

---

Theses, Dissertations, and Projects

---

2012

## The voice of the voiceless : client perspective of therapist self-disclosure

Pamela H. Lefever  
*Smith College*

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

---

### Recommended Citation

Lefever, Pamela H., "The voice of the voiceless : client perspective of therapist self-disclosure" (2012).  
Masters Thesis, Smith College, Northampton, MA.  
<https://scholarworks.smith.edu/theses/882>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact [scholarworks@smith.edu](mailto:scholarworks@smith.edu).

Pamela Lefever  
The Voice of the Voiceless:  
Client Perspective of Therapist Self-  
Disclosure

### **ABSTRACT**

This quantitative, descriptive cross-sectional study investigated whether the client prefers therapist self-disclosure or therapist non-disclosure during a therapeutic session. In addition, it examined whether the client's preference varied by demographic characteristics. Self-disclosure was limited to therapist self-revealing disclosures which are verbal revelations of a therapist's private life (e.g., experiences, religious beliefs) that are shared in-session with the client.

Using a convenience sampling method, sixty adult respondents who had been clients between 2007 and 2012 were selected to provide demographic information and their preference for therapist self-disclosure on 36 close-ended questions. The survey was distributed using the snowball method and SurveyMonkey.

Prior analogue studies hypothesized that clients preferred therapist self-disclosure during a therapeutic session. This study did not substantiate those findings. It found that a specific population of actual clients prefers therapist non-disclosure of self-revealing information. Caucasian women with advanced educational degrees who have depression, anxiety, and/or relationship issues prefer therapist non-disclosure. Since these findings reflected the preference of a specific sample, they are not generalizable to a more diverse population. Future research is warranted to explore the preference for therapist self-disclosure by a larger, diverse demographic sample of actual clients.

**THE VOICE OF THE VOICELESS:  
CLIENT PERSPECTIVE OF THERAPIST SELF-DISCLOSURE**

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

Pamela Lefever

Smith College School for Social Work  
Northampton, Massachusetts 01063

2012

## ACKNOWLEDGEMENTS

Without the support and encouragement of my son Andre Garron and husband J. Timothy Lefever, this would not have been possible. Thank you.

Without my girlfriends, Carrie, Judy, Laura, Karen, who logged many a mile walking and strategizing the end game, this would not have been possible. Thank you.

Without my mentors, Dr. Carey, Dr. Davidoff, Dr. Folks, who teased the best out of me, this would not have been possible. Thank you.

Without my collegiate colleagues, B. Chapman, M. Postal, A. Fleischer, Dr. Zakriski, who brainstormed alternatives when at a dead end, this would not have been possible. Thank you.

Without the snowball participants who shared their opinions, this would not have been possible. Thank you.

Without my research advisor Dr. Everett who patiently guided and forged the path ahead, this would not have been possible. Thank you.

I thank you all for sharing in this journey. Thank you for sharing the excitement, the struggle, the apprehension, the laughter, and the joy.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES .....	iv
LIST OF FIGURES .....	v
CHAPTER	
I INTRODUCTION .....	1
II LITERATURE REVIEW .....	4
III METHODOLOGY .....	25
IV FINDINGS .....	34
V DISCUSSION.....	48
REFERENCES .....	58
APPENDICES	
Appendix A: Human Subject Review Approval Letter .....	62
Appendix B: Recruitment Letter.....	63
Appendix C: Informed Consent Form .....	64
Appendix D: Survey.....	67

## LIST OF TABLES

### Table

1. Demographic Characteristics of the Sample .....	36
2. Use of Social Media .....	37
3. Reasons for Therapy .....	39
4. Summation of Top Three Reasons for Therapy .....	41
5. Clinical Situation Scale .....	43
6. Therapist Action Scale .....	43
7. Comparison of Therapist Self-Disclosure Preference by Race .....	45
8. Comparison of Therapist Self-Disclosure Preference by Education .....	46
9. Comparison of Therapist Self-Disclosure Preference by Use of Facebook .....	46

## **CHAPTER I**

### **Introduction**

This chapter introduces the study issue, purpose, design, and operational definitions of the concepts under investigation. It then briefly provides a historical perspective on the subject and the rationale for why the study is significant. It also discloses the limitations of the current research and makes suggestions for future research.

The purpose of this quantitative, descriptive cross-sectional study was to investigate the client perspective of therapist self-disclosure during a therapeutic session. In particular, the study focused on whether the client prefers therapist self-disclosure or therapist non-disclosure. For this study, the operational definition of therapist self-disclosure was: within-session reaction to a client by a therapist in which the therapist provides the client with personal information about the therapist's life. Personal information revealed by the therapist per this definition might consist of details about the therapist's activities, family life, and/or circumstances. These disclosures are often referred to as self-revealing disclosures (Knox & Hill, 2003).

The therapeutic dyad consists of two participants: the client and the therapist. It is predicated on the self-disclosure of the client. Historically, the therapist was to provide a Freudian "blank screen" to facilitate the client's psychodynamic process (Carew, 2009; Hanson, 2005; Wachtel, 2011). Therapists since Freud have not only questioned this premise but challenged it through their therapeutic practice. Theories have even embraced the benefits of therapist self-disclosure. Research has mainly investigated the therapist's opinions and actual

practice in regards to therapist self-disclosure. The client's voice has been silent although they are a critical participant in the therapeutic dyad. This research focused on the client perspective of therapist self-disclosure.

This study is significant because it provides objective, empirical information on a topic that has been framed historically by speculation, unsubstantiated opinion, and flawed research techniques. In an effort to address the historical weaknesses, a structured questionnaire with well-defined and consistently used terms was administered to clients in an effort to gather demographic characteristics of the sample and to measure their perspectives and preferences for therapist self-disclosure.

The study was limited to a focus on client preference of therapist self-revealing disclosure. As such, the practical implications of this research are also limited. Further research would be needed to substantiate the preliminary findings. Although limited, the data possibly could have an impact on whether a therapist elects to use revealing self-disclosure as an intervention. Furthermore, the research could highlight the need for professional training concerning therapist disclosure.

Further research of this topic would be needed to study the effects of the use of self-disclosure with specific client demographics (e.g., age, ethnicities) and symptomology (e.g., pathologies) since the current data did not address these potential correlations adequately. The study was also limited due to the use of questionnaires for clients. The study does not provide information on clients that have terminated treatment. Also, the self-reporting nature of the survey does not allow for confirmation of the self-disclosure experience during a therapeutic session through the use of taping and coding. Clearly the clients volunteering to report on their



beliefs could limit the use of the data. Clients who have a favorable opinion of their therapy experience could be more likely to agree to do the survey and thus skew the results.

The literature review that follows provides a more thorough examination of: 1.) definitions of therapist self-disclosure; 2.) theoretical implications of self-disclosure; 3.) historical perspective on the use of self-disclosure, and 4.) relevant empirical research on self-disclosure.

## **CHAPTER II**

### **Literature Review**

#### **Introduction**

There has been a long standing debate as to whether or not a therapist should self-disclose (Barrett & Berman, 2001; Knox & Hill, 2003). Freud's seminal work that posited that the therapist should be a "blank screen" ignited subsequent interpretations and challenges to his dictum of total non-disclosure by the therapist (Audet & Everall, 2010; Barrett & Berman, 2001; Wachtel, 2011). This was a dictum that Freud did not completely adhere to and one which he expressed disappointment that his followers tried to follow absolutely (Gill, 1983). This debate has mainly been between theorists, analysts, and therapists (Barrett & Berman). The critical part of the therapeutic dyad, the client, has been virtually silent (Knox, Hess, Petersen, & Hill, 1997).

The debate centers on whether the therapist should self-disclose in a therapeutic session. It is difficult to tease out whether or not to disclose since at times both sides of the debate argue the same point. For example, both assert that their position is the ethical stance. Non-disclosure is ethical because it is argued if the therapist discloses then the client-therapist boundary is pierced. As such, the sterile field for therapeutic transference is compromised and could prevent the critical goal of therapy from occurring. Those that support therapist self-disclosure profess it is unethical not to disclose because non-disclosure could re-traumatize the client (Wachtel, 2011). Thus, the client could perceive that they do not have an impact in the therapeutic alliance similar to their lack of influence at other times in their life.

Those that purport therapeutic neutrality argue that non-disclosure is an ethical intervention. They argue further that a non-disclosure intervention approach is supported by the belief that disclosure could cause therapeutic ruptures, reduce therapist role modeling potential, and compromise the client's sense of trust and safety. In addition, disclosure has even been attributed with creating uncertainty and confusion for the client about their therapeutic expectations. Such confusion has caused a reversal of roles in which the client feels burdened by the therapist's disclosures and may even care-take the therapist. Therapist disclosure has been found to interfere with the client's transference and even reduce client disclosures which is the very essence of therapy (Audet & Everall, 2003; Hanson, 2005; Roseborough, 2006). Therapist self-disclosure at a minimum removes the clinical focus from the client which could interfere with the therapy process.

In contrast, those that assert that therapist self-disclosure is an ethical intervention may frame their argument as follows. Disclosure benefits the client-therapist dyadic relationship by increasing their similarity, balancing their power, fostering transparency, and, in so doing, building a therapeutic alliance of trust and rapport (Simi & Mahalik, 1997). Self-disclosure advocates contend that the client benefits from therapist disclosure by the client potentially being able to establish an earlier connection with the therapist, as well as, perceiving the therapist as empathetic, credible, and more human. In addition, therapist self-disclosure is credited with being beneficial since it provides an opportunity for the client to witness their therapist modeling helpful behavior and to possibly have their personal experiences normalized (Roseborough, 2006; Simi & Mahalik, 1997; Watkins, 1990).

The debate might also be fueled not only by the lack of a consistent definition for the topic but also by more speculation than science. Therapist self-disclosure definitions that have

been challenged range from non-immediate, self-revealing disclosures of personal experiences (e.g., therapist's weekend activities) to immediate, self-involving disclosures of dyadic reactions (e.g., therapist's in-session emotions). Research has mainly investigated the therapist's opinions and actual practice of therapist self-disclosure. The lack of primary empirical research of the client perspective of therapist self-disclosure has resulted in the client's voice being silent and their opinion being extrapolated from analogue studies or the therapist's assumption of the client's opinion. Both of these approaches have not been found to reflect what the actual client thinks (Audet & Everall, 2003; Hill, Helms, Spiegel, & Tichenor, 1988a).

The client perspective on therapist self-disclosure has not received much attention even though studies have documented that a client's favorable opinion of therapeutic intervention portends of a beneficial outcome (Audet & Everall, 2003) and that it is a better predictor of successful therapy than the therapist perspective (Wampold, 2001). This study addresses historic research weaknesses in that it limits the definition to therapist self-revealing disclosure and collects data from the individual whose opinion is being studied, an actual client.

### **Therapist Self-Disclosure Definitions**

Therapist self-disclosure occurs when a therapist verbally reveals personal information to a client (Watkins, 1990). Self-revealing disclosure (Knox and Hill, 2003), also referred to as non-immediate disclosure (Audet & Everall, 2010), occurs when a therapist discloses during the session information about their activities out of the session (e.g., experiences, religious beliefs). Self-involving disclosure consists of therapist personal reactions, thoughts, or feelings that are expressed to client about within-session situations (e.g., therapist verbalizes anger at client for client's behavior) (Hanson, 2005). These definitions are blind to the potential of visual therapist self-disclosure. Theorists, therapists, researchers, and clients all acknowledge that it is virtually

impossible to not self-disclose since one's attire, speech, mannerisms, among other items/behaviors inform about the therapist's private life. Knox and Hill (2003) further delineated therapist self-disclosure into the following seven categories: disclosure of facts, feelings, insight, strategy, reassurance/support, challenge, and immediacy. Self-disclosure for this study was limited to the verbal revelations of a therapist's private life which are shared in-session with the client. The following literature review which references numerous extant empirical studies, by its nature, reflects the diversity of the definitions for therapist self-disclosure previously presented.

