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Emma M. Sando
Clinicians' Self-Disclosure of
Personal Experience with an Anxiety
and/or Mood Disorder

ABSTRACT

This study used a mixed methods design to examine an emerging field of inquiry in self-disclosure research, exploring the decisions clinicians make about the disclosure of their personal experiences with an anxiety and/or mood disorder to their clients. The researcher posited that this specific form of non-immediate disclosure might engender unique therapeutic benefits as well as particular ethical and professional dilemmas for practitioners.

Forty-nine licensed, clinical social workers participated in an anonymous online survey with quantitative and qualitative components that inquired about their self-disclosure decisions, including the frequency of their disclosures, the types of information they revealed, their perception of the efficacy of these disclosures, and their levels of hesitancy to discuss these interventions with professional peers. Two licensed, clinical social workers participated in in-depth interviews that investigated the impacts of their experiences with an anxiety and/or mood disorder on their practice generally and their self-disclosure decisions specifically.

The findings of this study suggest that many clinicians do disclose to their clients aspects of their personal experience with an anxiety and/or mood disorder. Participants disclosed effective coping skills most frequently, but also revealed their experience with medication, therapy, and symptoms to their clients. Rationales for these disclosures included benefit to the client, instilling hope, modeling healthy behaviors and attitudes, equalizing the therapeutic alliance and empowering the client. The findings indicated that while participants

overwhelmingly evaluated their disclosures as effective, they remained largely hesitant to discuss these interventions with their colleagues, and feared censure or other negative professional impacts.

**CLINICIANS' SELF-DISCLOSURE OF PERSONAL EXPERIENCE WITH AN
ANXIETY AND/OR MOOD DISORDER**

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

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2014

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CHAPTER I

Introduction

The clinical interventions therapists use have profound impacts on the course of treatment, as they shape the working alliance and stimulate therapeutic change, and carry ethical and practical consequences. As a result, a fundamental responsibility of the continuing evolution of psychotherapy is the development, implementation, and assessment of clinical tools to ensure that the practice of psychotherapy ethically and effectively advances the treatment of its clients. While some therapeutic interventions have achieved widely recognized endorsement, others remain controversial, as theoretical orientations take different stances on the appropriateness of their application as clinical tools. Despite its increasing acceptance among certain theoretical orientations, self-disclosure – the practice by which clinicians reveal personal information about themselves to their clients – remains a controversial intervention, and a growing body of research seeks to understand its therapeutic impact and ethical implications. As psychotherapy has increasingly recognized the role of the interpersonal in both the genesis and resolution of psychopathology and conceptualized therapy as a mutual, reciprocal experience co-created by its participants, the character of communication between therapist and client has gained far greater importance in the therapeutic process (Farber, 2003). This growing attention to communication has led to increased inquiry and interest into self-disclosure and its therapeutic impacts.

Studies suggest that self-disclosure is one of the least frequently used interventions by clinicians, yet is capable of producing significant therapeutic benefit to clients (Hill & Knox, 2003). Furthermore, research reveals that most clinicians use at least some self-disclosure during their clinical careers (Edwards & Murdock, 1994; Pope, Tabachnick, and Keith-Spiegel, 1997). This study attempts to fill an important gap in current knowledge and explores an emerging field of inquiry within self-disclosure research, investigating the decisions clinicians make about the disclosure of their own personal experience with an anxiety and/or mood disorder.

Research conducted thus far into self-disclosure demonstrates the value of its further examination as a clinical tool. Studies suggest that, when used in attunement with the clients' needs, self-disclosure may offer unique therapeutic benefits, and it is theorized that this intervention may advance multiple therapeutic goals simultaneously and thus produce therapeutic change in situations where other interventions have been unsuccessful (Ziv-Beiman, 2013). At the same time, research also suggests that the intervention presents serious ethical concerns that relate to the core social work values of beneficence, nonmaleficence, fidelity, autonomy, and justice, and should thus be studied and employed carefully (Peterson, 2002).

Self-disclosure is a complex intervention (Watkins, 1990; Edwards & Murdock, 1994), and its inherent intricacy, coupled with the variety of interventions identified as "self-disclosure," complicate efforts to clarify its consequences. Research suggests that different forms of self-disclosure may produce distinct impacts, and that the individual circumstances of a disclosure significantly affect its potential for therapeutic benefit or harm. Indeed, it is the combination of self-disclosure's significant potential for therapeutic change as well as harm, coupled with the ambiguity of its impacts, that produces the current "ethical uncertainty"

regarding its use as a clinical tool, and highlights the need for continued examination of its justifications, implementations and impacts (Peterson, 2002, p. 30).

Significant limitations to our current body of research have furthermore added to the uncertainty surrounding self-disclosure and impel further inquiry into this intervention. Much of the research conducted thus far has used ambiguously and diversely operationalized definitions of self-disclosure, and employed analogue designs that fail to reflect the dynamics of actual therapy situations and thus produce valid and generalizable data. As a result, studies have produced unclear and divergent results, overlooked important distinctions in types of self-disclosure, and failed to create a coherent body of data from which to identify larger patterns and trends within the research. In order to advance its understanding of this potentially useful intervention, the field would benefit from clearly defined and operationalized research that focuses on specific forms of self-disclosure. This study seeks to do so, by exploring the specific case of therapist disclosure of personal experience with anxiety and/or mood disorders, using a clearly operationalized definition of therapist self-disclosure.

This study investigates a particular type of self-disclosure that remains controversial: that of non-immediate self-disclosure. Increasingly, research into self-disclosure differentiates between immediate self-disclosure, which involves therapist self-disclosure of immediate reactions and countertransference in the moment, and non-immediate self-disclosure, which refers to therapist disclosure of personal information outside of the immediate relational dynamics of the therapeutic dyad. While immediate self-disclosure has become significantly more accepted and integrated into clinical practice, non-immediate self-disclosure remains considerably more controversial. This study seeks to gain insights into a specific form of this non-immediate self-disclosure, by exploring the choices clinicians make about disclosing their

own personal experience with an anxiety and/or mood disorder to their clients. It uses a clearly operationalized definition of self-disclosure that relates solely to non-immediate self-disclosure statements regarding aspects of the clinician's lived experiences with an anxiety and/or mood disorder. Thus, this study explores an emerging field of inquiry in the study of self-disclosure and investigates the particular factors affecting this unique case of self-disclosure.

As far as I have been able to discern, no research currently exists that inquires into the self-disclosure choices of clinicians regarding their own lived experiences with an anxiety and/or mood disorder. This appears to be a gap in our knowledge about self-disclosure, with important implications for clinical practice. In self-disclosing their own lived experience, clinicians who identify as having/having had an anxiety and/or mood disorder are singularly poised to integrate, for the benefit of their own clients, their experience as both therapists and clients, thus suggesting that the factors influencing their decisions – and the impacts of the intervention itself – may be unique. Disclosure of therapists' personal health information may bring with it additional, personal considerations that do not enter into other forms of self-disclosure; and it is possible that sharing this particular information may relate to the treatment in a unique way and offer distinctive therapeutic benefits.

This study seeks to understand the factors that guide the self-disclosure choices of licensed, clinical social workers who identify as either a.) having a current anxiety and/or mood disorder, that has lasted for at least six months and that they consider to be well-managed and does not prevent them from functioning in important life domains; or b.) having previously had an anxiety and/or mood disorder that they consider to be resolved. Specifically, it attempts to understand the following questions: What guides clinicians' decisions to disclose or not disclose aspects of their own personal experience with an anxiety and/or mood disorder to their clients? If

they do choose to disclose, why, when, what, and how do clinicians share this information with clients? If they choose not to disclose this information, what guides that decision? What are the ethical and practical implications that clinicians must consider when they make these self-disclosure decisions?

The findings of this study ask us to investigate our roles as therapists: how we use ourselves as tools, relate to our clients and ultimately promote therapeutic change and growth. Beyond expanding our knowledge base about self-disclosure, however, this research also raises broader questions about how the clinical community distinguishes between clients and therapists; about what identities and knowledge we sanction and privilege as professional, and which we alienate and silence; and about how we understand and develop our work. By providing space for the voices of clinicians who have lived experience with an anxiety and/or mood disorder to share their knowledge, this study seeks to promote dialogue within the clinical community that critically examines how we approach issues of mental illness and well-being, thus breaking down barriers to open communication and empowering and celebrating the many ways of knowing and understanding that exist within our profession.

CHAPTER II

Literature Review

Although increasingly researched and accepted in theory and practice, therapist self-disclosure remains a controversial and complicated clinical intervention. The literature on self-disclosure offers a diverse array of perspectives and insights, highlighting the host of theoretical, clinical, and ethical considerations this intervention elicits. In this chapter, I review the extant theoretical and empirical literature, exploring the evolving theoretical bases for self-disclosure practices as well as the important contributions of empirical research. I begin by defining self-disclosure and providing a brief overview of the arguments for its therapeutic usefulness. I then review the theoretical literature on self-disclosure, examine the primary clinical and ethical concerns that drive the current debates, and identify how these themes manifest in the findings of empirical research. Finally, I situate the dynamics involved in the specific case of therapist self-disclosure of personal experience with an anxiety and/or mood disorder within the matrix of these broader ethical, clinical, and theoretical concerns.

Definition of Self-Disclosure

The concept of self-disclosure refers to the revelation of personal information about therapists to their clients. In its broadest formulation, disclosure involves any mechanism through which information is shared about the therapist's personal life, including the therapist's physical

characteristics and attire; body language and other forms of non-verbal communication; verbal statements; and office décor, arrangement, and location (Zur, 2007; Peterson, 2002). While acknowledging the diverse manifestations of self-disclosure generally, however, much of the literature on the topic asserts that self-disclosure as a *clinical tool* is restricted to the realm of verbal communication, and excludes other forms of information sharing (Henretty & Levitt, 2010; Hill & Knox, 2001; Knox, Hess, Peterson & Hill, 1997; Ziv-Beiman, 2013). Indeed, the majority of literature focuses on verbal self-disclosure, with much of it operating from a similar perspective as that articulated by Hill & Knox (2001), who suggest that self-disclosure is “broadly defined as statements that reveal something personal about therapists” (p. 413). For the purposes of this study, I will adopt Hill & Knox’s formulation of self-disclosure, focusing solely on clinicians’ verbal communication of personal information.

Within this verbal conception of self-disclosure, however, a variety of definitions and distinctions exist. Indeed, definitional inconsistencies have plagued the literature and complicated the intervention’s empirical study: as researchers and theorists have sought to differentiate between types of disclosure in order to clarify the distinct consequences of its various forms, they have generated “widely discrepant definitions of therapist self-disclosure, which [make] it difficult to generalize across studies” (Knox et al., 1997, p. 275). Some authors differentiate between deliberate, unavoidable, and accidental disclosure, where deliberate disclosure refers to the intentional, verbal disclosure of personal information or other deliberate actions; unavoidable self-disclosure applies to aspects of the self over which the therapist may not have full control, such as accent or tone of voice; and accidental disclosure entails unplanned encounters outside of the office, spontaneous reactions, and other unintended interactions that confer personal information about the therapist (Zur, 2007).

While these categories differentiate between forms of disclosure according to the *process* by which the disclosures occur, other perspectives emphasize the relevance of the subject communicated, and seek to classify disclosures by their content. Simonson (1976) distinguishes between *personal disclosure*, which involves sharing intimate or personal information, and *demographic disclosure*, which conveys general or relatively impersonal information. Other distinctions have been made between *positive* and *negative* disclosure, where positive disclosure entails the clinicians' sharing of their experiences that are favorable or similar to their clients', and *negative* disclosure that involves the opposite (Watkins, 1990). Similarly, Hill, Mahalik and Thompson (1989) differentiate between reassuring disclosures that "support, reinforce, or legitimize the client's perspective, way of thinking, feeling, or behaving" and challenging disclosures that confront the client's perspective, thinking, or behavior (Hill et al., 1989, p. 291).

Other researchers and theorists view self-disclosure in greater specificity and advocate for more complex distinctions. Wells (1994) identifies four categories of disclosure: (a) information regarding therapist professional training and practice, including years of experience, areas of specialization, institution of education and degree, and professional ethics and values; (b) personal life circumstances, including experience relating to the client's personal life, aspects of personal identity, and attitudes and opinions; (c) countertransference responses, including the clinician's reactions to and feelings about the client; and (d) acknowledgement of therapist mistakes made in the course of treatment (Wells, 1994, p. 24). Watkins (1990) suggests using a four-dimensional model to identify self-disclosures, including the following dimensions: positive versus negative (positive referring to favorable information about the therapist, such as strengths or successes, and negative to unfavorable information, such as weaknesses or mistakes); similar versus dissimilar (consistency of the therapist's experience with the client's); past versus present;

and high, medium, or low intimacy (Watkins, 1990). Deconstructing self-disclosures into even more discrete groupings, Hill & Knox (2003) assert that important differences occur both in the function and impact of seven categories of self-disclosure: self-disclosure of facts, feelings, insight, strategy, reassurance/support, challenge, and immediacy.

One of the most comprehensive and clear distinctions to emerge from the literature has been the differentiation between immediate and non-immediate disclosure (Audet, 2011; Hill & Knox, 2001; Watkins, 1990; Ziv-Beiman, 2013). Immediate self-disclosure, also referred to as self-involving or interpersonal disclosure, refers to the therapist's revelation of immediate feelings and reactions to the client and experiences that occur within the context of the therapeutic relationship. These disclosures focus on the "client in the *here and now*" and the unfolding, interpersonal dynamics between therapist and client (Audet, 2011, p. 86). Non-immediate disclosure, also regarded as self-revealing or intrapersonal disclosure, applies to the disclosure of information about the therapist's personal life outside of treatment, such as life circumstances, past experiences, attitudes, values and beliefs. While these two forms of disclosure do overlap in some regards, they are largely viewed to be functionally distinct. Immediate self-disclosure is used to address process within the therapeutic relationship; to help clients identify, experience and integrate dissociated parts; and to promote clients' insight into the interpersonal impact of their behavior (Audet, 2011; Ginot, 1997; Watkins, 1990). Non-immediate self-disclosure is used to build rapport; reveal the humanity and fallibility of the therapist; equalize the client-therapist relationship; and model different perspectives and behaviors, including authentic self-disclosure (Audet, 2011; Ginot, 1997; Hill et al., 1989). Thus, these categories involve distinctions in both the *process* as well as the *content* of the disclosure: how, when and to what purpose therapists use these disclosures – as well as the actual

information conveyed – differs. Wherever possible, I will identify differences between these distinctions as I explore the relevant theoretical and empirical literature, examining the theoretical, ethical, and clinical implications of each form in greater detail.

Why Disclose? Primary Arguments for the Therapeutic Usefulness of Self-Disclosure

A variety of theorists and researchers advocate for the therapeutic usefulness of self-disclosure, and assert that it can be a potent clinical tool for advancing diverse treatment goals. Jourard's seminal works on self-disclosure produced the reciprocity hypothesis, which maintains that self-disclosing behavior on the part of one person elicits similar disclosure from another (Jourard & Jaffe, 1970). Jourard also found that self-disclosure establishes interpersonal closeness and leads to a better understanding of the self. Thus, reasons cited for using self-disclosure in treatment settings include eliciting disclosure from the client, building rapport and establishing trust in the working alliance, and facilitating the client's self-awareness and growth. Other clinical reasons posited for self-disclosure include a.) modeling open communication and healthy behaviors and attitudes for clients (Edwards & Murdock, 1994; Goldfried, Burckell & Eubanks-Carter, 2003; Hill & Knox, 2001); b.) encouraging client self-exploration and self-reflection, particularly of interpersonal patterns (Bridges, 2001); c.) confirming the client's sense of reality (Hill & Knox, 2001); d.) normalizing the client's experience and engendering feelings of universality (Knox et al., 1997; Knox & Hill, 2001); e.) equalizing power relations in the therapeutic dyad (Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Simi & Mahalik, 1997; Wells, 1994); f.) increasing similarity between client and therapist (Edwards & Murdock, 1994); g.) demystifying therapy and establishing the therapist's humanity and realness (Hill et al., 1989; Knox & Hill, 2003); h.) reinforcing healthy behavior and attitudes (Goldfried et al., 2003); i.)

empowering the client to participate as an active subject in treatment; j.) breaking through an entrenched impasse in treatment (Maroda, 1999); and k.) fostering the therapeutic alliance (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Hill & Knox, 2001; Wells, 1994).

Going beyond these arguments, Ziv-Beiman (2013) asserts that self-disclosure is powerful because it is an integrative intervention capable of advancing multiple therapeutic goals simultaneously. She maintains that therapist self-disclosure can enhance multiple dimensions of the *therapeutic alliance* – clients’ trust in their therapists, their perception of their therapists’ engagement, and the balance of power between them – while simultaneously promoting important *therapeutic goals* such as client insight, cognitive and behavioral change, and empowerment (Ziv-Beiman, 2013). Emphasizing that exploring clients’ reactions and responses to therapist self-disclosure is an integral component to the intervention, she suggests that therapists might use self-disclosure “when seeking to move concurrently toward different therapeutic goals requiring multiple – and potentially antithetical – therapeutic channels” (Ziv-Beiman, 2013, p. 68).

As the following sections explore, the multitude of rationales for self-disclosure described here are fiercely debated in the literature, with theoretical orientation heavily influencing clinicians’ perspectives on the therapeutic usefulness and ethics of self-disclosure. Empirical research offers mixed results in support of many of these arguments, thus complicating the theoretical and ethical debates surrounding self-disclosure.

Evolving Perspectives on Self-Disclosure and the Impact of Theoretical Orientation

The role of therapist self-disclosure in treatment has been debated since the beginning of clinical practice, and theoretical orientations assert varying positions on the efficacy and appropriateness of self-disclosure as a clinical tool (Farber, 2003; Henretty & Levitt, 2010). Since Freud's first injunctions against self-disclosure, clinicians of each generation have experimented with self-disclosure and challenged its proscription, advocating for its therapeutic advantages and for greater mutuality in the working alliance (Farber, 2003). This section seeks to provide a chronological overview of the conceptual and theoretical frameworks that have influenced clinical concerns relevant to self-disclosure, and to situate them within the broader arc of the evolution of clinical theory. In so doing, I pay particular attention to two trends in psychotherapy, as noted by Farber (2003), Bridges (2001) and Ziv-Beiman (2013): (a) the shift in treatment conceptualization from the intrapersonal to interpersonal, with human suffering and healing no longer seen as "mainly internal individual experiences but also as events rooted and conceptualized within the interpersonal realm"; and (b) the recognition of the therapeutic relationship as the "primary source of healing within the therapeutic process" (Ziv-Beiman, 2013, p. 61).

Classical Psychoanalysis: Freud asserted that therapeutic change derived from the resolution of the client's transference, an outcome that required the therapist to correctly interpret the projections of the client. The site of pathology and healing, therefore, was situated within the internal realm of the client's individual conflicts and urges, and Freud maintained that its analysis required the therapist to operate as a blank slate or "impenetrable mirror [that] reflect[s] nothing more than what is shown to him," else risk contaminating the transference and jeopardizing treatment (Peterson, 2002, p. 22). Although Freud himself appears to have ignored

these views in his own clinical work, the concept of therapist anonymity and objectivity became a cornerstone of classical psychoanalytic thought, which tends to view both immediate and non-immediate self-disclosure as a “symptom of the therapist’s countertransference” and a distorting influence on the client’s transference (Peterson, 2002, p. 22; Ziv-Beiman, 2013).

Yet even as Freud espoused the values of the “blank slate” approach, others within the field articulated arguments for the value of self-disclosure. Ferenczi offers one of the earliest appeals for self-disclosure, as he advocated for the centrality of a mutual relationship between therapist and client in the treatment of childhood trauma. He asserted that the analyst’s refusal to self-disclose and maintenance of an anonymous and neutral stance risked reenacting the client’s original trauma, while self-disclosure facilitated open communication and the challenging of existing power hierarchies within the therapeutic dyad, producing a relationship that promoted the resolution of the trauma (Ferenczi, 1932/1988; Ziv-Beiman, 2013). In particular, Ferenczi argued for the therapeutic value of clinicians’ admission of their errors to their clients, noticing that the quality of the relationship with his clients improved when he admitted his mistakes: “Something had been left unsaid in the relation between the physician and the patient, something insincere, and ... the admission of the analyst’s error produced confidence in his patient” (Ferenczi, 1932/1988, p. 199).

As classical psychoanalysis branched into different theoretical orientations, a diversity of opinions on self-disclosure emerged. **Ego Psychology**, the immediate derivative of classical psychoanalysis, continued to locate psychopathology within the individual and focused on the examination of intrapsychic conflicts through an insight-oriented process. Ego Psychologists held views on self-disclosure parallel to psychoanalysts, asserting that an anonymous and neutral approach provided the appropriate conditions under which to analyze the functions of the

unconscious ego, and served to strengthen the ego and advance the client's individuation (Ziv-Beiman, 2013). **Object Relations** was the first school of thought to acknowledge the interpersonal sources of psychopathology, and viewed the therapist's countertransference as a source of information about the client's object relations patterns. Contemporary theorists therefore endorse some immediate disclosure, arguing that disclosure of the clinician's countertransference enables clients to discover how others experience them and learn about parts of themselves they may have split off and projected onto the therapist (Ziv-Beiman, 2013).

