self-disclosures about your personal life that you would consider “off limits” to disclose on your social networking site, for instance, that you would never consider sharing online? Please explain.
- 8.) Do you believe your personal use of social networking site(s) is at all related to your *comfort level* to self-disclose with a client during therapy? Please explain your answer.
- 9.) Do you believe your personal use of social networking site(s) is at all related to *how often* you self-disclose with your clients? Please explain your answer.
- 10.) Do you believe the younger “internet generation” clinicians who have recently entered the field or will be entering the field soon will have different views and behaviors on using self-disclosure with clients than clinicians who did not grow up using social networking websites?
- 11.) Have you ever come across a scenario in which an inadvertent self-disclosure occurred after a client received information about you or one of your colleagues from a social networking site? If so, please explain how you or the colleague handled the situation.
- 12.) Do you find it necessary to have a social networking policy with your clients? Please explain and elaborate on the policy if you have one.



## Appendix J

### Human Subjects Review Approval Letter



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

February 10, 2013

Marie Desloge

Dear Molly,

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

*Please note the following requirements:*

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

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

*In addition, these requirements may also be applicable:*

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

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

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

Good luck with your study.

Sincerely,

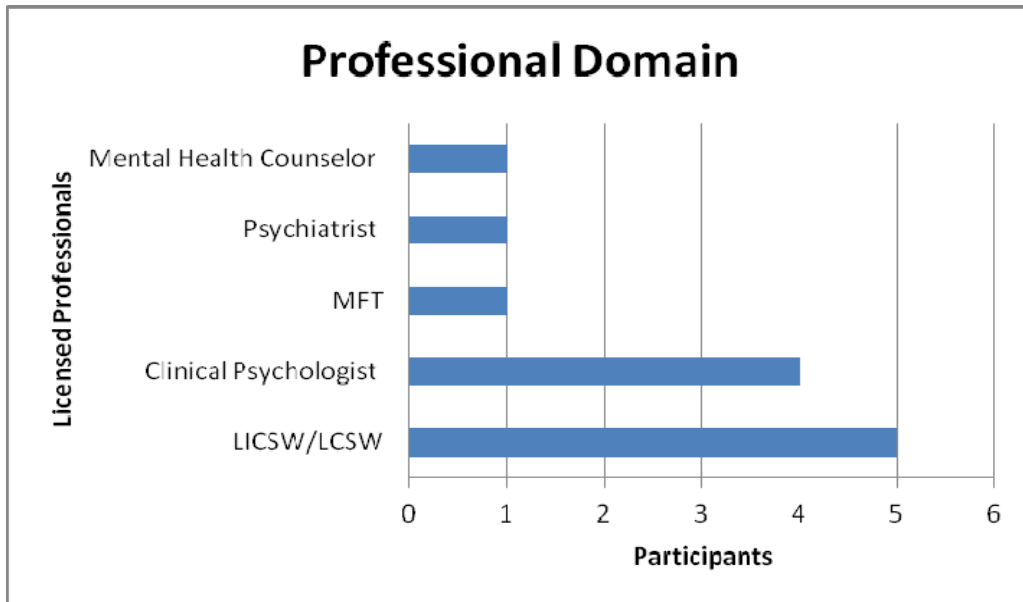
A handwritten signature in cursive script that reads 'Marsha Kline Pruett'.

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

CC: Mariko Ono, Research Advisor

**Figure 1**

**Participant Professional Domain**



**Figure 2**

**Participant Age Distribution**