### **Theoretical Background**

**Psychodynamic tradition.** As early as 1912, Freud advocated that the therapist act as a "mirror" or a blank screen so that the therapist would not interfere with the client's processing of information but would reflect the client's experience and thereby assist the client in the processing (Peterson, 2002). Therapist personal information was not to be injected into the session for it could divide the primary focus on the client and disrupt the therapist anonymity which might interfere with the client's psychoanalysis process. It was posited that there was an "inverse relationship between a client's knowledge of a therapist's personal life, feelings, and thoughts, and the client's capacity to develop transference<sup>1</sup> to the therapist (Freud, 1912, as cited in Knox & Hill, 2003), such that the more the client knew about her/his therapist, the less 'pure' the client's transference to the therapist" (Knox & Hill, 2003, p. 530).

Scientific advancement demonstrated that the mere act of observation has an effect on the observed. This concept challenged the viability of Freud's non-disclosure premise that the therapist could be an objective, non-interactive observer (Carew, 2009). Similarly, it was acknowledged that self-disclosure occurs non-verbally and inadvertently through one's attire,

---

<sup>1</sup> Transference is a process which occurs when a patient attaches feelings, wishes, thoughts, etc. associated with an individual from their past to their therapist. Thus, they *transfer* these reactions to another.

office space, and speech (Lane & Hull, 1990). Thus, it is virtually impossible to achieve Freud's non-disclosure mandate. The following theoretical constructs purport various positive intervention orientations in regard to therapist self-disclosure.

**Humanist theory.** Carl Rogers argued that the therapist should not be a blank screen but rather an interactive participant providing positive acceptance of the client during the therapeutic session (Carew, 2009; Knox & Hill, 2003; Robitschek & McCarthy, 1991). As such, he supported therapist self-disclosure as a means to equalize the sessions and create a trusting bond with the client (Jourard, 1971; Rogers, 1951). This he premised would foster the client's own self-disclosure and self-understanding resulting in therapeutic benefits (Carew, 2009). The humanistic movement which developed during the 1950's embraced Roger's belief in dual therapeutic transparency, collaboration, and openness for both members of the counseling dyad. It purported that the therapist's genuine revelations would assist in forging a client-therapist bond that would be instrumental in normalizing the client's concerns, presenting the therapist as a viable role model, and creating a nurturing "authentic I-Thou" relationship (Carew, 2009; Goldfried, Burckell, & Eubanks-Carter, 2003; Greenberg, 1990; Knox & Hill, 2003).

**Feminist theory.** Many of the tenants that humanist psychotherapists espouse feminist therapists also support and have expanded on. Feminist theoretical goals of equalizing the dyad power dynamics, empowering the client, and creating a genuine transparent, collaborative therapist-client relationship are believed to be enhanced by therapist self-disclosure (Mahalik, VanOrmer, & Simi, 2000). The feminist orientation supports therapist revelations not only of personal beliefs and experiences but also of credentials and values as a way to equip the client with necessary tools for making an informed decision about their therapeutic journey (Mahalik et al., 2000). In this regard, feminist therapists advocate disclosure of sexual orientation, life style,

values, and political preferences early in therapy. Feminist theorists believe that this information will provide the client with necessary tools to make an informed decision about continuing or even starting the therapeutic alliance. It is believed that the client could hypothetically weigh the therapist self-disclosures to determine if the potential therapeutic relationship will provide adequate role modeling, empathy, and beneficial support (Audet & Everall, 2010; Brown & Walker, 1990).

**Behavioral, cognitive, and cognitive-behavioral theory.** Behavioral, Cognitive, and Cognitive-behavioral theory posits that therapy benefits from a strong, trusting client-therapist connection. (For expediency, these three theoretical techniques will be referred to as cognitive-behavioral theory/therapy.) Therapists of this orientation believe this bond is strengthened through dual client-therapist self-revelations about their life experiences and struggles. In addition, cognitive-behavioral theorists posit that self-disclosure facilitates therapeutically beneficial within-session role playing of techniques appropriate for between-session practice by the client (Goldfried et al, 2003; Knox & Hill, 2003). This is subtly yet distinctly different than the humanist perspective in which the therapist functions as a potential role model for the client but does not actually role play situations with their client.

## **Empirical Research**

**Historical implementation of therapist self-disclosure.** Research evaluating the practical implications of a clinician's theoretical orientation (e.g., psychodynamic, humanist) has revealed that most clinicians disclose if they believe it is advantageous for their client regardless of their own theoretical, professional training (Hanson, 2005; Knox & Hill, 2003; Sokol, 2008). Some of the therapeutic benefits of therapist self-disclosure are that it potentially highlights therapist-client similarities, normalizes the client's concerns, strengthens the therapeutic bond,

provides modeling behavior, and/or a new perspective on the client's issue (Audet & Everall, 2010; Edward & Murdock, 1994; Simon, 1990). Empirical research has demonstrated that the client and therapist perspectives are not always in agreement (Audet & Everall, 2003). Therefore, the therapist's decision to disclose or not to disclose for the client's benefit cannot realistically be made without factoring in the client's opinion. Since studies have documented that a client's favorable opinion of treatment portends a beneficial outcome, it would appear advantageous to discern what the client perspective actually is of therapist self-disclosure.

**Therapist perspective on therapist self-disclosure.** Historically, the therapist took responsibility for developing the therapeutic alliance. Prior empirical research on therapist self-disclosure acknowledged this by focusing on the therapist opinion of therapist self-disclosure to the virtual exclusion of the client opinion of therapist self-disclosure (Barrett & Berman, 2001). These studies assumed that the therapist accurately reflected the client opinion. This was not the case for Audet's client. As an intern, her client reflected that Audet's self-disclosure was the "single most beneficial moment in her 12-session therapy" (Audit & Everall, 2010, p. 329). In contrast to the client's view, Audet's supervisor took the position that disclosure could compromise the therapeutic process.

Hill et al.'s research (1988a) documented the discrepancy between the client's opinion and the therapist's opinion. This study did so by having five female clients and their therapist separately rate their videotaped therapeutic sessions. The 65 videotaped sessions were evaluated on 21 factors (e.g., understood, supported, scared, misunderstood) as delineated in Hill's Counselor Verbal Response Modes Category System (1985). Hill et al.'s evaluative process study determined that clients do not reveal many of their reactions to their therapists, especially negative or angry feelings toward their therapists. As such, therapists were unable to discern



discrepancies in their assumptions about their client's experience and the client's actual reported experience. This highlights the potential disconnect between the therapist's assumption about their client's opinion and the client's actual opinion. Although the study is limited in its generalizability due to its assessment of the perspective of only five female clients and was restricted in the diagnostic category as well (e.g., anxious, depressed symptomatology), it nevertheless speaks to the relevance of developing techniques to discern the client perspective of the therapeutic process in order to more fully understand the client's dyadic experience.

Therapists have struggled with whether to disclose or not. Hill et al.'s (1988b) subsequent study found that therapists use self-disclosure only as 0-2 % of their therapeutic interventions. In that regard, it would not be a surprise that the same study documented that 5 of the 8 therapists queried perceived therapist self-disclosure as unhelpful to their clients. However, their clients reported that the most helpful intervention was the rarely used therapist self-disclosure. (For additional study discussion, please refer to *Client Perspective on Therapist Self-Disclosure*.)

**Simulated client perspective on therapist self-disclosure.** It currently is accepted that the client is a critical factor in the dyad, yet the client's voice is missing in the research. Analogue studies are a step removed from studies soliciting an actual client perspective on counselor self-disclosure. However, Hardin & Subich (1985) found that students and actual clients respond similarly and determined that the use of students for preliminary, pilot studies was warranted. Their study enlisted seventy-eight students and counseling clients at a large Midwestern university who completed the Expectations about Counseling (EAC) questionnaire. This survey consisted of 53 items used to elicit the participants' expectations about therapy (e.g., counselor characteristics, process characteristics). The study found that there was no statistically

significant difference in expectations for counseling between non-student clients, student clients, and non-client students.

Hendrick's (1988) exploratory analogue study sampled 235 undergraduate psychology students from a large southwestern university on their preference for therapist self-disclosure using a Likert-scale survey. Self-disclosure per this study was defined as both self-revealing and self-involving disclosure. The results indicated that potential clients would want significant disclosure especially concerning the therapist's professional issues (e.g., degree, theoretical orientation), personal and professional successes/failures, and interpersonal relationships. The findings are questionable since they do not factor in the opportunity cost of therapist self-disclosure. In other words, the student was merely asked to rate how much interest they would have in the self-disclosure of a therapist. The student was not asked to imagine a scenario in which he/she, the hypothetical client, was feeling distress over an issue that he/she wanted to consult with the therapist about. If that was the case, the results might be different because the student possibly would not want to focus on the therapist's life and opinions but rather use the time addressing their own issues. In addition, since the students were getting class credit for their research participation, responding expediently rather than with serious contemplation could impact the results.

Analogue studies have attempted to simulate conditions to replicate the client-therapist dyad in an attempt to elicit hypothetically accurate client reflections on therapist self-disclosure (Hendrick, 1988). Watkins (1990) completed a meta-analysis of 35 hypothetical therapist self-disclosure studies completed between 1973 and 1989 in which participants rated the therapist and the session. The participants of 34 of the studies were non-client college students. Only one study elicited the responses of actual clients. Watkins concluded that the non-client favored

positive therapist self-involving disclosure more than either negative self-involving disclosure or self-revealing disclosure. For this analysis, positive self-involving disclosure was defined as favorable in-session therapist responses as opposed to negative, unfavorable, immediate disclosures. In contrast, the only study using actual clients found that the participants favored no therapist self-disclosure more than high or low disclosure (note: medium disclosures were not studied). Although these findings support my hypothesis that clients would prefer no therapist self-revealing disclosure, the findings need to be tempered by the limitations of these studies. The data were collected from analogue studies that relied mostly on non-client college student responses concerning their initial therapy session. The generalizability of the results could be considered weak due to the small sample size, most respondents identified as Caucasian American, and that first session responses are not necessarily indicative of subsequent session preferences. In addition, Watkins determined that all the studies failed to meet Strong's (1971) five boundary conditions. These five boundaries framed therapy as a 1.) time-limited, 2.) conversation between a 3.) motivated, 4.) distressed client with a 5.) therapist of a different status. These conditions purportedly are necessary elements for research to sufficiently reflect an actual counseling experience. Even though Watkins asserted that failure in this area reduced generalizability of the results, I am not convinced of the veracity of Strong's conditions to qualify a study as adequately indicative of an actual clinical experience. In addition, although Watkins attempted to clearly delineate and analyze different aspects of therapist self-disclosure, at times his review was confusing and since I did not review the primary research reports, I maintain healthy skepticism of his conclusions.

Myers and Hayes's 2006 analogue study examined non-client perception of therapist self-disclosure during simulated portrayals of strong/positive and weak/negative therapeutic alliances.

Two hundred and thirty-six undergraduate students at a large mid-Atlantic university were randomly assigned to view one of three ten minute videotaped simulated therapy sessions of a 27 year old Caucasian female-actor client and a 33 year old Caucasian male-actor therapist. The tapes varied only in regards to therapist self-disclosure. The therapist in one hypothetical session provided “no disclosures”; in another session, the therapist provided “general self-disclosure”; while the therapist in the third scenario provided “countertransference” self-disclosure. For this study, no disclosure was defined as an empathetic statement by the therapist such as, “I can see why you would want to be different than your mother given...” General disclosure was defined as an anecdotal, empathetic revelation such as, “I remember my undergraduate days when I...” Countertransference disclosure was a revelation by the therapist of his own unresolved intrapsychic conflict as exemplified by “I struggle with trying... and so can understand your struggle.” Prior to viewing the videotaped session, the participants were provided a written script that informed them that they were viewing the seventh session either of a therapeutic relationship that was described as positive or one that was described as negative. Immediately after viewing the tape, the participants rated the therapist on 36 items (e.g., expertness, trustworthiness), the session on 24 features (e.g., depth, smoothness), and the client-therapist relationship on 12 characteristics. The three questionnaires used for these ratings were the Counselor Rating Form (CRF), the Session Evaluation Questionnaire (SEQ), and the Working Alliance Inventory (WAI-O-S), respectively.