Self-Psychology asserts that the experiential elements of therapy are central in promoting client growth, and views selective therapist self-disclosure as a legitimate therapeutic tool and a form of "empathic responsiveness" that provides necessary self-object experiences for the client, and therefore fosters the development of the client's cohesive self (Goldstein, 1997, p. 48). By self-disclosing in attunement to the client's self-object transference and developmental needs, self-psychologists believe the therapist functions as a self-object that provides corrective emotional experiences and promotes the resolution of the client's unmet self-object needs and healthy development (Goldstein, 1997). Thus, while self-psychology emphasized the interpersonal underpinnings of psychological distress and the importance of interpersonal elements in the therapeutic dyad, the therapist is conceptualized as using her "empathic subjectivity [in] the service of an investigation of the patient's subjectivity," rather than as a subject pursuing co-construction and mutual influence with the client (Ziv-Beiman, 2013, p. 60).

The first formalized pro-disclosure argument was articulated by **Humanistic psychotherapy**, when in the 1950s Rogerians adopted self-disclosure practices as a central tool for promoting the core condition of congruence within the therapeutic relationship (Henretty & Levitt, 2010; Cepeda & Davenport, 2006). Humanistic psychotherapy advocates for the

importance of honesty in the therapeutic process, and holds that self-disclosure – primarily of countertransference reactions – facilitates therapist authenticity, a crucial component to the development of a genuine therapeutic alliance and the client’s self-actualization and growth (Cepeda & Davenport, 2006; Goldstein, 1994; Ziv-Beiman, 2013). Self-disclosure demonstrates the therapist’s “humanness” and fallibility, thus serving to equalize the relationship and promote feelings of universality through the acknowledgement that all humans suffer (Ziv-Beiman, 2013). Similar to their humanistic counterparts, **existential** therapists view self-disclosure – including non-immediate disclosure – as a core therapeutic technique, whereby through sharing their own experiences of coping with existential questions, therapists serve as models and inspire their clients’ genuine pursuit of their own answers (Ziv-Beiman, 2013).

Intersubjective and relational theorists introduced a major shift in perspective on the therapist’s subjective participation in treatment, and thus on self-disclosure. These schools of thought assert that therapists and clients each bring their own form of “implicit relational knowing” into the therapeutic dyad, and reciprocally influence each other to create an “intersubjective field” within which the treatment occurs (Lyons-Ruth, 1998, p. 282; Goldstein, 1994; Ziv-Beiman, 2013). Thus, these schools of thought highlight the subjectivity of each participant and view the therapeutic relationship as the primary site of healing and growth (Lyons-Ruth, 1998). Intersubjective therapists advocate primarily for self-disclosure of the therapist’s countertransference reactions to the client, viewing immediate self-disclosure as a “powerful analytic process that can provide the patient with the unique opportunity to encounter, experience, and negotiate dissociated aspects of the self” and thus a catalyst for the client’s self-integration (Ginot, 1997, p. 365; Maroda, 1999; Ziv-Beiman, 2013). Relational therapists assert that “exposure to subjective otherness is essential for the foundation of the self,” and view

clinicians' self-disclosures as a form of intersubjective inquiry that advances their clients' development of their own subjectivity and self-awareness (Bridges, 2001; Ziv-Beiman, 2013, p. 60). Importantly, these schools of thought advocate for the careful assessment of the specific circumstances relating to a given disclosure, and most scholars refrain from making generalized statements about the use of any therapeutic intervention.

Feminist therapists view self-disclosure as a central therapeutic tool through which to actualize feminist values, and argue that self-disclosure facilitates egalitarianism, deconstructs positions of power within the therapeutic relationship, and provides clients with information that empowers them as active participants in their own treatment. Feminist approaches advocate for the self-disclosure of a wide range of information about the therapist, including personal values, opinions, and feelings – particularly those relating to political and social concerns – asserting that this sharing enables clients to make informed decisions about the selection and evaluation of their therapists (Simi & Mahalik, 1997). Feminist therapists emphasize the importance of therapists' extensive self-examination, and encourage the judicious and careful use of both immediate and non-immediate self-disclosure (Ziv-Beiman, 2013).

Cognitive Behaviorists believe that self-disclosure can be used to advance multiple therapeutic goals, including normalizing the client's experience, challenging negative interpretations, enhancing the client's motivation to change, providing feedback to the client about their interpersonal impact, strengthening the working alliance, and, most importantly, modeling and reinforcing effective coping skills and behaviors (Ziv-Beiman, 2013). Goldfried et al. (2003) endorse the use of both immediate and non-immediate self-disclosure and distinguish between their therapeutic impacts, identifying immediate self-disclosure as advancing the traditional behavioral principle of reinforcement and non-immediate self-disclosure as realizing

the principle of modeling. Cognitive Behaviorists emphasize the complexity of self-disclosure decisions and advocate for the careful appraisal of the therapist's intentions in employing this intervention (Goldfried et al., 2003; Ziv-Beiman, 2013).

Finally, **multicultural therapists** advocate using self-disclosure, particularly with clients from different sociocultural backgrounds from the therapist, as a way of building trust (Hill & Knox, 2002; Constantine & Kwan, 2003). However, this position is complicated and has been subject to important critiques. Lee (2014) emphasizes the culturally embedded nature of the self, and cautions that the use of self-disclosure inherently involves asserting the therapist's cultural norms that, in the context of the power dynamics of the therapeutic relationship – and particularly in cross-cultural/racial dyads where the therapist is White and additional dynamics of power and privilege may be enacted – may negatively impact the client and cause them to disengage. In cross-cultural/racial dyads in particular, Lee (2014) maintains that therapists must critically reflect on and interrogate their clinical assumptions and cultural biases, and discuss their mistakes with their clients.

Thus, as Farber (2003) and Ziv-Beiman (2013) assert, evolving views on self-disclosure parallel important conceptual advances in psychotherapy that affect clinical understandings of the root of psychological distress and its treatment. As psychotherapy has acknowledged the role of interpersonal factors in psychopathology and located the source of its healing in the interpersonal dynamics between client and therapist, self-disclosure has emerged as a therapeutic tool of potential significance and has attracted increasing interest and inquiry. While theoretical orientations hold differing opinions on its efficacy as a clinical tool, as Hill & Knox (2003) assert, all possess “marked respect for the intervention's potential impact” (p. 532).

Ethical Considerations of Self-Disclosure

While self-disclosure literature often makes reference to the ethics of its use, most literature focuses on determining self-disclosure's therapeutic efficacy rather than its ethicality as a clinical tool (Peterson, 2002). Yet, a clinician's choice to either self-disclose or withhold personal information carries with it important ethical implications related to key social work values. As I will explore in the empirical section of this literature review, the limitations of current research further complicate the appraisal of self-disclosure's complex ethical concerns. This section seeks to explore the primary moral questions identified in self-disclosure literature with regards to the intervention's application as a clinical tool.

Many of the ethical concerns that arise from self-disclosure relate to its impact on therapeutic boundaries. Self-disclosure is considered a boundary issue, as it alters the interpersonal boundaries between client and therapist and affects the therapeutic frame (Audet, 2011; Peterson, 2002; Smith & Fitzpatrick, 1995; Zur, 2007). When used appropriately and with clinical intention to benefit the client, self-disclosure is viewed as a *boundary crossing*, a "departure from commonly accepted practice that may or may not benefit the client" (Audet, 2011; Smith & Fitzpatrick, 1995; p. 500; Zur, 2007). When used primarily to serve the clinician's own personal needs, however, self-disclosure is considered a *boundary violation*, a behavior that risks serious harm to the client or the therapeutic process (Audet, 2011; Gutheil & Gabbard, 1995; Smith & Fitzpatrick, 1995). In particular, authors raise concerns that too much disclosure – in terms of frequency, duration, and level of intimacy – may rupture the boundaries of the professional, therapeutic relationship and transform it into a social one (Audet, 2011; Knox & Hill, 2003; Maroda, 1999). Thus, as with many aspects of self-disclosure, ethical concerns revolve around a question of degree. The specific boundary violations identified with

self-disclosure implicate fundamental social work values and include shifting the focus away from the client; burdening the client with information that is overwhelming, unnecessary or clinically irrelevant; engendering feelings within the client of needing to care for the therapist; and, in the most serious of cases, exploiting the client and producing a role reversal (Audet, 2011; Peterson, 2002; Zur, 2007). While existing literature does not investigate in detail the differences in the ethical implications of immediate versus non-immediate disclosures, it appears that more ethical concerns are identified with non-immediate disclosure, because it is seen as having a higher potential to shift the focus from the client and serve the clinician's own needs.

The central ethical concerns associated with self-disclosure relate to the social work values of beneficence and non-maleficence, which hold that clinicians intervene with the intention to benefit their clients and avoid harming them (Peterson, 2002; Zur, 2007). The principle of beneficence asserts that self-disclosure must be used with the intent to benefit the client first and foremost. Thus, self-disclosure may be ethical if the clinician perceives it to offer significant therapeutic value, while disclosures that are not intended to benefit the client, that shift the focus away from the client or burden the client with information irrelevant to their treatment, violate the ethical principle of beneficence and also risk violating the principle of non-maleficence. Similarly, some clinicians would consider it a violation of the principle of beneficence for therapists to choose *not* to self-disclose when they believe that the information would be helpful to their clients (Peterson, 2002).

The principle of non-maleficence relates to exploitation of the client and role reversal, the gravest ethical concerns elicited by self-disclosure. Within the therapeutic dyad, the clinician is broadly understood to occupy a position of power, and is ethically required to refrain from using that power in an exploitative way. Self-disclosure that serves primarily to meet the needs

of the therapist and impedes the client's treatment is therefore exploitative and unethical. Such exploitative disclosures may range in their impacts from generating momentary feelings of needing to take care of the therapist to establishing patterns of interacting within the therapeutic dyad that constitute a role reversal, with the client taking care of the therapist's needs (Audet, 2011; Peterson, 2002).

Additional social work values associated with the ethics of self-disclosure are the principles of autonomy, fidelity, and justice. The principle of autonomy maintains that therapists seek to advance their clients' independence and growth; fidelity upholds that clinicians must practice honesty with their clients; and justice implies that they should act fairly and equitably towards each of their clients (Peterson, 2002).

As it has been widely recognized that it is impossible – and in some cases even detrimental to treatment – for therapists to eliminate all self-disclosure in therapy, the primary question to explore is under what circumstances self-disclosure is ethical (Audet, 2011; Peterson, 2002). In this regard, theoretical orientations differ in how they interpret and apply social work values to their work, and how they perceive different factors to impact the ethicality of disclosure (Peterson, 2002). Classical psychoanalysis and feminist theory maintain perhaps the most opposing viewpoints on the ethicality of self-disclosure, and these orientations have made most of the contributions to the ethical debate on self-disclosure (Peterson, 2002).

Psychoanalytic thought asserts that by affecting the client's transference and thus its resolution, self-disclosure violates the principles of beneficence and non-maleficence. However, it is important to note that most contemporary psychoanalysts do embrace some self-disclosure. Feminist therapists, on the other hand, view self-disclosure as a “critical agent of therapeutic change,” that benefits the client by transmitting feminist values, modeling an egalitarian

relationship that empowers the client, and engendering honest communication. According to feminist theory, self-disclosure furthermore promotes client autonomy and justice by deconstructing positions of power within the therapeutic dyad and by providing clients with the information to choose therapists and evaluate their interventions (Peterson, 2002, p. 30; Simi & Mahalik, 1997; Ziv-Beiman, 2013; Zur, 2002). Thus, while psychoanalysts might consider non-disclosure as promoting beneficence and non-maleficence due to its role in creating the therapeutic environment necessary to advance the treatment of the client's transference, feminists might view non-disclosure as unethical for the very same principles, and assert that it serves primarily to maintain rigid power relations that protect the therapist and objectify the client, thus disempowering the client and impeding the therapeutic process.

Other theoretical orientations hold their own interpretations of self-disclosure's ethical application as a clinical tool. Due to the high value placed on the principle of fidelity, humanistic psychotherapy views self-disclosure as a central instrument for establishing the authentic therapeutic bond necessary for promoting the client's growth. Humanistic therapists maintain that self-disclosure acknowledges the truth that "all humans beings suffer from weaknesses and unresolved issues," demystifies the psychotherapy process, and serves to equalize the power differential (Knox et al, 1997; Ziv-Beiman, 2013, p. 61). Thus, similar to feminist therapists, humanistic therapists assert that self-disclosure advances the principles of fidelity, autonomy, beneficence, and non-maleficence.

Intersubjective and relational therapists believe that by exposing the client to the clinician's "subjective otherness" (Ziv-Beiman, 2013, p. 60) self-disclosure elicits the development of the client's self-awareness and is therefore of therapeutic benefit: as Renik (1995, p. 482-3) asserts, "not knowing the analyst's construction of reality does not help a patient

identify and reflect upon his or hers.” Self-disclosure is thus considered to further the important principles of autonomy, beneficence, and non-maleficence. Indeed, some intersubjective clinicians assert that a working alliance capable of engendering therapeutic change cannot exist without the intentional disclosure of the therapist’s qualities “as a real person,” and thus view self-disclosure as an ethical intervention necessary to successful treatment (Renik, 1995; Ziv-Beiman, 2013, p. 61).

Theoretical orientations therefore hold varying interpretations of the ethical concerns associated with self-disclosure. Importantly, most schools of thought – including contemporary psychoanalysis – maintain that some self-disclosure is inevitable, and therefore approach consideration of its ethics with the intent to identify the circumstances in which clinicians may ethically self-disclose to their clients. A variety of authors have identified elements relevant to determining the ethical appropriateness of a given disclosure: they include the clinician’s intention in disclosing, the content of the disclosure, the client’s traits, and special or rare situations impacting treatment.

Therapist Intention

Across all theoretical orientations, therapists’ intentions for disclosing are considered highly important to determining the intervention’s ethical soundness, and disclosures made with the intent of meeting therapists’ own needs are seen as exploitative and unethical (Gutheil & Gabbard, 1995; Peterson, 2002). However, as Goldstein (1994) emphasized, it can be difficult to evaluate whether the desire to disclose is based on the therapists’ needs or the client’s best interest. Goldstein (1994) advocated that in order for ethical self-disclosure to occur, therapists must know their clients well and be attuned to them before they consider disclosing.

Content of the Disclosure

Literature on self-disclosure identifies that certain content may be more ethical than others to disclose, with authors advocating for a variety of perspectives on what is appropriate.

Disclosure of therapists' theoretical orientation, style, and training are broadly considered to be professionally and ethically mandated for informed consent and consumer rights, thus furthering client autonomy (Peterson, 2002). Building off of this principle, feminist therapists argue that clients have a right to know about their therapists' political and personal values, biases, class background, and sexual orientation (Simi & Mahalik, 1997). Other authors raise concerns that disclosing information that is too personal in nature may frighten or burden clients, thus violating the principle of non-maleficence (Peterson, 2002). Certain subject matters have generated debate in particular, including such facets of personal identity as therapists' religious beliefs and sexual orientation, with authors advocating for both the disclosure and non-disclosure of this information (Peterson, 2002).

Importantly, some authors maintain a strict distinction between the ethical implications of immediate and non-immediate self-disclosure: Wachtel (1993) suggests that for many therapists, immediate self-disclosure is perceived as the only ethical form of disclosure and non-immediate disclosure is conceived of as a distraction from the client, and thus exploitative and unethical. In this framework, while immediate self-disclosure benefits clients by demonstrating their therapists' attunement to them and developing their therapists' understanding of them, non-immediate self-disclosure shifts the focus onto the therapists and derails exploration of clients' issues, undermining therapists' empathy and acknowledgement of their clients' needs. However, Wachtel (1993) himself advocates for a more context-dependent and individualized approach to

treatment that makes room for non-immediate disclosures, and suggests that non-immediate disclosures often relate to and provide information about in-session interactions.

Client Traits

Some authors suggest that there are certain groups of clients who are more likely to be harmed by self-disclosure, while there are other groups that may uniquely benefit from certain types of therapist self-disclosure (Goldstein, 1994; Peterson, 2002; Zur, 2007). Clients considered to be at greater risk include clients with poor boundaries or reality testing; clients who tend to focus on the needs of others; and clients who fear closeness, are self-absorbed, or avoidant of strong emotional content (Goldstein, 1994; Peterson, 2002). Authors also advocate for the benefit of therapist self-disclosure of specific information to particular groups of clients, including the disclosure of therapists' sexual orientation to clients identifying as lesbian, gay, or bisexual; therapists' spiritual beliefs to religious clients; and therapists' personal experiences with post-traumatic stress disorders and trauma to veterans and survivors of trauma (Peterson, 2002). Self-disclosure of these aspects of the clinician promotes the client's autonomy, benefits the treatment and working alliance, and models honesty. Zur (2007) and Peterson (2002) assert that self-disclosure may also be appropriate with children due to their stage of cognitive development, as therapist self-disclosure may serve to develop the client's emerging sense of reality and offer the best avenue to building trust and the therapeutic alliance. Similarly, with adolescents, therapist self-disclosure may engender the trust necessary for a successful working alliance, promote the client's autonomy, and model openness and honesty (Peterson, 2002; Zur, 2007).

Peterson (2002) asserts that if therapists choose to self-disclose to some clients and not to others for the above-mentioned reasons, they must evaluate their decisions according to the principle of justice, which requires that therapists treat all clients fairly and equitably. Thus, therapists must consider whether they would make the same disclosure to another client in a similar situation.

Special Circumstances

A variety of authors have explored the ethical ramifications of special circumstances on self-disclosure, arguing that certain situations present particularly complex ethical questions with regards to its use. When therapists experience bereavement or significant illness, their emotional presence and availability as well as their physical availability may be compromised and affect therapy with their clients, causing interruptions, misattunements, and even the end of treatment in the case of therapists' terminal illness (Goldstein, 1994). Some authors argue that disclosing the reality of the therapist's situation models authenticity and honesty for clients, while withholding information about therapists' circumstances may violate the principle of fidelity and client autonomy by infringing on informed consent, and may damage the working alliance and jeopardize treatment (Bram, 1995). Furthermore, clinicians have an ethical responsibility to not abandon clients, and in the case of significant or terminal illness, providing clients with information about the therapists' situation and their treatment options may be the best way to help prepare them to continue treatment elsewhere, thus maintaining the principles of beneficence and non-maleficence (Peterson, 2002; Henretty & Levitt, 2010). However, such disclosures also have the potential to negatively impact clients, by inhibiting their ability to assert their own needs or express negative emotions towards their therapists, and also carry a

heightened risk to be exploitative as therapists may seek to meet their own needs for relief or empathy (Bram, 1995). Thus, therapists in these positions are encouraged to seek help for managing their own feelings and reactions, so that they may continue to work with their clients in the most therapeutic manner possible.

Empirical Studies

An increasing body of empirical literature exploring the dynamics and consequences of self-disclosure as a clinical tool has emerged during the last half-century. This research has helped to illuminate the primary issues related to self-disclosure and identify important areas for further study. Yet, as a number of studies and reviews have identified, results have been overwhelmingly mixed and the implications of therapist self-disclosure remain unclear (Henretty & Levitt, 2010; Hill & Knox, 2001; Watkins, 1990). Much of the research employs analogue designs, resulting in findings that are subject to the limitations of the brief and artificial nature of this methodology, and poorly and divergently operationalized definitions of self-disclosure complicate analysis of data across studies. In this section, I summarize the extant empirical research and highlight results relevant to this study's subject matter. While summarizing the existing literature inherently requires including analogue designs, I have made an effort to primarily cite studies using real clients and/or real therapists, and to identify when I do specifically cite studies with analogue methodology. Similarly, to the extent possible due to varying definitions of self-disclosure across studies, I have attempted to distinguish between the empirical results for immediate and non-immediate disclosure.

Disclosure vs. Non-Disclosure

Research consistently suggests that clients respond more positively to disclosing therapists than non-disclosing therapists. In their review of 30 quantitative studies, Henretty & Levitt (2010) found that 20 studies corroborated that self-disclosure elicited more positive responses and perceptions from clients than non-disclosure, while only four studies determined that self-disclosure produced more negative than positive consequences. These studies found that self-disclosure positively impacted clients, increased client self-disclosure and was correlated with a higher level of client regard for or attraction to their therapists and a greater perception of therapist warmth (Henretty & Levitt, 2010). Interestingly, additional research suggests that self-disclosure's positive impacts may apply notwithstanding client expectations or preferences regarding self-disclosure (Peca-Baker & Friedlander, 1987; Vandecreek & Angstadt, 1985).

It is important to note that the overwhelming majority of empirical work exploring the impacts of disclosure vs. non-disclosure – including that reviewed in Henretty & Levitt (2010) and conducted by Peca-Baker & Friedlander (1987) and Vandecreek & Angstadt (1985) – has employed analogue methodology, and is thus subject to its limitations. However, the results of analogue designs have been corroborated by a number of naturalistic studies: in her exploration of real client responses to self-disclosure, Hanson (2005) discovered that self-disclosure (both immediate and non-immediate, with no difference identified between their impacts) was more likely to be experienced as helpful by the client, while non-disclosure was more likely to be experienced as unhelpful. Audet's (2011) study highlights the impacts of self-disclosure on increasing client comfort and relaxing boundaries to create a more human connection: prior to their therapists' disclosures, clients described their therapists as "formal," "rigid," "authoritarian," and "clinical," while after their therapists' disclosures, clients reported

interactions with their therapists as “more natural or organic,” “personable,” and “friendly.” Similarly, using a broad definition of self-disclosure that encompassed both its immediate and non-immediate forms, Barrett & Berman (2001) found that clients whose therapists self-disclosed more often, more intimately, and at greater length in response to their own disclosures (reciprocal disclosure) reported liking their therapists more and experiencing greater decreases in symptom distress than those whose therapists restricted self-disclosures (importantly, although therapists elevated their disclosure rates, their disclosures still remained moderate). This study’s findings may be particularly important due to its experimental design, as it was conducted over the course of treatment with therapists assigned to two clients, one to whom they increased disclosures and one to whom they refrained from making disclosures. However, its limitations include its failure to differentiate between immediate and non-immediate disclosures, and the brevity of its duration, as it analyzed only the first four sessions of the treatment relationship.

Self-Disclosure’s Frequency as a Clinical Tool

Research suggests that clinicians employ self-disclosure as a clinical tool rarely: Hill et al. (1988) found that therapist self-disclosure constituted roughly 1% of clinical interventions, while Hill & Knox (2002) determined that, based upon a review of relevant studies, self-disclosure accounts for on average 3.5% of clinical interventions. Attempts to identify the frequency of self-disclosure, however, have been made difficult by the varying definitions of self-disclosure employed in the research, and results have been mixed and unclear – although it appears that interventions such as reflections, mirroring, or interpretation occur significantly more often.

While clinicians may employ self-disclosure rarely, research suggests that most therapists do use some disclosure over the course of their clinical careers. In their study of 184 therapists, Edwards & Murdock (1994) found that 94% reported using some self-disclosure. Similarly, Pope et al. (1987) found that 93% of the over 400 therapists in their survey reported using self-disclosure in therapy. Echoing these findings, Ramsdell & Ramsdell (1993) found that 58% of clients in their survey reported experiencing therapist non-immediate self-disclosure at least once during treatment, and 6% identified their therapists as engaging in this form of disclosure at least 10 times over the course of their treatment. Although results are mixed, studies suggest that certain theoretical orientations may be more likely than others to disclose, with psychodynamic clinicians disclosing least (Carew, 2009; Edwards & Murdock, 1994), humanistic and cognitive behavioral disclosing more, and feminist therapists disclosing most (Simi & Mahalik, 1997).

Important Factors Influencing Self-Disclosure

A number of factors appear to influence the dynamics of self-disclosure and its implications as a therapeutic tool. Studies exploring the type, content, frequency, timing, and intimacy of disclosures, as well as attributes of the therapist and client, suggest that each of these constitutes an important factor affecting the use and consequences of a given self-disclosure.

Type of Disclosure: Immediate vs. Non-Immediate and Additional Considerations

Empirical research supports the distinction between immediate and non-immediate self-disclosure. In their review of quantitative research, Henretty & Levitt (2010) found that the only distinction between types of self-disclosure that appeared to reliably affect clients was between immediate and non-immediate disclosure, with studies suggesting that immediate disclosures

elicited more positive responses from clients. However, research suggests that other qualities of self-disclosure may interact with the immediate/non-immediate dimension to impact a disclosure's ultimate outcomes, and point to the importance of exploring further distinctions. In his review of the extant literature, Watkins (1990) found a distinction between immediate and non-immediate self-disclosures when coupled with the valences of positive/negative, determining that positive immediate disclosures tended to be more favorably received by clients than negative immediate disclosures and non-immediate disclosures. Similarly, Hill et al. (1989) found that clients identified reassuring/supportive, immediate disclosures as more helpful and as increasing their involvement in the therapy process than challenging immediate disclosures and both forms of non-immediate disclosure.

Overall, while these studies suggest more positive findings for immediate self-disclosure, research suggests that non-immediate disclosure also elicits positive client feedback and has therapeutic benefit (Hill & Knox, 2002). In their examination of clients' perceptions of helpful therapist disclosures, Knox et al. (1997) found that clients perceived their therapists' non-immediate self-disclosures as "important events in their therapies" – indeed, although they were given a global definition of self-disclosure that included its immediate form, the study's participants chose only to discuss non-immediate disclosures (p. 280). Clients identified helpful disclosures as non-immediate disclosures that contained largely historical rather than immediate information, that were made in the context of the client's disclosure of important personal issues and were experienced by the clients as intended to reassure or normalize their experiences. While Knox et al. (1997) identify potential explanations for their sample's focus on non-immediate self-disclosure, they suggest that this emphasis may be meaningful. Additionally, in an analogue experiment, Nilsson, Strassberg and Bannan (1979) found that clients preferred non-immediate

self-disclosing clinicians to clinicians who only engaged in immediate self-disclosure. These studies suggest the importance of continuing to examine and assess the therapeutic efficacy of non-immediate disclosure.

Content of Disclosures

Research suggests that clinicians self-disclose particular topics more often than others. A number of studies have found that clinicians tend to most frequently disclose about their counseling style and professional qualifications and experience – a topic area that certainly seems to be ethically mandated information to share with clients (Edwards & Murdock, 1994; Robitschek & McCarthy, 1991). Interestingly, Edwards & Murdock (1994) found that disclosures of success/failure experiences were the second most common topic of self-disclosure reported in their study, a finding that may relate to this study as it involves the sharing of potentially vulnerable personal information, and as clinicians' own experiences with anxiety and/or mood disorders may fall within the broader denomination of success/failure experiences. Studies suggest that therapists appear to disclose least about sexual issues (Edwards & Murdock, 1994; Robitschek & McCarthy, 1991), as well as political affiliation and personal finances (Robitschek & McCarthy, 1991).

Frequency & Intimacy of Disclosures

Studies have found mixed results regarding the ultimate impacts of the frequency and intimacy of disclosures. In his review of empirical studies, Watkins (1990) found that no clear results could be drawn regarding the impacts of disclosure intimacy: while some studies found that moderate and non-intimate disclosures resulted in more favorable ratings of counselors and

elicited greater client disclosure than did non-disclosure or highly intimate disclosures, other studies found that varying degrees of intimacy in disclosures engendered similar effects, or that clients preferred no disclosure. Henretty & Levitt (2010) obtained different results in their review of the extant literature: they found that while self-disclosure in general was correlated with elevated levels of client disclosure, infrequent disclosures of low to moderate intimacy appeared to particularly elicit increased client self-disclosure. However, as both Watkins (1990) and Henretty & Levitt (2010) themselves point out, the overwhelming majority of these studies – and, in Watkins (1990) case, all – utilized analogue methodology and focused on an initial interview rather than extended treatment relationship, and their findings may therefore have limited applicability to real therapy settings. Yet, although naturalistic research into this area is limited, it appears to replicate the results of analogue studies: Audet (2011) found that clients reported positive experiences with infrequent, low to moderately intimate disclosures that resonated with their experiences and were responsive to their therapy needs. These findings are important to consider for this study, as therapist self-disclosure of personal experience with an anxiety and /or mood disorder has the potential to be considered a highly intimate disclosure.

Timing of Disclosures: Process within Session & the Arc of the Treatment Relationship

The timing of disclosures can be conceived in terms of both process within a given session and within the context of the arc of the treatment relationship. Interestingly, little research appears to have been conducted into the intra-session context for disclosures. A number of studies have identified that therapists and clients appear to rate therapist self-disclosures as most helpful when made in the context of client material (Burkard, 2006; Knox et al., 1997; Wells, 1994). Hanson (2005) found that some clients reported positive responses to their

therapists incorporating self-disclosure into “small-talk” that they used to transition into or out of sessions; clients identified that pre-session disclosures put them at ease and effectively “broke the ice, and reminded them that their therapist was present with them, while post-session disclosures helped to externalize the client’s focus as part of the ending of the session and to emphasize their therapists’ humanity.

Research suggests that the timing of disclosure within the broader arc of the therapeutic relationship appears to have a direct impact on the rationale for its use as well as its ultimate consequences. Audet & Everall (2010) found that moderate, non-immediate disclosure in the early stages of treatment can facilitate client comfort and build rapport, by increasing personable interactions rather than more formalized ones and establishing expectations for the emergent relationship. Inappropriate or misattuned disclosure at this stage in treatment can hinder the development of a working alliance, by producing discomfort, uncertainty, and role confusion in the client (Audet & Everall, 2010). Similarly, Hanson (2005) found that skilled disclosure in the early stages of treatment facilitated rapport building, while unskillful disclosure impeded its development. Wells (1994), however, found that the effects of disclosure depended less on the timing of the treatment phase, but rather on the degree of rapport experienced between client and therapist, with disclosures made in the context of low rapport being received negatively by the client, and disclosures made during moderate to high report experienced more positively.

Interestingly, research suggests that therapists may be more likely to self-disclose during the termination process – and that therapists who have not previously disclosed may do so in the final session. Hill et al. (1989) found that seven of the eight therapists in their study used “good-bye” disclosures in their final session with their clients, and for three of these therapists, these were their only disclosures, “indicating that even therapists who believe that disclosures are

inappropriate use them to end the therapy with a “gift” of a disclosure” (p. 294). These results suggest that clinicians may use disclosures in termination for unique purposes, and that as a result, these disclosures may carry specific significance and impacts than other disclosures.

Therapist and Client Attributes

Research examining the effects of specific therapist and client attributes on self-disclosure has produced largely mixed results, although a number of trends have emerged from the research. Studies inquiring into the role of the therapist’s professional status, years of clinical experience, and theoretical orientation have generated inconsistent findings, although it appears that experienced clinicians may self-disclose more frequently than their less experienced counterparts, and that psychodynamic therapists may disclose less than other orientations, but that difference may not be as significant as theory indicates and a wide range of disclosure attitudes may exist among therapists of the same theoretical orientation (Carew, 2009; Henretty & Levitt, 2010; Mathews, 1988). Henretty & Levitt (2010) found that research consistently indicates no correlation between therapist age and level of education and disclosure rates. Similarly, studies found that neither the gender of the client, the therapist, or the gender pairing affected the frequency of therapist self-disclosure and did not consistently affect clients’ perceptions and responses to disclosure (Henretty & Levitt, 2010; Edwards & Murdock, 1994).

Research examining the interaction between the ethnic identities of therapists and their clients have obtained mixed results. Studies exploring Mexican or Mexican Americans’, African-Americans’ and Asian-Americans’ perceptions and responses to self-disclosure have found that ethnicity and culture may interact with self-disclosure; however, the small number of studies has

impeded the development of a clearer understanding of their relationship and this remains an important area for further inquiry (Henretty & Levitt, 2010).

Importantly for this study, while research has been limited, studies point to a relationship between client symptomatology/diagnosis and therapist self-disclosure. Kelly & Rodriguez (2007) found that therapists disclosed more to clients with lower initial symptomatology. Similarly, Simone. McCarthy and Skay (1998) determined that clinicians were most likely to disclose to clients diagnosed with adjustment disorders, anxiety disorders, and post traumatic stress disorders, followed by mood disorders; and that clinicians were least likely to disclose to those diagnosed with personality disorders, impulse control disorders, behavior disorders, and psychotic disorders. These findings may be particularly important for this study, as it seeks to understand the disclosure choices of clinicians about information relating to their own anxiety and/or mood disorders to their clients, who may likely be diagnosed with similar disorders themselves. Building on the current research, this study seeks to better understand how the symptomatology/diagnosis of the *therapist* – potentially in interaction with that of the client – informs clinicians’ self-disclosure decisions about information relating to their own diagnosis.

Discrepancies in Therapist and Client Perceptions of Self-Disclosure’s Efficacy

Importantly, research suggests that while clinicians tend to rate self-disclosures as marginally effective, clients tend to rate disclosures as beneficial. Hill et al. (1989) found that therapists consistently rated their self-disclosures as less helpful than did their clients; Hill et al. (1988) found that while therapists were divided, with some therapists believing self-disclosure was helpful and others rating it as unhelpful, clients identified self-disclosure as the singularly most helpful intervention conducted during the session. This apparent discrepancy in

perspectives is important to consider when evaluating the limitations of this study, which examines only the perceptions of clinicians, and thus its findings may not accurately represent self-disclosure's impacts on clients.

Primary Impacts of Self-Disclosure: Effects on the Client, Therapy Process, and Therapeutic Relationship

Empirical literature has begun to illuminate the consequences of therapist self-disclosure on clients and the therapeutic process. Importantly, research suggests that the success or failure of a given disclosure depends heavily upon the clinical context and clinicians' skill: studies identified that self-disclosure can have positive and negative effects – at times, simultaneously – depending upon the context, skillfulness of execution, and relevance of the disclosure (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Wells, 1994). Indeed, clients in Wells (1994) study reported ambivalence about their therapists' disclosures, citing that disclosures had both positive and negative impacts on the therapy. Echoing this variance in impact, effects of self-disclosure on client perceptions of their therapists are mixed, although research does reliably demonstrate that self-disclosure is associated with increased client perception of therapist warmth (Henretty & Levitt, 2010).

In general, research suggests that clients respond well to disclosures that are made in the context of or in direct response to client material; are conducted within the context of moderate to high rapport; maintain focus on the client and a sense of professionalism; are perceived by the client as intended to be normalizing or reassuring; demonstrate the therapist's involvement in the therapeutic process, and attunement and responsiveness to the client's presenting issues and needs; are not lengthy or overly detailed; equalize the power relations in the therapeutic dyad; are

contextualized, acknowledged, or explained by the therapist; and involve full exploration of the client's reactions and responses to the self-disclosure (Audet & Everall, 2010; Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Wells, 1994). Clients identified that such positive disclosures fostered the working alliance; increased client comfort and heightened respect, trust and safety; enhanced mutuality and connection; increased confidence in their therapists' expertise and level of involvement in their treatment; equalized power relations in the therapeutic dyad; made clients feel validated, understood, appreciated, and cared for; stimulated client insight and self-reflection; elicited client self-disclosure and deepened client engagement in the therapeutic process; and empowered clients by increasing their sense of personal agency in the treatment relationship and their lives (Audet & Everall, 2010; Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Wells, 1994).

Research has found that clients respond negatively to disclosures that are poorly timed, not relevant or in response to the client's material, conducted in the context of low trust or poor rapport within the therapeutic relationship, lengthy and highly detailed, perceived by the client as misattuned to their needs, elicit feelings of being judged or morally chastised and fail to explore the client's reactions and responses (Audet & Everall, 2010; Hanson, 2005; Wells, 1994). Clients report that such harmful disclosures damage the therapeutic relationship; decrease client sense of safety and trust in clinicians' competency, attunement, and involvement in the therapeutic process; violate client boundaries; shift the focus from the clients onto the therapists; elicit negative client emotions; make clients feel that they need to care for their therapists; cause client inhibition in or disengagement from the therapeutic process; and can ultimately lead to client termination of treatment (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Wells, 1994).

A variety of studies have reached the resounding conclusion that the primary impacts of self-disclosure – both negative and positive – appear to be on the therapeutic relationship itself (Audet, 2011; Audet & Everall, 2010; Burkard et al., 2006; Hanson, 2005; Wells, 1994). Audet & Everall (2010) and Hanson (2005) found that clients experienced “enhanced relationships” with therapists who disclosed carefully and with attention to basic skills, while clients whose therapists disclosed unskillfully, too frequently, or who maintained a strict policy of non-disclosure were less likely to experience a positive alliance with the therapist (Hanson, 2005, p. 103). These studies found that attuned self-disclosures fostered the therapeutic alliance by engendering connection and intimacy; establishing trust, safety and accountability; equalizing the power relations; and developing deep, emotional understanding, respect, and attunement. Participants in Knox et al.’s (1997) study furthermore reported that self-disclosures increased their perception of their therapists as more human and real, which in turn enhanced the connection between them, while clients in Wells (1994) study reported self-disclosures increased feelings of mutuality (Wells, 1994). Research suggests that therapists’ disclosure in cross-cultural counseling situations – particularly the disclosure of their personal reactions to and experiences with racism and oppression – may play a particularly important role in strengthening the working alliance (Burkard et al., 2006) (However, this study’s findings are limited to therapeutic dyads where the therapist is White and the client is of Color). Misattuned disclosures, on the other hand, damaged the working alliance by decreasing safety and trust, creating role confusion or reversal, and engendering distance, disconnection or disengagement (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Wells, 1994). These findings appear particularly significant given research that suggests the quality of the therapeutic relationship can be an important indicator of treatment outcome (Falkenström, Granström & Holmqvist, 2013) as well

as the findings of Farber, Berano, & Capobianco (2004), who found that the quality of the therapeutic relationship impacted client's perception of safety in disclosing personal information.

The findings of Audet (2011), Audet & Everall (2010), Hanson (2005), Knox et al. (1997) and Wells (1994) appear to corroborate the theoretical assertions of feminist clinicians that self-disclosure exerts an equalizing effect on the therapeutic relationship and empowers clients to assume a more active role in their own treatment. Audet (2011) found that therapist self-disclosure reduced the client's perception of being objectified and increased his/her sense of self as "worthy of respect and as 'functional' in spite of the problems worked on in therapy," thus enabling the client to shift from a passive object of examination to the empowered position of collaborator in the therapeutic process (p. 96). Similarly, clients in the studies of Knox et al. (1997), Hanson (2005), and Wells (1994) identified that disclosures equalized the power differential and made the therapeutic relationship feel "more balanced" (Knox et al., 1997; p. 281).

Studies inquiring into self-disclosure's impact on treatment outcomes remain limited and the findings appear to be mixed; while research suggests that self-disclosure in general can elicit positive, immediate effects, its distal impacts are more unclear (Hill & Knox, 2003). Kelly & Rodriguez (2007) found that therapist self-disclosure did not appear to be related to client reports of symptom change. In their survey of former clients, however, Ramsdell & Ramsdell (1993) found that clients identified self-disclosure as positively affecting their therapy. Similarly, Barrett & Berman (2001), found that clients of therapists who increased the frequency, length, and intimacy of disclosures reported greater decreases in symptom distress than did clients of therapists who refrained from self-disclosure. Thus, preliminary findings indicate that self-

disclosure may impact treatment positively – even potentially with regards to its distal effects – but further research is needed to clarify the intervention’s short and long-term consequences.

Limitations of Empirical Studies

Empirical research to date is subject to a number of important limitations that highlight the need for continued, careful examination of self-disclosure as a clinical tool. As mentioned previously, definitional inconsistencies have plagued self-disclosure research and constitute one of the primary obstacles to the meaningful aggregation of data: while some studies have defined self-disclosure broadly as any self-revealing statements made by clinicians, other research has examined distinct categories of self disclosure (Henretty & Levitt, 2010; Hill & Knox, 2001). As Hill & Knox (2001) and Audet (2011) point out, these widely varying definitions are also frequently poorly operationalized, resulting in important methodological shortcomings that produce mixed results and “render meaningful analysis of findings across studies difficult, if not impossible” (Henretty & Levitt, 2010, p. 69).

A second, major problem with the extant research relates to its dependence on analogue methodology. Most self-disclosure studies have been analogue in design, simulating the therapeutic encounter with participants who are not engaged in therapy. The artificial context and brevity of the relationship involved in these studies complicate the applicability of their findings to actual therapy situations, where the “evolving context and relationship are crucial” (Audet, 2011; Henretty & Levitt, 2010; Hill & Knox, 2001, p. 415). “In essence, [analogue designs] decontextualize a situation in which context exerts a great degree of influence” (Farber, 2006, p. 147, as cited in Henretty & Levitt, 2010, p. 70). As Henretty & Levitt (2010), quoting Knox et al. (1997), assert:

The contrived, single “session” with a non-client student volunteering for course credit, who reads a transcript or watches a recorded mock therapy interaction before rating the therapist does not “capture actual client internal experience of the dynamics of therapist self-disclosure in genuine therapy settings, nor does it give information about the perceived consequences, if any, of this intervention on clients in long-term psychotherapy” (Knox et al., 1997, p. 274).

Thus, much of the data on self-disclosure is subject to the serious methodological limitations of the analogue design, whose applicability to actual therapy situations and the internal experience of real therapy clients, in both the immediate and long-term, is questionable.

A third concern with empirical research to date has been its focus on operationalizing self-disclosure by frequency, rather than by other important variables (Hill & Knox, 2001; Henretty & Levitt, 2010). As Hill & Knox (2001) assert, “There is no compelling reason to believe that more disclosures should lead to better outcome. It may even be that therapist self-disclosure yields its positive effects because it occurs so infrequently” (p. 416). They maintain that other self-disclosure variables are more relevant to its treatment impacts and should be studied, such as the timing, type, and quality of disclosures as well as client readiness. Other authors have echoed Hill & Knox’s (2001) concerns that these situational and contextual variables, which may “moderate and/or mediate the link between therapist self-disclosure and various measures of therapeutic process and outcome,” have been left out of the extant research and advocate for their inclusion in future studies (Henretty & Levitt, 2010, p. 70; Knox et al., 1997; Watkins, 1994).

Finally, factors regarding the sampling methods of many self-disclosure studies compromise their generalizability. Many naturalistic studies have employed qualitative methodologies with small sample sizes or case studies, and the vast majority of studies have involved therapists and clients who identify as White, American, and female, thus rendering the data subject to important biases and limitations based upon race, culture, and gender experience

(Constantine & Kwan, 2003). As Constantine & Kwan (2003) point out, cultural and racial backgrounds of the therapist and client may significantly affect the nature and impacts of self-disclosure and are therefore important considerations to take into account.