It was found that if the therapeutic relationship was considered strong/positive, then general disclosure was more favorable than no disclosure and that the session was considered to be deeper and the therapist was perceived to be more expert. However, if the relationship was weak/negative, then no disclosure was considered more favorable than either general disclosure

or countertransference. In this case, the session was perceived as shallower and the therapist as less expert. In addition, students who had had prior therapy experience perceived countertransference to be more favorable than general disclosure in regards to the depth of the session and more favorable than both general disclosure and no disclosure in regards to positivity. Students without prior therapy experience found general disclosure to be more favorable in regards to session depth and more favorable than both countertransference and no disclosure in regards to positivity.

This is one of the few studies that considered other aspects of the therapeutic alliance that might influence the client perception of therapist self-disclosure. It looked at the impact that the quality of the therapeutic alliance (e.g., strong/positive, weak/negative) could have on preference for therapist self-disclosure and if students' prior therapy experience affected their perception. Although this research attempted to distinguish different types of therapist disclosure it unfortunately did so in a flawed fashion that compromised the study.

As previously defined, both general disclosure and no disclosure encompassed empathetic disclosure. Furthermore, the quoted examples (provided above) that were given in the study for the different disclosures highlight that the definitions were not distinct but overlapped. Thus, it would not be possible to ascertain what was being measured, or which definition of disclosure was being responded to. This is a fatal flaw of the research. For example, if no disclosure and general disclosure both consist of an empathetic response, then it cannot be determined whether no disclosure, general disclosure, or both are preferred or not by the non-client student. In addition, these definitions do not correspond to historically accepted definitions of therapist self-disclosure and complicates comparison of empirical results. General and countertransference disclosure would meet the historical definition for revealing disclosure and

both countertransference and no disclosure would meet the historical definition for involving disclosure. This study has critical internal and external flaws associated with its operational definition of disclosure and unfortunately adds to empirical research confusion in regards to therapist self-disclosure. The generalizability of the results is limited because it was an analogue study of a convenience sample whose participants consisted mostly of European American (90%), female (67%), psychology/education students with a mean age of 20.45 years who got extra credit for their participation.

Sokol (2008) conducted a simulated study on therapist revealing self-disclosure. In this study, sixty-six undergraduate students reflected on ten minutes of a scripted hypothetical audiotaped therapy session in which the therapist disclosed resolved or unresolved issues or did not disclose. The non-client subjects were mostly female students (2/3rds) with a mean age of 20 who received extra credit in their introductory psychology course at a medium-size Midwestern university for their participation. The therapist was portrayed by a 47 year old female and the client by a 24 year old Caucasian male. Each participant rated only one of three hypothetical audiotaped sessions. In one simulated session, the therapist did not reveal personal information; in a different portrayal, the therapist revealed three ongoing struggles; and in the third therapy condition, the therapist revealed three of her resolved struggles. The revelations were of issues similar to those the subjects might have had (e.g., relationship and/or career concerns). The findings of this simulated study suggested that non-client participants preferred disclosure of therapist resolved concerns over unresolved disclosures. Non-disclosure was the least favorable intervention. Not the least of the concerns I have in regards to these findings is that Sokol has previously misrepresented the findings of Watkins' meta-analysis and so it causes me to question his analysis. Sokol asserted that Watkins concluded that clients preferred therapists who

infrequently disclosed. However, Watkins clearly reported that the information was inconclusive in that regard. In addition, the following research features of Sokol's study could challenge its findings and their generalizability. It is an analogue study of mostly Caucasian students getting credit for their participation rather than a study of actual clients. In addition, it does not account for other mediating factors that could confound the results. For example, most of the hypothetical clients are female who are asked to reflect on a therapy session depicting a male client, another step removed from their personal experience.

**Client perspective on therapist self-disclosure.** Research on the client perspective of therapist self-disclosure has historically been dominated by studies of the client's therapist's hypothesis of what the client thinks about therapist self-disclosure or by analogue studies of the non-client perspective on therapist self-disclosure. Both of these approaches are removed from obtaining the actual client opinion on therapist self-disclosure. Burisch (1984) found extrapolating information problematic and preferred to rely on data collected directly from the source (e.g., actual client) whose experience/opinions were being studied, rather than to extrapolate from one group for the opinions of another group.

Hill et al. (1988a ) conducted a pilot study consisting of four cases of actual client reactions to their therapist's interventions. This study highlights the significance of obtaining the actual client perspective. Four adult, depressed females who had never had psychotherapy received treatment from experienced therapists. After each 50 minute session, the client rated the helpfulness of their therapist intervention. Post-session interviews of the therapists found that the therapists did not accurately interpret their client's reactions and did misjudge what their clients perceived as helpful interventions. Furthermore, it found that clients, although generally willing to disclose their reactions to researchers, hesitate or do not disclose many of their reactions to

their therapists, especially negative or angry feelings. Although this study highlights the significance of actual client feedback rather than therapists' hypothesized client preference, its generalizability needs to be tempered by its limitations. Mediating factors that could influence the study results would be that it was of adult, depressed females receiving therapy for the first time. In addition, most of the clinicians rated themselves as psychodynamically oriented and, as such, could consider certain interventions helpful that therapists with a different orientation (e.g., behaviorist, humanists) would not consider helpful. The findings could also have been confounded by the independent and confidential post-session evaluation by the client and therapist which could have influenced their future therapeutic engagement.

Hill et al.'s (1988b) exploratory study of therapist and client perspective on helpful therapist response modes uncovered a discrepancy between what the client and the therapist value in the therapeutic session. The study looked at eight cases of brief psychotherapy of depressed, anxious, adult, female clients over 127 sessions. Both the therapist and the client evaluated their videotaped sessions using the revised Hill Counselor Verbal Response Modes Category System. Clients rated therapist self-disclosure more valuable than the other eight verbal therapist response modes examined (e.g., approval, information, direct guidance, closed question, open question, paraphrase, interpretation, confrontation). In contrast, therapists rated interpretation as the most helpful response mode. Of the eight therapists, five rated therapist self-disclosure as one of the least helpful interventions while only three rated it the most helpful response mode. One weakness of the study is that it did not provide an operational definition for self-disclosure and as such one could not determine if the findings refer equally to both revealing and involving self-disclosure or only address one aspect of self-disclosure. To further tease out the strength of the finding, one would need to investigate the influence of other mediating



factors. For example, female clients might prefer self-disclosure more while those that have never been in therapy might welcome self-disclosure as a method that reduces the stress associated with the new situation by mimicking other comfortable interactions. Likewise, since more therapists had identified as psychodynamic, the findings might reflect the therapist's reluctance to value self-disclosure due to training and possibly their self-awareness and tension associated with using that intervention. Although the study was limited in generalizability due to assessing only eight cases of brief psychotherapy for female clients with co-occurring anxiety and depression, it highlights the need to gather facts rather than to hypothesize an actual client perspective of therapeutic interventions.

In an effort to determine if analogue studies accurately reflect the actual client perspective on therapist self-disclosure, Hendrick (1990) conducted a comparative tandem empirical study of 24 clients at an outpatient psychology department clinic and 24 undergraduate students. For the present study, both students and clients were surveyed for their preference on therapist self-disclosure using Hendrick's 1988 Counselor Disclosure Scale. The findings were similar to those of her 1988 analogue study. Both client and students were interested in therapist professional issues, success/ failure, personal feelings, and interpersonal relationships among other topics. They had little interest in therapist sexual issues or attitudes. Hendrick therefore concluded that analogue studies could thus be relied on to reflect potential client perspectives. This conclusion is not clearly supported by the study. Although this appears to be a study of actual clients, it is not clear if that was the case. The client population was drawn from future clients that were providing their intake information for subsequent therapy at the clinic. There was no data collected to determine if these individuals, potential clients, had previously been in therapy. Thus, they could merely represent a different analogue population, just not

undergraduate students. Another limitation of the study is that both the client and the students self-selected to or not to participate. In addition, since there were only 24 participants, it would be difficult to generalize the results from the research. As Hendrick noted, the sample size was adequate solely for a pilot, exploratory study.

Knox et al.'s (1997) qualitative study of thirteen, current, private psychotherapy adult clients focused on the beneficial aspects of therapist self-disclosure. Data collected during two semi-structured interviews per client revealed that participants perceived therapist self-disclosure to normalize their concerns, equalize the therapeutic relationship, as well as provide valuable perspective and reassurance. The study lacked representativeness due to its small sample size, the fact that all participants, clients and therapists were European American from only one geographic region, and that all clients were able to afford private therapy. Although an auditor was used to reduce potential qualitative bias, such bias still could be a risk factor. Because the study did not differentiate between self-revealing and self-involving disclosure, it is unclear if one or both forms of disclosure provide long-term benefits.

Barrett and Berman (2001) investigated if therapist reciprocal self-disclosure would impact symptom distress and client perception of their therapist. The study was conducted at an outpatient clinic affiliated with the Department of Psychology at the University of Memphis. Eighteen doctoral students were instructed to increase the number of reciprocal self-disclosures during sessions with one client and provide no disclosures with another client. Reciprocal self-disclosures were disclosures of personal information about experiences, feelings, and reactions that were similar to the client disclosure in topic, intimacy, and language. After each of their first four sessions, each of the 36 clients responded to Likert scale questions about their symptoms, how much they liked their therapist, and how much the therapist had disclosed. Findings

revealed therapeutic benefits of reciprocal self-disclosure to be that the clients reported less symptom distress and liked their therapist more than clients in the no disclosure condition. Unfortunately, the study does not distinguish self-revealing and self-involving disclosure and thus is inconclusive on the role each potentially plays psychotherapeutically. Since the clients and the therapists were similar in age (27 and 28 mean age, respectively), other mediating factors could have influenced the results and reduced generalizability. The study does not address nonreciprocal disclosure or disclosures occurring past four sessions.

Hanson's (2005) client centered research supported her hypothesis that participants rated therapist disclosures to be more helpful than non-disclosure (i.e., more than twice as helpful) and that self-revealing and self-involving disclosures were considered equally beneficial. In addition, the reasons participants gave for why self-disclosure was helpful were similar to reasons therapists gave for disclosing (e.g., improves therapeutic alliance). One hundred and fifty-seven incidents of disclosure and non-disclosure (131 and 26, respectively) were coded from audiotaped interviews of 18 white Canadian participants (16 women, 2 men) who were currently in therapy and had been in therapy for 2 to 10 years. Prior to their interviews, respondents received information on disclosure, non-disclosure, and topics that would be discussed during the interview (e.g., their relationship with their therapist, whether disclosure or non-disclosure was helpful or not). The Knox et al. (1997) operational definition for therapist self-disclosure was used. Self-revealing disclosure was defined as an interaction in which the therapist shares personal information. Self-involving disclosure was defined as interactions in which therapist shares responses to client that develop during the therapy session. The participants generally requested being guided by the interviewer's questions during their 35-90 minute audiotaped interview. To establish inter-rater reliability, one-fourth of the results were coded by two raters

with different theoretical backgrounds than Hanson's feminist/humanist approach. These codes correlated with Hanson's, therefore she coded the remaining findings into themes (e.g., fostering therapeutic alliance, egalitarian relationship, skill modeling) using the constant comparison method. The client's perception of helpful and unhelpful incidents was then correlated with disclosures or non-disclosures and with disclosure types of self-revealing or self-involving.

Hanson's 2005 study is one of the few empirical studies that examined actual client perception of therapist self-disclosure. It provided a rich resource of data through its quantitative and qualitative collection techniques. However, Hanson's theoretical feminist orientation could bias the interview questions and her analysis, interpretation, and coding of the participants' responses. Hanson stated that, "I think a relationship in which power imbalances are minimized can in itself be therapeutically beneficial" (p.102). These imbalances are often minimized through therapist self-disclosure. In addition to potential researcher bias, the study is limited in its generalizability due to its small sample size of mostly Canadian, Caucasian women. The potential participants were provided detail information about the interview topics and thus could have had an interest in discussing favorable therapeutic sessions that included therapist self-disclosure. Those that did not have a favorable experience possibly would not want to recall the sessions and would decide not to participate. Data were used that described clients' experiences of more than 10 years ago. The use of retrospective data can further limit the generalizability of the results.