Situating this Study

While no research inquires directly into self-disclosure of clinicians' lived experiences with an anxiety and/or mood disorder, the literature reviewed above suggests important considerations for the current study. First of all, non-immediate self-disclosure remains significantly more controversial than its counterpart immediate disclosure – and appears to raise more theoretical debates and ethical concerns. Similarly, empirical research has produced mixed results with regards to the impacts of non-immediate disclosure, and although some studies have associated positive results with non-immediate disclosure, immediate disclosure appears to consistently receive more positive ratings. In addition, theoretical, ethical and empirical literature warns against highly intimate disclosures and disclosures of unresolved issues, asserting that these disclosures are more likely to raise ethical and boundary concerns and are less likely to be perceived as helpful by clients. Thus, some literature suggests that the form of self-disclosure examined in this study may be less likely to be therapeutically beneficial, as the revelation of personal experience with an anxiety and/or mood disorder constitutes a non-immediate and potentially intimate disclosure, and may involve the disclosure of issues that remain unresolved for the therapist. However, other literature suggests that this form of disclosure may be clinically indicated. Theoretical arguments for this form of non-immediate disclosure include modeling healthy behaviors and attitudes, instilling hope, equalizing the therapeutic relationship, and empowering the client. Furthermore, ethical literature suggests that the disclosure of therapists' shared experience with their clients may be particularly important to certain groups of clients,

including those suffering from PTSD – a disorder with anxiety and mood dimensions – thus raising the possibility that a parallel need may be true for clients suffering from anxiety and/or mood disorders. Research also supports the widespread use of disclosure in general to clients with anxiety and/or mood disorders, indicating that in general therapists perceive that self-disclosure benefits these populations and is potentially less likely to harm them than other groups of clients. Thus, the current extant literature on self-disclosure both raises concerns with the specific form of disclosure examined in this study and also identifies its potential for therapeutic benefit, highlighting the importance of this study and the need for additional research into this emerging field of inquiry.

Clinical Recommendations: Integrating Theory, Ethics and Empirical Evidence

A number of authors have identified recommendations for optimizing the therapeutic benefit of therapist self-disclosures based upon reviews of the extant theoretical, ethical, and empirical literature. The following recommendations are synthesized from the works of Burkard et al. (2006), Henretty & Levitt (2010), Hill & Knox (2003), Hill & Knox (2001), Lee (2014), and Wells (1994):

1. Therapists should disclose infrequently and judiciously, as self-disclosure potency and potential to create positive impacts may relate to the rarity with which it is employed.
2. Therapists should interrogate their reasons for self-disclosing, and only disclose when their motivation is to benefit the client.
3. Therapists should primarily disclose in the context of relevant client material.
4. Therapists' disclosures should be made with attention to their clients' particular needs and preferences, relational issues, and presenting concerns. Therapists' decisions to disclose should be made with particular attention to the clients' cultural, racial, and other social identities and the intersection of those with their own identities: this requires that therapists interrogate their clinical assumptions

and cultural biases and be attentive to the reenactment of power and privilege within the therapeutic relationship.

5. Therapists should make self-disclosures that are not highly intimate, as highly intimate disclosures may frighten or burden the client. However, therapists' disclosures should contain some level of intimacy if they are to engender trust and help the client to perceive the therapist as more human and real.

6. Immediately after disclosing, therapists should return the focus back to the client and explore their clients' reactions and responses to the disclosure. Exploration of the disclosure should occur immediately, as well as be revisited over the course of the therapy, as its meaning for the client may change overtime.

7. Therapists should self-disclose primarily about issues that are mostly resolved, in order to ensure that they have the distance from the topic to maintain their focus on their clients and avoid using the disclosure for their own needs.

8. Therapists should consider using self-disclosure during termination, as a way of demystifying themselves and the therapeutic process, and thus empowering their clients to continue their personal growth post-therapy.

CHAPTER III

Methodology

Research Design

This study was approved by the Smith College Human Subjects Review Committee (see Appendix D for the HSRC approval letter), and used a mixed methods research design, comprised of two components: a brief, anonymous online survey with both qualitative and quantitative elements; and a small sample of in-depth, qualitative interviews. The online survey included a total of 16 questions in three sections: 1.) two screening questions to ensure participants met eligibility criteria, followed by the consent to participate; 2.) eight questions related to self-disclosure, three of which included short narrative questions with fill-in text boxes; and 3.) five demographic questions, regarding clinician diagnosis or disorder type, years practicing, theoretical orientation, and racial/ethnic and gender identities. I included demographic questions in both my survey and interview components in an attempt to ensure that the research did not commit the ethical error of excluding populations or failing to document the sample's diversity. I used a multiple choice format for these demographic questions with the options to use a text box if participants' identity markers were not included in the options, and I consulted with colleagues in order to arrive at the categories offered in my demographic section. I used the Select version of SurveyMonkey to administer the survey, as it allowed me to use SkipLogic and data collection mechanisms not available on the basic version (please see

Appendix B: Survey Materials for a copy of the online interface of the survey). The survey included an invitation to contact me at my school address via a separate email if a participant were interested in being interviewed for an in-depth interview. Thus, the survey remained anonymous, while the interview portion was confidential.

Once potential participants for the interview portion contacted me, I provided them with a specific Informed Consent document for the interview portion, along with a stamped, self-addressed envelope so that they could return a copy to me with a wet signature, which I required before scheduling the interview appointment. The interview component of the study involved two interviews with each participant: an in-depth first interview lasting no more than 45 minutes; and a shorter, follow-up interview lasting between 5-15 minutes. Interviews were conducted via the phone in a confidential location.

For the first in-depth interview, I used a semi-structured format, with eleven prepared questions pertaining to the following topic areas: participants' general experiences of conducting clinical work with an Anxiety and/or Mood Disorder diagnosis; their perspectives on disclosure in general and specifically disclosure of their own experiences with their Anxiety and/or Mood Disorder; and their perceptions of the broader clinical community's stance towards clinical disclosure of personal experience with mental illness. These questions served to stimulate dialogue with interviewees, and depending upon the progression of the interview, I asked additional questions or omitted prepared questions. At the end of the first interview, I asked participants five demographic questions parallel to those presented in the survey, regarding clinician diagnosis or disorder type; years practicing; theoretical orientation; and racial/ethnic and gender identities.

I incorporated these secondary interviews into my research design to enable participants to share reflections stimulated by the first interview, and to provide me an opportunity to ask any additional questions that arose over the course of conducting the interviews and survey. The brief follow-up interview was recommended by the thesis findings of a Smith student in the summer of 2013, who found this method was an effective way to track the incidence of common themes and attain a richer, more reflective body of qualitative data.

Rationale

I chose to conduct this study using a mixed methods research design for a variety of reasons. As the literature review suggests, the choices clinicians make about self-disclosure of their own Anxiety and/or Mood Disorders is an emerging area of inquiry, and thus recommends itself to a qualitative design that allows for a broad, exploratory investigation. However, because this study relates to questions of clinical judgment and orientation, which are qualities developed and evaluated specifically within the context of the clinical profession, I believed it was important to contextualize the individual perspectives gained from the interviews in an understanding of general trends within the clinical community regarding this issue. Incorporating quantitative data enabled me to gain a snapshot into these broader patterns, thus allowing for not only a more detailed and rich interrogation of the findings of the qualitative components, but also a more complete understanding of this issue on a broader scale as it pertains to the current status and evolution of the clinical profession.

In addition, on a practical level, a mixed methods approach enabled me to obtain the data sufficient to conduct the study: given the sensitive nature of the subject of inquiry, I anticipated that recruiting the number of participants required for a purely qualitative, interview-based study

might be difficult. I believed I would have a better chance of obtaining the quantity of data required for meaningful analysis through combining quantitative and qualitative information. A further benefit to this design is that it may have broadened my sample, as it provided an avenue to reach participants who may have been willing to participate in the anonymous survey's quantitative components, but not its qualitative components or the interview portion. As a result, I was able to incorporate their data to arrive at a more complete understanding of the clinical community's stance towards this issue, as well as to reduce some of the potential for this study to bias its outcomes towards clinicians who feel comfortable discussing the subject at hand.

Sampling Techniques

In an effort to attain a meaningful sample in terms of both size and diversity, I used three strategies to recruit participants for this study. All were convenience samples, with two of the strategies being snowball samples. First, I sought to engage participants through the National Association of Social Workers (NASW), in order to broaden my sample pool and obtain greater nationwide representation of participants in this study. I contacted each of the State Chapters of the National Association for Social Workers (NASW) via email, providing them a brief overview of my study and asking them to advertise the link to my survey (please see Appendix A: Recruitment Materials for the email to NASW Chapters). I stated explicitly in this preliminary contact that my study involved an anonymous, online survey and an in-depth interview portion, and that all measures would be taken to protect the privacy and confidentiality of all participants. As I wished to focus this study on clinicians practicing in the 50 states of the U.S., I did not outreach to the NASW Chapters for Guam, International, Virgin Islands, or Puerto Rico. After my initial contact with most of the State Chapters, it appeared that I needed to obtain approval

from the National Office before the individual Chapters could agree to advertise my survey. However, the NASW National Office for Workforce Studies confirmed that I only needed to obtain approval if I wished to purchase mailing labels in order to mail my survey to individual members, rather than ask for advertising space. Once I clarified the situation with the State Chapters, I was able to advertise my study through the Chapters of California, Connecticut, and Wisconsin. The methods through which my survey was advertised varied depending upon the Chapter, and included posting on chapter Facebook pages, electronic newsletters, and list-serves. After this first round of emails, two months later I sent out a second set of emails to all of the chapters that had not responded to my first inquiry, and was able to advertise my study through the Maine and Idaho/Oregon Chapters.

Secondly, I used my connections with Smith College School for Social Work students and faculty to recruit participants in a snowball sample. I contacted my personal friends and acquaintances in the student body at Smith and asked them to forward information about my study to licensed clinical social workers in their acquaintance who might be interested in participating, or who could forward the email on to their own connections. I emailed professors in my acquaintance asking them if they would be interested in forwarding information about my study to colleagues they anticipated might be interested in advertising or participating in my study. I also advertised my study via Facebook, and asked friends to forward my advertisement to others who might be interested.

Similarly, as a third recruitment strategy, I contacted select former and current colleagues from my first- and second-year internships in an effort to recruit therapists from community mental health organizations in Seattle and King County (please see Appendix A: Recruitment Materials for my email to Smith SSW students and Seattle Contacts). I also was able to advertise

my study to the network of women therapists in Seattle to which my own therapist belonged, through the Women's Therapy Referral Service.

I sought to minimize the potential for coercion that arose by using my connections in the Smith and Seattle communities through a number of methods. Firstly, by requiring participants to be LCSWs/LICSWs, I ensured that I was unable to influence my fellow students to participate directly in my study. I used my connections to Smith second-year students solely to disburse the survey to third parties who qualified, and solicited their assistance only via a generalized email and broader, Smith-related social media sites and not via personalized emails to individual students. In outreaching to my professors, colleagues and other contacts in the mental health field in Seattle, I initiated preliminary contact to ask if each individual would be interested in receiving the advertisement email and stated clearly that it was entirely their choice to accept the advertisement email, as a way of ensuring that coercion did not occur due to a personal, preexisting relationship. I explicitly articulated that the survey was voluntary and anonymous unless a person chose to agree to an interview, in which case their information was kept confidential. As a result, I had no way to discern who participated unless they agreed to an interview, and I believe that this anonymity minimized the potential for coercion.

Confidentiality

The online survey component of this study was explicitly anonymous, as I designed it through SurveyMonkey and had no way of determining the identities of the participants. As an additional precaution, I disabled SurveyMonkey's capacity to track internet IP addresses, so that there would be no way of tracking the specific IP addresses of individuals who had accessed my survey.

All of my interviews were conducted on the phone. In order to maintain the confidentiality of participants, I completed these interviews in my apartment or office, with the windows closed and door shut, and only myself present at the time of the interview. Interviewees' responses were recorded via audio recording and written notes compiled during the interview, which were then integrated into a single transcription for each interview. Once transcription was complete, all recordings were erased from the recorder and stored on my computer, which was password protected. All electronic transcriptions and other data were coded, and each document was password protected and kept on my personal computer. All physical research materials including recordings, transcriptions, analyses and consent/assent documents were kept in a locked file cabinet in my personal residence, where they will be stored for three years after my study according to federal regulations. Upon the completion of my study, all electronic data were erased from my personal computer and transferred for storage onto a USB device, which will remain locked in the same file cabinet for the required period of time. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed.

Data Analysis

All in-depth interviews were transcribed in their entirety, minus speech dysfluencies, in order to preserve the highest authenticity and detail for the coding process. After transcription, I read each interview and coded them for prominent themes internal to the individual interview, and began to identify broader points of connection and difference across the interviews. After reading all the interviews, I then re-read each of them, recoding themes as necessary into broader categories, and coding for any themes that emerged in the entirety of the interviews that I may

have overlooked in an individual interview. During this second re-reading of each interview, I also identified sections of verbatim speech that I wished to include in my analysis. I followed the same procedure for all qualitative survey responses, compiling them into a single word document and coding for themes within and between responses over the course of multiple readings, and ultimately selecting sections of text to present in the findings section.

After completing two readings of these initial interviews, I compiled a list of themes and questions stimulated by the review and coding process. I then selected the most prominent areas for follow-up for each interviewee, and asked each clinician about them in my second, shorter interview, which usually included three to four questions. This interview was also transcribed in its entirety, and read twice over, following the same coding process as the in-depth interviews. In the second reading, I again identified quotations to be used in my analysis.

The quantitative data were analyzed using the services of the Smith College statistical analyst, Marjorie Postal. She used descriptive statistics, as well as t-tests, crosstabs, chi-square tests, and non-parametric correlations to determine correlations between demographic characteristics and patterns of responding to survey items. These data primarily presented frequencies with which participants answered questions in particular ways and correlations between these frequencies and demographic aspects of the participants. These results are presented in the Findings chapter.

Strengths and Limitations

The strengths of this design are multiple. On a practical level, using a variety of data (qualitative and quantitative) obtained through multiple channels of collection (survey and in-depth interview) and recruitment strategies (outreach to NASW Chapters, Smith School for

Social Work students, and Seattle area connections) enabled me to increase the likelihood of attaining enough data to analyze and arrive at meaningful results. By recruiting via three separate channels, I believe I attained a more diverse sample, and may also have reduced the bias I would have encountered if I had conducted only a single convenience sample. Such diversity of data also enabled me to gain a richer, more complex understanding of the subject at hand.

Furthermore, this study used a clearly delimited and operationalized definition of self-disclosure based on the distinction between immediate and non-immediate disclosure, the most widely supported distinction in the extant literature. As a result, the findings of this study will be clearly understandable and easily relatable to other research. Finally, this study focused on the perspectives of experienced clinicians, who are more likely to have developed the clinical judgment and insight in order to appropriately use self-disclosure as a clinical intervention.

The limitations of this survey include the sampling technique, size and diversity. All of my recruitment strategies were convenience samples, and thus subject to the shortcomings inherent in this sampling technique, which lacks the scientific rigor provided in clinical trials or other methods that come closer to attaining the randomness and representation required to eliminate bias and draw more generalizable conclusions. While it may be impossible to ethically engage in true clinical trials regarding this topic, a more random sampling technique may have produced a more generalizable sample.

In addition to technique, my study's small sample size affects its generalizability. I obtained only 49 usable survey responses – just shy of the 50 I needed for statistical analyses with greatest power – and only two interview participants, which was significantly less than the five to eight interviewees I had hoped to attain for the in-depth, qualitative component. As two of my recruitment strategies involved communities I am associate with, my study suffers the risk of

representing only a subsection of clinicians, rather than a sample representative of all clinicians practicing in the U.S. Secondly, perhaps due to the overwhelmingly white, female composition of licensed clinical social workers – and the overrepresentation of women in answering questionnaires and surveys – the perspectives of clinicians of color and clinicians of different gender identities are significantly underrepresented in my study. This may have particularly important consequences for the generalizability of my findings, due to research that suggests that self-disclosure may be viewed and enacted differently in different cultural contexts (Diaz-Peralta Horenstein & Downey, 2003).

Thirdly, because I inquired about a sensitive, personal topic, my study risks overrepresenting the perspectives of clinicians who feel comfortable with their diagnoses and their self-disclosure decisions, and feel at ease talking about them. Thus, I may have failed to capture an important section of the population of clinicians, who may feel that their diagnoses are private or risky to discuss, or who may have not wished to discuss the subject for other reasons. Finally, because I elicited responses from clinicians and not their clients, this study may contain bias regarding the success of their self-disclosure interventions, as it necessarily depends upon the perceptions of clinicians rather than direct feedback from the clients involved.

CHAPTER IV

Findings

Demographics of Survey & Interview Participants

A total of 49 clinicians participated in the online, anonymous survey portion of this study, and two clinicians participated in the in-depth interview component after having completed the survey. Of the 49 survey participants, 47 provided demographic information. The overwhelming majority of participants identified as female and either European-American/White or from regions of Europe broadly considered racially white. Forty-one participants or 87% identified as female; six participants or roughly 13% identified as male. No participants reported identifying as transgender, intersex, genderqueer, genderfluid, gender non-conforming, or as not identifying strongly with any gender. Thirty participants or 64% identified as European-American/White (two of whom also identified as Northern and Southern European, respectively); nine participants or 19% identified as Northern European; three participants or 6% identified as Eastern European, and one identified as Southern European. Six participants identified as clinicians of color, or roughly 13% of the total participants: one identified as African-American; one as African-American and East Asian; one as Southeast Asian; one as Cape-Verdean; one as Mexican/Mexican-American/Chicano and Latino/a; and one as Russian and Cuban. Additionally, two clinicians further specified that they identified as Jewish, with one identifying as Sephardic.

Both of the interview participants identified as White, with one identifying as male and the other as female.

Most survey participants – almost 70% – identified as having a current, managed diagnosis of an anxiety and/or mood disorder, while just over 30% reported that they had a diagnosis in the past that they considered resolved. Both of the interview participants identified having current diagnoses, and identified that these diagnoses had been active for a significant period of time.

TABLE 1.1

Anxiety/Mood Disorder Status	Number of Participants	Percentage of Total Respondents
Current/active	34	69.4%
Past/resolved	15	30.6%

The majority of survey respondents – close to 45% – identified their diagnosis as a combined anxiety and mood disorder, while roughly a third of participants identified as having only a mood disorder. Clinicians identifying as having solely an anxiety disorder represented the smallest group of participants in this study, with less than 25% of respondents identifying with this category. Both of the interview participants identified their diagnoses as mood disorders. Although one of them reported having had anxiety symptoms as a child, these symptoms were not currently sufficient to receive an anxiety diagnosis.

TABLE 1.2

Diagnosis	Number of Participants	Percent of Total Respondents
Anxiety Disorder	11	23.9%
Mood Disorder	15	32.6%
Combined Anxiety & Mood Disorder	20	43.5%

Participants in this study reported a range of years practicing clinical work: 44.7% of survey respondents identified as having practiced for under ten years, while 55.3% of respondents identified as practicing for 10 years or more. The shortest length of time practicing was 1 year; the longest was 42 years. Distribution based upon length of time practicing was fairly even among clinicians practicing less than ten years, with one, three, five and seven years of clinical practice being the most commonly identified experience statuses. Within the group of more experienced participants, 19 clinicians identified as practicing for between 10 and 29 years, constituting 40% of all respondents; 11 of these clinicians, or 23.4% of the total respondents, reported practicing for between 10 and 13 years. Seven clinicians, or 15% of all respondents, identified as having practiced for 30 years or more. Both of the interview participants reported lengthy careers as clinicians, reporting 35 and 23 years of clinical practice.

TABLE 1.3

Years of Clinical Practice	Number of Participants	Percent of Total Respondents
Under 10 years	21	44.7%
10-29 years	19	40.4%
30 years +	7	14.9%

Clinicians reported a wide range of theoretical orientations, and were relatively evenly distributed across the four major orientations provided. Psychodynamic and cognitive behavioral were the most commonly identified orientations, with respectively 55.3% and 57.5% of participants claiming these identities. Eclectic was the least represented theoretical identification, with 48.9% of participants nevertheless selecting this orientation. Seven participants, or about 15% reported identifying with “other” theoretical orientations, reporting use of EMDR, Child Centered Play Therapy, Dialectical Behavioral Therapy (DBT), Exposure Therapy, Narrative Therapy, Attachment Theory, Reality Therapy, and Somatic Psychotherapy. One interview participant identified as Cognitive Behavioral, with an emphasis on Acceptance and Commitment Therapy (a form of third-wave CBT); the other identified as primarily Eclectic with Cognitive Behavioral influences.

TABLE 1.4

Theoretical Orientation	Number of Participants	Percent of Total Respondents
Psychodynamic	26	55.3%
Eclectic	23	48.9%
Relational/Intersubjective	25	53.2%
Cognitive Behavioral	27	57.5%
Other	7	14.9%

Self-Disclosure Data

Participants overwhelmingly identified self-disclosures of information relating to their diagnoses as rare interventions: no survey participants reported disclosing this information often or always to their clients, and over a third of respondents reported never disclosing this information. The majority of survey participants – almost 45% – identified engaging in self-disclosure rarely, while 20% reported disclosing sometimes. Both interview participants reported using self-disclosure rarely. Thus, clinicians’ intentional disclosure of information relating to their anxiety and/or mood disorder appears to follow trends found in other self-disclosure research that suggest that self-disclosure is one of the least frequently employed interventions in clinical work.

TABLE 2.1

Frequency of Self-Disclosures	Number of Participants	Percent of Total Respondents
Never	17	34.7%
Rarely	22	44.9%
Sometimes	10	20.4%
Often	0	0%
Always	0	0%

No significant difference was found in self-disclosure rates based upon the type of disorder participants identified, the currency of their diagnosis, or their years of clinical practice. Interestingly, a number of respondents identified that rather than openly disclose to their clients, they make concealed, indirect or generalized disclosures, using their own experience either without naming it as such or without connecting it to their diagnosis, or including it within a generalized disclosure. One participant reported drawing on her personal experience to guide treatment without mentioning it, noting that “while I don't specifically name myself, I do weave in my experience of seeking treatment for anxiety and managing generalized anxiety over the long term by conveying empathy and psycho-education.” Similarly, other clinicians indicated that while they do not self-disclose, they reference their personal experience without declaring it as such: one clinician noted, “Sometimes I will refer to "someone's" experience with symptoms for the purpose of education about medication, treatment process, etiology and/or hope without indicating it is informed by my own experience.” Another clinician also reported concealing her disclosures by labeling them as another person’s, stating “While I frequently draw upon my

personal experience, I do not identify it as such – rather, I present it as another person’s experience. Patients seem to find that comforting and helpful.” One clinician reported making indirect disclosures of symptoms, using descriptions of his experience without directly naming it as his own or connecting it to a diagnosis: “I may describe from time to time the ‘felt experience’ of anxiety to communicate empathy.” Other clinicians reported using generalized disclosures that include the clinician within a broader group: one clinician reported, “I disclose that everyone has anxiety and has to learn to manage it, including myself. I do not disclose my diagnosis.” Interestingly, a group of clinicians reported making generalized disclosures relating specifically to therapy participation:

I disclose to a few, if it comes into our work, that therapy is something therapists engage in too, to normalize the experience. I don't disclose my personal medication or treatment. – Survey Response

[I] have not disclosed more than to say that “today I happen to be in this chair but everyone can benefit from sitting in your seat. – Survey Response

There are times I have mentioned that people with my training have spent years on the couch! – Survey Response

These reports suggest that clinicians find a variety of ways to use their lived experience with an anxiety and/or mood disorder to inform the treatment of their clients, without directly disclosing their own diagnosis and experience. While some of these reports appear to clearly be non-disclosures, the status of others appears more vague, as they contain elements of self-disclosure presented within a context that inherently generalizes and de-personalizes the information. These clinicians’ reports highlight a gray area within definitions of self-disclosure, and point to the need to further clarify the definitions of this intervention.

Factors Guiding Self-Disclosure Choices

Clinicians identified a variety of factors that influenced their self-disclosure decisions. Perceived benefit to the client emerged as the most prominent factor influencing clinicians' decisions to disclose or not disclose, with almost 80% of clinicians identifying this concern as relevant to their choices. Roughly half of clinicians identified appropriate timing, concerns about revealing personal health information, or instilling hope as important factors guiding their decisions. Interestingly, client symptomatology/diagnosis appeared to be the least common factor impacting clinicians' decision making, with roughly a quarter of clinicians reporting this as an influential concern. A similar 26.5% of all respondents identified other, additional factors impacting their disclosure that were not provided within the choices. Thus, in line with the findings of Edwards & Murdock (1994), these results suggest that clinicians primarily disclose for ethical reasons.

TABLE 2.2

Guiding Factor	Number of Participants	Percent of Total Respondents
Benefit to Client	39	79.6%
Client Symptomatology/diagnosis	13	26.5%
Timing – appropriateness for client at this time	27	55.1%
Concern about revealing confidential personal information	25	51%
Instilling hope of recovery/management of the disorder/symptoms	26	53.1%
Other	13	26.5%

Interestingly, categories of guiding factors were significantly related with varying disclosure rates. Clinicians who did not select client symptomatology, timing, or instilling hope had lower mean rates of disclosure than did those participants who checked these categories; similarly, participants who did not select concern about revealing personal information had higher mean disclosures rates than those who did identify this category as a guiding factor. Benefit to client was the only category where no significant difference was found in disclosure rates; as is explored in the next session, this finding may be due to the fact that concerns about disclosure's benefit to clients served as a rationale for both disclosure and non-disclosure.

Benefit to Client

Concern about benefit to the client emerged as the fundamental factor guiding clinicians' decisions both to disclose and to not disclose. On the one hand, clinicians identified that the primary impetus for disclosure needed to be the perception that it would benefit the client; on the other hand, clinicians reported that concerns about shifting the focus away from the client onto the therapist ultimately led them to choose non-disclosure:

One of the primary principles that I think is important is that self-disclosure has to...have some benefit for the patient first and foremost. –Interviewee 1

I think that self-disclosure needs to be pretty minimal...you really need to keep your focus on the client: to self-disclose only when you really feel like it will help them...So in general, I think that self-disclosure is something to be thought out and carefully weighed for the cost/benefit. –Interviewee 2

I have had urges to self-disclose, and in all scenarios it came from a wish to comfort or reassure a client that they aren't alone. I have found other ways of providing that support that doesn't involve self-disclosure. It's important to me that their therapeutic process does not become about me. – Survey Response

I have found in work with patients that they want the focus on them and their issues. –Survey Response

Participants who reported self-disclosing asserted that disclosure benefited their clients by (a) providing information for the client to make more informed decisions about their treatment options, including the disclosure of treatment strategies and coping skills; (b) reducing stigma associated with mental illness and normalizing the client's experience; (c) reducing stigma associated with therapy and specific treatment strategies, such as medication, and normalizing the exploration of different avenues of treatment; (d) modeling self-disclosure about experiences with and positive attitudes about mental illness; (e) instilling hope in treatment and the client's own inner capacities for healing; (f) building rapport and fostering the therapeutic alliance; (g) equalizing power within the therapeutic relationship; and (h) empowering clients to trust their own judgment and to engage as active participants in their own treatment. Due to the variety of qualitative data garnered from the study about these rationales, they will be explored more in depth in later sections of this chapter.

Participants who elected not to self-disclose cited concerns about (a) shifting the focus away from the client; (b) using the intervention to meet their own needs; (c) perceiving that their own experiences were not relevant to the client's presenting concerns; (d) harming the client due to specific aspects of client symptomatology or other traits, and (e) negatively impacting the development and interpretation of the transference. One clinician also identified that the limitations of diagnostic categories also rendered such disclosures unhelpful. The following quotes, in addition to the previous ones, illuminate some of the above-mentioned perspectives:

A disclosure...is least effective when knowing something personal/specific about the therapist interferes in important transference processes and puts too much of the therapist "in the room." –Survey Response

I don't believe in the current lexicon...[diagnoses are] mere heuristic devices which create a rationale for insurance companies often [and], in my opinion, [are] too reductional other than for sometimes directing pharmacological interventions. Furthermore, it interferes with transference. – Survey Response

Participant responses suggest that most clinicians engage in an evaluation of the potential for client benefit versus client harm when considering self-disclosure, and that this cost/benefit analysis comprises a fundamental element of their decision-making process. Emphasizing the importance of this analysis, one clinician indicated that determining that the client “won’t be harmed by the information,” increased their inclination to disclose if they perceived it might help the client. Whether choosing to disclose or not disclose, clinicians consistently identified that their choices involved careful consideration and thought: as one clinician noted, “I am extremely strategic when I do disclose.”

Client Symptomatology/Diagnosis & Symptom Relevancy

Just over 25% of participants in this study identified that their clients’ symptomatology or diagnosis influenced their self-disclosure decisions. Clinicians who chose this concern as a guiding factor had mean disclosure rates that were higher than those of participants who did not, and statistical analysis revealed this difference to be statistically significant ($p = .031$). Interestingly, however, while this factor appears to statistically relate to higher rates of disclosure, the qualitative data primarily point to concerns clinicians hold about the perceived relevancy or mismatch of their symptoms to their clients, and appear to relate more to non-disclosure than to disclosure. Interviewee 2 was the only participant who identified how client symptomatology might factor into a decision to disclose, reporting that she would be more likely to disclose if her clients’ “diagnoses were similar to mine or something I could relate to,” as it would make her disclosure more relevant and therefore useful. She also expressed, however, that she would not disclose to certain types of disorders, articulating a perspective reflected in empirical findings that suggests that clinicians are more likely to disclose to clients with anxiety

and/or mood disorders than to those with psychotic, personality, or behavioral disorders: “I don’t see many people who are really chronically, severely mentally ill with psychotic or dissociative diagnoses, so I think that if that were the case I definitely wouldn’t be doing self-disclosure.”

Another survey participant emphasized the importance of client symptomatology in her disclosure decisions, but suggested that clients with high anxiety or who are very unwilling to try new interventions may not be able to make use of therapist self-disclosure:

Sharing is not effective...if the client is not willing to try interventions. Sometimes for people with very high anxiety and...panic attacks, it's hard for them to calm down enough to start trying calming interventions and some are not willing to try. – Survey Response

Thus, this clinician reported that even a serious anxiety disorder might also cause them to choose non-disclosure. Rather than worry about self-disclosure negatively impacting these clients, for this clinician, particular client attributes may simply preclude the effectiveness of disclosure as a therapeutic tool.

Other participants echoed the concerns Interviewee 2 made about symptom relevancy, but identified that these concerns lead them to not disclose: as one participant noted, “Sharing is not effective if one's symptoms are not very similar to the client's.” Two clinicians specifically reported that the perception that their own symptoms were not as severe as those of their clients lead them to choose non-disclosure, as they did not feel it would be helpful or relevant to disclose their own experiences in these cases. One clinician reported having a “very remote history; [I] have not had situation were I felt it [disclosure] would be of benefit.” Another explained that although she shared a similar type of diagnosis as her clients – anxiety – her symptoms varied both in type and degree from her clients to such an extent that she felt the disclosure would not be helpful:

I have not shared a lot of my experiences with clients because the adults that I have seen that have an anxiety disorder are more extreme in their symptoms than mine, and often they also suffer panic attacks, agoraphobia, OCD...My symptoms are more muted and not as dramatic, and not as ongoing throughout the day so that there is not always a common thread where I can share with them. – Survey Response

These clinicians highlighted the importance of making disclosures relevant to their clients' presenting concerns and diagnoses. They articulated that their own symptoms, while of a similar type, differed from those of their clients to such a degree that disclosure would not have been relevant to their clients and therefore would not have been of therapeutic benefit. Thus, while the quantitative data indicate a relationship between clinicians' concerns about client symptomatology and higher disclosure rates, the qualitative data suggest that clinicians' worries about symptom relevancy may be related non-disclosure. As a result, the exact relationship between client symptomatology and disclosure remains unclear in this study.

Appropriateness of Timing

Just over half of clinicians identified that appropriate timing influenced their decisions to disclose or not disclose. While statistical analysis suggests that clinicians who selected timing as a concern had higher mean disclosure rates than those who did not ($p = .021$), it remains unclear as to why this factor was associated with greater average disclosure rates. While only a few qualitative survey responses elaborated on this element, both interviewees emphasized its importance. All responses focused on timing as it related to the process of building the therapeutic relationship, with participants providing different perspectives on how the use of self-disclosure related to the development of the working alliance. One clinician reported using self-disclosure as a tool to develop rapport with clients in the beginning stages of the relationship, a perspective consistent with findings in other self-disclosure research: "I've utilized

disclosure to normalize a patient's feelings regarding therapy participation, which was effective in relationship building." However, other survey participants and both interviewees articulated an opposing perspective – also noted in self-disclosure research – that they used self-disclosure only *after* they had established the therapeutic relationship with the client. Interviewee 1 identified that the prior establishment of a working alliance was necessary before he considered self-disclosing, in order to clearly establish the focus on the client and thus avoid the client's misinterpreting the self-disclosure as the therapist's seeking to shift the focus onto himself: "I think the first factor would be that my therapeutic relationship with the person has to be fairly mature – so that it doesn't come out wrong that I'm using this for my therapy rather than theirs." Similarly, Interviewee 2 identified the importance of establishing the client's trust in the therapist's competency and intentions before disclosing: "This isn't like something I'd do in the first session, this is after I feel like we've got some rapport, and if I feel like this client trusts me and believes that I've got some intuition and perspective to offer." Other survey participants echoed the responses found in the interviews: "After having built a therapeutic relationship with the client, it has been effective to share personal coping strategies which can be directly applied to the client's presenting issues."

Interestingly, one survey participant identified that her only self-disclosure in her career about her experience with an anxiety and/or mood disorder occurred during termination, in response to her client's direct questioning:

[I] only disclosed directly once, in over a decade of practice. We were terminating, as [the] client was moving; she was planning to continue seeking treatment for [a] mood disorder, which she had struggled with without support for years. She asked me if I had ever dealt with [a] similar [mood disorder], and if I thought it was really possible to feel better, at which point I disclosed... [I] [w]as not able to monitor long term impact of this disclosure, but it was clearly effective/helpful for her at the time, and my sense is that that probably has not changed.– Survey Response

Thus, this clinician appeared to perceive that this disclosure was made more appropriate by its timing in termination, and perhaps as well due to its being in response to her client's direct questioning. Yet, as she noted, one of the impacts of self-disclosure in termination is that she was unable to monitor the impacts of the disclosure beyond its effects on her client in the immediate session.

Concerns About Revealing Confidential Personal Information

Half of all respondents identified that concerns about revealing their own personal health information impacted their decisions about disclosure. Although only a few respondents provided explanations for these concerns, they appeared to be related with non-disclosure and to stem from fears about what clients might do with the information, a finding supported by the statistical analyses that found this factor was associated with lower mean disclosure rates ($p = .011$). These fears ranged from general breaches of the therapist's confidentiality, to using the clinician's information for adverse purposes. As one clinician noted, "Who knows if they [clients] will keep confidence?" Another respondent reported that self-disclosure raised safety concerns due to the population with whom she worked: "I work with a criminally mandated population who may use this disclosure to obtain more than necessary information about me personally."

Instilling Hope

The desire to instill hope emerged as one of the primary factors guiding clinicians' decisions to disclose information about their own diagnoses with their clients. Clinicians who chose this factor had statistically significant higher mean disclosure rates than those who did not;

indeed, this factor was the factor most significantly related to higher mean rates of disclosure of all the factors analyzed ($p = .000$). Roughly 50% of clinicians identified this as an important factor on the “Guiding Factors” question on the survey, and it was one of the most highly referenced factors in the qualitative components of the survey and in the interviews. Most disclosures aimed at instilling hope focused either on instilling hope of recovery, hope of ability to manage symptoms in general, or hope in the efficacy of treatments or of specific coping skills, as illustrated in the quotes below:

I have used disclosure to inform a client that I once had panic attacks but through help and coping skills that I do not have them anymore. This disclosure helped the client see that there is hope in recovery and that many people who are high functioning (like their therapist) can have symptoms and be okay. – Survey Response

[My client] asked me if I had ever dealt with [a] similar [mood disorder], and if I thought it was really possible to feel better, at which point I disclosed some of my history, changes in how I saw the world before I felt better and since, and coping and some treatment strategies I had used/continued to use. I explored with her how it felt to hear these things, she stated that it made her feel much more hopeful about her own life. –Survey Response

[To a] client with PTSD, [I] disclosed how it takes a lot of hard work but that it can be resolved so it doesn't take over your entire life. This client felt hopeful that her symptoms would decrease with therapy. – Survey Response

[A] client who was hesitant about whether therapy could help, asked directly whether I had ever benefited from such treatment. I was able to say yes and offer specific instances where this was so. – Survey Response

These disclosures appear to focus on instilling hope by emphasizing the prospect of recovery or symptom management through therapeutic treatments and the use of coping skills. When making these disclosures, clinicians often identified specific treatments or coping strategies that they had found helpful; indeed, as discussed in a later section, disclosing coping strategies was the overwhelmingly most common type of personal information related to their own diagnoses that clinicians shared with their clients.

These disclosures instill hope primarily by emphasizing the efficacy of treatment, and demonstrate the agency of the clinicians primarily through their decisions to pursue different treatment strategies or select coping skills. Thus, these disclosures involve a subtle emphasis on external factors; although they acknowledge the role of the individual making the disclosure in their recovery, their explicit reference is to the healing capacity of treatment rather than the internal sources of healing within the client. Another type of disclosure, however, appears to instill hope by emphasizing the capacity for self-change within the individual and thus the client. These disclosures seek to present behavioral and attitudinal changes that the clinician found helpful, so that clients can consider similar ways to empower themselves and attain greater agency over their symptoms:

Primarily, where I will self-disclose as far as depression is concerned, is to help people to *see* that you can act beyond how your depression tells you to act. And, you *can* live your daily life, even when you don't feel like it. When your energy or your interest or your motivation is depressed, you still can pursue a life and pursue activities that day that you value and that are important to you. – Interviewee 1

Interestingly, all disclosures aimed at instilling hope seem to inherently contain an element of modeling, as they demonstrated an attitude or perspective on mental illness and treatment that the clinician found helpful. Thus, there appears to be an overlap in functionality of disclosures that simultaneously instill hope and model important attitudes and perspectives.

Additional Reasons Cited for Disclosure or Non-Disclosure

Throughout the qualitative components of the survey and the interviews, clinicians identified a variety of reasons beyond the scope of the multiple choice options for their decisions to either disclose or not disclose. The following sections explore the most salient of these factors described by the survey and interview participants.

Concerns About Client Functioning and Stability

A number of participants highlighted the role of particular client attributes in influencing their decisions either to disclose or not disclose. One clinician mentioned above suggested that the client's functioning level was integral to tipping the balance of her decision to self-disclose, stating "I usually disclose if the client is particularly insightful and high functioning, [and] won't be harmed by the information." Interviewee 2 cited similar concerns, stating that assessing her clients' "degree of insights or their ability to see the big picture," and "whether I feel like [the client] would understand my disclosure, and not misunderstand it" was an important part of her analysis when she considered disclosing. She also highlighted that perceiving that the client would benefit from a sense of joining or connection with her factored into her decision to disclose. Another clinician discussed concerns about the impacts of disclosure depending upon the client's stability:

While I am very open about anxiety, I think unless the [client] is stable it can cause distrust or even make them feel pressurized to use the exact same coping skills you used since they worked for you. – Survey Response

This clinician worried that disclosing to unstable clients could negatively affect both the therapeutic relationship and clients' progress, as it could engender client distrust in the therapist or make them feel pressured to employ coping skills merely because the therapist had endorsed them, rather than due to their therapeutic benefit or relevance to the clients' presenting concerns. Thus, although multiple participants identified client attributes as affecting their disclosure choices, they differed in their opinions about what, how and why these factors affected their clinical decisions.

Impacts of Theoretical Orientation

Interestingly, only a few clinicians directly referred to aspects of theoretical orientation as impacting their self-disclosure decisions. One clinician identified that some disclosure was inherent to practicing Dialectical Behavioral Therapy, in particular with respect to coping skills, therefore explicitly connecting her orientation to her disclosure practices. The only other aspects of orientation participants referenced related to classical psychodynamic concepts and the perception that disclosure interferes with transference. Thus, theory appeared to impact rationales both for disclosure and for non-disclosure; but, in general, participants in this study did not explicitly connect their decisions regarding disclosure to theoretical principles.

Disclosure in Direct Response to Client Questioning

Three participants reported that their disclosures occurred in response to direct client questioning about their therapists' experiences. While these disclosures occurred within a broader treatment context that may have suggested self-disclosure for other reasons, these clinicians appeared to attribute their self-disclosures to their clients' questioning, and did not indicate that they would have disclosed otherwise:

I had a [client] who was having very frequent panic attacks...Having suffered from terrible panic attacks throughout high school and college - I empathized with her. At first I just gave coping skills and tried to help her identify her triggers...She asked me a few weeks later if I had suffered from them due to the nature in which I was advising her- I felt given our rapport it would be ok to disclose that I did. – Survey Response

[A] [c]lient who was hesitant about whether therapy could help, asked directly whether I had ever benefited from such treatment. I was able to say yes and offer specific instances where this was so. – Survey Response

I have actually only disclosed directly once, in the context of being asked directly by a client whom I was in the process of terminating with [due to] client relocating. – Survey Response

These clinicians appeared to feel comfortable with self-disclosing in response to their clients' questions, perhaps because they occurred in such explicit context of client material. Importantly, these disclosures seemed to be isolated events that were not connected to further client questioning. Interestingly, Interviewee 1 highlighted how extended client questioning raises additional ethical and clinical considerations regarding the use of self-disclosure, as it may shift the motivation and therapeutic benefit of the disclosure: "The engaging moments are when people ask for more details and I have maintain boundaries due to the therapeutic motivation [of] the disclosure."

Providing Information & Normalizing Client Experience and Treatment Options

A number of participants reported making disclosures in order to provide the client with information that they felt would advance the client's understanding and assist them to make informed decisions regarding their treatment. An important component of this "information providing" rationale was related to dispelling misguided fears or misunderstandings about treatment strategies, most particularly about medication:

You know, people have expressed fears [about medication] like...it's going to make me not feel anything, or it's going to change my personality; they're afraid of all sorts of things, and I just try and let them know *my* experiences and those of other clients so that they can realize it's not that scary, and very few people have severe side effects, and so on and you know, to get off of an anti-depressant if it's not working for you. – Interviewee 2

[An effective disclosure was] [s]haring the difference that medication made in the symptoms. – Survey Response

Thus, clinicians used these disclosures to incorporate important educational opportunities into treatment that assisted clients in making informed decisions, while respecting client autonomy and leaving space for the client's own expertise by emphasizing the personal quality of the information presented.