**Summary.** The empirical data from analogue studies and the scarce client studies provide competing results. This reflects the ongoing controversy of whether to disclose or not. This ambivalence by the client highlights and informs the therapist that therapist self-disclosure intervention should be implemented with caution. One size does not fit all not only for the client

but also for the therapist. Furthermore, research has confirmed that self-disclosure intervention effectiveness or lack thereof is correlated with the therapist's skills in implementing it (Hanson, 2005; Sokol, 2008).

**Limitations and biases of research.** There are numerous limitations of the prior research based on therapist opinions, analogue scenarios, and scarce client based studies. It has not been proven that the opinion of a therapist or a non-client reflects that of an actual client (Audet & Everall, 2010). Similarly, these findings can not necessarily be extrapolated to reflect opinions of other groups. Most of the studies were limited by geography, culture (i.e., Americans of European descent), age, socio-economic status, and language (i.e., English-speaking population). Most were qualitative studies that have inherent difficulties due to interpretation (e.g., biases) that quantitative studies would better limit (Knox et al., 1997). Furthermore, the studies would be compromised since the data were retroactively collected from individuals that possibly present with a self-selection bias. In addition, it is difficult to compare or extrapolate research findings from prior studies due to the discrepant definitions used for self-disclosure (e.g., disclosure consisting of intrapersonal, interpersonal, and/or self-involving information) (Barrett & Berman, 2001).

### **Study Implications**

Therapists have debated whether it is appropriate and/or beneficial to self-disclose during a therapeutic session. Research has reflected an attempt, albeit, not an adequate attempt to address the concerns surrounding the decision to disclose or not. Historically the research has been compromised by not using a consistent definition of self-disclosure which would allow for comparative analysis between and at times even within a research finding. In addition, the research has not adequately factored in a critical part of the therapeutic dyad, the client. Self-

disclosure has been viewed from the therapist or non-client perspective. This study attempts to give a voice to the actual client perspective on a therapist self-disclosure. Gabbard, Gunderson, and Fonagy (2002) echoed the concerns of the National Institute of Mental Health (“Exploratory/Developmental Grants for Psychosocial Treatment Research,” 1993) that the dearth of empirical research presents a scientific weakness that could challenge therapist intervention efficacy. Since the therapeutic alliance is a dynamic relationship created by both the therapist and the client, it is critical that the voice of the client be heard and factored into the treatment plan. This study investigated whether the client prefers therapist self-revealing disclosure to another therapeutic intervention. The next chapter describes the methodology used to carry out the present study.

## **CHAPTER III**

### **Methodology**

This chapter describes the methods used to recruit a sample, collect, and analyze the data from an internet survey on client preferences for therapist self-disclosure or therapist non-disclosure during a therapeutic session.

#### **Research Design**

The purpose of this quantitative, descriptive cross-sectional study was to investigate the client perspective of therapist self-disclosure during a therapeutic session. Because of limited knowledge about the client perspective of therapist self-disclosure in the therapeutic session, the design of this study was both exploratory and descriptive in nature. Cross sectional designs examine phenomena at one point in time and are most often used to show the relationship between phenomena. Quantitative methods were used to accommodate a correlational analysis of research variables. Data were collected using a quantitative survey. In particular, the study focused on whether the client prefers therapist self-disclosure or therapist non-disclosure. The following two hypotheses were investigated. The first hypothesis was: Clients prefer therapist non-disclosure as measured by the clinical situation scale and the therapist action scale over therapist self-disclosure. The second hypothesis was: Client's preference for therapist self-disclosure as measured by the clinical situation scale and the therapist action scale varies by client demographic characteristics (e.g., age, client/therapist gender, symptomatology, social media use). For this study, the operational definition of therapist self-disclosure was: within-

session reaction to a client by a therapist who provides the client with personal information about the therapist's life. Personal information revealed by the therapist per this definition consisted of details about the therapist's activities, family life, and/or circumstances. These disclosures are often referred to in the literature as self-revealing disclosures (Knox & Hill, 2003).

### **Sample**

The criteria to participate in this nonprobability, convenience sample were that the individual 1.) was 18 years old or older, 2.) reads English, 3.) was currently in or has had therapy at any time during the following years: 2007, 2008, 2009, 2010, 2011, and/or 2012, and 4.) was willing to fill out the internet survey on SurveyMonkey. It was important that participants had been in therapy during the last 5.5 years so that their experiences were more recent and easier to recall than from a longer time frame. Parameters for the sample size were at least fifty respondents, but not more than two hundred. The operational definition of therapist was broadly defined since clients are not always aware of or recall their therapist's credentials. For the purpose of this study, if participants checked that they had been in therapy, it was assumed it was with a licensed or unlicensed mental health therapist or mental health counselor with a degree in or getting a Masters, PhD, or PsyD in psychology, social work, or counseling.

Once the study was approved by the Human Subjects Review Committee (Appendix A), 55 colleagues, friends, and other participants were recruited by email (Appendix B) beginning on March 12<sup>th</sup> through March 21<sup>st</sup> of 2012 using the snowball method. The short recruitment letter explained the purpose of the research, criteria for participation, and requested the recipient to forward the email to additional, potential respondents. It explained that to complete the survey (Appendix D) the recipient simply needed to click on the link provided to SurveyMonkey. This link took the participant directly to the survey where they were asked to read the informed



consent letter (Appendix C) and to decide whether or not to participate in the survey. The email also provided information about how to contact the investigator should additional information be needed.

The participants were expected to be Caucasian from middle to upper socioeconomic backgrounds. The study would probably not provide significant data on the perspective of African Americans, individuals from a different culture, those over sixty-five years old, and institutionalized users of mental health services. These limitations were due to project time constraints/restrictions (e.g., dual commitment of internship and thesis) which prohibit accessing populations that were more challenging to reach (e.g., inner-city residents). Even though these were significant limitations to the study, it was still expected to provide critical information on the client perspective of therapist self-disclosure which has been under-researched. This study thus would contribute to a foundation for future, more inclusive, studies.

### **Data Collection**

Data were collected using a quantitative, closed-ended survey. A quantitative method using closed-ended questions was preferred over a qualitative study because it allowed for objective, standardized empirical information to be collected. The consistency of a structured, written survey allowed for a more scientific interpretation of precisely measurable numerical data than data obtained through a qualitative study which needs to be coded and is open to additional subjective interpretations. This data provided results that could be generalized with a higher degree of reliability.

Participants partook in an online survey at the website SurveyMonkey. The data were gathered and saved through their website. They were asked to read a letter of informed consent (Appendix C). If they clicked on the “I agree” button to continue, they were asked to print a copy

of the consent letter for their records. Any participant that did not click the “I agree” button at the end of the informed consent letter was taken to a screen that thanked them for their time and they were not able to participate in the survey. If the participant agreed to the informed consent letter, they were asked three initial questions to further screen the participants. These consisted of the following: 1.) Are you 18 years old or older? (A. Yes B. No); 2.) Have you been in therapy for a mental health issue or a life issue? (A. Yes B. No); and 3.) Did you see a therapist for one or more sessions during 2007-2012? (A. Yes B. No). If the participant was not 18 or older and did not answer yes to questions 2 and 3, the survey sent them to a page that explained that they had been disqualified and thanked them for their time. They were asked to exit the survey. If the participant was 18 years or older and answered yes to questions 2 and 3, they were guided through the survey.

### **Data Collection Instrument**

The self-developed questionnaire incorporated concepts addressed in prior empirical research about therapist self-disclosure. Hendrick’s (1988 and 1990) Counselor Disclosure Scale used a Likert scale to assess how much participants (e.g., actual clients, hypothetical clients using students) would like to know about their therapist (i.e., preference for therapist self-disclosure). Knox and Hill (2003) determined that there were seven categories of therapist self-disclosure. The current survey investigated the client preference for therapist revealing disclosure per Knox and Hill’s literary analysis of extant research.

The three categories of information collected by the self-report survey were: 1.) Participant’s 16 demographic characteristics, 2.) Responses to 7 clinical mini-vignettes, and 3.) Likert ratings of 10 different therapist interventions. This self-developed survey used multiple

methods of information gathering in an effort to elicit real life responses as well as to explore the participant's ideal therapeutic use of therapist self-disclosure.

Participants were asked about their: 1.) Age (e.g., specific age(s) might prefer therapist self-disclosure), 2.) Gender (e.g., specific gender might prefer therapist non-disclosure), 3.) Racial/ethnic identity (e.g., culture might influence preference), 4.) Education (e.g., educational level obtained might influence preference for non-disclosure), 5.) When in treatment (e.g., recent treatment facilitates recall of experience), 6.) Therapist gender (e.g., gender might influence preference), 7.) Daily use of Twitter, Facebook, email, cell phone (e.g., demonstrates comfort level with personal self-disclosure and could influence preference), and 8.) Symptomology (e.g., possibly therapist self-disclosure more conducive to certain diagnoses). Examples of demographic questions were: 1.) What is your gender? (male, female, transgendered male, transgendered female, other (please specify )) and 2.) On a daily basis, how often do you twitter? (0, 1-10 times, 11-25 times, 26-50 times, more than 51 times).

Participants were then asked to select the therapist response that they preferred for different therapeutic issues as described by a one sentence statement referred to above as the clinical mini-vignette (i.e., Clinical Situation Scale). One of the choices for each situation would involve a therapist self-disclosure (e.g., therapist personal experience similar to client's issue; therapist private weekend activities). The following is an example of a therapy session mini-vignette statement: The client is upset about a bad relationship she has with her boyfriend's parents. The client then selects her preferred therapist response from the following two choices: A. Therapist tells client how he dealt with a bad relationship he had with his girlfriend's parents; or B. Therapist asks client to describe details of the bad relationship.

To further explore the client's attitude about a therapist self-disclosure, participants were then asked to rate on a Likert scale their opinion of 10 different therapist techniques (i.e., Therapist Action Scale). The Likert scale consisted of a.) Strongly disagree, b.) Generally disagree, c.) Neutral, d.) Generally agree, and e.) Strongly agree. A client was asked to rate a statement similar to the following: A therapist should tell the client how the therapist fixed his/her own problems.

The survey was estimated to take ten to fifteen minutes to complete. Due to the ease of completing the survey for the respondents, the access to the sample, and the interest demonstrated by friends and colleagues in this topic, the study seemed highly feasible.

### **Ethics and Safeguards**

Before completing the online survey, participants were asked to read an electronic informed consent letter (Appendix C). This letter provided the following information: 1.) Researcher profile, 2.) Study purpose, 3.) Reason asked to participate, 4.) Handling of confidential, anonymous responses, 5.) Voluntary participation, and 6.) Participation benefits and risks. If the participants clicked on the "I agree" button to continue, they were asked to print a copy of the consent letter for their records. Any participant that did not click the "I agree" button at the end of the informed consent letter was taken to a screen that thanked them for their time and they were not able to participate in the survey.

Minimal risk from participating was anticipated. Participants might have felt somewhat uncomfortable and ambivalent about reflecting on and assessing their therapeutic sessions. They could also have felt conflicted by enjoying the self-disclosure of the therapist yet believe that it was not conducive to their therapeutic needs. The participant was informed that they had the right to not answer any question in the survey as well as not to complete the survey. This, and the

fact that the data collected would be kept confidential and was completely anonymous, assisted in ameliorating the participant's concerns.

The benefits of participating in this study was that the participant would perceive himself/herself as a significant member of the therapeutic dyad and that their perspective was important not only for their therapy but for advancing beneficial therapeutic interventions for others. This was expected to be an empowering experience. Participants were not paid for their involvement in the survey.

Participation and responses to this study were anonymous and kept confidential. Only I, my thesis advisor, and a statistical analyst had access to the data, and again, no identifying information was attached to the responses (i.e., none was collected). The data from this study will be kept locked for a period of three years as required by Federal regulations, was password protected, and will be destroyed if not needed for further use. In publications or presentations, data will be presented as a whole.

Participation in this study was voluntary. Participants could withdraw before the study began. Participants could discontinue participation at any time without penalty. Participants could choose to answer or not answer any question(s) they wished. Participants could contact the Chair of the Smith College School for Social Work Human Subjects Review Committee or me for questions or concerns about the study.