Participants also identified a related, and oftentimes overlapping, rationale for these and similar disclosures: they reported that they disclosed for the purpose of normalizing the client's experience or treatment options, most particularly medication:

[A] young adult client felt that taking SSRIs for anxiety and mild depression would confirm that she is "crazy" and unlike her peers. Because I had been working with this client for almost a year and had strong rapport, I shared that I take SSRIs and many of my colleagues and friends do as well, in an effort to normalize the option of seeking psychopharmaceutical treatment. – Survey Response

A client shared...appreciation for knowing how common depression was and that I tried several avenues of treatment. –Survey Response

[For a] lot of people with depression, part of the symptomology is a negative self-view, right? So you know, people will sometimes be putting themselves down for feeling down...And that's when sometimes I will self-disclose, to normalize it. – Interviewee 2

Thus, beyond merely providing information, these clinicians shared their experiences with the symptomatology of their disorders in order to normalize clients' experiences, as well as their experiences with treatment options to demystify them and open dialogue about the options their clients were considering. An important theme that emerged in these normalizing disclosures was the prevalence of disclosures aimed at normalizing medication specifically as a treatment strategy. This appears to be related to the perception by clinicians that medication carries with it a particular stigma, as mentioned above, and that a significant percentage of clients tend to be resistant to it: As Interviewee 2 stated, "I'd have to say that a surprising number of people are still resistant to medication for treatment of mental health symptoms."

Thus, an important connection appears to exist between disclosures aimed at normalizing treatment strategies and those providing information about them in order to facilitate client informed decision-making: these disclosure tended to overlap, as providing information about treatment options also often serves to normalize and demystify them.

Modeling Healthy Behaviors and Attitudes: Destigmatizing Symptoms and Treatment

Clinicians who chose to self-disclose often reported using self-disclosure to model healthy perspectives and approaches to their clients. These disclosures appeared to serve modeling functions in their latent and manifest content: not only did these disclosures provide the lived experiences and perspectives of the clinician as an example, but the act of disclosure itself modeled important attitudes and approaches to mental illness and recovery. Oftentimes, as mentioned earlier, these disclosures also aimed at instilling hope in the client.

An emphasis on modeling rejection of the shame and stigma often associated with mental illness emerged in the interview component of this study. Both interview participants reported that through their self-disclosures, they sought to model to their clients that they had no reason to be ashamed of their disorder:

I'm not hiding anything shameful, and I think maybe that's one of the benefits in self-disclosure: if I model for my patients, when appropriate, that it's not a shameful thing to be depressed; it's a biological fact, a biological, psychological fact of life for us, and we can either own it and learn how to live our life in spite of it, or we can let it dominate our life and cripple us...we have that choice. We don't always have a choice of how we feel, we have a choice of what we choose to do in *spite* of how we feel. – Interviewee 1

I'm not ashamed of the fact that I have depression...and so I want to model that, I want to live in a place of not being ashamed of who I am. – Interviewee 2

Disclosures about medication also contained a common theme of reducing the stigma associated with medication, as illustrated in the above section on normalizing. While clinicians appeared to use these disclosures primarily to normalize and educate the client about medication as a treatment option, they simultaneously modeled a perspective on medication that challenged its stigma. Thus, while a variety of factors guided these clinicians' decision to disclose, the desire to open treatment avenues for the client by dispelling the stigma associated with medication and model a normalizing attitude were integral.

Impasses & Client Ambivalence to Treatment: Expanding Treatment Options

Participants identified that there were specific treatment situations that would compel them to self-disclose: clinicians reported self-disclosing when they perceived a client was ambivalent about or resistant to pursuing treatment that the clinician felt might help, or otherwise “stuck” and unable to make progress. Survey responses suggested that disclosures aimed at helping a client who was ambivalent or skeptical of treatment most often served to provide information and related most often to medication, coping skills, or specific treatments that the clinician had experienced.

I usually disclose if the client is particularly insightful and high functioning, won't be harmed by the information and is ambivalent about taking medication. – Survey Response

A client was adamant that coping skills are ineffective. [We] discussed various coping skills that have helped this writer in the past and the client was willing to give them a try. – Survey Response

I had a client who was experiencing daily panic attacks. She was hesitant to stop taking benzos, and do formal exposure. She told me that I don't have to live with the panic attacks. The way I told her that actually, she does not know my background, was an indirect, but very effective disclosure. It lead to discussion about her belief that people cannot recover. – Survey Response

Interestingly, these disclosures appeared to have the aim of also expanding the client's treatment options, by providing information that might open the client to exploring new treatment options. Clinicians reported that these self-disclosures did indeed appear to advance the client's willingness to try previously unexplored treatment avenues, as evidenced by the quotes above and the following quotes:

A client was skeptical of mindfulness, and was willing to try it more [after the disclosure]. – Survey Response

Yes, it [the disclosure] was effective. [The] [c]lient seemed encouraged, and more open to considering a range of possible treatments. – Survey Response

Other clinicians reported that they would need to perceive the client to be “stuck” or treatment to be at an impasse before they would consider disclosing, thus suggesting that they used self-disclosure only when necessary as a final effort to progress the treatment:

There was one case where a client simply did not try anything and I finally did bring this up. In this case, even though the client got a bit defensive and said that she felt I did not understand her limitations, that evening the client contacted me and thanked me for the session and said that she felt it had been really helpful. – Survey Response

A person would have to be just quite stuck in being unable to profit from what we have been trying to do without self-disclosure. It might be one of those kind of last ditch things in terms of helping to get the person unstuck. Let’s say a person is so overwhelmed by their lethargy from their depression, and we haven’t been able to get around that... then I might use some of the self-disclosure. – Interviewee 1

Both of these disclosures sought to bring about change and move the therapeutic process out of an entrenched impasse. These clinicians’ emphasis on the “last ditch” nature of their disclosures – that they were used as a last resort when all other avenues had failed – suggests the power of self-disclosure and offers one explanation for the rarity of these disclosures.

Coming Alongside: Joining, Sharing Experience, Promoting Egalitarianism and Empowering the Client

Multiple participants emphasized the important joining function that self-disclosure often served, and identified that sharing information through the revelation of their own personal experience often increased its influence on the client:

[My] [p]atient was not getting adequate treatment for her symptoms. She was losing faith in herself and starting to go into a self-criticism loop. We discussed that others find themselves in the situation of finding it hard to get appropriate treatment if you do not fit in pre defined boxes. I shared I had similar difficulties and recognized how hard it was and from that place of twinship that she was not alone. [The] [i]ssue is not resolved but client keeps fighting. – Survey Response

When teaching DBT skills I often will disclose that I find a particular skill helpful. Usually the client is then more likely to want to learn and practice the skill. – Survey Response

These quotes suggest that clinicians were aware of the parallel processes that were often elicited by self-disclosures: beyond providing information or instilling hope, they emphasized that disclosing their own personal experience helped them to join with their clients and to influence their clients in a way that was distinct from if they had merely presented the information in an impersonal manner.

Indeed, beyond merely joining with their clients and working from a place of twinship, a number of participants reported that by self-disclosing and sharing their own experience, they changed how they related to their clients in such a way that the disclosure empowered their clients to engage in their own process of self-development and growth:

Knowledge is power, and knowing that there is a wide range of experiences is helpful...[My clients are] the expert on them, and I'm not. You know, I have training and experience, but I'm not *the* expert... I kind of resist that role, and I believe that healing comes from within, and we each have our own path to it and ways of discovering what's best for us. And I really want to empower folks to trust their own inner judgment and where they are at that moment to make the best decisions for themselves about how to deal with things. – Interviewee 2

I'm not the expert, but a fellow journeyer, and I'm sharing perspectives and experiences with people...I never have and I don't now see myself as the person who fixes someone else or has the answers – but rather helping them to think through and process through until they find their own answers. – Interviewee 1

These clinicians suggested that they use self-disclosure to equalize power within the therapeutic relationship, and as an invitation to their clients to engage as active agents in their own treatment. In this regard, they highlighted the importance of emphasizing to their clients that their disclosures were only meant to share their own personal experience and encouraging their clients to only take what felt relevant or helpful from the disclosures:

I really try to make sure that people realize that whatever they choose is certainly their choice, I'm not trying to bias them, but I just want them to know, you know, this has been my experience. – Interviewee 2

[A]nother principle that I always use is that I always emphasize with [my clients], this is my experience and take what might fit for you and let go of the rest. I don't pretend to be a model for everyone, but you know, if it fits, if it helps, fine, if it doesn't, you're welcome to just let go of it. – Interviewee 1

In similar fashion, another clinician identified that she uses disclosure about her own history in order to inform her clients about the particular perspective she brings to therapy about the role of “learned behavior” and “environment” in symptomatology, thus promoting her clients' agency in selecting and evaluating their therapist. Thus, by offering up their personal experience, these clinicians altered the power relations in the therapeutic dyad and encouraged their clients to engage critically with the material of the disclosure, thus highlighting their clients' expertise and autonomy, and inviting them to collaborate in the therapeutic process as partners.

Disclosing from a Place of the Clinician's Own Symptomatology

Interestingly, only one survey participant identified that his own symptomatology at times lead to disclosures that were driven more by his anxiety than by his perception of client benefit:

I'm not sure [about an ineffective disclosure]. Although I'm confident I have shared purely for the sake of feeling anxious in the moment...and it was less helpful for myself or anyone involved... Sometimes I've probably not been able to repair [the situation]...or I acknowledge what might have been going on for me. – Survey Response

Thus, this participant appears to be an outlier among the sample of this study. Although he cited benefit to client as his primary rationale for his decision-making, he also identified being aware that at times, his own symptomatology affected his capacity to act in ways that advanced the

client's best interest, and that he made disclosures as a result of his own anxiety. While he repaired these situations by acknowledging what was happening for him at the time, he also admitted that sometimes repair in these contexts was not possible, thus suggesting once again the powerful impacts self-disclosure can engender. The outlier status of this participant's response suggests that in general, having an anxiety and/or mood disorder does not appear to affect clinicians' capacity to use self-disclosure in a clinically judicious manner.

Types of Information Disclosed

Clinicians reported disclosing multiple categories of information to their clients relating to their diagnoses. Almost 80% of clinicians reported disclosing personal experience with effective coping strategies, making this information overwhelmingly the most popular disclosure content reported in this study. The frequency with which clinicians identified disclosing personal experience with medication, personal experience in therapy, and personal experience with symptoms appears to be fairly evenly distributed, with between 27.8% and 36.1% of clinicians reporting having disclosed these categories of information. Although an additional 25% of clinicians indicated that they disclosed other types of information, most of these responses related to generalized disclosures that included the clinician within a broader group, and were not necessarily true forms of self-disclosure.

TABLE 2.3

Category of Information	Number of Participants	Percent of Total Respondents
Personal experience with medication	10	27.8%
Personal experience in therapy	13	36.1%
Personal experience with symptoms of the diagnosis	12	33.3%
Personal experience with effective coping strategies	28	77.8%
Other	9	25%

Most of the disclosures discussed by clinicians in the qualitative components of this study related to or included sharing coping skills. Clinicians reported disclosing coping skills in both group and individual therapy settings, primarily with the goal of educating their clients, instilling hope, and providing information to help them make informed decisions as well as to increase client buy-in for trying these skills.

With clients, it's helpful when I have a life coping skill that is something they can identify with and use, and they know that I have experienced something similar to them. – Survey Response

When teaching DBT skills I often will disclose that I find a particular skill helpful. Usually the client is then more likely to want to learn and practice the skill. – Survey Response

I've...disclosed information about the use of coping skills to provide psychoeducation regarding the use or benefits of those skills. –Survey Response

Interestingly, while less than 30% of clinicians reported disclosing their experiences with medication, disclosures about medication were widely represented in the qualitative survey material as well as in the interviews. As highlighted in the previous sections on clinicians' rationales for self-disclosure, therapists cited self-disclosing about their own use of medications in order to dispel fears and stigmas associated with medication, to normalize it as a treatment option, and to educate clients about its use and consequences.

While clinicians often reported disclosing coping skills alone, when clinicians disclosed about their symptomatology they often did so in tandem with providing information about their experiences with treatment, medication, effective coping skills or healthy behaviors and attitudes they found helpful. Thus, while coping skills appeared to constitute a "stand-alone" disclosure, no clinicians identified an instance of direct disclosure of their symptomatology without mentioning some of these additional experiences. Clinicians' decisions to include information about treatment, coping skills, and attitudinal/behavioral changes – which can be seen as positive and emphasizing agency/action in the face of symptoms – may be related to concerns about not wishing to burden or overwhelm the client, and serve as a means of reducing the risk that the disclosure would elicit client caretaking of the therapist and increasing the likelihood of instilling hope. Indeed, one clinician identified concerns with disclosing the clinician's symptomatology specifically, asserting that sharing information about one's own symptoms constituted content that risked being overly intimate and frightening the client: "I think it can be overbearing and intimidating to a patient to tell them about your own symptomatology."

Finally, as alluded to above, clinicians cited a range in the types of information they disclosed, with some clinicians disclosing only one type of information, while a number of

clinicians explicitly identified that they disclosed multiple types of information to their clients about their experiences with their diagnoses:

I described personal experience with meds, counseling and other coping strategies. –Survey Response

I sometimes disclose...experiences I had...when I was significantly depressed, due to some other situational factors. And sometimes I will disclose mistakes I've made and...ways in which I got myself out of my own funk. Sometimes I will also disclose the fact that – I guess I use it to model that we have a responsibility to reach out for the help we need...when I was most depressed, all my so-called friends stayed away in droves. And, I had to take the responsibility of asking specific friends if they would be there, if I could sit down and talk with them, and that made a big difference when I took that ownership of asking for the help I needed. –Interviewee 1

Thus, while coping skills constituted the most common disclosure reported on this survey, clinicians often shared multiple types of information about their own experiences with an anxiety and/or mood disorder. Furthermore, the disclosure of their own experiences with the symptoms of their disorder did not appear to be given to clients without additional disclosures relating to their progress or management of those symptoms.

Clinicians' Perceptions of Self-Disclosure's Efficacy

While clinicians' perceptions of the effectiveness of their disclosures varied, the overwhelming majority of clinicians responding to the question of efficacy reported they believed their disclosures had at least some degree of efficacy. Most participants (81%) fell within the middle two groupings, identifying their disclosures as either "effective" or "somewhat effective," with slightly greater representation in the "somewhat effective" category. Additionally, just over 50% of all survey participants who engaged in self-disclosure considered their disclosures to be either "effective" or "very effective." Only 5% of participants reported their disclosures were "not at all effective." Interestingly, this study found a significant, positive

correlation between perception of efficacy and disclosure rates: as clinicians' perception of efficacy increases, so does their disclosure rate ($p = .000$).

TABLE 2.4

Degree of Effectiveness	Number of Participants	Percent of Total Respondents
Not at all effective	2	5.4%
Somewhat effective	16	43.2%
Effective	14	37.8%
Very effective	5	13.5%

Uncertainty about the efficacy of self-disclosure and the difficulty of appraising its impact, however, was a concern repeatedly articulated among survey and interview participants. Clinicians reported being unsure of how their disclosures affected their clients, beyond what their intuition told them, unless their clients specifically voiced their reactions.

It's hard to measure how much and when it really is effective. Sometimes years later a patient will disclose that it was helpful to hear this information. – Survey Response

Hard to rate the effectiveness beyond that it seemed appreciated by the client. I didn't solicit specific reaction then or later from client about the disclosure. – Survey Response

It's not always clear whether any insights, information or interpretation is effective in that moment. In both cases I've used self-disclosure it would be difficult to measure efficacy--although it did not appear to damage the therapeutic relationship or working alliance in any way. – Survey Response

Not sure how I'd know it wasn't [effective], other than speculation that client may have thought I was biased about meds because I shared I used them. – Survey Response

I perceive it to be pretty effective. I mean, I think it's been helpful in most cases. And you know what, the truth is I've never got feedback or asked a client, so how did it affect you. – Interviewee 2

For the most part, I think it has been fairly effective. Although if a person seems to make progress, it's pretty hard to know exactly what you can attribute that to. – Interviewee 1

Almost universally, interview and survey participants' responses suggested that they had not explored their clients' reactions to their disclosures, and that as a direct result, they felt more uncertain about the impacts of their disclosures and had to rely on intuition alone to guide their analysis. These findings are surprising given the emphasis in the extant literature on the integral nature of exploring the disclosure's impacts on the client to the intervention itself. Only two participants described discussing the consequences of their disclosures with their clients. In one case, the disclosure negatively impacted the client, and the clinician reported "We discussed how difficult it was to know something specific/personal about me." In the other case, the client and clinician explored how the disclosure – made during termination – had made the client more hopeful:

I explored with [the client] how it felt to hear these things, she stated that it made her feel much more hopeful about her own life. [I] [w]as not able to monitor long term impact of this disclosure, but it was clearly effective/helpful for her at the time, and my sense is that that probably has not changed. – Survey Response

As a result of directly exploring the client's response to the disclosure, this clinician appeared to feel more confident in her assessment of its efficacy. This participant also suggested that had the disclosure not occurred during termination, she would have monitored its impact as the therapy progressed, and therefore appeared to have a more long-term approach to integrating the intervention into the therapeutic process than that articulated by most other participants.

Hesitancy Discussing Disclosures

Most clinicians reported they felt some degree of hesitancy to discuss their disclosures of their diagnosis with other clinicians: 17% reported feeling “very hesitant,” and 30% reported feeling “hesitant.” An additional 35% reported feeling “somewhat hesitant,” and only 17% of clinicians reported feeling “not at all hesitant.” Participants’ level of hesitancy was not found to be significantly related to their years of clinical practice or to the currency of their diagnosis.

TABLE 2.5

Degree of Hesitancy	Number of Participants	Percent of Total Respondents
Not at all hesitant	8	17.4%
Somewhat hesitant	16	34.8%
Hesitant	14	30.4%
Very hesitant	8	17.4%

Two clinicians – one interview participant and one survey participant – reported significant concerns about discussing their diagnoses or related self-disclosures with other professionals in the field. They identified concerns regarding how such a disclosure could impact their employment, both in terms of obtaining and maintaining jobs, and suggested that they viewed the broader mental health community as competitive and unsympathetic towards individuals with mental health issues:

I have been a social worker for 12 years now, first in a family services agency and more recently in home care agencies. The agencies, and colleagues outside them, are competitive and assertive. I don't want anyone knowing I have a diagnosis of mental illness. I simply keep medical issues to myself, except when I needed a total knee replacement, or have prolonged bronchitis, or something else obvious.

–Survey Response

I haven't talked about my depression hardly at all in the social work community ... I would feel more guarded with potential employers or... professional colleagues than I would be, you know, with a client... Because I've seen full well the way employers deal with people who have mental health problems. And it's not in a kind or understanding way in a lot of cases. And that's also the case in the medical community and the mental health community: unfortunately, we don't take very good care of our own. – Interviewee 1

While these therapists felt primarily silenced around their identities as individuals with mental illness, Interviewee 2 reported that she felt her colleagues generally accepted that therapists lived with mental illness and were also therapy clients, but identified that she felt censured primarily around her use of self-disclosure:

I think that most people are anti-self disclosure on almost any level, so I would have to say that it is my belief that most of the therapists I know are thinking and were taught that you don't self-disclose, and that it's not therapeutic... I don't hear people talking about it, it's not something that's brought up in workshops, you know?... I would say *most* of the people that I know who are therapists – not most actually, but a lot of them – have been in therapy or have... clients that are therapists, and I've had clients that were therapists, so I think that that's out there, and that's well-known... Therapists are seeking help, but they're not necessarily going to share that with their own clients. – Interviewee 2

This participant articulated views quite distinct from those cited above, reporting greater concern about sharing her use of self-disclosure with her colleagues than her diagnosis. For this clinician, although she felt the clinical community normalized mental illness and therapy participation in the personal lives of therapists, she believed that self-disclosure in general, as well as specifically of therapist experience with mental illness, was considered untherapeutic and remained stigmatized.

Effective and Ineffective Disclosures:

Participants reported a wide array of effective disclosures in both the survey and interview components of this study. The most common attributes of effective disclosures were that they were aimed at instilling hope, usually involved the sharing of coping skills, and

occurred when the client was stuck or treatment was at an impasse. Additional qualities of effective disclosures were that they normalized the client's experience and/or treatment strategies, occurred in response to client's direct questioning, and aimed at modeling healthy behaviors, attitudes, and perspectives for the client. Participants identified that these disclosures appeared to make their clients hopeful and more open to exploring different treatment options.

Interviewee 1 provided a detailed example of a disclosure he perceived to be effective:

[My client] has seasonal effective disorder with depression, post traumatic stress disorder because of an extremely violent past she's had, and currently is in...a psychologically abusive relationship, and basically stated to me when we first started some time ago, that life was hopeless...why should she go on...She was one of the people that was very stuck, and I disclosed for her how I had found a way to keep on doing my work in spite of not feeling like it, in spite of being extremely depressed, and that going on and doing something each day that I knew was meaningful, even though it didn't feel meaningful at the time and I didn't feel like doing it...was really important to getting through that period for me. And I think it opened up for her the possibility for her that she could do something similar too. – Interviewee 1

This disclosure contained many of the elements of other effective disclosures reported in this study: it occurred during an impasse in treatment, involved modeling healthy attitudes and behaviors, shared coping strategies, and helped to instill hope in the client. Interestingly, only three participants – one survey and both interview participants – provided examples of ineffective disclosures.

I can remember telling a client that I take an antidepressant and the client was still not willing to take one. – Survey Response

I shared about my history and anti-depressants and how my experience made me feel more open-minded about antidepressants, because I was rather anti-medical for years... and I think I got the feedback from somebody that they felt like I was trying to convince them to take medicine, and so that I would say was a backfire.
– Interviewee 2

[It] doesn't come to mind right now where [disclosure] really backfired. I've had some situations where people have basically shown me by their words or actions that they still didn't buy that this was possible for them. And sometimes, they just cannot see past – they cannot trust that they can do something like this, they may drop out of therapy. But I haven't had any situations where it obviously dramatically backfired on me...[but] the people were still caught in their hopelessness, and that did win the day. – Interviewee 1

Interestingly, in two out of three of these ineffective disclosures, the consequences were that the disclosure merely failed to be useful or to progress the therapy, rather than that it harmed the client. In the third disclosure, it appears that the disclosure did negatively impact the client, by making the client feel pressured to take medication. Additionally, two out of the three disclosures related to medication specifically; perhaps these disclosures were particularly difficult due to the stigma associated with medication, which tends to create strong opinions about the use of medication.

Only two clinicians reported information about how they repaired ineffective disclosures. Both reported that discussing the disclosure with their clients served as an important vehicle for repairing the situation:

We discussed how difficult it was to know something specific/personal about me.
– Survey Response

I repaired [the disclosure] by just reiterating you know I'm sorry, that wasn't what I meant, trying to help clarify that this was certainly their choice and I was sharing my experience to see if they would...be open to knowing that in my case, it made me more aware of the potential benefits. – Interviewee 2

For one clinician, discussing the disclosure involved clarifying her intentions in making the disclosure, and emphasizing the client's agency in how they wished to use the information. For the other clinician, exploring the meaning of the disclosure and its emotional impact on the client helped to repair the situation. While conclusions cannot be drawn from these two examples alone, it seems that these reports echo suggestions made in the literature and highlight important

strategies for repairing ineffective disclosures, particularly if the disclosure has negatively impacted the client.

Impacts of Diagnosis on Clinical Practice: Acceptance of an Anxiety and/or Mood Disorder

Clinicians highlighted that their own experiences with an anxiety and/or mood disorder informed their approach to treatment on a number of levels. Both interview participants identified that their own personal process of accepting or understanding their diagnosis had important impacts on their work with their clients. For Interviewee 1, accepting his depression allowed him to have greater agency and management over his own symptoms, and as a result, his practice:

[I]t was actually much more difficult for me to deal with [my depression] earlier on in my life, because I did not admit that that was the case for me. I constantly blamed the fact that I was feeling miserable and lacking in energy and had a very negative outlook – I was blaming that on external factors. And the more I did that, and was trying to change things on the outside, of course it didn't help...It's actually been a lot easier to deal with once I've owned the fact that I do have episodes of depression, and I've owned how they effect me - it has allowed me to go on to do my daily work no matter how I feel, because I know that if I'm struggling today or feeling down or having a negative outlook, I know where that's coming from. – Interviewee 1

Interviewee 1 emphasized that his experiences with his depression offered important, personal learning opportunities that affected his own approach to and understanding of therapy. In discussing the impacts of his depression on his ability to be present in his work with his clients, Interviewee 1 highlighted how accepting his diagnosis has helped him to strategically manage the symptoms of his depression, and constituted an important facet of his clinical development:

[B]eing depressed makes it harder to come to work, and I have to be aware that if I am feeling negatively about something or have a negative attitude towards something, or I'm just not be feeling as sharp on a given day, if its during a time when I'm depressed, then...I can change my expectations of myself and I don't have to change myself or set unrealistic expectations for myself – I know that this is part of what goes with practicing at that time. So I can accept the fact that there are days when I'm going to be sharper than others. – Interviewee 1

Thus, for Interviewee 1, his own experiences with his depression emphasized the importance of attitudinal and behavioral changes and the power of shifting internal ways of relating to his depression – perspectives that he currently emphasizes through self-disclosure with his own clients. For Interviewee 2, her own process of coming to understand her diagnosis played a similarly critical role in developing the perspective with which she currently approaches clinical work:

I don't think I even realized how many years I had depression....So I think [this experience] just enabled me to understand how hard it is sometimes to get the diagnosis and to understand what's going on with oneself. And the other thing ...is just the recognition that...so many people on my side of the family have mood or anxiety disorders, and I really believe that there's a huge biological or genetic component. So...that helped me to normalize it, and to just understand how important understanding biology and family history is. – Interviewee 2

Thus, Interviewee 2 reported that her experiences provided her with an experientially based understanding of the difficulties of obtaining a diagnosis, as well as the importance of understanding the biological and interpersonal underpinnings of mental illness. Similarly to Interviewee 1, she reported that these perspectives continue to guide the lens through which she understands and interacts with her own clients, and how and when she chooses to self-disclose about her own experiences.

Using Personal Experience to Inform but not to Assume: The Facilitation of Empathy

Clinicians identified that their own experiences with an anxiety and/or mood disorder acted as an important gateway for understanding their clients' experiences, and facilitated their capacity to access empathy for their clients and to be non-judgmental. They emphasized that this sense of connection had to be mediated by careful attention to the client as an individual, and that while they used their own experiences to inform their knowledge of the client, they were mindful to not assume that they shared the same experience with their clients:

I think that it helps me to be more empathetic for some of the struggles that [my clients] have. When people talk to me about everything feeling hopeless, or when they talk to me about feeling totally worthless, or when they talk about not having the energy to get up and get moving, I know what they're talking about...I know that I'm not in their shoes; [but] I know what that was like for me...and I have a sense of how hard it is to do some of this... It's not that I assume that...they're feeling the same way I did; but I know there's a parallel there. – Interviewee 1

I think I'm...more accepting, more understanding, when people describe stuff...I can often very much relate to what they're saying and feeling. I think [my experience] help[s] with empathy; the other thing is not being judgmental. – Interviewee 2

These clinicians reported that their own experiences helped them to understand their clients' symptoms and also their experiences in therapy. As Interviewee 2 noted, the years she spent not understanding what was happening to her and the difficulty she experienced in finally obtaining a diagnosis, helped inform her understanding of client experience both outside of therapy as well as in treatment: "I think it just enabled me to understand how hard it is sometimes to get the diagnosis and to understand what's going on with oneself." In particular, Interviewee 1 highlighted that his experiences in treatment helped him to understand the shame involved with diagnosis and treatment in an intimate and personal way:

I know that my own experiences in getting help helped me be much more sensitive to how threatening it is – how difficult it is for people to really reach out. Earlier on, I carried a great deal of shame and I had a difficult time – I think I had been getting help with my own depression for 3-4 years before I even told my own mom. And so I appreciate how that shame factor weighs heavy on people, and so that makes me more sensitive to how difficult it is for people to open up. It makes me more patient. If people start [therapy], and then bolt, I understand what that is. Sometimes they open up the doors and feel really vulnerable and are not ready to be that vulnerable.

For this clinician, his experiences that brought him into intimate contact with shame directly influenced his therapeutic judgment and interventions, as he sought to model for his clients the importance of accepting their disorder and rejecting any related stigma and shame. Similarly, multiple clinicians articulated that their own experiences in therapy provided an important rubric for guiding their decisions to disclose or not disclose with their own clients:

In my own therapy with psychiatrists, [and] therapists, I have never wanted to know whether any of them had a diagnosis of mental illness. While I have benefitted greatly from personal material they did share, mostly about the spiritual life, families, and professional interests, I specifically wanted any personal health or mental health topics off the table. – Survey Response

One of the things that's been helpful for me [in guiding my disclosure decisions] is...when I was in therapy myself, [my therapist's] disclosure...made an impact on me, and made me feel safer and feel better about, you know, this is ok, it's been helpful for me, I think it can be helpful for other people. – Interviewee 2

While one participant drew on her own experience of not wanting to hear information about her providers' mental health issues to arrive at a position of non-disclosure in her practice, another participant's experience with the positive impacts of receiving disclosures from her therapist lead her to engage in self-disclosure with her own clients. Thus, clinicians appear to draw on their own experiences to empathize with their clients, and this lived experience becomes an important source of information that guides their clinical judgment and approach to treatment.

CHAPTER V

Discussion

This study sought to gain insights into an emerging field of inquiry. Its purpose was to explore clinicians' use of self-disclosure to their clients regarding their own personal experience with an anxiety and/or mood disorder. Specifically, this study examined whether or not clinicians chose to disclose to their clients, and why; when, how and what information they shared if they did disclose; how effective they perceived their disclosures to be; and the extent to which they felt comfortable sharing their views and approaches towards self-disclosure of their own anxiety and/or mood disorder in the broader clinical community. In so doing, it sought to identify whether any connections existed between self-disclosure choices and the status and type of clinicians' diagnoses, their theoretical background, and years in clinical practice.

Primary Findings

Almost half of all clinicians in this study identified having a combined anxiety and mood disorder, a finding that may reflect the high comorbidity rates between anxiety and mood disorders. The majority of clinicians who participated in this study identified that their diagnosis was currently active, rather than past and resolved. The high representation of current diagnoses among the participants in this study is interesting in light of the frequent recommendations in literature that emphasize it is preferable to self-disclose only regarding resolved issues. However, the criteria for this study were that clinicians with current diagnoses perceive their disorders to

be managed, perhaps suggesting that a managed, current diagnosis may be similar enough to a resolved one to make self-disclosure a beneficial clinical tool.

A significant majority of clinicians participating in this study – 65% – identified disclosing information relating to their diagnosis at some point in their careers, while 35% of participants reported never disclosing. Thus, while these numbers suggest slightly lower disclosure rates for this specific form of disclosure than those found for disclosure in general (Edwards & Murdock, 1994; Pope et al., 1997), significant numbers of clinicians do disclose this information. For those participants who did disclose, all identified disclosures as infrequent interventions that they used “rarely” or “sometimes.” No participants in this study endorsed the frequent use of disclosure of their own experiences with an anxiety and/or mood disorder, a finding that corroborates the results of extant research on self-disclosure rates in general.

This study found clear trends in clinicians’ reasons for choosing self-disclosure or non-disclosure. The overwhelming majority of participants – almost 80% – identified that perceived benefit to the client was an important factor guiding their decision to either disclose or not disclose. In line with this emphasis on client benefit, roughly half of clinicians identified that concerns about appropriate timing and the desire to instill hope in their clients guided their decisions, while about a quarter of participants reported aspects of their clients’ symptomatology affected their use of self-disclosure. Interestingly, selecting each of these factors was significantly related to higher mean rates of disclosure; most significantly, instilling hope was strongly correlated with higher disclosure rates. However, approximately half of all participants reported that concerns about the potential consequences to themselves as well as to their clients of disclosing personal health information also influenced their choices – apparently towards non-disclosure – thus suggesting that self-disclosure of personal experience with an anxiety and/or

mood disorder may provoke particular ethical and personal conflicts in clinicians, as they gauge their disclosure's potential impacts both for their clients and themselves.

Clinicians identified additional considerations that influenced their use of self-disclosure, highlighting the complex nature of these decisions. Participants reported that assessing their clients' functioning and stability, and the relevancy between their own symptoms and those of their clients were important elements to determining the appropriateness of disclosure. These findings appear to corroborate current research that suggests that clients are most likely to find helpful those disclosures that are relevant to and made in the context of their own material. Furthermore, clinicians articulated a variety of rationales for the use of disclosure, reporting that they employed it to provide information to help clients make informed treatment decisions; to normalize their clients' experience; to demystify, destigmatize and normalize treatment options; to instill hope, both in clients' internal strengths and capacity to manage their symptoms as well as in treatment options; to model healthy communication, behaviors and attitudes about living with a disorder; to end an entrenched impasse or promote treatment progress in the face of client ambivalence; to equalize power relations; and to empower their clients to view themselves as active agents in their own treatment. Interestingly, perhaps more so than found in other disclosure research, participants in this study emphasized the role that disclosure played in allowing them to "come alongside" their clients: to join with them, to share information from a place of similar experience, to act as a guide by modeling attitudes, behaviors and coping strategies while emphasizing client choice, and to empower their clients to approach treatment as an active collaborator. In doing so, clinicians reported that they were often guided by their own experiences of their diagnoses and of seeking treatment.

Importantly, only one participant reported disclosing as a result of dynamics of his own symptomatology rather than his clinical judgment, thus suggesting that the potentially negative impacts of clinicians' diagnoses on their ability to use clinical judgment and to employ self-disclosure in clinically appropriate ways is minimal if not negligible. Overall, these findings suggest that, while this form of self-disclosure may engender unique cost/benefit analyses for clinicians considering its use, clinicians are generally making decisions regarding self-disclosure of their anxiety and/or mood disorder based on ethical reasons. The results of this study therefore appear to corroborate the conclusions of Edwards & Murdock (1994), who determined that clinicians' use of self-disclosure in general was made for ethical reasons.

This study found that clinicians overwhelmingly self-disclose about their personal experiences with coping skills: almost 80% of participants reported disclosing effective coping strategies. Perhaps this tendency to self-disclose coping strategies relates in part to the recommendations found in the literature that suggest clinicians disclose relating to resolved issues rather than unresolved ones. In comparison, only about a third of clinicians reported disclosing personal experience with symptoms, therapy, and medication. Furthermore, while sharing coping skills appeared to constitute a "stand-alone" disclosure, and participants frequently made reference to providing this information on its own, disclosures of clinician symptomatology appeared to universally be paired with the disclosure of other information, most often coping skills or healthy behaviors and attitudes that clinicians sought to model. I suggest that participants use this pairing in an attempt to avoid shifting focus onto themselves and burdening the client: by emphasizing the positive "take-aways" they learned, they demonstrate that they do not need caretaking and are able to model effective coping strategies for their clients, thus maintaining the focus on their clients.

Participants overwhelmingly identified they perceived self-disclosures relating to their own experiences with an anxiety and/or mood disorder as helpful to their clients and as clinically effective. Furthermore, this study found a significant relationship between the perception of efficacy and disclosure rates: clinicians' frequency of disclosure increased with their perception of its efficacy. Ninety-five percent of participants who responded to the question about the efficacy of self-disclosure reported they perceived self-disclosure as effective to some degree, while only 5% of participants reported that they considered self-disclosure "not at all effective." Furthermore, 50% of clinicians reported that they considered self-disclosure to be "effective" or "very effective," while roughly 45% of clinicians perceived it to be "somewhat effective." Thus, while they varied in their perceptions of the *degree* of self-disclosure's efficacy, the clinicians in this study generally believed that self-disclosure was effective to some extent.

In light of the overwhelming endorsement self-disclosure received by this study's participants, it is interesting that clinicians reported significant degrees of hesitancy in broaching their own self-disclosures with their colleagues and with the broader clinical community. Roughly 83% of participants reported some degree of hesitancy in discussing this information with their colleagues, and almost 50% reported feeling "hesitant" or "very hesitant." Those clinicians who provided qualitative accounts worried that they would be judged by their colleagues – either regarding their diagnosis or their use of self-disclosure – and that such disclosures might impact their employment options. They reported that they feared being censured by the broader professional community for both their disclosures and their diagnoses, and thus felt doubly vulnerable and maintained silence around their use of disclosure. Thus, it seems that these clinicians were forced to develop their self-disclosure practices in isolation from

their peers, losing important opportunities for dialogue and learning provided by supervision and group consultation.

This phenomenon may perhaps be linked to another finding of this study: many clinicians reported difficulty assessing the efficacy of their own disclosures beyond what their intuitions told them, because they did not explore their clients' reactions and responses to their disclosures. Only two participants in this study made direct reference to discussing their clients' reactions to their disclosure, a finding that appears surprising given the widespread assertion in literature that exploring the disclosure's impacts on and meaning for the client is a fundamental element to the intervention itself. If these clinicians had felt they could access the broader clinical community for reflection and feedback on their disclosures, would they have been more likely to experience learning opportunities that would have encouraged them to process their disclosures with their clients? Perhaps their concerns about being censured by their surrounding professional communities encouraged them to believe they would find a similar void and silence in literature regarding self-disclosure, thus preventing them from gaining access to the perspectives articulated across the literature. For whatever reason, it appears that these clinicians may have been cut off from the evolving debate on self-disclosure and thus from important information that they could have employed to guide their use of self-disclosures.

Interestingly, this study found that more years of clinical practice were not correlated with higher rates of self-disclosure, a finding that contradicts the results of other literature. One potential explanation for this is that the categories used to determine frequency in this study may have been too broad to have tracked more nuanced changes in frequency: as research suggests that self-disclosure is a tool that is generally used rarely, it may be that even if clinicians increased their use of self-disclosure as they gained experience, the categories used in this study

may not have been sensitive enough to highlight that difference. In other words, because it is such an infrequent clinical intervention, clinicians who used self-disclosure rarely at the beginning of their practice and who have since increased their disclosure might still rate their current use of disclosure as rare.

A novel finding of this study was that whether or not clinicians directly disclosed, they appeared to use their personal experiences with an anxiety and/or mood disorder to inform their work with their clients and communicated this information in a variety of ways. Interestingly, this study found that some clinicians used masked disclosures to share their lived knowledge with their clients without naming it as such, by presenting their experiences as if they were someone else's or by making generalizations about a broader group to which the clinician belonged. This finding suggests that regardless of whether they directly disclose, clinicians are finding ways to integrate their professional knowledge as therapists with their personal experience as clients in the service of their clients' treatment.

Strengths and Limitations

This study has both strengths and limitations that are important to consider when evaluating the data obtained. By using a mixed-methods design that incorporated both qualitative and quantitative elements, this study was able to simultaneously attain an in-depth, nuanced understanding of the self-disclosure choices of clinicians who identify as having an anxiety and/or mood disorder, and to situate these individual findings within a broader context of patterns and trends. In turn, the illumination of these general dynamics allowed for a more detailed and rich interrogation of this study's qualitative components.

A further strength of this study is that it uses a clearly defined and operationalized definition of self-disclosure that is based upon the categories of immediate and non-immediate self-disclosure, the most widely supported distinction identified in extant literature. Employing a specific definition of self-disclosure that is informed by relevant literature allows this study's findings to relate to other current self-disclosure research. Furthermore, as research suggests that different forms of self-disclosure may engender disparate therapeutic impacts, by focusing on the non-immediate self-disclosure of clinicians' personal experience with an anxiety and/or mood disorder, this study is able to identify specific trends and impacts related this unique form.

By restricting its sample to licensed clinicians, this study focused on the perspectives of experienced clinicians who were more likely to have developed significant clinical judgment and insight into their use of self-disclosure. Finally, engaging in primary and follow-up interviews provided for greater clarification and opportunities to flesh out additional themes, thus allowing for the emergence of a more thorough and rich body of data.

This study is also susceptible to important limitations – most importantly, the generalizability of its findings may be impacted by elements of its sampling technique, size and diversity. Its findings are subject to the shortcomings of convenience samples, which lack the scientific rigor of clinical trials or other methods that approach the randomness and representation required to eliminate bias and reach more generalizable conclusions. While it may be impossible to ethically engage in true clinical trials on this topic, a more random sampling technique may have produced a more generalizable sample. In addition to technique, my study's small sample size and lack of diversity in gender and racial identities affect its generalizability. Furthermore, as participants in my study overwhelming identified as white and female, the perspectives of clinicians of color and clinicians of different gender identities are significantly

underrepresented in my study. Similarly, because I recruited through communities with which I am associated, my study risks representing a subsection of clinicians, rather than a sample representative of all clinicians practicing in the U.S.

In addition, because this study inquires about a sensitive and personal topic, it risks over-representing the perspectives of clinicians who feel comfortable with their diagnoses and their self-disclosure decisions. As a result, the findings may fail to capture the voices of clinicians who may feel that their diagnoses are too private or risky to discuss, or who may not have wished to discuss them for other reasons. Finally, because I sought the perspectives and perceptions of clinicians and rather than solicited direct client feedback, this study's findings regarding the ultimate impacts of disclosures may be biased – a limitation which may be particularly important to bear in mind, given that research suggests that clinicians tend to rate the efficacy of their disclosures consistently lower than do their clients.

Implications for Research & Practice

This study provides important insights into the self-disclosure choices of clinicians who identify as having/having had an anxiety and/or a mood disorder, an emerging field of inquiry where much remains to be explored and researched. The findings of this study provide an important springboard from which to identify further avenues of investigation. By focusing on clinicians' perspectives, this study captured an important but limited viewpoint, which excluded client feedback. Examining clients' reactions and responses to clinicians' disclosures of lived experience with an anxiety and/or mood disorder, and their perception of the impact of these disclosures on treatment, would be a logical and critical next step to developing our understanding of the effects of this specific form of disclosure. Similarly, exploring the

perspectives of clinicians of Color and of gender identities other than female regarding self-disclosure of their anxiety and/or mood disorder constitutes an additional, important area for further study.

The results of this study also have potential ramifications for practice. While preliminary, this study's findings suggest that for clinicians who have personal experience with an anxiety and/or mood disorder, there may be particular situations when attuned, judicious use of self-disclosure about their lived experience may be indicated as a clinical intervention with their clients. In particular, when the client's presenting issues are relevant to the clinician's experience and treatment is at an impasse, clients are "stuck," or are ambivalent about treatment options, self-disclosure aimed at normalizing client experience or treatment options, instilling hope, modeling healthy behaviors, attitudes and coping skills, and empowering clients may offer unique possibilities for advancing treatment. However, the findings of this study also suggest that the consequences of this potent clinical tool are complex and highly context-dependent, thus emphasizing the importance of careful clinical assessment of the specific circumstances at hand, and the thorough exploration of its impacts on the client subsequent to its use. The multiple considerations – both personal and professional – that clinicians may weigh with regards to the specific type of disclosure examined in this study furthermore suggest its complicated and unique nature as a clinical intervention and highlight the need for opportunities to dialogue, access literature, and obtain supervision around its use. One of this study's important results is the discovery that, in response to these considerations, clinicians use disguised or concealed disclosures as a way to impart the perspectives of their lived experience to their clients, without violating their own confidentiality or risking professional censure – a distinct and innovative intervention in its own right that may hold important implications for practice. Indeed, the results

of this study indicate that clinicians often felt they could not access their peers for support or feedback and remained silent about their use of self-disclosure, because they perceived that discussing these disclosures would place them in a position of enhanced vulnerability as a result of the censured status of both self-disclosure and the revelation of their personal diagnosis this discussion would require. Perhaps as a result, many participants reported that they did not process their clients' responses to their disclosures, an action that the literature considers a fundamental element of self-disclosure itself. These findings therefore emphasize the need to promote dialogue within the clinical community, so that clinicians may continue to develop their judgment and insight into their use of self-disclosure, and the clinical profession may develop its understanding of the unique dynamics and consequences of this potent therapeutic intervention.