### **Data Analysis**

Descriptive and inferential statistics were used to analyze the survey responses. Descriptive statistics were used to analyze the data received from the demographic portion of the survey. Using descriptive statistics for this instrument allowed for the comparison of the subjects in terms of numerous variables (i.e., gender, age, education) and the summarization of

the data within a comprehensive frequency table. However, this analysis does not establish a causal relationship, it only provides a correlation. Further research would be needed to ascertain a causal relationship. The Pearson's  $r$ , one-way ANOVA, and t-tests were used to determine if there was a correlation between demographic characteristics and a client's preference for therapist self-disclosure.

## **Discussion**

There were potentially inherent methodological and personal biases in the research. A social desirability bias might be of concern since respondents might attempt to respond as they believe the researcher or their therapist would respond. In addition, those in therapy could have a favorable view of the process and thus would respond favorably to any technique they were asked about. However, those that were in therapy but not during the inclusion time frame might have discontinued therapy due to a dislike of therapist self-disclosure. This study would not capture their opinion.

Using a standardized, close-ended survey could introduce methodological biases. The participant would be provided structured scenarios for which there were limited responses to select as their preference. Although close-ended questions increase comparability of answers and decrease the opportunity for subjective interpretation, it also restricts the depth of the answers and limits the expanse of understanding of the therapeutic dyad dynamics. Said dyad dynamics could possibly be more fully clarified through the use of an open-ended survey or interview questions.

My personal biases may affect the manner in which my study was conducted and how the information, although numerical, was interpreted. Prior to developing my thesis topic, I naively believed that therapists did not and should not self-disclose. I supported Freud's concept that it

interfered with the client's therapeutic needs. However, I was not only surprised to learn that most contemporary therapists self-disclose but that they believe that their clients prefer self-disclosure. Since my brief personal therapeutic experience as a client did not support their conclusion, I wanted to investigate the client perspective. Accordingly, I predict that self-disclosure will be found less valuable and at times problematic by clients. In this regard, the results of the study will be valuable in giving a voice to the once voiceless participant in the therapeutic dyad, the client. Hopefully, this voice will resonant to enhance the efficacy of their treatment. The findings from the present study are summarized in the next chapter.

## **CHAPTER IV**

### **Findings**

This chapter presents the descriptive and inferential statistics used to analyze the survey responses. Descriptive statistics facilitated the comparison of sample characteristics and the relationship among demographic and background variables (e.g., age, social media use). A summarization of this data is presented within a comprehensive frequency table. Inferential statistics highlighted findings that could be inferred or generalized to a larger population based on the statistical significance of the sample data. The frequency distributions were examined separately for the clinical situation scale and the therapist action scale to determine participant's preference for therapist self-disclosure (first hypothesis). To determine if there was a correlation between demographic characteristics and preference for therapist self-disclosure, the therapist action scale responses were analyzed using Pearson's  $r$  correlation, one-way ANOVA, and t-tests (second hypothesis). Descriptive and inferential analysis of the data found a statistically significant preference by actual clients for therapist non-disclosure during a therapeutic session. It also determined that there were differences in preference by some client characteristics. These findings supported the original research hypotheses.

#### **Demographic Data Survey**

All of the respondents were 18 years old or older, could read English, and had been in therapy for one or more sessions during 2007 to 2012. Of the 69 respondents, the responses of nine participants were eliminated since these respondents did not answer questions after the



initial screening questions. The remaining sixty participants completed the demographic portion of the survey. Their responses are summarized in Table 1. These participants also completed the seven questions of the clinical situation scale and the ten questions of the therapist action scale. A respondent elected not to answer a question less than 1% of the time.

**Age.** All participants were 18 years old or older. The youngest respondent was 18 and the oldest was 86 years old. The average age for the respondents was 44 years old. The majority of the participants (n=21, 36.2%) were in the over 50 age range followed by the 18 to 36 age range (n=19, 32.8%). The 37 to 50 age range was the least represented (n=18, 31.0%). Of the 60 participants, two did not provide their exact age.

**Gender.** The majority of participants were female (n=55, 91.7%). In addition, there were four males (6.7%) and one transgendered male who participated (1.7%).

**Race and ethnicity.** The majority of the participants identified as White (n=46, 76.7%) followed in the following descending order: European (n=6, 10.0%), Hispanic/Latino (n=5, 8.3%), with only one respondent (1.7%) identifying as either Asian, Bi/Multi-racial, or Other (“kind of a nice crème brûlée”). Two other groups (i.e., African American/Black (n=0, 0%), Native American (n=0, 0%)) were choices for race and ethnic identity but were not represented in the sample.

**Sexual orientation.** The majority of participants were heterosexual (n=51, 86.4%), while six were lesbians (10.2%), and two were bisexual (3.4%). One respondent did not provide information on sexual orientation. There were no responses to the categories of asexual, gay, or other.

**Highest level of education.** Most of the respondents had advance degrees. The majority had a Master’s degree (n=25, 41.7%) followed by those with a Bachelor’s degree (n=17, 28.3%).

There were 11 participants who had a Doctoral degree (18.3%). Six participants had some college (10.0%) and one had an associate's degree (1.7%). There were no responses to the categories of some high school, high school/GED, or vocational training.

Table 1.

Demographic Characteristics of the Sample

Characteristic	f	Valid %
<b>Age</b>		
18-36	19	32.8
37-50	18	31.0
51 +	21	36.2
<b>Gender</b>		
Female	55	91.7
Male	4	6.7
Transgendered male	1	1.7
<b>Race</b>		
White	46	76.7
European	6	10.0
Hispanic	5	8.3
Asian	1	1.7
Bi/multi-racial	1	1.7
Other	1	1.7
<b>Sexual Orientation</b>		
Heterosexual	51	86.4
Lesbians	6	10.2
Bisexual	2	3.4
<b>Education</b>		
Some College	6	10.0
Associate Degree	1	1.7
Bachelor Degree	17	28.3
Master's Degree	25	41.7
Doctoral Degree	11	18.3

## Background Information

Participants were asked a series of questions about the frequency of their use of social media, reasons for seeking therapy, the number of therapy sessions they attended, and the gender of the therapist.

**Social media.** As presented in Table 2, all 60 participants answered all four questions on their daily use of social media.

Table 2.

### Use of Social Media

Social Media	f	Valid %
Twitter		
0	56	93.3
1-10 times	3	5.0
11-25 times	1	1.7
Facebook		
0	25	41.7
1-10 times	30	50.0
11-25 times	5	8.3
Email		
0	4	6.7
1-10 times	48	80.0
11-25 times	6	10.0
26-50 times	2	3.3
Cell phone		
0	5	8.3
1-10 times	50	83.3
11-25 times	5	8.3

The overall majority of respondents did not twitter daily (n=56, 93.3%) while three twittered between 1 to 10 times daily (5.0%), and one twittered 11 to 25 times daily (1.7%). No one twittered daily 26 to 50 times or more than 51 times, the other two categories provided.

Fifty percent of the respondents acknowledged checking Facebook between 1 to 10 times daily (n=30) while 25 never checked Facebook (41.7%) and five checked it between 11 to 25 times daily (8.3%). Again, no one checked Facebook daily 26 to 50 times or more than 51 times, the other two categories provided.

The majority of the respondents (n=48, 80.0%) sent 1 to 10 personal emails daily while six sent between 11 to 25 emails daily (10.0%) and two sent 25 to 50 emails daily. Four reported never sending an email daily (6.7%). No one acknowledged sending more than 51 emails daily.

Fifty percent of the participants used their cell phone for personal calls 1 to 10 times daily (83.3%) while five used it between 11 and 25 times daily (8.3%) and five never used it daily (8.3%). No one reported using their cell phone daily from 26 to 50 times or more than 51 times daily, the other two categories provided.

Overall, the most frequently used forms of social media by the participants were email and cell phone, which might be associated with the age distribution of the sample. Had the sample consisted of a higher percentage of participants between the ages of 18 and 36 the frequency of Facebook and Twitter usage might have been higher.

**Reason for therapy.** The participants were asked to rank the top three reasons for seeking therapy from a list of 16 with “Other” being a choice to specify. As shown in Table 3, the main reason given for entering therapy was depression (n=18, 30.5%) followed in descending order by relationship concerns (n=16, 27.1%), anxiety (n=13, 22.0%), bereavement (n=2, 3.4%), and sexual abuse (n=1, 1.7%). Nine individuals reported their main reason for therapy under the

“Other” category as bipolar, desire to feel grounded and supported while in transition, eating disorder and anxiety, emotional healing and support, family issue with stepson, life adjustment, many converging life crossroads overwhelming, repeating patterns of dysphoric interactions, and a sleep problem. Each “Other” reason separately represented 1.7 percent.

Table 3.

Reasons for Therapy

Reason	Main		Second		Third	
	f	Valid %	f	Valid %	f	Valid %
Depression	18	30.5	13	25.0	5	16.1
Anxiety	13	22.0	12	23.1	8	25.8
Relationship concerns	16	27.1	11	21.2	5	16.1
Bereavement	2	3.4	3	5.8	2	6.5
Sexual abuse	1	1.7	0	0.0	1	3.2
Suicidal thoughts	0	0.0	1	1.9	2	6.5
Health	0	0.0	1	1.9	2	6.5
Verbal abuse	0	0.0	1	1.9	1	3.2
Sexuality	0	0.0	0	0.0	2	6.5
Other	9	15.3	10	19.2	3	9.7

The participants then ranked their second most important reason for entering therapy. The second reason for getting therapy was for assistance with depression (n=13, 25%) followed in descending order by anxiety (n=12, 23.1%), relationship concerns (n=11, 21.2%), bereavement (n=3, 5.8%), suicidal thoughts (n=1, 1.9%), health (n=1, 1.9%), and verbal abuse (n=1, 1.9%).

Ten respondents reported their second reason for therapy under the “Other” category as depression and anxiety, family issues, maintenance of therapeutic gains, managing feelings of anger and fear, overweight, self-awareness, self-exploration, wanting to improve self and my life, and self-development. Each reason separately represented 1.7 percent of “Other” with self-awareness being listed twice and thus it represented 3.4 percent. Eight participants did not list a second reason for having been in therapy.

Only 31 participants had a third reason for therapy. The third most frequent reason given for therapy was for assistance with anxiety (n=8, 25.8%) followed equally by depression (n=5, 16.1%) and relationship concerns (n=5, 16.1%). Then each of the following four categories was selected as the third reason for therapy by two individuals (total of n=8, 26.0%): suicidal thoughts, health, sexuality, and bereavement. The two categories of sexual abuse and verbal abuse were selected as the third reason for therapy by only one respondent each (total n=2, 6.4%). Three respondents reported their third reason for therapy under the “Other” category as anger, growth, and “I just want to be happier.” Each reason separately represented 3.2 percent of “Other” (total n=3, 9.7%). Twenty-nine participants did not list a third reason for having therapy.

Respondents did not report the following as one of their top three reasons for attending therapy: domestic violence, substance use, homicidal thoughts, physical abuse, financial concerns, or mandated to see a therapist. These reasons have not been included in the Table 3 or 4 (n=0, 0.0%).

To determine how often a reason was given for attending therapy, a total of the responses for each reason was calculated. The ranking of the top three reasons for attending therapy is consistent with the findings of each reason for therapy previously presented. As Table 4 shows,

depression (30%) was the main reason given for seeking therapy followed closely by anxiety (27.5%) and relationship concerns (26.7%).

Table 4.

Summation of Top Three Reasons for Therapy

Reason	Total of Top 3 Reasons	
	f	Valid %
Depression	36	30.0
Anxiety	33	27.5
Relationship concerns	32	26.7
Bereavement	7	5.8
Sexual abuse	2	1.7
Suicidal thoughts	3	2.5
Health	3	2.5
Verbal abuse	2	1.7
Sexuality	2	1.7

**Number of therapy sessions.** Of the 60 respondents, 28 (46.7%) reported currently being in therapy while 32 (53.3%) reported that they were not presently in therapy. The majority of the respondents (n=23, 38.3%) reported having more than 41 therapy sessions during the last 5.5 years from 2007 to 2012. Fifteen (25%) reported 11 to 20 sessions during that time period while twelve (20%) reported 1 to 10 sessions, seven (11.7%) reported 21 to 30 sessions, and three (5.0%) reported having 31 to 40 sessions between 2007 to 2012. The median value of the five ranges was the 21 to 30 sessions range for the 60 respondents.

**Therapist's gender.** Most of the respondents (n=47, 78.3%) had female therapists. Eleven (18.3%) had male therapists. Two reported seeing for equal time frames a male and a female therapist (3.3%).

### **Clinical Rating Scales**

To measure a participant's preference for therapist self-disclosure during a therapy session two sets of scales were created: Clinical Situation Scale and Therapist Action Scale. Both scales were instrumental in providing data to corroborate the study's hypotheses. The first hypothesis was that clients prefer therapist non-disclosure over therapist self-disclosure. To test the first hypothesis, the frequency of the respondent's preference for therapist self-disclosure or non-disclosure as reflected in the clinical situation scale and therapist action scales was examined.

**Clinical Situation Scale.** This scale measured the respondent's preference for therapist self-disclosure to seven clinical mini-vignettes. One of the choices for each therapy session vignette involved a therapist self-disclosure. As shown in Table 5, the majority of the responses to the vignettes were for therapist non-disclosure. Of the 60 participants, 55 (93.2%) to 59 (98.3%) of the respondents preferred non-disclosure. In contrast, the vignette involving domestic violence elicited a different response. Fourteen, or 23.3%, of the 60 respondents preferred therapist disclosure compared to 46, or 76.7%, who preferred non-disclosure.

**Therapist Action Scale.** To further explore the participant's attitude about therapist self-disclosure, participants provided their opinions on five therapist self-disclosure techniques using a Likert scale. As shown in Table 6, the respondents overwhelmingly rated therapist non-disclosure as the preferred therapeutic technique. The response rates for non-disclosure ranged from 49.2 % to 88.1% representing the opinion of 29 to 52 participants.



Table 5.

Clinical Situation Scale

TOPIC	RESPONSES				TOTAL f
	Self-Disclosure		Non-Disclosure		
	f	%	f	%	
Relationship	2	3.3	58	96.7	60
Mood	2	3.4	57	96.6	59
Affair	1	1.7	59	98.3	60
Drinking	2	3.3	58	96.7	60
Domestic Violence	14	23.3	46	76.7	60
Economic	2	3.4	57	96.6	59
Parenting	4	6.8	55	93.2	59

Table 6.

Therapist Action Scale

TOPIC THERAPIST:	RESPONSES				Non-Disclosure		TOTAL f
	Self-Disclosure		Neutral		f	%	
	f	%	f	%			
Problems	2	3.4	9	15.3	48	81.4	59
Experiences	7	12.1	12	20.7	39	67.2	58
Weekend	1	1.7	6	10.2	52	88.1	59
Never tell	17	28.8	13	22.0	29	49.2	59
Always tell	4	6.7	9	15.0	47	78.3	60

The second hypothesis posed in the study was that clients preference for therapist self-disclosure as measured by the clinical situation scale and the therapist action scale varies by client demographic characteristics (e.g., age, client/therapist gender, symptomatology, exchange of personal information electronically). To test this hypothesis the therapist action scale responses were used to compare participants by specific demographic characteristics. As part of the analysis, it was necessary to determine the internal reliability of the scale. Cronbach's alpha test for internal reliability indicated strong internal reliability for the five questions in the therapist action scale that assessed therapist self-disclosure ( $\alpha=.81$ ,  $N=57$ ,  $N$  of items=5). The responses were scored to create the scale for analysis. Strongly agree was coded 5 to represent preference for disclosure while strongly disagree was coded 1 to represent preference for non-disclosure. Therefore, a higher score indicated a greater preference for therapist self-disclosure. To accommodate this analysis pattern, question 35 had to be reverse coded. The mean of this scale for the five questions was 2.01, the median was 2.00. This scale was then used as the dependent variable to determine if there were differences in agreement with self-disclosure by age, gender, race, sexual orientation, education, use of social media, and reason for therapy.

**Age.** The Pearson's  $r$  correlation showed no statistically significant association between age used as a ratio independent variable (e.g., 18 years old, 36 years old) and self-disclosure though it did approach significance ( $r=-.256$ ,  $p=.052$ , two-tailed). The findings indicate that as the respondent's age increases their preference for therapist self-disclosure decreases.

A one-way ANOVA was used to test for differences in therapist self-disclosure preference by age categories (18-36, 37-50, 50+). There were no statistically significant differences in preference for therapist self-disclosure by age category ( $F(2,55)=2.772$ ,  $p=.0710$ ).

**Gender.** A t-test was not run because the groups were very uneven and one group was very small (4 males, 55 females). However, a means test determined that males did have a higher mean on the scale of 2.59 compared to the mean for females of 1.98. The sample of males was too small to infer that the mean difference was significant.

**Race and ethnicity.** Race was recoded into the following two categories: white and people of color. People of color included all those that did not identify as white (e.g., European, Asian). A t-test was used to determine whether there were differences in therapist self-disclosure preference by race. As shown in Table 7, the results indicate there were statistically significant differences in self-disclosure by race ( $t(58) = -2.289$ , two-tailed  $p = .026$ ). The average preference for therapist self-disclosure in the white group ( $n = 46$ ) was lower ( $M = 1.9$ ) than the average score in the people of color group ( $M = 2.36$ ,  $n = 14$ ). The higher mean score in the people of color group suggests a greater preference for therapist self-disclosure.

Table 7.

Comparison of Therapist Self-Disclosure Preference by Race

Race	N	Mean	t	df	p
White	46	1.90	-2.289	58	.026
People of Color	14	2.36			

**Sexual orientation.** A t-test found that there was no statistically significant difference for therapist self-disclosure between those that identified as lesbian and heterosexual. The bisexual group was too small to be included in the test.

**Highest level of education.** One-way ANOVA was used to determine whether there were statistically significant differences in preference for therapist self-disclosure by education. The

results did not find a statistically significant difference in preference for therapist self-disclosure by education. As Table 8 demonstrates, when education categories were recoded into two groups: bachelors or below and masters and above, the t-test results showed a statistically significant difference ( $t(58) = 2.556$ , two-tailed  $p = .013$ ). The bachelors and below had a higher mean ( $M = 2.28$ ) than the masters and above group ( $M = 1.84$ ), which suggests a greater preference for therapist self-disclosure among participants with bachelor's degree or less.

Table 8.

Comparison of Therapist Self-Disclosure Preference by Education

Education	N	Mean	t	df	p
Bachelors or below	24	2.28	2.556	58	.013
Masters and above	36	1.84			

Table 9.

Comparison of Therapist Self-Disclosure Preference by Use of Facebook

Frequency Use of Facebook	N	M	F	df1	df2	p
Never used	25	1.714	4.609	2	57	.014
1-10 times	30	2.215				
11-25 times	5	2.280				

**Social media.** One-way ANOVA was used to test for differences in preference for therapist self-disclosure by respondent's use of social media. As shown in Table 9, the results found a statistically significant difference ( $F(2,57) = 4.609$ ,  $p = .014$ ) in preference for therapist self-disclosure by use frequency of Facebook. A Bonferroni post hoc test determined that the

statistically significant difference was between those who said they never used Facebook (M=1.7) and those that checked 1-10 times (M=2.2). Those that checked Facebook 1-10 times daily preferred self-disclosure. No other statistically significant differences were found in use of Twitter, email, or cell phone.

***Reason for therapy.*** One-way ANOVA was again used to test for differences in therapist self-disclosure preference by reason for seeking therapy. The results found no statistically significant differences in self-disclosure preference by the three main symptoms of depression, anxiety, and relationship concerns. The responses to the remaining reasons for therapy (e.g., bereavement, sexual abuse) were too few to be included in the test.

## **Summary**

The study findings of actual client participants identified a population that prefers therapist non-disclosure during a therapeutic session. In addition, the data found that there was a correlation between some of the respondent's demographic characteristics and their preference for non-disclosure. The following discussion chapter will provide a framework to interpret the data presented in the Findings chapter. It will also reflect on the strengths and limitations of the research and its implication for social work practice and future research.

## **CHAPTER V**

### **Discussion**

#### **Overview of Study**

This chapter provides an interpretation of the findings and compares them with prior empirical research on therapist self-disclosure. It also addresses the study's strengths and limitations, as well as, its implications for social work practice and future research. The study design was a quantitative, anonymous internet survey used to investigate the client perspective of therapist self-disclosure. My research questions were: Do actual clients prefer therapist self-disclosure to non-disclosure during a therapeutic session? Is there a difference in the preference for therapist self-disclosure based on the demographic variables measured? I hypothesized that actual clients would prefer therapist non-disclosure. In addition, I hypothesized that demographic characteristics would influence the client's preference for therapist self-disclosure.

#### **Interpretation of Findings**

The first research question examined whether actual clients preferred therapist self-disclosure to non-disclosure. The results documented that the majority of respondents preferred therapist non-disclosure on both the clinical situation scale (93.2 to 98.3%) and the therapist action scale (49.2 to 91.6%, M= 76.0 %). This is consistent with the hypothesis that clients would prefer therapist non-disclosure; however, it contradicts many of the findings of prior empirical research. Prior research often consisted of analogue studies which relied heavily on non-client student participants' preferences for therapist self-disclosure. Prior empirical studies

also relied on the therapist's speculation about whether their clients preferred therapist self-disclosure (Barrett & Berman, 2001). The extant studies did not use actual clients and thus extrapolated from one sample the preference of another sample, the actual client (Hardin & Subich, 1985; Watkins, 1990). It has been documented that there is a difference between what a non-client (e.g., student, therapist) thinks and what an actual client thinks (Burisch, 1984). The following discussion of the differences in preference for therapist self-disclosure by demographic characteristics provides other reasons that clients generally prefer therapist non-disclosure.

It is important to recognize that the study results are the responses of a specific population niche. As such, this niche does not reflect the general population. This is due in part to the convenience snowball technique used to obtain participants. The findings need to be viewed as the preference of this specific participant niche consisting of mostly Caucasian females between 18 and 86 years old who identified as heterosexual, had a higher level of education (e.g., master degrees), and listed therapeutic concerns of depression, anxiety, and/or relationship issues as their reason for therapy.

The second research question investigates whether there is a difference in the preference for therapist self-disclosure based on the demographic variables measured. As I hypothesized, some demographic characteristics did influence the client's preference for therapist self-disclosure. Although, prior empirical research lacks information about the preference for therapist self-disclosure by the participants' demographic characteristics, the current study provides some insights into this area.

**Age.** Across the three age categories (i.e., 18-36, 37-50, 51+), participants expressed a similar preference for therapist non-disclosure. No statistically significant difference was found.

However, the Pearson's  $r$  correlation did approach significance ( $r=-.256$ ,  $p=.052$ ) when the actual ratio age of the participant was used. It found that as age increased, the preference for therapist non-disclosure increased and therapist self-disclosure decreased. As one accumulates their own knowledge, it would be assumed that they would have sufficient life experiences such that they would not be interested in the therapist's self-revealing disclosure but want to take advantage of the therapist's skill and knowledge that specifically addresses their own concern. In contrast, a younger client would possibly be curious as to how one navigates life and would welcome therapist self-revealing disclosures. Although prior research does not address the age differences in therapist self-disclosure directly, one could argue it does so indirectly. Through analogue studies that use a non-client college student population, the prior studies have provided information on a younger, less experienced sample. It is this demographic that the extant research reports to prefer therapist self-disclosure to non-disclosure (Hendrick, 1988a; Sokol, 2008), a finding consistent with the current study.

**Gender.** The results showed that males preferred therapist self-disclosure more than females. However, these findings cannot be generalized due to the small sample size of males and the inability to obtain a statistically significant result.

**Race and ethnicity.** There was a statistically significant difference in preference for therapist self-disclosure based on race. People of color preferred therapist self-disclosure more than whites. Unfortunately, there is no research studying this demographic, thus one is left to speculate why this occurred. Possibly, since people of color represent a minority, they could be more curious about therapist self-revealing disclosure in an effort to figure out a life strategy based on information about their therapist's life experiences. In addition, they could use therapist



disclosure as a way to test the creditability of the therapist and/or to determine how much they have in common with the therapist.

**Sexual orientation.** Since there was no statistically significant difference between lesbian and heterosexual preference for therapist self-disclosure, sexual preference was not a factor influencing therapist self-disclosure preference.

**Highest level of education.** Respondents with more education (i.e., masters and above) had less interest in therapist self-disclosure than those with less education (i.e., bachelors and below) as evidenced by the statistically significant difference found between these two educational categories. This appears consistent with this study's prior findings that those of a younger age, and therefore less life experiences and knowledge, preferred therapist self-disclosure. Conversely, as an individual gains knowledge through advance degrees and life experiences, there is less interest in the therapist's experiences and more appreciation for the therapist's skills.

**Social media.** There was a statistically significant difference in preference for therapist self-disclosure between those that never use Facebook and those that use it 1 to 10 times. Those that use Facebook possibly are not only disclosing personal information but receiving personal information of others (i.e., revealing disclosures). It might be reasoned that an individual's comfort level with Facebook might suggest that one would take personal revelations as a normal and expected dimension of the therapeutic alliance. There was no statistically significant difference found in preference for therapist self-disclosure with other forms of social media use (i.e., twitter, emails, cell phone).

**Reasons for therapy.** There was no statistically significant difference found in the reasons given for therapy and the preference for therapist self-disclosure. Furthermore, extant

empirical studies do not provide insight into this area. Prior research has not addressed the potential implication of diagnosis on preference for therapist self-disclosure (Watkins, 1990).

**Summary.** Prior empirical studies did not assess the actual client's preference for therapist self-disclosure. Rather the data were obtained from easily available analogue populations (e.g., non-client, college students) or from therapists' predictions of their clients' preferences. Neither data base provided the actual client's perspective as the current study did. As such, it should not be a surprise that findings of actual clients differ from prior predictions about their preferences. In contrast to prior research, the current study found that a specific population prefers therapist non-disclosure of self-revealing information. It was found that Caucasian women with advanced educational degrees who have depression, anxiety, and/or relationship issues prefer therapist non-disclosure.

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

**Strengths.** SurveyMonkey facilitated an efficient collection of responses from a potentially diverse demographic population. This approach also increased the possibility of obtaining honest responses from clients. Research has documented that respondents are more likely to respond honestly to questions about therapy techniques when posed by a third party (e.g., a survey) rather than by their therapist (Hill et al., 1988a). The use of quantitative, clear, unambiguous, closed-ended survey questions allowed respondents to complete the survey quickly.

Another strength of the survey was that the questions solely dealt with one type of therapist self-disclosure, therapist revealing self-disclosure. There were no questions that either dealt with therapist involving self-disclosure nor were any questions structured to determine whether the client preferred revealing to involving disclosure. This was done so not to repeat

weaknesses of prior research in which the operational definition of disclosure was poorly defined, not consistently defined within the study, as well as conflated. Poorly structured definitions undermined prior research results.

The survey intentionally used short, brief questions in an effort to eliminate multiple interpretations of the question. Thus, brief, mini-vignettes and Likert scale questions, each consisting of only one sentence, were used to reduce ambiguity and provide clarity.

Using actual clients who had at least one recent clinical experience during 2007 to 2012 is a definite strength of this study. The responses of recent, actual clients have a higher probability of reflecting a real rather than virtual therapeutic preference.

The snowball sampling technique efficiently contacted potential participants who had internet access. Since the requests for participants were generated through personal friends and professional contacts, the pool of participants was demographically limited as the findings proved. The limitation of this approach also was a strength of the study. Snowball sampling inadvertently collected responses from a specific population niche and therefore provided an in depth look at this population's preference for therapist non-disclosure. As such, the study ultimately focused on one, very specific, population niche consisting of white women with higher education seeking therapy for depression, anxiety, and relationship concerns.

**Limitations.** This convenience sample using the snowball method to obtain participants has as its weakness that participants needed to be able to access and use a computer with internet capability. Also, the sample was limited because participants were contacted through personal and professional connections. The findings confirmed that the sample represented a specific population niche. Since the sample was of a specific group, their responses would not be able to be generalized.

The study could have benefitted not only by attempts to reach a more diverse population but also by collecting data from a larger group. Due to the limited sample size, many of the sub-sample variables were too small to generate significant findings.

The informed consent letter explained that the study was about a client's preference for therapist self-disclosure. This could have influenced a participant's responses to answers that confirmed their personal belief about therapist self-disclosure and therefore biased their answers. It would have been preferable to have explained that the study was about a client's perspective on various therapy approaches. Then, after the study was completed, the client could have been debriefed electronically and provided information that the study was specifically assessing their preference for therapist self-disclosure.

The "forever" survey question terms (i.e., "always should", "never should") possibly skewed responses to the more neutral response choice. Thus, respondents did not commit to the agree or disagree choices. The Likert choice of "neutral" provided limited information. Replacing that choice with "no opinion" would have been more informative. Likert questions that were initially created to disguise what the purpose of the survey was were unnecessary once the informed consent explained the intent of the survey. Therefore, those deceptive questions should have been rewritten to assess the participant's preference on therapist self-disclosure.

Qualitative, open-ended questions about therapist self-disclosure that was beneficial or detrimental for the client were lacking. These could have added a level of depth that the quantitative answers did not provide. Also, the responses could have highlighted areas for further study.

Using SurveyMonkey to collect data meant that participants could reside anywhere in the world. Thus, it would have been helpful to know what geographic areas the respondents

represented. Similarly, it would have been helpful to know if the participant who identified as Asian was an Asian American or an Asian from another country. This information would facilitate more precise analysis. It is unclear how a person that identifies as white from Europe would have answered the racial/ethnic question.

Not knowing at what age participants were in therapy was another weakness of the study. Although the responses were given by adults, those that were currently 18 years old could be reflecting on a therapeutic session that occurred when they were a minor. Since the criteria was that one had to be 18 and have had therapy between 2007 and 2012, the respondent could have been as young as 12 when they received therapy. Clearly, their impression of the treatment could be different than someone that had therapy at 18.

### **Implications for Practice and Policy**

Prior research overwhelmingly asserted that clients preferred therapist self-disclosure during a therapeutic session. This study, however, found that there is a specific demographic that prefers therapist non-disclosure. Thus, clinicians should handle revealing self-disclosure sensitively if they elect to self-disclose since there is no definitive or sufficient research supporting a position to or not to disclose. There needs to be training programs, classes, supervision, and continuing education opportunities for an on-going dialogue about the use of therapist self-disclosure which highlights the need for being sensitive to the client's unheard voice, the client's wishes, and the client's needs.

### **Recommendations for Future Research**

There is an opportunity for future research that does not explain prior to the study what it is investigating so not to influence the participants. Participants knowing that the study is about therapist self-disclosure who believe that a therapist should not disclose during a therapeutic

session might provide answers that would support their belief (i.e., respondent bias). However, this would be less likely to occur if participants were informed what the study was about in a debriefing statement after they completed the study. Alternatively, increasing the sample size might have reduced the likelihood of respondent bias. In an effort to reduce retrospective bias, future research would benefit by using a sample that consisted of individuals in treatment at the time of the study.

As previously acknowledged, the therapeutic alliance is enriched and results are more beneficial if the client supports the therapeutic interventions being used (Audet & Everall, 2003). In that regard, future research that correlates the client preference for therapist self-disclosure and the client's demographic characteristics would be warranted. It would provide critical factors for the therapist to consider when deciding whether it is beneficial to disclose or not.

In addition, future research would be enhanced by incorporating qualitative, open-ended questions about client's beneficial or detrimental experiences with therapist revealing self-disclosure. Client responses to qualitative questions should add richness and depth to quantitative data collected. A sample made up of a larger, diverse group might increase the generalizability of the research findings.

## **Conclusion**

Self-disclosure is ubiquitous. It occurs visually not only through one's mannerisms, dress, and office décor but also through verbal inflection and dialogue. The historical debates as to whether a therapist should verbally self-disclose to their client still echo and are presently engaged in not only between those of different theoretical orientations, but between analysts and clinicians. As research has shown, this is not a bad thing. However, the data provided to date does not adequately address the topic. It has been flawed by more speculation than science, more

assumptions than facts, more theoretical bias than correlation. Research has adequately acknowledged that therapist self-disclosure occurs and that actual clients have confirmed its benefits but also its harm. In contrast to past studies, this study clearly presented a clinical niche that did not prefer self-disclosure to non-disclosure. Since current research is not sufficient to inform the clinician when to use or not use disclosure as a therapeutic intervention, the clinician is encouraged to handle it with care and use it only in the best interest of their clients. Hopefully, as additional research is completed using actual clients the therapist can be provided with information about the use of self-disclosure so as to utilize it as and when appropriate.

## References

- Audet, C. T., & Everall, R. D. (2003). Counsellor self-disclosure: Client-informed implications for practice. *Counselling and Psychotherapy Research, 3*(3), 223-231. doi: 10.1080/14733140312331384392
- Audet, C. T., & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance & Counselling, 38*(3), 327-342. doi: 10.1080/03069885.2010.482450
- Barrett, M.S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology, 69*(4), 597-603. doi: 10.1037//0022-006X.69.4.597
- Brown, L. S., & Walker, L. E. A. (1990). Feminist therapy persp[ective on self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (135-154). New York: Plenum Press.
- Burisch, M. (1984). Approaches to personality inventory construction: A comparison of merits. *American Psychologist, 39*, 214-227. doi: 10.1037/0003-066x.39.3.214
- Carew, L. (2009). Does theoretical background influence therapists' attitudes to therapist self-disclosure? A qualitative study. *Counselling and Psychotherapy Research, 9*(4), 266-272. doi:10.1080/14733140902978724
- Edwards, C. E., & Murdock, N. L. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling and Development, 72*(4), 384-389. doi:10.1002/j.1556-6676.1994.tb00954.x



- Gabbard, G. O., Gunderson, J. G., & Fonagy, P. (2002). The place of psychoanalytic treatments within psychiatry. *Archives of General Psychiatry*, 59(6), 505-510. doi: 10.1001/archpsyc.59.6.505
- Gill, M. M., (1983). The interpersonal paradigm and the degree of the therapist's involvement. *Contemporary Psychoanalysis*, 19, 200-237.
- Goldfried, M. R., Burckell, L. A., & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behavior therapy. *Journal of Clinical Psychology/In Session*, 59(5), 555-568. doi:10.1002/jclp.10159
- Greenberg, L. R., (1990). Self-disclosure in psychotherapy: Working with older adults. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (175-189). New York: Plenum Press.
- Hanson, J. (2005). Should your lips be zipped? How therapist self-disclose and non-disclosure affects clients. *Counselling and Psychotherapy Research*, 5(2), 96 – 104. doi:10.1080/17441690500226658
- Hardin, S. I., & Subich, L. M. (1985). A methodological note: Do students expect what clients do? *Journal of Counseling Psychology*, 32(1), 131-134. doi:10.1037//0022-0167.32.1.131
- Hendrick, S. S. (1988). Counselor self-disclosure. *Journal of Counseling & Development*. 66, 419-424. doi:10.1037/0022-0167.35.3.222.
- Hendrick, S.S. (1990). A client perspective on counselor disclosure (brief report). *Journal of Counseling & Development*, 69, 184- 185. doi:10.1002/j.1556-6676.1990.tb01483.x
- Hill, C. E., Helms, J. E., Spiegel, S. B., & Tichenor, V. (1988a). Development of a system for categorizing client reactions to therapist interventions. *Journal of Counseling Psychology*, 35(1), 27 – 36. doi: 10.1037/10412-003

- Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988b). Effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35*(3), 222-233. doi: 10.1037/0022-0167.35.3.222
- Jourard, S. M. (1971). *The transparent self*. New York: Van Nostrand Reinhold.
- Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44*(3), 274 – 283. doi: 10.1037/0022-0167.44.3.274
- Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology, 59*(5), 529-539. doi:10.1002/jclp.10157
- Lane, R. C., & Hull, J. W. (1990). Self-disclosure and classical psychoanalysis. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (31-46). New York: Plenum Press.
- Mahalik, J. R., VanOrmer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M.M. Braceck (Ed.). *Practicing feminist ethics in psychology* (pp.189-201). Washington, DC: American Psychological Association. doi: 10.1037/10343-009
- Myers, D., & Hayes, J. A., (2006). Effects of therapist general self-disclosure and countertransference disclosure on ratings of the therapist and session. *Psychotherapy: Theory, Research, Practice, Training, 43*(2), 173-185. doi: 10.1037/0033-3204.43.2.173
- Peterson, Z.D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory/Research/Practice/Training, 39* (1), 21-31. doi: 10.1037///0033-3204.39.1.21

- Robitschek, C. G. & McCarthy, P. R. (1991). Prevalence of counselor self-reference in the therapeutic dyad. *Journal of Counseling and Development*, 69, 218-221.  
doi:10.1002/j.1556-6676.1991.tb01490.x
- Rogers, C. R. (1951). *On becoming a person: a therapist's view of psychotherapy*. Boston: Houghton Mifflin.
- Roseborough, D. J. (2006). Psychodynamic psychotherapy: An effectiveness study. *Research on Social Work Practice*, 16(2), 166-175. doi:10.1177/1049731505281373
- Simi, N. L., & Mahalik, J. R. (1997). Comparison of feminist versus psychoanalytic/dynamic and other therapists on self-disclosure. *Psychology of Women Quarterly*, 21, 465 -483.  
doi:10.1111/j.1471-6402.1997.tb00125.x
- Simon, J. C. (1990). Criteria for self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (207-225). New York: Plenum Press.
- Sokol, J. (2008). Ongoing struggles versus resolved issues: Are either appropriate for a therapist to reveal? *UW-L Journal of Undergraduate Research* 11, 2-5.
- Strong, S. R. (1971). Experimental laboratory research in counseling. *Jouranal of Counseling Psychology*, 18, 106-110. doi: 10.1037/h0030614
- Wachtel, P. L. (2011). *Therapeutic communication: Knowing what to say when*. New York: The Guilford Press.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ: Erlbaum.
- Watkins, C. E. (1990). The effects of counselor self-disclosure: A research review. *The Counseling Psychologist*, 18(3), 477-500. doi: 10.1177/0011000090183009

## Appendix A

### Human Subject Review Approval Letter



---

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

March 12, 2012

Pamela Lefever

Dear Pamela,

Your responses are terrific and all make good sense. I was fascinated to read about the social media research! 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 research.

Sincerely,

A handwritten signature in black ink that reads 'David L. Burton'. The signature is written in a cursive style with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.  
Chair, Human Subjects Review Committee

CC: Joyce Everett, Research Advisor

Appendix B  
Recruitment Letter

To Friends and Colleagues,

I am a second year student at Smith College School for Social Work with a focus in clinical social work. I am conducting a survey which investigates if a client prefers a therapist to self-disclose during a therapy session. If you are 18 or older and have received at least one session of clinical therapy in the last 5 years, I would appreciate your participation in an online anonymous survey that should take 10-15 minutes. You can do so by following this link:

[https://www.surveymonkey.com/s/Self-Disclosure\\_Survey](https://www.surveymonkey.com/s/Self-Disclosure_Survey). The data collected will be used for my Master's thesis.

If you know of individuals that are 18 or older and have received at least one session of clinical therapy in the last 5 years, I would appreciate you forwarding this message so that they could have the opportunity to participate.

Thank you for your time and assistance.

Pamela Lefever

MSW Candidate 2012

Smith School for Social Work

**(personal information deleted by Laura H. Wyman, 11/30/12)**

## Appendix C

### INFORMED CONSENT FORM

Smith College School for Social Work

Dear Study Participant,

My name is Pamela Lefever. I am a graduate student at Smith College School for Social Work. I would appreciate if you would complete a brief survey that will be used for my Master's thesis.

The purpose of this study is to learn if a client prefers a therapist to self-disclose during a therapeutic session. The data collected will be used for my Master's thesis, and possibly in professional publications and presentations.

I am asking that you be a participant for my study based on the fact that you meet the following criteria: 1.) You are 18 years old or older, 2.) You read English, and 3.) You have had psychological assistance with a therapist within the last five and a half years ( 2007-2012). If you choose to participate in the online anonymous survey, you will be asked to provide information about yourself (e.g., age, sex). Then, you will be asked to indicate the response you would prefer the therapist make to a hypothetical therapy session. Finally, you will be asked to rate, from strongly agree to strongly disagree, a therapist's response to a client. The study is about your opinions and what you would prefer. Therefore, there are no right or wrong answers. The survey should take ten to fifteen minutes.

There is a small risk that by participating in the survey you might feel somewhat uncomfortable providing your preferences. You may benefit from the study by sharing your thoughts. This information will provide valuable information about the client's perspective of therapist self-disclosure. There will be no compensation provided for participating in this study.

Your participation and your response to this study will be anonymous, as I will not know your identity. The online survey provider removes all identifying information about respondents before sending the survey information to me. Only I, my thesis advisor, and a statistical analyst at Smith College will have access to the data. The data from this study will be kept locked for a period of three years as required by Federal guidelines, will be password protected, and then destroyed if not needed for further use. In publications or presentations, data will be presented as a whole. No identifying information will be included.

Your participation in this study is voluntary and you may discontinue your participation at any time without penalty. You may choose not to answer any question(s) you wish, including demographic questions. Once you have hit the "submit" button your information cannot be withdrawn, as I will have no way of knowing which information is yours. If you have any questions or concerns, please contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974 or myself at extension 178 or at **(personal information deleted by Laura H. Wyman, 11/30/12)** **(personal information deleted by Laura H. Wyman, 11/30/12)** Please print a copy of this consent for your records.

Thank you for your participation in the study.

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

\_\_\_\_ I AGREE

\_\_\_\_ I DO NOT AGREE



## Appendix D

### Survey

2. Are you 18 years old or older?
  - A. Yes
  - B. No
3. Have you been in therapy for a mental health issue or a life issue?
  - A. Yes
  - B. No
4. Did you see a therapist for one or more sessions during 2007-2012?
  - A. Yes
  - B. No
5. What is your age? \_\_\_\_\_
6. What is your gender?
  - A. Male
  - B. Female
  - C. Transgendered male
  - D. Transgendered female
  - E. Other (Please specify): \_\_\_\_\_
7. What is your racial/ethnic identity?
  - A. African American/Black
  - B. Asian
  - C. Native American
  - D. Hispanic/Latino
  - E. European
  - F. White
  - G. Bi- or Multi-racial
  - H. Other (please specify) \_\_\_\_\_
8. What is your sexual orientation?
  - A. Asexual
  - B. Gay
  - C. Lesbian
  - D. Bisexual
  - E. Heterosexual
  - F. Other (Please specify): \_\_\_\_\_
9. What is your highest level of education?
  - A. Some high school
  - B. High school/GED
  - C. Vocational training
  - D. Some college
  - E. Associate's degree
  - F. Bachelor's degree
  - G. Master's degree
  - H. Doctoral degree
10. On a daily basis, how often do you twitter?
  - A. 0
  - B. 1-10 times
  - C. 11-25 times
  - D. 26-50 times
  - E. More than 51 times

11. On a daily basis, how often do you check facebook?  
A. 0 B. 1-10 times C. 11-25 times D. 26-50 times E. More than 51 times
12. On a daily basis, how often do you send personal e-mails?  
A. 0 B. 1-10 times C. 11-25 times D. 26-50 times E. More than 51 times
13. On a daily basis, how often do you use your cell phone for personal calls?  
A. 0 B. 1-10 times C. 11-25 times D. 26-50 times E. More than 51 times
14. Using the following list, please click the MAIN reason you went to a therapist.  
A. Depression B. Anxiety C. Domestic violence D. Relationship concerns  
E. Substance use F. Suicidal thoughts G. Homicidal thoughts H. Health  
I. Sexuality J. Bereavement K. Physical abuse L. Sexual abuse  
M. Verbal abuse N. Financial concerns O. Mandated to see therapist  
P. Other (Please specify): \_\_\_\_\_
15. Using the following list, please click the SECOND most important reason you went to a therapist. (If there was not another reason, please skip to question 17.)  
A. Depression B. Anxiety C. Domestic violence D. Relationship concerns  
E. Substance use F. Suicidal thoughts G. Homicidal thoughts H. Health  
I. Sexuality J. Bereavement K. Physical abuse L. Sexual abuse  
M. Verbal abuse N. Financial concerns O. Mandated to see therapist  
P. Other (Please specify): \_\_\_\_\_
16. Using the following list, please click the THIRD most important reason you went to a therapist. (If there was not another reason, please skip to question 17.)  
A. Depression B. Anxiety C. Domestic violence D. Relationship concerns  
E. Substance use F. Suicidal thoughts G. Homicidal thoughts H. Health

- I. Sexuality
- J. Bereavement
- K. Physical abuse
- L. Sexual abuse
- M. Verbal abuse
- N. Financial concerns
- O. Mandated to see therapist
- P. Other (Please specify): \_\_\_\_\_

17. Please click approximately how many therapy sessions you had during 2007 – 2012.

- A. 1-10
- B. 11-20
- C. 21-30
- D. 31-40
- E. More than 41

18. Are you currently in treatment?

- A. Yes
- B. No

19. For most of your therapy sessions, what was the gender of the therapist that you usually met with?

- A. Female
- B. Male
- C. Transgendered male
- D. Transgendered female
- E. Other (Please specify) \_\_\_\_\_

#### THERAPY SESSION

For questions 20-26, please click the therapist response that you would prefer if you were the client who had the issue being discussed.

20. The client is upset about a bad relationship she has with her boyfriend's parents.

- A. Therapist tells client how he dealt with a bad relationship he had with his girlfriend's parents.
- B. Therapist asks client to describe details of the bad relationship.

21. The client is sad most of the time and doesn't find life interesting.

- A. Therapist tells client about time therapist was depressed.
- B. Therapist asks client to describe a time when he/she did not feel sad.

22. The client is bored with 18 year marriage and is thinking about having an affair.

- A. Therapist asks him to explain what would make the marriage not boring.

- B. Therapist tells him what happened to his neighbor when he had an affair while married.
23. The client is concerned about the amount of alcohol he/she is drinking since he/she does not remember activities while drinking.
- A. Therapist asks questions to learn when and why client drinks.
- B. Therapist says she is a recovering alcoholic and tells how she recovered.
24. The client loves her husband and wants to keep the family together but her husband hits her when he is mad.
- A. Therapist explains how domestic violence groups helped her stop the pattern of abuse in her life.
- B. Therapist explains what domestic violence is and the dangers of it.
25. The client is experiencing anxiety because of being unemployed and having financial concerns.
- A. Therapist taught client relaxation technique to manage stress.
- B. Therapist told client about how he/she overcame stressful event.
26. The client was overwhelmed by demands and rudeness of her 17 year old daughter.
- A. Therapist shared the difficulties she/he had with her/his 18 year old son.
- B. Therapist provided ways to structure more positive home environment so that client could reduce negative interactions with daughter.

#### THERAPIST ACTIONS

For the following, please click the statement that best reflects how much you agree or disagree.

27. A therapist should aggressively challenge a client's thinking.
- A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree
28. A therapist should encourage the client to talk about his/her concerns.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

29. A therapist should tell the client how the therapist fixed his/her own problems.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

30. A therapist should share her/his experiences that are similar to client's concerns.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

31. A therapist should help the client recognize personal strengths and abilities.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

32. A therapist should tell what he/she did over the weekend to their client.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

33. A therapist should give the client homework to do between appointments.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

34. A therapist should encourage the client to develop plan to deal with their concerns.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

35. A therapist should never tell information about their activities to the client.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree

36. A therapist should always let client know if the therapist has had a similar problem.

A. Strongly disagree B. Generally disagree C. Neutral D. Generally agree E. Strongly agree