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APPENDIX A: RECRUITMENT MATERIALS

NASW Chapter Email:

Dear _____ Chapter of NASW,

My name is Emma Sando, and I'm a member of NASW. I'm currently enrolled in the Master of Social Work program at Smith College School for Social Work, and I am contacting you to ask for your assistance with a study I am conducting in conjunction with my Master's thesis.

For my thesis, I am conducting a mixed methods study into the self-disclosure choices of clinicians who identify as having currently or having had previously a diagnosis of an anxiety and/or mood disorder. I am examining when, why, and how clinicians choose to disclose or not disclose their personal experiences of their diagnoses to clients.

My study consists of two components: a brief (15 minutes or less) online, anonymous survey, and a small set of in-depth, qualitative interviews. My study has been approved by the Human Subjects Review Board, and all measures will be taken to protect the privacy and confidentiality of participants.

I would greatly appreciate any assistance you would be able to provide me in recruiting participants for my study. I am seeking practicing LICSWs with a current or previous diagnosis of an anxiety and/or mood disorder to participate in my study. Attached, you will find a flyer for my study with a link to the survey. Would you be able to publicize this information to your membership, or explain to me how I might go about doing so? If you feel unable to directly assist me in my recruitment efforts, I would greatly appreciate any ideas you might be to offer me with regards to recruitment methods.

Please do not hesitate to contact me if you have any questions or concerns.

Many thanks!

Sincerely,

Emma M. Sando
MSW Candidate, August 2014
Smith School for Social Work

Email to Smith Students:

Dear Colleague,

My name is Emma Sando, and I am contacting you to ask for your assistance with a study I am conducting in conjunction with my Master's thesis at Smith College School for Social Work.

For my thesis, I am conducting a mixed methods study into the self-disclosure choices of clinicians who identify as having currently or having had previously a diagnosis of an anxiety and/or mood disorder. I am examining when, why and how clinicians choose to disclose or not disclose their personal experiences of their diagnoses to clients.

My study consists of two components: a brief (15 minutes or less) online, anonymous survey, and a small set of in-depth, qualitative interviews. My study has been approved by the Human Subjects Review Board, and all measures will be taken to protect the privacy and confidentiality of participants.

I would greatly appreciate any assistance you would be able to provide me in recruiting participants for my study. I am seeking practicing LICSWs with a current or previous diagnosis of an anxiety and/or mood disorder to participate in my study. Attached, you will find a flyer for my study with a link to the survey. If you feel unable to help me directly assist me in my recruitment efforts, I would greatly appreciate any ideas you might be to offer me with regards to recruitment methods.

Please do not hesitate to contact me if you have any questions or concerns.

Many thanks!

Sincerely,

Emma M. Sando
MSW Candidate, August 2014
Smith School for Social Work

**SEEKING LICENSED CLINICAL SOCIAL WORKERS TO
PARTICIPATE IN BRIEF SURVEY STUDY!**

If you are an LCSW/LICSW and have a CURRENT or PAST DIAGNOSIS of an ANXIETY AND/OR MOOD DISORDER your participation in the following study would be greatly appreciated:

If you are a Licensed Independent Clinical Social Worker (LICSW), and have a current or previous diagnosis of an anxiety and/or mood disorder, I would appreciate hearing from you. Participation in this study will entail completing a brief, online survey. If you choose, you may also participate in an in-depth interview.

My name is Emma Sando, and I am a Masters of Social Work student at Smith College School for Social Work. I am conducting a mixed methods study for my MSW thesis, to be presented in the summer of 2014. The purpose of this study is to explore the self-disclosure decisions of clinicians who identify as having a current or previous anxiety and/or mood disorder. I am examining when, why, and how clinicians choose to disclose or not disclose their personal experiences with their diagnoses to clients.

There will be no monetary compensation for participating in this study, but benefits will include assisting with the development of a new field of inquiry and broadening your own understanding of therapist self-disclosure.

The following link will take you to an informed consent document before you begin the survey. Your responses will be kept anonymous and confidential.

Thank you for your time, energy, and perspective!

Emma Sando
MSW Candidate, August 2014
Smith School for Social Work

APPENDIX B: ONLINE-SURVEY QUESTIONS & SURVEY INFORMED CONSENT

SURVEY QUESTIONS & TEXT

Screening Questions:

1. Are you a licensed clinical social worker?
2. Please select which of the following statements best describes you:
 - I have a current diagnosis of an Anxiety and/or Mood Disorder, which (a) has been an active diagnosis for greater than 6 months, and (b) I believe this disorder is well-managed and does not prevent me from functioning in important life domains.
 - In the past, I have been diagnosed with an Anxiety and/or Mood Disorder, but that diagnosis is no longer currently active and I consider the condition to be resolved.
 - I have never received a diagnosis of an Anxiety and/or Mood Disorder.

For those who identify as never having had a diagnosis, they will be thanked for their participation but informed that they are not eligible for the survey. For those who answered positively to either of the first two options, they will be prompted through the following questions. None of the following questions will be mandatory, and participants may choose to skip any question they wish.

Introduction to Survey:

Thank you for your interest in this survey!

This survey seeks to gain insight into the self-disclosure choices of clinicians who have personal experience with Anxiety and/or Mood Disorders. Before beginning, please take a moment to read the following information on informed consent, so that you may make the most appropriate decisions about your participation:

[INSERT INFORMED CONSENT DOCUMENT FOR SURVEY]

Please answer the following questions to the best of your ability. You may skip any question that you do not wish to answer; however, I would greatly appreciate your response to all questions that are relevant to you, so that I may be able to obtain the greatest depth of information.

Self-Disclosure Questions:

1. How often do you disclose to clients information relating to your own experience with an Anxiety and/or Mood Disorder?

- Never
- Rarely
- Sometimes
- Often
- Almost Always

2. What guides your decisions to disclose or not disclose? *Please check all that apply.*

- Benefit to Client
- Client Symptomatology/Diagnosis
- Timing – appropriateness for client at this time
- Concern about revealing confidential personal information
- Instilling hope of recovery/management of the disorder/symptoms
- Other (please specify), or use this dialogue box if you feel your answers above require further explanation: _____

At this point, only participants who identify as having disclosed to their clients will be prompted through the following self-disclosure questions. All other participants will be routed to the demographic questions.

3. If you do disclose, what aspects of your diagnosis have you disclosed?

- Personal experience with medication
- Personal experience in therapy
- Personal experience with the symptoms of the diagnosis
- Personal experience with effective coping strategies
- Other (please specify): _____

4. Please rate the degree to which you feel disclosing this information has been effective in general:

- Not at all effective
- Somewhat effective
- Effective
- Very effective

5. In general, to what degree do you feel hesitant to discuss your disclosures of your diagnosis in conversation with other clinicians?

- Not at all hesitant
- Somewhat hesitant
- Hesitant
- Very Hesitant

6. If you are willing, could you briefly summarize an instance when you did disclose and the disclosure was effective?

(NARRATIVE)

7. If you are willing, could you briefly summarize an instance when disclosure was not effective?

(NARRATIVE)

8. If you reported an instance where disclosure did not go well, could you briefly summarize how you repaired the situation?

(NARRATIVE)

Demographic Questions:

It is important that I gather some demographic data, so that I may accurately characterize my sample's diversity and generalizability. If you feel comfortable, please answer the following demographic questions.

1. If you are willing, could you identify your diagnosis, either specifically through the dialogue box or categorically through the options?

- I am currently diagnosed/have been diagnosed in the past with: _____
- I identify as having/having had an Anxiety Disorder
- I identify as having/having had a Mood Disorder
- I identify as having/having had an Anxiety and a Mood Disorder

2. How many years have you been practicing clinical work? (Please specify numerically)

FILL IN BOX

3. What theoretical orientation(s) do you identify with? *Please check all that apply.*

- Psychodynamic
- Eclectic
- Relational/Intersubjective
- Cognitive Behavioral
- Other, please specify: _____

4. Gender identity can be a complex, highly personal identity. Please answer this question to the best of your abilities, given the limited options below. What is/are your gender identity/ies? *Please check all that apply.*

- I identify as female
- I identify as male
- I identify as transgender
- I don't identify strongly with any gender
- I identify as genderqueer, genderfluid, or gender non-conforming
- I identify as intersex
- I identify differently than the options listed here (if you wish, please specify): _____

5. Racial/ethnic identity is complex and can be difficult to capture in demographic questions, which necessarily simplify this important personal identity. Acknowledging that this survey is also subject to such limitations, please answer the following question to the best of your ability. If you wish to provide me any feedback on the categories listed here, please do so in the narrative box at the end.

What race(s) and ethnicity(ies) do you identify as? *Please check all that apply.*

- Central African (including Angolan, Burundian, Cameroonian, Central African, Chadian, Congolese, Equatorial Guinean, Gabonese, Rwandan, Sao Tomean)
- East African (including Djiboutian, Ethiopian, Eritrean, Kenyan, Mauritian, South Sudanese, Somali, Ugandan)
- West African (including Beninese, Burkinabé, Cape Verdean, Gambian, Ghanaian, Guinean, Guinea-Bissauan, Ivoirian, Liberian, Malian, Mauritanian, Nigerian, Nigerien, Senegalese, Sierra Leonean, Togolese)
- Southern African (including Basotho, Batswana, Comoran, Malagasy, Malawian, Mozambican, Namibian, Seychellois, South African, Swazi, Tanzanian, Zambian, Zimbabwean)
- African-American/Black

- American Indian/Alaskan Native (please specify your Tribe/Nation)
- Aboriginal Australian/Torres Straight Islander
- Pacific Islander/ Native Hawaiian
- Caribbean
- European-American/White
- Northern European (Austrian, British, Danish, Estonian, French, Finnish, German, Icelandic, Irish, Latvian, Lithuanian, Norwegian, Swedish, Swiss)
- Eastern European (Albanian, Belarusian, Bosnian, Bulgarian, Croatian, Czech, Georgian, Hungarian, Moldovan, Polish, Serbian, Slovakian, Romanian, Russian, Ukrainian)
- Southern European (Greek, Italian, Maltese, Portuguese, Spanish)
- Mexican/Mexican-American or Chicano
- Latino/Latina (including Puerto Rican, Dominican, Cuban, Central and South American)
- Middle-Eastern/Northern African
- South Asian (including Bangladeshi, Bhutanese, Indian, Maldivian, Nepalese, Pakistani, and Sri Lankan)
- Southeast Asian (including Burmese, Thai, Laotian, Cambodian, Vietnamese, Indonesian, Malaysian, Singaporean, Timorese, Bruneian, and Filipino)
- East Asian (including Chinese, Taiwanese, Japanese, Korean, and Mongolian)
- Biracial/Multiracial/Mixed (please specify in the dialogue box below)
- I identify differently than the categories mentioned here (please specify), or I wish to further specific my race/ethnicity: _____

Wrap Up & Interest in Interview:

Your survey is complete! Thank you for participating.

I am seeking to expand upon the information garnered in this survey by conducting a number of qualitative, in-depth interviews with clinicians. If you would be interested in participating in an in-depth interview with me regarding your decisions about self-disclosure, please contact me at

esando@smith.edu and I will provide you with an informed consent document and additional information about the interview process. Many thanks for your interest in my study!



SCHOOL FOR SOCIAL WORK

**Consent to Participate in a Research Study
Smith College SSW • Northampton, MA**

.....

Title of Study: Self-Disclosure of Clinicians with Anxiety and/or Mood Disorders

Investigator: Emma M. Sando

T: (XXX) XXX-XXXX

Smith College School for Social Work (MSW)

.....

Introduction

- You are being asked to participate in a research study about the use of self-disclosure by clinicians who have experienced anxiety and/or mood disorders.
- You were selected as a possible participant because:
 - (1) You are a licensed clinical social worker, and
 - (2) You have identified as having either (1) A current diagnosis of an anxiety and/or mood disorder, which has (a) been an active diagnosis for greater than 6 months, and (b) you believe is well-managed and does not prevent you from functioning in important life domains; or (2) You have been diagnosed with an anxiety and/or mood disorder in the past, but that diagnosis is no longer currently active and you consider the condition to be resolved.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is explore if, when, why and how clinicians who identify as having (1) a current, managed anxiety and/or mood disorder, or (2) a previous anxiety and/or mood disorder diagnosis that is currently resolved, choose to disclose that information to their clients.
- This study is being conducted as a thesis requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things: To participate in a short (15 minutes or less), anonymous online survey about the decisions you make regarding self-disclosure of your anxiety and/or mood disorder with clients. The survey will include 8 questions about your self-disclosure practices, and 5 demographic questions.

At the end of the survey, you will have an option to contact me should you be interested in participating in a confidential, in-depth interview, which is a completely voluntary and separate portion of the study. Should you choose to participate in the in-depth interview, please note that your survey responses will no longer be anonymous, but rather confidential, as some of the interview questions overlap with the survey questions.

Risks/Discomforts of Being in this Study

- This study includes the risk that thinking about your diagnosis and your choices about self-disclosure may be distressing and create difficult or strong emotions.

Benefits of Being in the Study

- The benefits of participation for you may include the opportunity to assist in creating a body of knowledge about the use of clinical self-disclosure by therapists of their personal experiences with anxiety and/or mood disorders. Benefits may also include the opportunity to reflect on and gain insight into your practice, your diagnosis, and how the two may interrelate and influence each other within the realm of self-disclosure. Additionally, this study may provide the chance to engage in a dialogue about the dual identities clinicians may hold as both clients and therapists. Finally, all participants will have access to the information contained in my thesis, should they so desire.

Confidentiality

- This study is anonymous. I will not be collecting or retaining any information about your identity that can be used to identify you.

Payments

- I am unable to offer any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with me or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, I will not use any of your information collected for this study. You may withdraw simply by exiting the survey without submitting your data. However, if you do submit, the responses cannot be withdrawn later, as I will have no way of identifying your survey from any others.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Emma Sando at esando@smith.edu, or by telephone at (XXX) XXX-XXXX.

If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your decision to click the “continue” button below and proceed into the survey indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

APPENDIX C: IN-DEPTH INTERVIEW QUESTIONS & INTERVIEW INFORMED CONSENT

INTERVIEW QUESTIONS

Diagnosis & Disclosure Questions:

Preface to Interview: In this interview, I hope to gain a more in-depth understanding of how your personal experience with an anxiety and/or mood disorder affects your practice and guides your decisions regarding self-disclosure. I will begin by asking a few questions generally about your experience as a clinician with an anxiety and/or mood disorder, and then move into asking questions more explicitly related to the decisions you make about the disclosure of this information to your clients. Some of the responses will be an amplification of the answers you've already given on the survey, but will allow for a fuller, richer discussion and will provide me with more detailed information. All your answers will be kept strictly confidential.

- 1.) What has it been like for you to be a practicing, LICSW who has personal experience with an Anxiety/Mood Disorder?
- 2.) How do you feel your experiences with an Anxiety/Mood Disorder have affected your practice?
- 3.) What is your perspective on self-disclosure generally, and specifically as it relates to disclosing information about your own experiences with an Anxiety/Mood Disorder to your clients?
- 4.) What personal values, philosophy, life experiences, or theoretical orientation would you say guides this perspective/approach?
- 5.) What do you feel are the most salient factors at play for you when you decide to disclose or not disclose your own experiences with an Anxiety/Mood Disorder to a client?
- 6.) If you have disclosed information regarding your own experiences with an Anxiety/Mood Disorder, how effective have you experienced such disclosures to be as a therapeutic intervention?
- 7.) Could you provide an example of a disclosure that you felt was particularly effective?
- 8.) Could you provide an example of a disclosure that you felt was not effective, and discuss how you repaired the situation?

Alternate questions to 7 & 8 if the clinician has never disclosed:

- 7b.) Can you describe an experience with a client where you felt tempted to disclose your own history of an Anxiety/Mood Disorder, but did not?

8b.) Could you imagine a situation in which you would disclose this information?

6.) Oftentimes, clinicians may feel a sense of internal conflict about whether or not to disclose personal information to clients, an experience that may be relevant to your own disclosure decisions, given the sensitive nature of personal health information. If you experience such conflict when making self-disclosure decisions regarding your experiences with an Anxiety/Mood Disorder, how do you negotiate/balance the competing concerns?

7.) To what extent do you view self-disclosure of your own Anxiety/Mood Disorder as distinct or unique from other forms of self-disclosures?

8.) In your experience, to what extent do you feel that the clinical community is open to discussing the experience of therapists who have/have had diagnoses, and therapist self-disclosure of these diagnoses to clients?

9.) As you reflect on your self-disclosure decisions regarding your Anxiety/Mood Disorder, are there any questions or concerns that endure/remain for you regarding aspects of these decisions?

10.) Is there anything that you feel is missing from our conversation, and that you would like to discuss?

11.) What has it been like to talk with me about your disclosure decisions regarding your Anxiety/Mood Disorder?

Demographic Questions:

I would like to ask you some demographic questions, so that I may accurately characterize the diversity and generalizability of my sample for the in-depth interview portion of my study.

1. How many years have you been practicing clinical work?

2. Given that this study includes clinicians from a wide variety of diagnoses (Anxiety and Mood Disorders), this question is asked in order to accurately identify and represent any variances dependent upon diagnosis in the experiences and self-disclosure choices of clinicians. To the extent that you feel comfortable, could you identify which type of diagnosis you have, either by providing the diagnosis or identifying whether you have an Anxiety or Mood Disorder, or both?

3. Could you please identify your theoretical orientation(s)?

4. Can you please identify your gender identity/ies? You may respond with all identities that feel relevant.

5. Could you please share your racial/ethnic identity/ies? Please respond with all identities that are relevant.



SCHOOL FOR SOCIAL WORK

**Consent to Participate in a Research Study
Smith College SSW • Northampton, MA**

.....

Title of Study: Self-Disclosure of Clinicians with Anxiety and/or Mood Disorders

Investigator: Emma M. Sando

T: (XXX) XXX-XXXX

Smith College School for Social Work (MSW)

.....

Introduction

- You are being asked to participate in a research study about the use of self-disclosure by clinicians who have experienced anxiety and/or mood disorders.
- You were selected as a possible participant because:
 - (3) You are a licensed clinical social worker, and
 - (4) You have identified as having either (1) A current diagnosis of an anxiety and/or mood disorder, which has (a) been an active diagnosis for greater than 6 months, and (b) you believe is well-managed and does not prevent you from functioning in important life domains; or (2) You have been diagnosed with an anxiety and/or mood disorder in the past, but that diagnosis is no longer currently active and you consider the condition to be resolved.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is explore if, when, why and how clinicians who identify as having (1) a current, managed anxiety and/or mood disorder, or (2) a previous anxiety and/or mood disorder diagnosis that is currently resolved, choose to disclose that information to their clients.
- This study is being conducted as a thesis requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: To participate in an interview with me lasting no more than 45 minutes regarding your decisions about self-disclosure of your anxiety and/or mood disorder with clients, and how you feel that disclosure or non-disclosure of your diagnosis has affected your clients and practice. You may choose to interview with me over the phone, via skype, or in person, whichever you prefer of the feasible options for us given geographic proximity. During this interview, your answers will be recorded, so that I may most carefully and thoroughly review them. Should you choose to interview over the phone or via skype, I will turn the phone or computer on speaker phone so that I may record your answers. You will also be asked to be available for a much shorter, follow up interview that will last no more than 15 minutes, which will provide the opportunity for you to reflect on the first

interview, offer any additional comments and clarifications, and answer any follow-up questions I may have.

Risks/Discomforts of Being in this Study

- This study includes the risk that talking about your diagnosis and your choices about self-disclosure may be distressing and create difficult or strong emotions.

Benefits of Being in the Study

The benefits of participation for you may include the opportunity to assist in creating a body of knowledge about the use of clinical self-disclosure by therapists of their personal experiences with anxiety and/or mood disorders. Benefits may also include the opportunity to reflect on and gain insight into your practice, your diagnosis, and how the two may interrelate and influence each other within the realm of self-disclosure. Additionally, this study may provide the chance to engage in a dialogue about the dual identities clinicians may hold as both clients and therapists. Finally, all participants will have access to the information contained in my thesis, should they so desire.

Confidentiality

- The records of this study will be kept strictly confidential. Research records will be kept in a locked file, and all electronic information will be coded and password protected. Audio recordings will be kept in a locked file cabinet, used solely for the purpose of this study, and will be destroyed once they are transcribed by deleting them from the digital recorder. I will not include any information in any report I may publish that would make it possible to identify you.
- The data will be kept for at least three years according to federal regulations. They may be kept longer if still needed for later research. After the three years, or whenever the data are no longer being used, all data will be destroyed.

Payments

- I am unable to offer any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with me or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone within 72 hours following the interview. After that point, transcription will have begun and your information will be part of the thesis.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Emma Sando at esando@smith.edu, or by telephone at (XXX) XXX-XXXX. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

October 9, 2013

Emma Sando

Dear Emma,

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

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form. **Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

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

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

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

Congratulations and our best wishes on your interesting study.

Sincerely,



Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor