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Heather Smith-Jackson
Adoption and the Use of Self Disclosure:
A Qualitative Inquiry of the Clinical Professional

ABSTRACT

One of the intentional purposes of this study was to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with a concentration on adopted mental health professionals. This study: explored the nature of therapeutic relationship, investigated continued controversial topic of self disclosure and explored specifically adoption identity formation and self disclosure grounded in social constructivism.

Twelve female participants who identified as mental health professionals completed in person interviews. The goal was to recruit 16 participants evenly divided between clinicians who were adopted and non adopted. However because of limitations, the sample consisted of 11 non adopted clinicians and 1 adopted clinician.

Six themes emerged from analysis of transcribed interview data: (1) client focused self disclosure (2) therapist identity focused self disclosure (3) therapist theoretical orientation influence on self disclosure (4) Number of years of experience and use of supervision (5) identity as a therapist and as an individual (6) Need for connection and isolation as it relates to relationships and identity. Despite great efforts only one adopted clinician was recruited to the study; therefore the original research question provided valuable insight on self-disclosure in clinical practice and suggested directions for future research.

Adoption and the Use of Self-Disclosure: A Qualitative Inquiry of the Clinical Professional

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

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2015

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I

Introduction

The purpose of this study is to explore the following question “How does adoption influence the use of self disclosure in clinical practice?” The term *adoption* will be defined as a clinical professional that has been legally adopted from a biological family to a non biological family during childhood or adolescence. Adoption can be described as both a *closed adoption* and *open adoption*. *Closed adoption* refers to an adoption in which information is missing or withheld about the biological family’s medical, genetic or reason for adoption by a non biological family. *Open adoption* refers to an adoption in which information about the family’s medical, genetic, reason for adoption is provided and may include interactions with biological family while adopted by a non biological family. The operational definition of *self disclosure* will be as follows: “interactions in which the therapist reveals personal information about him/herself [self revealing] and/or reveals reactions and responses to the client as they arise in session [self involving]” (Hanson 2005 p 96). The use of *clinical practice* refers to professionals working with any given population that includes an assessment and treatment of clients in a given population for mental health, behavioral or substance use disorders (National Association of Social Workers 2015). This operational definition will include *clinical professionals* such as Licensed Masters of Social Work, Psychologists and Licensed Clinical Social Workers.

One of the intentional purposes of this study is to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with concentration on adopted clinical professionals. There is a substantial amount of self disclosure literature, but limited insight from the perspective of professionals who have been adopted and are currently practicing in a clinical setting. Current research does not include the exploration of identity development

and its influence on clinical practice of an adopted clinician. However, there is research pertaining to general identity development as it relates to external and internal processes which will be further explored. Although there is limited information pertaining to the number of adults identified as adopted in the United States, statistics reviewed from 1990 indicated that 214,448 children entered the foster care system, 16,211 of whom were adopted (Administration for Children and Families Archives 2015). The statistics provided to the public provides information regarding adoption rates in 1990, but I was unable to find any statistics about clinicians who identify as adopted or even adults who were adopted as children.

This study will explore the nature of the therapeutic relationship with clients who may themselves experienced circumstances similar to that of the adopted clinician or non adopted clinician. This study will investigate the use of self disclosure, which may be influenced by adoption identity formation and non adopted self disclosure. My hope is that this study will contribute to literature in the United States regarding clinical professionals who are adopted and not adopted, identity formation by clinical professionals and the use of self-disclosure in clinical settings. This study will focus on the adopted clinicians' identity and how this may impact the context, type and frequency of self-disclosure, as compared to non adopted clinicians. By conducting this study, I will be taking into consideration perspectives of clinical professionals as well as the experiences these professionals as individuals.

The necessity of exploring this aspect of self disclosure has been undoubtedly present in my own work as a developing clinical professional. I was adopted at the age of three and have been accepted, loved and integrated into a non biological family. My interests were never to look for my biological family contrary to my adoptive sister's desires. The research I've found in my

inquiries tends to focus on mental health outcomes and “the search” of the biological family. My interests lie within the creation of my new adopted self identity specifically as a result of the adoption, and how this adoptive identity influences self disclosure. Literature suggests that individuals have several different shifting identities as a result of being in different social situations, but an acquired adoptive self identity is something always present in practice and present as being an individual; it is something I cannot escape nor leave aside (Vingnoles et al 2006). Just recently in clinical practice, there was a situation where self disclosure was appropriate. I realized in that moment, I disclosed a piece of my adoptive identity rather than the identity of my former non adopted self. Within this experience, there was a developing therapeutic relationship which is also influenced by the attachment patterns acquired both pre adoption as well as post adoption. I find it necessary to connect attachment in terms of the therapeutic relationship, self identity formation, and self disclosure, because as an adopted clinical professional, this is the context of who I am.

By exploring both attachment theory and social constructivism as it relates to identity, I will begin to gain a more clear understanding of theories and the influence on self disclosure. After the completion of this study, I hope that this information will give awareness to clinical professionals who are adopted or not adopted and continue to contribute to self disclosure and identity formation literature.

II

Literature Review

The literature review focuses specifically on the therapeutic relationship, the use of self disclosure from clinical perspectives, adoption identity and how adoption influences the use of self disclosure. These concepts inform the research question. Does adoption status influence self disclosure in the practice of licensed mental health professionals? The chapter is divided into three sections. Section one will focus on the nature of the therapeutic relationship and will present the theoretical framework of social constructivism, as the grounding theory for this research. Section two will focus specifically on the use of self disclosure in the therapeutic relationship. Section three will discuss adoption identity and the influence on self disclosure.

The Nature of the Therapeutic Relationship and Theoretical Framework

Within the therapeutic relationship, there are two individuals in the treatment room building a relationship that will be the catalyst for change to the client's development and functioning (Sommers-Flanagan & Sommers-Flanagan, 2014). Doctors Sommers-Flanagan and Sommers-Flanagan state "we began thinking and talking about the possibility that it might be the relationship between client and therapist- not necessarily the methods and techniques employed - that produced therapeutic change" (p 135). The client enters treatment with the understanding that the clinician is capable of exploring what it is that has brought the client to treatment, and if the client doesn't connect with the clinician, a transition to another provider is recommended or termination occurs. The client is an individual with his or her own history, his or her own values and own context that has shaped who he or she has become in the world. The clinician too, is a product of social exchanges with his or her own environment. Somers-Flanagan and Somers-Flanagan emphasize the importance of a clinician's self awareness, developmental awareness,

cultural awareness and psychosocial awareness when establishing a therapeutic relationship. The clinician has too, developed in response to his or her's own history, his or her's own values and own context. Paul Rosenblatt states (2009) "we may choose to label as 'therapy' only those interactions that fit within a limited model of roles, statuses, and intentions, but that does not erase the possibility that any interaction may have therapeutic consequences" (p172). In other words, the interactions between both the clinician and the client will inevitably influence both parties regardless of ethics, roles and expectations of the professions; it is as a result of basic human interaction that the relationship transforms and changes in response to the development of the relationship. There are two complex individuals within the treatment room; one clinician is not identical to another clinician just as one client is not the same as another client. The therapeutic relationship is constructed by the interaction of two separate realities (Somers-Flanagan & Somers-Flanagan, 2014).

Dr. Paul Rosenblatt describes the therapeutic relationship between a client and a clinician but with an emphasis on the client's interactions with a clinician. Rosenblatt states "in the collaborative relative system, much might affect a therapist, including how the client understands and reacts to the therapist's disposition, motivation, self disclosure and skill and what the client reveals about his or her life that may lead to the therapist to a new sense of his or her own life" (p169). This presentation of the therapeutic relationship reflects the nature of a relationship within social constructionist theory. Social constructionist theory emphasizes the development of relationships as the mutual interaction with other individuals and one's own reality (Slavin, 2013). Doctor, Malcom Owen Slavin states (2013) "the vital Otherness from which we construct a human self (a psychological identity, a subjective world) is inevitably highly colored by the experiences embedded in those others whose identities must be absorbed to shape our own- from

family to the larger culture. We must become deeply attached to- and then, in some measure, differentiate, free ourselves from and re-establish - vital connections to others” (p297). In the therapeutic relationship, individuals work together to develop the understanding of why the client has sought treatment, what the purpose of treatment will mean, what the clinician means to the client and what the client means to the therapist (Rosenblatt, 2009).

Thomas Shovholt discusses The Cycle of Caring as a continuous series of professional attachments and separations to establish a collaborative therapeutic relationship (Shovholt, 2005). He states “the quality of the counseling relationship has consistently found to have the most significant impact on successful client outcome. The particular treatment that the therapist delivers does not affect outcomes.. therapists within treatment account for a large proportion of the variance” (p83). The therapeutic relationship is constructed by the two unique individuals within the room and the ability to establish the relationship influences the client’s desire to remain in treatment and have a sense of connection with the therapist. The Cycle of Caring is defined by three stages: empathetic attachment, active involvement and felt separation. The relational process begins with the therapist’s willingness to develop a collaborative relationship with the client built upon openness and trust. Without this, there is an unspoken element of the relationship that could ultimately end in termination or the manifestations of resistance and resentment (Rosenblatt, 2009).

Other literature recognizes that empathy is vital and contains different dimensions that contribute to the therapeutic relationship. Authors Fernandes Coutinho, Olivera Silva and Decety state (2014) “the metaphor of the human brain as social organ is supported by findings from neurodevelopment and attachment, suggesting that our brain develops in the context of our

relationships and that brains regulate one another during moment-to-moment interactions. The establishment of human bonds and interactions is essential for human survival” (p541). The nature of the therapeutic relationship is influenced by the degree to which a clinician can demonstrate empathy. Fernandez Coutinho, Olivera Silva & Decety (2014) defined empathy as “the process by which one infers the affective state of another person and experience a similar state in ourselves, while at the same time keeping a distinction between the self and the other, in other words, being aware that the origin of that is experience is the other and not oneself” (p542). These authors then continue to discuss empathy and the role within the therapeutic relationship. They state that the clinician’s ability to self regulate personal states of affect, both physiologically and cognitively, in response to clients is found specifically within the therapeutic relationship. These authors argue that therapeutic relationships can produce change within the client but that the process of empathy within the clinician leads to a more clear understanding of a client’s presenting problems (Fernandez Coutinho, Olivera Silva, & Decety, 2014).

As the client begins to develop a relationship with the clinician, the clinician is also developing a relationship with the client. The clinician will be abiding by his or her own code of ethics and own modality of treatment but the clinician cannot remove personal context which is constantly informing treatment practice; context of a client is always present. There is a significant gap in the literature about the clinician in the therapeutic relationship due to expectations and historical expectations of the therapeutic relationship. Found within research, the client is perceived as the focus of research rather than the clinician. Rosenblatt (2009) states,

Much of the literature, particularly the literature from modernist or medical model perspectives, is about a detached and objective therapist with clear boundaries, working with considerable therapeutic resources to help clients.. The therapist is the observer who engineers what goes in therapy; the client is the observed for whom therapy is

engineered. Thus the literature constructs a reality in which there would be no point to looking for the effects of therapy on the therapist. During training, in supervision and the literature on how to do therapy, therapists are warned that problems may arise if therapy affects the therapist – countertransference, compassion fatigue, the breakdown of boundaries of personal reserve and the like (p 170).

Certain modalities of training do influence the therapeutic relationship and the use of self disclosure in the room. Lynda Carew discusses different theoretical frameworks and how they inform the use of self, self disclosure which ultimately impacts the therapeutic relationship. Carew discusses the historical content of Carl Rogers and his use of transparency to transform the therapeutic relationship into a positive interaction. Carew found that clinicians who practice with a more classic, psychodynamic approach were more reflective about the principles of self disclosure and how it influences the therapeutic relationship. Other modalities such as Cognitive Behavioral Therapy, Systemic and Person Centered initiated a greater flexibility using self disclosure in the therapeutic relationship. Historically, psychoanalytic practitioners have avoided the use of self because of issues relating to countertransference and transference. Authors Berzoff, Flanagan and Hertz (2011) state “All psychoanalytic models have the same conceptual base, the dynamic unconscious, although they may differ in certain fundamental ways. All deal with transference and countertransference and the use of method of free association” (p 6). All of the clinicians regardless of modality utilized stated that disclosure was used to bond with the client, to demonstrate empathy in the relationship and to recognize the power imbalances within the treatment relationship (Carew, 2009).

Author Stephanie Brody extends the discussion about self disclosure, informed by social constructionism. Brody states (2013) “we pride ourselves that our analytic instruments can rise above our own reactivities, rigidities, and resistances to explore profound tacts of affective pain, even when our patients elicit powerful emotion in us. But personal vulnerability raises a different

manner of test within the analytical dyad. Ultimately, we are no less vulnerable by our patients, however refined our powers of self reflection” (p 76). Both Brody and Rosenblatt suggest that the therapeutic relationship is a relationship that affects both the client and the clinician; a view in line with social constructionist perspective. The consequences of a clinician’s rigidity and the inability to establish the therapeutic relationship ultimately leads to misattunement or termination of the therapeutic relationship. Rosenblatt suggests that the client influence on the clinician in the therapeutic relationship could in fact be beneficial. He states “being defined by a client as deeply empathic and sensitive to others may move a therapist who has felt down, unconfident and cautious because of assumed limitations to become more aware of personal empathic and social sensitivity resources and to become more confident” (174). These perspectives suggest that the client does have influence on the clinician in the therapeutic relationship, but the influence is one grounded in the reality that the clinician is an individual, in addition to a professional.

Brody also emphasizes the impact of the therapeutic relationship on the clinician as a human person. In speaking about the experiences of clinicians Brody (2013) states

Our desire to have a powerful impact stands side by side with our helplessness. The great risk may be that in an effort to uphold the powerful identification with our analytic identity, we lock ourselves into an either/or battle. If we are human, we are not analytic; if we are analytic, we are not human. We must commit to an unshakeable belief in the principles of anonymity, a principle that reinforces a false sense of grandiosity and is a hopeless effort to preserve our sense of omnipotence (p78).

In addition to her discussion around the nature of the therapeutic relationship as a construction of both expectation and interaction, Brody elaborates further on the inevitability of countertransference and transference in the therapeutic relationship. Brody states (2013) “do not leave sufficient room for an appreciation of the unpredictable impact on the patient when the

analyst unintentionally cracks the transference by suddenly emerging as a vulnerable human being. I would hardly say that these moments are best for any patient, but enactments of all sorts of inevitable, and I believe they are often surprising both to the patient and the analyst” (p78). Brody’s discussion captures the essence of the undeniable reality of the therapeutic relationship: these two individuals have influence on one another and the influences that they do have are unavoidable.

Self Disclosure

For purposes of this research, self disclosure will be defined as “behaviors, either verbal or nonverbal, that reveal personal information about therapists themselves to their clients” (Carew, 2009, 266). Different modalities of clinical practice tend to have diverse expectations of the use of self disclosure. Despite having differing opinions about self disclosure, research has suggested that self disclosure and the use of self disclosure is beneficial to the therapeutic relationship under certain circumstances (Carew 2009).

In a study conducted in the United Kingdom, professionals were divided up into four practice modalities: Psychodynamic, Cognitive Behavioral Therapy, Systemic and Person Centered, and asked to elaborate on the use of self disclosure in the therapeutic relationship (Carew 2009). The objective of this study was to explore the perceptions of therapists practicing but to understand whether or not theoretical background influenced the use of self disclosure within the therapeutic relationship. These findings would essentially assist in developing a framework that addresses the use of self disclosure. The findings suggest that all modalities of practice fell within a spectrum of self disclosure, but if there was self disclosure across modalities, it was to build upon the therapeutic relationship. She further concluded that client

perspectives needed to be taken into consideration in order to utilize self disclosure in an appropriate manner regardless of theoretical orientation.

In addition, self disclosure has been shown to strengthen the therapeutic relationship and assists to eliminate or alleviate power dynamics in the therapeutic relationship (Anderson & Anderson, 1989). Carew has also argued that self disclosure is beneficial in the therapeutic relationship. She states, “the belief amongst all participants who used self disclosure as a therapeutic strategy was that it was a bonding, empathic, sharing quality that helped address power imbalances within the relationship. Participants were particularly concerned that disclosures did not distract from the client’s issues and become therapy for themselves “ (Crew, 2009, p 271). Andersen and Anderson (1989) contribute to this discussion by acknowledging that self disclosure contributes to the development of a positive therapeutic relationship, but that not all self disclosure is definitively positive.

In a qualitative study, nine participants were interviewed to explore therapist self disclosure and the influence on the therapeutic relationship. The study found that self disclosure from a therapist can influence the boundaries within the therapeutic relationship either positively or negatively (Audet, 2011). Audet discusses the use of immediate self disclosure and non immediate self disclosure but ultimately concludes that therapist self disclosure is viewed more favorably because it establishes a sense of support in the therapeutic relationship. In addition, Audet discusses boundaries as it relates to self disclosure and acknowledges the power dynamics in the therapeutic relationship. Audet (2011) states,

One type of boundary that is contingent on disclosure norms between client and therapist. The client is characteristically the primary discloser expected to bare all of therapy to be effective while the therapist maintains a predominantly non-disclosive stance applies his or her expertise to the issue at hand. An ethics perspective explains

that boundary concerns are identified with therapist disclosure include shifting the focus away from the client, inviting social dynamics conducive to a friendship, generating client feelings of needing to care for the therapist and in extreme cases, risking exploitation of the client and role reversal (p 87).

Audet goes on to refute the ethical boundaries by stating that it is not the use of self disclosure that may lead to exploitation, but it is the intent of the clinical professional that determines if self disclosure is warranted.

From a client perspective, Audet explores the impact of self disclosure on clients during therapy. Audet explains that there have been both cases in which clients have encountered self disclosure as unfavorable but other uses of self disclosure as favorable. Audet states (2011) “another study focusing on client experiences of helpful therapist disclosure showed that clients perceived their disclosing therapist as more real, human or imperfect, which had an equalizing effect on the on the relationship” (p91). In the study Audet conducted, findings suggest that the use of self disclosure can impact the nature of therapeutic relationship both negatively and positively but the outcome is determined by frequency and whether or not disclosure is congruent with the client’s discussion and values (Audet, 2011).

Other literature also discusses personal experiences of clients and the use of self disclosure in the therapeutic relationship. Jean Hanson conducted a studying involving eighteen clients which explored the use of self disclosure and the ethical limitations of doing so. Hanson’s findings suggest that these clients found self disclosure to be helpful in the therapeutic relationship and found that non disclosure was twice as likely to be unhelpful. Hanson organized results by the participants in categories of: helpful disclosures, unhelpful disclosures, helpful non disclosures and unhelpful nondisclosures. Hanson found that participants who have experienced

helpful disclosures found that it positively impacted the therapeutic relationship by creating a stronger alliance with the therapist and assisted with a more egalitarian relationship. Unhelpful disclosures were often found to create a sense of distrust in the therapeutic relationship and left the client feeling more negatively self reflective. Helpful non disclosures discussed the concept of transference and indicated that clients were able to develop their own sense and opinions about the therapist. Unhelpful nondisclosures directly influenced the nature of the therapeutic relationship. Clients often felt as though there was a lack of connection to the therapist which was detrimental and harmful to the therapeutic relationship. Hanson (2005) concluded this study by discussing the importance in the skill of disclosure and the timing of disclosure indicating that self disclosure may be useful with the correct intent in doing so.

Literature discussing social constructivism and identity development suggest that self disclosure and the use is influenced by individual identity within the therapeutic relationship, for both the clinician and the client. The literature suggests that individuals have different motivations to self disclose as a result of the exchanges the individual has with the external and internal self (Akrin & Hermann, 2000; Vignoles et al, 2006). Arkin and Hermann suggest that an individual's sense of self and presentation in daily life impacts multiple relationships by social exchanges which contributes to overall identity development. Arkin and Hermann (2000) state,

high impact self presentational episode in which positive therapeutic outcomes arise when clients perceive the therapist has a favorable view of them. The objective of psychotherapy is reconceptualized as the construction of a useful, productive, positive identity. This can be best achieved by selectively withholding certain (negative) information from the therapist and through a collective emphasize the positive (p 501).

Arkin and Hermann suggest that the therapeutic relationship influences and is influenced by the client's identity development. Arkin and Hermann (2000) state “ therapists offer positive feedback to their clients based on the client's self presentations, identifying identities that the

client prefers and then reinforces those identities. Newly acquired self knowledge can easily be attributed to the demands of the social situation” (p 502). Arkin and Hermann discuss the client perspective of identity development but do not necessarily address the identity development of the clinical professional. They do however, argue that all self concept is malleable and subject to change inside the therapeutic relationship. They suggest that individuals experience the external world which shapes the internal development of self in response to social situations (Arkin & Herman, 2011). These findings suggest that the development of personal identity can be applicable to both the clinical professional as well as the client considering self concept is ever changing.

Similar literature on social constructivism examines the motivations within identity development. Vignoles et al state (2006) “the processes shaping both individual and group identities are guided by motives to protect feelings of self esteem, continuity, distinctiveness and efficacy” (p 308). This suggests that the clinical professional’s identity may be influenced by the social expectations of belonging and identifying as a clinical professional. According to this literature, there are three levels in which an individual’s identity becomes defined: individually, relationally and within group levels of self representation. The study found that self esteem, motives for personal meaning, continuity had effects on different dimensions of identity (Vignole et al, 2006). Vignoles et al state (2006) “participants rated as more central and were happier with elements of identity that provided a greater sense of meaning in their lives. These findings support the influence of a motive for meaning on processes of identity construction beyond the influence of concerns for esteem” (p 324). In the concluding discussion, Vignoles et al discusses personal identity development and its influence in relationships with others which relates to self disclosure. Vignoles et al state (2006) “if identity construction is guided

simultaneously by multiple identity motives, then- over time and in an absence of external constraints - a physiologically healthy individual will likely find non conflicting ways of satisfying each motive” (p328). In other words, clinical professionals are guided by multiple identity motives simultaneously, which may ultimately impact the use of self disclosure. Somers Flanagan and Somers Flanagan (2014) suggests that self disclosure be utilized if the disclosure is in congruence to the client’s focus in treatment. Somers Flanagan and Somers Flanagan (2014) state “the ability to be congruent includes an internal dimension that involves therapists being in touch with their inner feelings or real self plus an external or expressive dimension that allows therapists to articulate their internal experiences in ways clients can understand” (p 137). Self disclosing in a meaningful and purposeful way can result in positive outcomes. Similarly, client identity development is influenced by similar motivations that assist to construct identity development which may impact motivation for self disclosure to a clinical professional.

Other literature exploring self disclosure has recognized that research is often presented from a white heteronormative perspective. Authors Dennis Falk and Pat Noonon Wagner state (1985) “the present study focused on self disclosure among white, middle class Americans; some cultures react quite differently to self disclosure” (p 558). These authors support the understanding that relationships develop after individuals move from “superficial information to more personal information”. In addition, these authors discuss and describe this process of disclosing to relate to one another in a more meaningful way. They state, “ an essential aspect of healthy personality and a necessary condition for close, personal relationships. On the other hand, concern has been expressed about sharing too much too quickly” (Falk & Wagner, 1985, p558).

These authors continued to incorporate and acknowledge response styles as a positively determining factor when utilizing self disclosure. The research included attempted to address the cultural differences in responses but failed to explicitly discuss more in depth variance amongst different cultures. These authors did however, discuss egocentrism and the influence of self disclosure. Falk and Noonan Wagner (1985) state,

perspective taking is manifested by behavior that indicates an active effort to understand and incorporate the information and feeling presented by the other person without making a value judgement. Egocentrism is manifested by behavior that indicates an interest in presenting one's own feelings and thoughts and evaluating the information and feelings presented by the other person from one's own frame of reference. Perspective taking has been related to cooperative interaction. Perceiving an interaction as cooperative has been related to other positive perceptions of the interaction such as satisfaction, comfort and warmth (p 560).

More research on cultural differences has emerged examining mental health clinicians and the ways in which mental health clinicians can modify and change communication to increase the likelihood of self disclosure. The article "Extending boundaries: Clinical Communication with Culturally Linguistically Diverse Mental Health Clients and Careers" was the first article to transparently discuss the nature of mental health treatment and how this intersects with individuals of different cultural backgrounds. Authors Wendy Cross and Melissa Bloomer (2010) state "historically there have been challenges to the assumptions that cross cultural similarities in abnormality exist. Earlier, cultural anthropologists suggested that abnormality was relative and should be addressed in conjunction with cultural normals and deviations tolerated relative to that society" (p 269). This was the first article that further discussed the nature of therapeutic work and the intersection of different cultural backgrounds. This article took a more medical perspective and addressed the complications that evolve from

communication which prevent full and understanding verbal exchanges. The sample included seven focus groups of mental health professionals working with culturally diverse clients. The subthemes identified from this research suggest that respect and cultural understanding influence basic communication exchanges which limits or increases capacity to self disclose (Cross & Bloomer, 2010). This research concluded that mental health clinicians need to continuously acquire cultural knowledge to promote and increase the chance for culturally sensitive self disclosure while working with cultures different from one's own.

Other research discussing self disclosure in cross cultural counseling argue that graduate programs often only teach limited courses resulting in a deficit when working with different ethnicities. Authors Alan Buckard, Sarah Knox, Michael Groen, Maria Perez and Shirley Hess(2006) state, "Whether counseling relationship was good or tenuous, however, our participants observed that immediately proceeding the self disclosure, clients were usually discussing how they had coped with racism or oppression; relatedly, perhaps, the therapists reported being concerned about the counseling relationship and worried that their clients perceived them as racist" (p22). The authors then discuss clinical observations, "noting this sense of discomfort and hesitation, potentially an indication of client's cultural mistrust, our participants reasoned that it was important to validate clients' experiences by acknowledging the role of racism/oppression in clients' lives, or to acknowledge their own racist/oppressive beliefs. Thus, our participants had clear reasons for delivering self disclosure" (p 22). The clinicians who disclosed within this study do so not for insight but to develop the therapeutic relationship and to validate client experiences of racism and oppression, indicating that self disclosure used in an appropriate manner can be beneficial to cross cultural counseling (Buckard et al, 2006).

Further research on self disclosure discusses the use of self disclosure within a supervisor trainee relationship; a comparative relationship between a clinician and client. This research focuses on the use of self disclosure in the supervisor trainee relationship and examines how the trainee comes to self disclosure in the professional relationship. This research indicated that the type of relationship established between the trainee and supervision, how the trainee utilizes supervision and how the trainee comes to understand supervision influences self disclosure in professional relationships (Gunn & Pistole, 2012). Authors Josh Gunn and Carole Pistole describe the trainee supervisor relationship from the attachment perspective and reflect upon the reciprocity within the relationship of trainee and supervisor. Gunn and Pistole (2012) state,

In the meager attachment based supervision research; the alliance was stronger when trainees perceived the supervisor as having a secure attachment pattern and supervisor highly anxious attachment predicted lower trainee professional development.. In addition, trainee disclosure and lack thereof, is important in supervision because spoken and unspoken therapy related personal thoughts, feelings, and attitudes are vital to the supervisor's ability to monitor learning and ensure effective client services. Research indicates that more than 90% of trainees withhold some information from the supervisors. Fear of evaluation and need to appear competent can provoke intense even detrimental anxiety, failure to manage emotion effectively may hinder the trainee's ability to apply knowledge and disclose to the supervisor (p230).

The research concluded that the use of self disclosure within the trainee supervisor relationship was directly influenced by the supervisor alliance and client focus. Although the limitations of this study were "self report measures," the discussions indicated that perceptions and recall may be biased and influenced (Gunn & Pistole, 2012). This research further indicates that it is the individual's developmental of the authentic self that promotes use of self disclosure rather than the context of the relationship. Jesse Geller, of Yale University, provides further perspective on professional development, personal development and the use of self disclosure. Geller (2003) states, "therapist who have found their own voice may experience the coming

together of these conceptually distinguishable states of decision making as an organic event. One can experience the decision to self disclose as inherent in the decision to pursue a particular treatment goal. Beginners, by contrast, often find themselves trying to choose between conflicting models of realizing a particular goal, all of which feels as if they have a legitimate claim” (544). Geller describes the cognitive decision making process and discusses the variance between beginning clinicians and those who have practiced. Geller discusses the differences that arise with the use of self disclosure and emphasizes context within the therapeutic relationship. Geller (2003) states, “there are no risk free self disclosures, nor is there such a thing as just listening in psychotherapy. The commonly heard phrase implies that it is possible not to communicate when in the role of listener. Therapists convey as much comprehensible content about themselves when listening as when they are talking” (p547). Geller not only describes the use of self disclosure from a professional development perspective, he focuses on the necessity to meet the need of the client. Geller concluded by stating “I have reasoned that competent use of self disclosure in psychoanalytic existential psychotherapy depends on a therapist’s ability to flexibly accommodate his or her activity level, depth of involvement, and expressivity to meet the idiosyncratic requirements of individual patients at each phase of therapy” (p553). Geller not only suggested self disclosure as a mechanism of personal discretion but also an entity of professional development as it intersects with the professional identity. In essence, the literature is suggesting that self disclosure is influenced by personal identity, one’s theoretical orientation, the duration of experience and the use of supervision that develops professional identity.

Adoption Identity and Self Disclosure

Literature that addresses adoption identity commonly utilizes the framework of loss and unresolved grief. Identity development appears to be altered due to the termination and loss of connection with biological counterparts (Lifton, 2010) As a result, adopted individuals live with parallel identities: a previous non adopted self identity and an adopted self identity.

Understanding this parallel process of identity may be essential for adoptive professionals in clinical practice to refine and re-examine self reflection and personal identity development. In addition, adoption identity development seems relevant to current literature on how identity is defined as an individual, relationally and within a group (Vignoles et al 2006).

Betty Lifton, an adoption psychotherapist, describes the birth of these parallel identities within those who are adopted. She illustrates an adoptee along with a “ghost mother” and “ghost baby” which are symbolic representations of the biological mother and the former life of the adoptee. Lifton argues that these portions of identity are frozen in time until the adoptee reconnects or chooses to reconnect with biological counterparts. Lifton describes the parallel experience of these identities as a form of dissociation. She states (2010) “the adoptees’ ghost kingdom can be seen as the nursery where the ghost baby remains behind with the ghost mother, even as the adopted child grows up with the adoptive parents in the real world. Doubling has taken place - the splitting of the self. For in order to survive in the family in which they mysteriously find themselves, adoptees dissociate - split off the self that might have been” (p 72). Lifton describes adoptees who have sought clinical therapeutic treatment who felt as though there was something not fulfilled within them. She recalls one of these clinical encounters “adoptees often have a hard time remembering when and what they were told since so many of

their feelings were split off. But once they get in touch with the vulnerable child they were -so alone and with no one to talk to about what they were experiencing - their memory returns” (p 77). Adoption identity is described as a parallel process that may exist even if the adoptee seeks reunification with biological counterparts. As a practicing professional and with the research previous discussed regarding identity development, it may be essential for the clinical professional who is adopted to gently integrate former and present self.

Further literature addresses identity development within the framework of social constructivism and adds additional perspective to adoption identity development. Authors Penny, Borders and Portnoy (2007) describe adoption and identity as a process in which an adoptee endures for the duration of his or her life. They state, “ adoptees must integrate a cultural heritage from their adopted family as well as a genealogical and cultural heritage from a birth family, about which they probably have limited knowledge” (p 30). They further discuss the negative implications of functioning as the adoptee progresses into adulthood but with the focus on loss of a previous life. They reviewed 100 adoptee narratives written by adoptees ages 35 to 55 years of age and developed five categories as it related to adoption: phase one, limited awareness, phase two, emerging awareness, phase three, drowning in awareness, phase four, remerging from awareness and phase five, finding peace with adoption. In addition, these adoptees were asked to evaluate connectedness to other individuals and evaluate quality of life.

The results found that 55% of adoptees were exploring adoption related issues and concerns related to adoption. One of the specific adoption related concerns focused on the ability to disclose to family members personal conflict regarding adoption. Results found that 75% of respondents felt that they could openly discuss adoption with family members, but 29% of phase

three and 38% of phase four selected this statement (Penny, Borders and Portnoy 2007). In other words, one's own personal process of adoption, and how it relates to identity, is influenced by a new acquired identity of non adoptive family, new values and expectations of the non adoptive family and the ability to for the adoptee to maintain the previous identity. Other findings explored connection with adoptive family and the self disclosure to search for biological counterparts. Respondents felt that they would hurt their adoptive parents due to a false sense of loyalty and did not have the conversation regarding the search because the adoptees felt the biological parents made the right decision giving up parental rights. All aspects of these findings suggest that identity development may have influenced adoptees disclosure to the adoptive parents. In addition, these findings indicated that there are varying experiences of adoption identity development and how individuals integrate former non adoptive selves with current adoptive selves. Overall, these phases did not necessarily address the varying contexts of the adoptive families but did address adoptees willingness to disclose searching for biological counterparts and general discussion of adoption (Penny, Borders & Portnoy, 2007). Literature has discussed that individual identity is arranged relationally; therefore, disclosure within a safe relationship has led to disclosure relating to adoption. If the practicing clinician identifies as being adopted, self disclosure may occur in response to a client, which supports the clinician's continuity of an adoptive self rather than the previous non adoptive identity.

Other literature grounded in social constructivism suggests that American values construct adoption loss and contribute to identity formation. Author Irving Leon (2002) states, "so much of kinship and family in American culture is defined as being nature itself, required by nature or directly determined by nature that is quite difficult, often impossible, in fact, for Americans to see this as a set of cultural constructs and not biological facts themselves" (p 652).

Leon describes adoption stigma and its influence on individual self esteem. He states, “ a developmental study of younger children’s beliefs about adoption indicated significantly more negative attributions of adoptees by nonadopted children than adopted children themselves” (p 656). This suggests that social interactions, social norms and societal expectations in America influences identities of those who are not adopted but interact with adoptees. Leon continues to address cross cultural findings in other countries as it relates to adoption and found that biological basis for the construction of personal meaning did not exist, the formation of what is ‘real’ did not exist but instead the connection within the parent child relationship endured. Adoptees are influenced by the societal constructions of adoption which may also influence sense of identity individually, relationally and within a group. Clinicians may choose to withhold this aspect of their identity and choose not to disclosure because of societal stigma related to adoption.

Authors Howe, Shemmings and Feast (2001) discuss adoptees’ feelings of difference as it relates to identity, feelings of belonging as it relates to identity, age at placement and gender differences associated with the willingness to discuss adoption. Howe, Shemmings and Feast (2001) state “ being adopted was felt to be an important and relevant difference that had to be acknowledged and addressed by adoptive parents. Adopters who did not acknowledge the difference- who rejected difference were denying a relevant and potentially important aspect of their child’s origins and identity” (p339). They continue, “the task of integration (adoptive family) does not sit comfortably with that of accepting that adopting and being adopted is relevant difference that has to be acknowledged by both parents and adoption children. The resolution of these potential tensions is a test of the parents’ abilities to handle the complex nature of the child-parent relationships implied in adoption” (p339). The age of adoption has

been a noted factor in an adoptees identity within an adoptive family. Howe, Shemmings and Feast developed a model in responses to adoptees identity development as it related to being adopted in a new adoptive family. There were significant gender differences within this study, which found that female adoptees were more likely to discuss adoption than male adoptees. In an article relating to self disclosure and gender, women were also more likely to self disclose due to projected boundaries in a supervisor-student relationship (Heru et al, 2006). This literature highlights and mirrors the therapeutic relationship. The supervisor must maintain certain boundaries within supervision which compares to the therapeutic relationship of a professional maintaining certain boundaries with clients. Both genders were found to disclose elements of their identities as it related to adoption within relationships, but females were more likely to self disclose in general. There were specific times in which the adoptees' chose to disclose elements of their adoption which could be accurate in describing how clinicians choose to disclose with clients.

Other literature by authors, Mary Jago Kreuger and Fred Hanna (1997), emphasize an existential perspective as it relates to adoptive identity and parallel identities of the former self and adopted self. Additionally, these authors acknowledge and discuss the development of identity by acquiring a sense of belonging in a non biological family but offer additional perspectives as to why adoptees search for biological counterparts in the frameworks of loss, meaningless, isolation and death. In addition, these authors speculate about the new acquired identity as a result of what has been openly discussed with the adoptee and what is unsaid creates assumptions and beliefs by the adoptee.

The existential perspective is essentially an individual's ability to make meaning of one's self in the world. Adoption literature often cites that adoptees have a lack of continuity in identity and is often described as problematic for future development into adulthood (Jago Kreuger & Hanna, 1997). Jago Kreuger and Hanna state "the primordial phenomenon of disclosing the truth of one's being offers a sense of grounding in one's own authentic being. It is through authenticity that one genuinely experiences being in the world. For the adopted individual, the uncovering his or her own truth begins with the awareness of the desire to search" (p 197). For those adoptees who remain conflicted about their sense of being in the world are expected to have difficulties in disclosing themselves and presenting themselves as authentic beings. This literature speaks directly to previously discussed literature regarding identity formation. Vignoles et al (2006) describe the continuity motive and the distinctiveness motive as ways in which individuals maintain continuous identity and differentiation from others. In addition, Vignoles et al argue that those who are motivated to maintain certain aspects of identity such as continuity and distinctiveness often describe and rate elements of those identities as central components of identity (2006).

Individuals who identify, acknowledge and have come to terms with adoption may be more inclined to self disclose. They will have developed the self-reflection and self-awareness to disclose this as a central component of his or her identity. More specifically, clinicians who do identify as being adopted, may be more likely to disclose because identifying as adopted is an effort to maintain self-continuity, a way in which the adoptee can relate to others by having a sense of meaning in the world. The use of self-disclosure and what the clinician decides to disclose will be influenced by the clinician's identity and life post adoption. The clinician may have refined skills related to self-disclosure and self reflection because he or she has always

questioned his or her own identity; making his or her ability to empathize with clients more possible in the nature of the therapeutic relationship. The nature of the therapeutic relationship with his or her clients will allow for the use of appropriate self-disclosure, but what the clinician discloses may ultimately be a product of an adopted identity.

III

Methodology

The purpose of this qualitative study is to explore the following question “Does adoption status influence the use of self disclosure in clinical practice?” One of the intentional purposes of this study is to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with concentration on adopted clinical professionals. In order to begin to explore this particular research question, a phenomenological framework is most appropriate for the research question. According to John Creswell (2013) a phenomenological qualitative study is, “an emphasis on a phenomenon to be explored, phrased in terms of a single concept or idea.. a philosophical discussion about the basic ideas involved in conducting a phenomenology” (p 78). A qualitative study would complement this research approach because “qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2013, p44). A qualitative study would allow for exploration of these particular research topic. With this particular research question, social constructivism has been utilized as the theoretical framework to explore identity and the use of self disclosure in the therapeutic relationship.

In order to begin to understand the experiences of the participants, semi structured interviews have been conducted and have been broken down into questions pertaining to adopted clinical professionals and non adopted clinical professionals. The semi structured interview is constructed to first establish an understanding of the participant by discussing prior experience, age, racial identification and a screening question specifically to address self disclosure. These questions described are as follows: “how old are you?”, “how would you define self

disclosure?” and “how do you identify racially?” The beginning of the structured interview are screening questions to establish clinical experience and explore clinical experiences. These questions used are as follows: “Where did you go to school to obtain your degree?” “Could you tell me a little bit about your role there?” These questions were included to determine whether or not the participant had the educational capacity and experience to discuss and articulate about self disclosure with clients. The questions then touch upon the nature of the therapeutic relationship which is to again, assess the participants understanding and perceptions of the relationship which may be used for data analysis. These questions are as follows: “how would you define clinical work?” , “what makes this work clinical?” and “would you say your relationship with clients is relatively the same across differing populations?”. Additional questions were developed in response to the participants statements regarding self disclosure, identity and adoption. Some are as follows, “are there any areas of identity that you feel as though I did not discuss and would like to discuss further?” As the interviews continued, new areas of focus have been developed in response to participants to include in additional interviews. These are as follows: “use of supervision and discussing self disclosure?” and “educational experiences around self disclosure and adoption”.

Sample

The goal was to recruit 16 participants evenly divided between clinicians who were adopted and non adopted. However because of limitations further described below, the sample consisted of 11 non adopted clinicians and 1 adopted clinician. The inclusion criteria included clinical professionals that are obtaining their BSW, be obtaining their MSW, have an LMSW, have an LCSW, have a PSYD, be a LMFT, be a behavioral specialist or a case manager that must be involved in clinical practice, at least two years clinical experience paid or non paid. The

inclusion criteria utilized focused on clinical professionals that have established a therapeutic relationship with clients in a professional mental health setting. Professions such as nurses or doctors were excluded from the study because although they have relationships with clients involved in a clinical setting, but they do not have therapeutic relationships.

The sampling strategy for the research question “does adoption status influence the use of self disclosure in clinical practice?” was convenience sampling. This strategy was used to connect to professional and personal networks in addition to snowball sampling. According to Creswell (2013) snowball sampling is, “identifies cases of interest of people who know people who know what cases are information rich” (p158). In order to I reached out to fellow colleagues and former colleagues who then referred me to more possible participants, which is a reflection of the snowball sampling methodology. Some of these colleagues have worked with individuals who have been adopted and may have networks for additional participants. A combination of convenience sampling and snowball sampling were useful to find research participants.

Due to the small number of clinicians who define themselves as adopted, I utilized my research supervisor as a means to reach out to Department of Children and Families in Massachusetts, reached out to my field supervisor through Smith College and reached out to Department of Children and Families in Connecticut and Adoptions from the Heart in Connecticut. The recruitment process has been substantially difficult because of the inability to find an adoptive community, which will be further addressed in the discussion portion. In addition, recruitment has been significantly difficult due to agency policies. In the beginning of the recruitment process I had reached out to Rushford, a mental health and addiction services agency to recruit clinicians, but was unable to utilize this as a recruitment agency due to policies

in place. Convenience and snowball sampling were the only successful ways to recruit participants but I encountered barriers despite my persistence.

After receiving the approval, social media was utilized in order to reach out to colleagues and individuals in my social networks. Some of the individuals that responded were prior colleagues and were interested in participating. Some of the other individuals that “commented” on the post stated that they were adopted, but were unable to participate due to the focus of the therapeutic relationships in the thesis. This response in itself was surprising because some of these individuals were not previously identified as adopted. Unfortunately, these individuals cannot participate in the study because of the credentials I have specified which has left out individuals that are not practicing clinically but are adopted. Social media was utilized because of the accessibility, but the use of Facebook specifically, excludes those who are not utilizing Facebook to connect with others. When considering this, I have also utilized Instagram and posted a picture of the thesis approved recruitment document. One individual reached out and wanted to participate, but this participant was not adopted.

One of the ways I attempted to gain adopted participants was by reaching out to local and community run support groups for adoptees. One of the respondents contacted me via telephone to discuss participating in my thesis study. I contacted three support groups held locally in the town of West Hartford, Connecticut. The group facilitator responded and provided me with individuals that could be possible participants. The facilitator forwarded my thesis information to those who attend the group and were open to participation. One respondent discussed the process of reunification with her biological family and then inquired the status of my personal reunification with my biological family. The conversation concluded with me self disclosing to the clinician that I was not pursuing a connection with my biological parents.

Despite multiple outreach phone calls to this potential participant, she never returned my calls and therefore did not participate in the study. This has prompted me to consider the different subgroups within the adoptee community. With the understanding of different adoption stories, it is only safe to assume individuals are at different places of acceptance and awareness and because of these differences; adoptees do not share a unified experience of “adoption” and may in fact, feel different from adoptees within in different stages. Further exploration of subgroups within adoption would be beneficial to explore and will be further discussed in the discussion. Another participant, who identified as adopted through the support group, also responded via email. This participant did not necessarily meet the criteria for participating in my study but provided similar services comparable to a clinician, specifically with the adopted community. This mental health professional came to understand her role from a different perspective, which has allowed me to consider the different perspectives that individuals hold of their professional jobs. Although she was not definitively a clinician, she was providing services that would be comparable to the therapeutic relationship, but this participant did not identify as such and did not participate in the study.

Interestingly enough, the individuals who participated in the study were individuals I have had prior relationships with or who I have had personal face to face connection with. This experience reflects the theoretical orientation of social constructivism and emphasizes the importance of relationships, another significant component to my thesis. As I was recruiting many of the individuals who responded to me were adopted but they did not meet the criteria for participating. The only participants that inevitably discontinued or did not follow up for a second appointment were adopted clinicians. The one adopted clinician who did participate was a clinician who had years of psychotherapy to address adoption. Future research may include

exploration of how adoption status influences relationships later in life. This part of the results was not something I had anticipated, but allowed space for me to consider that different people engage with adoption status in different ways.

Of those who are participated, I did not anticipate a definitive number of male clinicians or definitive number of females, but the entire sample were females limiting the male perspective. I had anticipated a much more diverse sample and only interviewed three clinicians of color. The sample that I have used will not be generalizable due to the number of participants and strategy to recruit. There were not a significant amount of participants to completely understand the experience of being adopted and a clinician in order to reach a saturation of data.

Ethics and Safeguards

After constructing the semi structured interview, I had to determine what type of interview is most appropriate to accommodate the needs of the research being conducted and the interviewers themselves. In the beginning of the research study, most the interviews occurred in person but I have left the interview structure itself up to the interviewee and telephone was also available if necessary. In addition, participants who agreed to participate reviewed the consent in the beginning stages of recruitment. The participants were encouraged to sign whether or not they would like to be recorded and video recorded. This was an option left up to the participants. In addition, the consent form included the possibility of additional information to obtained by the researcher. This section was included to either clarify statements that had been made or to gather additional information.

In order to ensure confidentiality of participants, no use of real names is within the documentation. When transcribing the interview, I have utilized pseudonyms that will assist me to remember the participants, but are not actual identifies for the participants. As of right now,

interview notes and the interviews themselves are locked in drawer I only have access to. In order to conduct these interviews, I had to receive an IRB approval from Smith College School for Social work and have all of the participants sign informed consent.

Data Collection and Data Analysis

In the tradition of qualitative research, data analysis and data collection happened concurrently. Due to financial limitations, I have decided to transcribe my own interviews. I have typed the interviews and have printed the written transcripts. I have highlighted significant phrases or commonly stated phrases among the participants. In order to organize the data, phenomenological data analysis utilizes horizontalization or “highlighting significant statements, sentences, or quotes that provide an understanding of how the participants experienced the phenomenon” (Creswell, 2013 p82). After locating finding these significant statements, I began to organize the data by textural description or themes, or structural description, which is context associated with the experience (Creswell, 2013). The semi structured interviews have produced new areas of focus, which has led to the development of new questions to be discussed upon interviewing. This is reflective of the terminology Creswell (2013) utilizes bracketing or “suspending our understandings in a reflective move that cultivates curiosity” (p 83). In order to explore the professional and personal experience of mental health professionals, I had to step away from assumptions that have been informed by my own personal experience to explore topics that have emerged from the interviews.

Upon any confusion, or the researchers inability to fully comprehend an experience, I contacted participants for further clarification and member checking. Creswell (2013) states, “triangulation is when researchers make use of multiple and different sources, methods, investigators and theories to provide corroborating evidence. Typically, this process involves

corroborating evidence from different sources to shed light on a theme or perspective” (p 251). By contacting participants and discussing current findings, the participants can offer feedback about experience or about previous themes that have been developed to maintain validity. The audio recordings that I have utilized have been substantially helpful when transcribing the interview. After conducting of the interviews, codes have been developed to focus upon the actual words of the participants and general experiences relating to certain questions of the semi structured interviews. A code by themes has been developed as well as a code for words to assist with reliability.

IV Findings

Table 1

General Demographics of Participants Who Confirmed Participation

<u>Demographics</u>	<u>%</u>
Age	
20-25 years	33.3 %
25-30 years	33.3 %
30 + years	33.3 %
Race	
White Non Latino	75%
Latino	8.3%
Asian	8.3%
African American	8.3%
Education	
BSW	25%
Obtaining MSW/MSW Licensed	58.3%
PhD	16.6 %
Biological Sex	
Female	100%
Male	0%
Gender Identified	
Female	100%
Years Clinically Practicing	
1-2 years	16.6%

3-4 years 58.3%

5+ years 25%

N=12 total participants

TABLE 2

General themes of self disclosure and statements of participants

THEMES		QUOTATIONS
Client focused self disclosure		<p>“Redirected it back to the purpose of treatment”</p> <p>“a way to connect”</p> <p>“depends on the setting”</p>
Therapist identity focused	Clinicians discussed personal identities that influenced their practice with clients	<p>“racially insulting me”</p> <p>“I have anxiety too”</p> <p>“sarcasm and humor”</p> <p>“I can’t say it has entered the room”</p> <p>“I think, well I’m a mom too”</p>
Therapist theoretical orientation focused	Clinicians reflected upon their theoretical orientations and style of practice	<p>“Is it going to help the client?”</p> <p>“a way to connect to someone in relation to something they are going through”</p>
Therapist experience/use of supervision	Clinicians discussed influence of educational institutions and reflected upon professional development	<p>“should really be discussing it in supervision”</p> <p>“What I learned so far stay away from it”</p> <p>“It changed from what I learned in school to how I do practice”</p>

TABLE 3

Adopted themes parallel identity process to non adopted clinicians

THEMES	QUOTATIONS	
Identity as a therapist and as an individual	Adopted clinicians had similar experiences	<p>“It’s one of my many identities but it’s not my main identity anymore”</p> <p>“I felt I was a whole person after reconnecting with my biological family”</p>
Connection and isolation	Clinicians, non adopted and adopted discussed connection and isolation; further exploration and understanding adoption and adoptees experience	<p>“I felt alienated growing up”</p> <p>“she realized that I understood”</p> <p>“I considered adopting with my partner”</p> <p>“I took a class on it in school”</p> <p>“ I feel like the system needs to do more”</p>

RESULTS:

Identified below are themes that emerged from 12 interviews of clinical professionals regarding the use of self disclosure, identity and adoption: 1. Client focused self disclosure; 2. therapist identity focused self disclosure; 3. therapist theoretical orientation focused self disclosure; 4. duration of experience and use of supervision as an influence on self disclosure; 5. identity as a therapist and as an individual; 6. the need for connection and the isolation as it relates to identity. The themes that have emerged as a result of interviews do not however fully address the initial research question of “does adoption status influence the use of self disclosure?”

Client focused self disclosure

All of the interviewees that participated identified that they have encountered the pressure to self disclose or were called upon by clients to self disclose. The operational definition of *self disclosure* will be as follows: “interactions in which the therapist reveals personal information about him/herself [self revealing] and/or reveals reactions and responses to the client as they arise in session [self involving]” (Hanson 2005 p 96) All participants identified professional boundaries and the strategic use of self disclosure. The participants that had just recently graduated with their MSW or had their BSW, would often reflect upon the nature of the treatment relationships. Often, these participants redirected the questions clients asked back to the nature of the work as one participant stated “I would redirect the question back to the purpose of treatment”. Other participants that had identified as using client focused self disclosure described it as “a way to connect with their clients” and often reflected the nature of the therapeutic relationship rather a space to disclose personal information. One of the participants discussed context as an important factor in the use of self disclosure. This clinician stated “I think it depends on the setting” and reflected upon the characteristics of the clients that she interacts with. This clinician then went on to explain that the therapeutic relationship and context of the relationship with mandated clients as considerably different than with those receive services because of personal choice. Of the twelve participants, two worked directly with mandated clients and both discussed the context of the relationship as a factor that influences client focused self disclosure.

Therapist Identity Focused

All of the clinicians that participated discussed personal attributes reflecting identity but clinicians discussed identity under different circumstances. Two clinicians identified their ethnicity and race as influencing interactions with clients. One clinician of color specifically referenced a client that “was racially insulting me” based upon her physical presentation. In addition, this participant explained “the client asked if I was capable of doing the work because of my age? But the race part came up initially. The client claimed that I was young claimed that I was young, but also stated oh, you’re just a young Indian. I knew she was in crisis, but some part of me felt compelled to answer to that but I chose not to”. Three of the twelve participants were clinicians of color and the rest were non latino females. None of the white clinicians discussed an intersection of personal racial identity with interactions with clients. One participant stated “I can’t say that it has entered the room”. Three white clinicians expressed pieces of their personality as it relates to personal identity. These participants stated “I have anxiety too” and “I usually am sarcastic and use a lot of humor”. Three clinicians identified as having children of their own and utilizing personal roles of being a mother as an influence of self disclosure and personal identity; one participant specifically this as a way of connecting and self disclosing. This participant stated “well, it was difficult because I am a mother too”. It was evident that clinicians of color spoke more openly about racial identity as it intersects with self disclosing to clients, whereas white clinicians very rarely stated that their racial identity influenced self disclosure.

Therapist style as an influence on self disclosure

All participants referenced theoretical orientation or style of practice as a factor that influenced the use of self disclosure with clients. Four of the participants that graduated with their MSWs reflected upon the nature of the therapeutic relationship and goals of treatment by voicing some variation of the statement: “I thought, is it going to help the client?”. Other participants identified situations in which they used self disclosure as a way to connect to their clients. One clinician reflected upon an interaction with a young male student who recently lost his dog and self disclosed the loss of her dog when she was a child as well. All of the participants referenced self disclosure and the appropriate use of self disclosure as a way to connect to someone in relation to something that they were going through. Different contexts of therapeutic relationships often changed the depth of personal self disclosure. One participant who worked with court mandated clients stated “well, I knew what she was talking about and acknowledged that, but when she asked how I knew, I had to somewhat lie. I didn’t want her knowing that I went to that store too”. This is a direct reflection of what these participants had identified throughout the interview as boundaries of the therapeutic relationship, and also a reflection of varying contexts that may influence the use of self disclosure. Many clinicians referenced their personalities and styles such as: personal centered, relational, psychodynamic, strength-based which impacted the foundations and development of the therapeutic relationship. One participant, who identified as using a relational approach stated: “sometimes I do it more in the beginning when engaging with the client to let them know that I am genuinely interested”.

Number of years with experience and use of supervision

The use of self disclosure was often influenced by the number of years of clinical experience of the interviewees. The majority of those interviewed had been practicing 3-4 years and the experience had been related to school based internships. Three of the participants had been practicing for more than 5 years. Duration of experience often influenced the understanding and reflections upon self disclosure. One more experienced clinician stated “well, in school they teach you things, especially with using self disclosure. When I was going through school they said absolutely not and that was when psychotherapy really had established itself in the late 70s, very Freudian (laughing). I still am meaningful when I use self disclosure but I have come to understand it as a tool not just something you do casually”.

All of the participants who had recently graduated had a more rigid response to self disclosure and often stated “no I do not use it” but when further explored referenced times in which they had disclosed to clients. One MSW recent graduate explained that “we were basically told to stay away from it” but later identified that she had disclosed to a client. Duration of experience often reflected a comfort in the use of self disclosure and understanding self disclosure as a tool rather than something that should not be used. One more experienced clinician stated “ it changed from what I learned in school to how I do practice” and further explained that self disclosure and the use of self disclosure is a tool of practice that assists in the reciprocal relationship with the clients she sees. Of the participants that recently graduated with their MSW, four clinicians discussed the use of supervision as a space to discuss clinical decision regarding self disclosure but could not determine specific times in which they had directly discussed situations with their supervisors. One participant stated “well, I definitely bring that up in supervision” and yet later stated, “sometimes I have so much to discuss in supervision and I do forget”.

Adoption themes parallel process: identity as a therapist and as an individual

One clinician identified as adopted and participated in the interview process. This clinician had similar conceptualizations of the use of self disclosure as those participants who were not adopted. Additionally, this participant reflected upon many aspects of her personal identity, considering adoption status both personally as a therapist and as an individual identity. This participant stated “it is one of my many identities but its not my main identity anymore”. This clinician discussed that she had been adopted at birth but felt disconnected to her adopted family because of her adoption status. The clinician then went onto discuss her journey connecting with her biological family stating, “I felt I was a whole person after reconnecting with my biological family”. She stated that after this experience, her adoption status no longer was the center of who she perceived herself to be. This clinician utilized self disclosure which was directly related to her adoption status with a client who was also adopted as a means of “connection”. This participant was the one of two participants that indicated a significant identity shift. The other clinician later identified in life as lesbian but did not consider sexual orientation as an influence on self disclosure, but rather just personal identity.

Connection and Isolation

Found within almost all interviews were themes of connection and isolation to clients professionally, personally and in relation to adoption. The one clinician who identified as adopted, found herself “alienated” growing up an feeling set aside in her adoptive family. This clinician discussed that her adoptive family was in support of reunification due to the nature of adoption and she found discomfort in peer relationships. This clinician discussed that her closest friend in childhood was also adopted and that this relationship helped her through childhood.

This clinician explained that she often felt disconnected from her family and felt different than her peers, who were not identified as adopted. The participants who were non adopted clinicians never made reference to alienation or that their identity had been compromised unless they were considering pieces of their identity in marginalized populations. One participant reflected upon the nature of defining herself as a lesbian and considered sexual orientation as a piece of her identity. This participant did not consider her sexual orientation as an influence on self disclosure, but through out the interview identified that this aspect of identity, may influence the therapeutic relationship and self disclosure.

This adopted clinician also discussed a self disclosure to a client who also was adopted and stated that there was a change in relationship for the better. The clinician had stated “she felt like no one understood her or knew where she was coming from. She was just there and felt as though because she was adopted she wasn’t able to connect with anyone”. The participant continued to state “it was a changing point in our relationship. I had to think about timing and consider whether or not my personal disclosure would benefit her. It did significantly and from then on our relationship changed positively. It was almost as if I knew where she was coming from because of that shared disclosure”. Some of the other participants indicated that they had disclosed and it positively impacted the nature of the therapeutic relationship, but none referenced adoption status because they had not experienced it or facets of their identities in childhood.

At the same time, participants who were not adopted also found the need to connect with clients in a different manner other than adoption or birth status. One participant stated “well, I was working with a younger boy who lost his dog. I couldn’t help but to think of my own loss of

a pet when I was younger. I disclosed that I had lost an animal too growing up.” This statement reflected a shared personal experience relating to loss and the clinicians decision to self disclose to establish connection, similarly but yet different than those identified as adopted. After discussing further this clinician concluded “this self disclosure wasn’t harmful and probably was the reason why he kept coming back. He felt safe and supported in that”. The nature of this disclosure was in fact a personal self disclosure, but not one of which reflected personal identity to form connection. In the disclosure used by the adopted clinician, the use of her self disclosure was to establish connection to a client who felt misunderstood and alienated. Although these disclosures both emphasize the connection between the client and clinician; both expressed a shared experience but one expressed adoption identity. Another clinician referenced a relationship with her client who was a young adult. She stated “well, I know that this person would come in and talk about all of the wrong choices that she made over the weekend or at least that is what I anticipated because that’s what she always does, but surprisingly she didn’t. She ended up making a different decision and not socializing with the people I thought she would be with over the weekend. Couldn’t help but feel a certain way”.

Despite differences in identity, seven out of the twelve participants discussed adoption and the need for connection and isolation. At the end of the interview, the interviewees were asked to reflect upon the current word of “adoption.” Seven out of twelve participants discussed their interest in adoption but the need for change within the current system. One clinician specifically stated “I feel like the system needs to do more” and further discussed her experience in working with a client who was adopted and currently in middle adulthood. She described her client and stated “he still feels that everyday” and “it’s hard to help him” indicating that his adoption has shaped his life experience. Three non adopted clinicians stated that they were

considering adoption and have considered it before. One clinician who identified herself as lesbian is considering adoption instead of alternative means to have children. Both non adoptive and adopted clinicians discussed the need to further explore this area of research and life experiences of adoptees. Two participants stated that there needs to be further education and a foster care system change. One participant stated that she had taken a class on it as an elective while in school and still feels underprepared working with this population. One participant discussed the process of aging out and its impact on children who are not legally adopted. Seven out of twelve participants indicated that the adoption and foster care system have a lack in resources for foster and adopting parents. Despite the differences, both non adopted participants and adopted participants suggest that further research is necessary and essential for children in the foster care system or pending adoption. The participants indicated the necessity to support individuals who are looking to adopt such as continuing education to support children who will become adopted to enhance the relationships post adoption. As a result, families who are integrated into a family post adoption, will have the resources to support children integrating into families. In addition, these participants identified individuals who are not adopted and “age out” of the foster care system as a current concern which is a factor that proceeds isolation and diminishes connection.

V

Discussion

The operational definition of *self disclosure* will be as follows: “interactions in which the therapist reveals personal information about him/herself [self revealing] and/or reveals reactions and responses to the client as they arise in session [self involving]” (Hanson 2005 p 96) . The clinical professionals that participated perceived self disclosure both negatively and positively, but all identified using self disclosure in the therapeutic relationship and treatment context. Other uses of self disclosure in treatment specifically reflected the identities of clinicians as they practiced with clients. These participants discussed personal aspects of their identities as well as theoretical orientations as an influence on the use of self disclosure. Several of the newer clinicians, who have just recently graduated, indicated the use for supervision to continue to explore self disclosure as a mechanism in the therapeutic relationship. All clinicians referenced and discussed educational institutions as an influence on the use of self disclosure, but only the more experienced clinicians identified self disclosure as a source of professional development to be integrated into clinical repertoire. Of the twelve participants, one identified as adopted. Analysis of the data from this individual interview suggests that there is a parallel process in the use of self disclosure and the intersection with professional and personal identity. In analyzing data from the adopted participant’s interview, themes emerged related to the use of self disclosure and identity that were distinct from non adopted participants. However, these themes must be interpreted cautiously, as they emerged from a singular interview.

Many of the interviewees shared personal experiences related to their own identities within the context of the therapeutic relationship. One participant discussed her own personal

reflections of her identity, stating that race was a core concept of her identity. The research discussed in the literature review highlighted how individuals hold different aspects of their identity, but the ones that are most core to the individual, are held most central. Vignoles et al(2006) state, “if identity construction is guided simultaneously by multiple identity motives, then- over time and in an absence of external constraints - a physiologically healthy individual will likely find non conflicting ways of satisfying each motive” (p328). Research focusing on identity supported and reflected the clinician of color who expressed that her identity was reflective of her racial identity, but that her identity was questioned by a client or external constraints. This reflection is a direct result of unconscious racism which was explicitly inquired about regarding the clinician’s race.

In this study, individuals who identified themselves as white rarely considered their race as a factor influencing the therapeutic relationship or other aspects of clinical practice. This suggests that individuals of color hold their race central to their conceptualization of personal identity and individuals who identified as white did not necessarily consider race within the room. Many of the white clinicians did however; highlight aspects of their identities in which they found most dominate. For example, one clinician had stated “I have anxiety like you too” or “I considered me being a mother”. Clinicians utilized these aspects of their identities to connect with clients whether through personal self disclosure, and use of self and use of empathy while working with clients. Although these clinicians did not necessarily address race in clinical practice, these individuals made reference to these aspects of their identities as the core ways in which they established and nurtured ongoing connections with clients.

Clinicians who identified as white displayed limiting understandings that a white identity has influence and power over their clients. Inevitably, these clinicians acknowledged the power in the relationship but failed to address and be held accountable for such. Research reflected in the literature review discussed the influence of egocentrism and the influence upon self disclosure. Falk and Noonan Wagner (1985) state, “perspective taking is manifested by behavior that indicates an active effort to understand and incorporate the information and feelings presented by the other person without making a value judgement” (p560). These authors continue to include egocentrism within the research and how self disclosure is influenced from a place of power. Of these clinicians who identified as white, none considered this perspective, but acknowledged their power in the therapeutic relationship.

Adoption Identity

The adopted clinician also identified as a white female. This clinician expressed alienation throughout childhood due to her adoption status with social connection and referenced a relationship in childhood that encouraged social connection; another adopted friend. The clinician that was interviewed shared the importance of processing her biological family as a part of her story. After reunifying with her biological family, the participant stated that she then considered her status as an adoptee just another aspect of her multifaceted identity. This clinician discussed disclosing to a client about her adoption status after an ongoing struggle with a client in a therapy session. After disclosing her personal adoption status the client reacted differently to the clinician. Interestingly, this clinician doesn't identify adoption as a core or central component of her identity but rather something that she has processed through years of psychotherapy before clinically practicing. This identity process is similar to the presenting literature suggesting that there was a reduction of external constraints (Vignoles et al, 2006).

Of the other clinicians interviewed, the non adopted clinicians did not reference portions of their identity that had radically shifted except those who identified in a marginalized population. One clinician discussed how her sexual orientation had been more considered as she identified as a lesbian during adolescence and how this influenced her immediate and personal life, but did not consider this while working with clients. As she became to understand her sexual orientation, her considerations of this portion of her identity changed personally but not professionally.

Self Disclosure

There was a general consensus and saturation of data indicating the interviewees understood self disclosure. Some clinicians identified this as “personal facts relating to historical history..anything personal relating to yourself as the clinician”. The articulation and details related to self disclosure varied based upon age and amount of years clinically practicing. Of those who described self disclosure, the more general definitions were given by those who had recently graduating and just had started to practice. Those who felt ambivalent about the use of self disclosure were individuals currently obtaining their Masters in Social Work or who just graduated. Many of these individuals also referenced the need for supervision and the use of supervision regarding self disclosure. The literature however, indicated that like a therapeutic relationship, there are boundaries that are established which may influenced by the nature of the relationship. Gunn and Pistole (2012) state, “Fear of evaluation and need to appear competent can provoke intense even detrimental anxiety, failure to manage emotion effectively may hinder the trainee’s ability to apply knowledge and disclosure to the supervisor” (p230). These findings suggest there are factors which influence ability to disclose in supervision. When asked in further detail, most of the newly graduated clinicians made general statements about the use of

supervision. These statements also support this research indicating that the use of supervision and what was disclosed was based upon perception, bias and the supervisor trainee relationship (Gun & Pistole, 2012). The clinical professionals who had been practicing for a longer period of time arrived at their own understanding and used self disclosure in relation to their authentic therapeutic self. Some of these individuals referenced their education received at an earlier stage of professional development but then shared that they developed their own use of self disclosure over time.

Therapeutic Relationship as Reciprocal

Of the interviewees that described this professional development of self disclosure, these individuals also discussed a personal and professional self within the room. They identified that they are a person aside from being a clinician and that these are not necessarily mutually exclusive. This new perspective of the person within the therapeutic relationship has been found within the literature (Gellar, 2003; Rosenblatt, 2009; Shoholt, 2005). Despite the time individuals had spent practicing, both newly graduated and experienced clinicians identified some elements within the therapeutic relationship and how both therapist and client establish the relationship; trust, empathy, ability to listen and boundaries. Almost all of the clinicians discussed therapeutic sessions with their clients that indicated that clients impacted them professionally or personally. These exchanges support the view that that the nature of the therapeutic relationship is reciprocal and by definition, is evolving.

Limitations and Recommendations

The information obtained in these thesis interviews did not necessarily address the initial research question because of the difficulty in sampling adopted clinicians and instead has given

direction to new areas of research. These new areas would further explore adoptees in general and non adoptees as relating to the construction of identity. The research findings that came from this research study emphasize the importance of social constructivism and the relationships individuals develop with others.

In order to obtain participants for my research study, a convenience sampling method was used to recruit. Interestingly enough, the participants who responded, were individuals I have had prior relationships with or who I have had personal face to face connection with. Personal connection appeared to be the common factor as to whether or not participants followed through with participating; all but one participant I had prior interactions with. This experience reflects the theoretical orientation of social constructivism and emphasizes the importance of relationships, another significant component to my thesis. As I was conducting my research, many of the individuals who responded to me were adopted but they did not meet the criteria for participating. Some of the professionals that I interviewed did not have the clinical relationship with clients that that study required. If I were to replicate this study, I might consider a broader understanding that the type of relationships differ rather than understandings of self disclosure. Due to the perceptions of the professionals as well, it may be beneficial to broaden professional titles considering individuals define themselves professionally in different ways.

Research may want to examine adoption from a more general perspective considering there is limited research pertaining to adoptees. This research may want to explore adoption disclosure from those who do not clinically practice. Some individuals were public about their adoption whereas other individuals were not. Further exploration regarding disclosure of adoption status may help future practice with adoptees to gain an understanding of personal

experience of adoption. From the experience I gained an understanding of the different experiences of adoption and the broad understanding of “being adopted” is not a shared experience. Future projects may wish to support that a clinical professional in approaching an adoptee with this understanding of differing experiences which lead to different feelings towards adoption.

In addition, this research has indicated the necessity for adoptees to have community aside from online connection; a fundamental need for a human is connection with others. The difficulties in finding this sample population may be a parallel process and experience of adoptees; they are in existence but have limited connections to other adoptees. Other considerations related to adoption may include, what motivates individuals to adopt? Many of the clinicians that I had interviewed were interested in adopting children and many clinicians stated that they understood the hardships that may come from doing so. Of the individuals I interviewed, all but the adopted clinician expressed interest in adopting. Future research may look to explore whether or not the nature of the helping profession influences desires to adopt because we are “in the helping profession”. What personal characteristics or motivations do individuals have to adopt?

More research is needed to develop a clearer understanding of racial identity development for white clinicians and how it influences clinical practice. This research may be beneficial in the creation of workshops that encourage the discussion of privilege and encourage the discussion of what being white means. Many of the interviewees were white clinicians and had graduated from programs in which they received their Bachelor’s in social work. These clinicians recognized areas in which they held power over their clients but could not identify that

race had influenced the nature of therapeutic relationships. Some clinicians felt mistrusting of clients in different settings ie. Probation or transitional housing which could be helpful in future research as well: understanding stereotypes informed by context and racial identity development.

Although I did not receive the turnout of adopted clinicians that I had desired, there was a lot of rich information I received whether it be from adopted or non adopted clinicians. While conducting my thesis, I have reconsidered connecting with my biological sister who was adopted as well. My adoptive family has been in support of connecting with biological counterparts and has been since my childhood. Interestingly, I have reconnected with my oldest brother after finding out I had a biological nephew; which was the central reason for him reaching out, the social connection to the biological counterpart. In addition, my middle brother and I have lost touch through the years. Our lives grew distant as we entered adolescence. He had a child with a female who recently contacted me. The woman wanted her son to know his biological aunt. The original research regarding adoption emphasized an existential perspective to make meaning of one belonging in the world and I find this existential desire within each individual not just adoptees. Social connection and the desire for biological connection are found within individuals who are not necessarily adopted. Future research may want to examine and further examine those considering reunification with biological counterparts in general because there is something significant about biological counterparts who have been socially disconnected. This was reflective in the responses given by the adopted clinician and the adopted clinician who inevitably withdrew from the study. This was an aspect of other interviews that were not considered before and may indicate the need for future research: the reunification stages with a biological family post adoption. The adopted clinician discussed conflict with her adoptive family while wanting to reunify with her biological counterparts, “ my sister actually had a really

difficult time. If anyone were going to work with a family wanting reunification, know that it is emotional and it can stir up a lot of things”. These statements indicate that the reunification process and different stages of reunification may be an area of focus for those working with adoptees who want to reunify but also for the clinical professional to understand that adoptees may not want reunification. This portion of my thesis went unexplored because the participant that was officially interviewed, desired reunification. The interviewees that withdrew also desired reunification but even within these experiences, there is the alternative experience of why individuals choose not to reunify, which may be beneficial for clinical practice.

Future research may want to further examine this complex understanding of the clinical professional, a more intricate look within the co-existing selves which appeared to be a parallel process for those who identified themselves as adopted. The clinician that identified herself as adopted utilized self disclosure with an adopted client to connect within the therapeutic relationship but stated that she does not consider doing so with other clients. This emphasizes that adoption status may influence self disclosure but context is considered. While conducting some of the interviews, some interviewees disclosed pieces of their historical background that I did not know prior to the interviews. Most of these interviewees, I had relationships with and the disclosure within the context of the thesis interview was surprising. One individual disclosed that she had a trauma history and another who was unable to work with divorced clients because of their own experience. The degree of involvement or degree of relationship would be interesting to examine to consider whether or not these influence the use of self disclosure in addition to context.

In conclusion, there is emerging evidence to suggest that self disclosure may be influenced by adoption status but this study failed to answer the initial research question however, this research has illuminated considerations for future research. The one adopted clinician that did participate in the study confirmed that there was an identity shift from pre-adoption to post adoption where she felt disconnected and then a whole individual. The general participants indicated the need to explore and continue to develop an understanding of the adopted community and the societal implications of societies disconnect or lack of awareness. The inability to find participants who identified as adopted may indicate that this population could be hidden and disconnected. The individuals who initially desired to participate and then retracted, felt compelled for unidentified reasons. Furthermore, the experience of adoption varied and should be understood person to person identified as adoption. The majority of these participants were newly graduated and have identified that self disclosure is controversial yet beneficial in the context of the therapeutic relationship. Additionally, this study suggests that newly graduated clinicians who identify as white, have limited understandings of racial identity within the context of the therapeutic relationship. The lack of awareness has the potential to wound clients of color by continuing to create oppressive dynamics within clinical practice and unconsciously promote racism in practice.

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APPENDIX A : HSR REQUEST TO REVISE LETTER



School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

October 28, 2015

Heather Smith-Jackson **A16**

34 Hillside St,

Newington, CT 06111

Dear Heather,

Thank you for the effort you have put into your Human Subjects Review (HSR) application. Our job as a federally mandated human subjects review committee is to make sure that all research projects which we approve follow federal guidelines for research with humans, including informed consent, protection of vulnerable participants, the ability to withdraw from projects, appropriate storage and collection of data, and other items discussed in the HSR manual.

Part of our job is to ensure that the research results are worth the risks and costs to the participants. The actual benefits to the researcher, participants, and the field of social work, must be worth the time and energy participants will put into being a part of the study. Projects that are unclear in their questions and methods may lead to results that are not beneficial to the participants or to the field.

Attached you will find your proposal with our required changes in **MS Word Track Changes** and our requests for revisions marked as *New Comments* in the margins. These comments will provide guidance to make substantive changes in accord with HSR federal guidelines for research.

Please make all changes to your research proposal with **MS Word track changes** or indicate changes in another way (e.g. bold type or highlighted type) so they are easily read in order to

speed the return of your revision. If you feel we have misunderstood your study and there are changes you do not wish to make, please explain in the margins with a *Comment/s*. Sometimes we ask for changes that do not make sense to applicants because something was unclear to us and your explanation can clarify these issues.

Please understand that we function with a collaborative model- we want to help all applicants learn from their research while protecting all human subjects. Should you have any concerns about committee comments, please review with your thesis advisor, who may follow up with a contact to the Chair, HSR Committee.

Please return your application to Laura Wyman at lwyman@smith.edu. Please label each document you send with **your name, the term "HSR," the term "Revision", and the number of the revision**. As an example, if your name is Sara Jones, we should receive an application revision document like this: "SaraJones HSR Revision1.docx".

Please label the subject line of your email as HSR Revision.

Please note that most of your correspondence will come from me through Laura.

Sincerely,



Elaine Kersten, EdD
Co-Chair, Human Subjects Review Committee

CC: Julie Berrett-Abebe, Research Advisor

APPENDIX B: HSR RESUBMISSION APPROVAL LETTER



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

November 8, 2015

Heather Smith-Jackson

Dear Heather,

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,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

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

CC: Julie Berrett-Abebe, Research Advisor

APPENDIX C: INFORMED CONSENT

October 10 2015

Dear Potential Research Participant,

My name is Heather Smith-Jackson and I am a graduate student at Smith College School for Social Work. I am conducting a study on how adoption influences the use of self disclosure from a clinical perspective. The data that is found will be used in my master's thesis. You were selected as a possible participant because you are a practicing clinical professional and may have been adopted. If you are interested in participating in this study, you must have a MSW, LMSW, LCSW, PSYD or MD who has two years of clinical experience either paid or non paid. If you choose to participate, we ask that you read this form and ask any questions that you have before agreeing to be in the study.

One of the intentional purposes of this study is to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with concentration on adopted clinical professionals. This study is being conducted as a research requirement for my master's in social work degree. Ultimately, this research may be published or presented at professional conferences.

If you agree to be in this study, you will be asked to do the following things: after accepting role of participant, there will be a 45 minute in person interview session. I will be asking questions specific to identity, self disclosure and adoption. I will ask for you to provide demographic information about yourself. The interview will be tape recorded and I will be taking notes reflecting body language. I may contact you by telephone to gain a more clear

understanding of your responses or to contact and discuss whether or not my own observations are accurate.

This study has the following risks. There is the possibility that discussing material may resurface unsolved feelings regarding adoption. There is a possibility that there will be feelings regarding adoption that may trigger me, the interviewer. In addition, those clinical professionals who are not adopted may be triggered discussing adoption as well. If these professionals discuss emotional distress, I will provide them with a list of providers in the town that the professional lives in. The benefits of participating in this study include: adopted clinical professionals sharing experiences that are not discussed in common scientific literature which directly influences the knowledge students are offered and knowledge about marginalized populations, specifically, clinicians who are adopted. The benefits to social work practice include a more clear understanding of the marginalized population of adult adoptees without focusing on the outcome or mental health. This study would contribute to literature that views clinical professionals as human beings with conscious decisions to self disclosure and personal reasons for doing so.

Your participation will be kept confidential. With the exception of my research advisor and myself knowing demographics, the interview and results, will be kept anonymous. After I transcribe the interview, I will utilize pseudonym instead of your actual name. In addition, I will lock consent forms, audio tapes and interview notes in a locked room only I have access to. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage

period. We will not include any information in any report we may publish that would make it possible to identify you.

You will receive a 5.00 gift card for Starbucks for participating. The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study 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 up to the point noted below. 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 by 12/31/2015. After that date, your information will be part of the thesis, dissertation or final report.

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, Heather Smith-Jackson, hsmithjackson@smith.edu or by telephone at 860 805 6700. If you would like a summary of the study results, one will be sent to you once the study is completed. 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.

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. You will

also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

1. I agree to be [audio or video] 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: _____

Please return this consent form to me by 2 weeks within receiving to indicate intention of participating in the study (I suggest that you keep a copy of this consent form for your records).

If I do not hear from you by then, I will follow up with a telephone call.

If you have any further questions about this study, participation, rights of participants, or this consent form, please feel free to ask me at the contact information below.

Thank you for your time, and I greatly look forward to having you as a participant in my study.

Sincerely,

Heather Smith-Jackson

34 Hillside Street

Newington CT 06111

860 805 6700

hsmithjackson@smith.edu

APPENDIX D : INTERVIEW GUIDE

This information will be utilized during the analysis of the data to determine if there were variations within these specific categories to discuss further in my reflective portion of this paper. My questions are broadly defined as :

1. Feelings and thoughts about the use of self disclosure in general (to both adopted and not adopted clinical professionals)
2. Personal accounts of what is and what is not appropriate with clients and with what specific clients (to both adopted and non adopted clinical professionals)
3. Feelings and thoughts about adoption (relationship with adopted families : for those adopted) Feelings and thoughts about adoption (personal reflection/feelings about childhood: not adopted)
4. Experiences negative and positive regarding adoption (both groups)
5. Past experiences of the use of self and adoption as a means of disclosure/reactions/thoughts while doing so (for those adopted) past experiences of the use of self and family as a means of self disclosure/thoughts/reactions while doing so (for those not adopted)
 - a. Outcome of that treatment relationship
 - b. Personal reflections between disclosure and clinical relationships
6. Reflections about self identity (both adopted and not adopted individuals)
7. Thoughts and feelings about self disclosure of individual administering the interview

With these questions, I believe that I can thoroughly conducted semi structured interviews and to begin to explore the question “How does adoption influence the use of self disclosure in clinical practice”

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I

Introduction

The purpose of this study is to explore the following question “How does adoption influence the use of self disclosure in clinical practice?” The term *adoption* will be defined as a clinical professional that has been legally adopted from a biological family to a non biological family during childhood or adolescence. Adoption can be described as both a *closed adoption* and *open adoption*. *Closed adoption* refers to an adoption in which information is missing or withheld about the biological family’s medical, genetic or reason for adoption by a non biological family. *Open adoption* refers to an adoption in which information about the family’s medical, genetic, reason for adoption is provided and may include interactions with biological family while adopted by a non biological family. The operational definition of *self disclosure* will be as follows: “interactions in which the therapist reveals personal information about him/herself [self revealing] and/or reveals reactions and responses to the client as they arise in session [self involving]” (Hanson 2005 p 96). The use of *clinical practice* refers to professionals working with any given population that includes an assessment and treatment of clients in a given population for mental health, behavioral or substance use disorders (National Association of Social Workers 2015). This operational definition will include *clinical professionals* such as Licensed Masters of Social Work, Psychologists and Licensed Clinical Social Workers.

One of the intentional purposes of this study is to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with concentration on adopted clinical professionals. There is a substantial amount of self disclosure literature, but limited insight from the perspective of professionals who have been adopted and are currently practicing in a clinical setting. Current research does not include the exploration of identity development

and its influence on clinical practice of an adopted clinician. However, there is research pertaining to general identity development as it relates to external and internal processes which will be further explored. Although there is limited information pertaining to the number of adults identified as adopted in the United States, statistics reviewed from 1990 indicated that 214,448 children entered the foster care system, 16,211 of whom were adopted (Administration for Children and Families Archives 2015). The statistics provided to the public provides information regarding adoption rates in 1990, but I was unable to find any statistics about clinicians who identify as adopted or even adults who were adopted as children.

This study will explore the nature of the therapeutic relationship with clients who may themselves experienced circumstances similar to that of the adopted clinician or non adopted clinician. This study will investigate the use of self disclosure, which may be influenced by adoption identity formation and non adopted self disclosure. My hope is that this study will contribute to literature in the United States regarding clinical professionals who are adopted and not adopted, identity formation by clinical professionals and the use of self-disclosure in clinical settings. This study will focus on the adopted clinicians' identity and how this may impact the context, type and frequency of self-disclosure, as compared to non adopted clinicians. By conducting this study, I will be taking into consideration perspectives of clinical professionals as well as the experiences these professionals as individuals.

The necessity of exploring this aspect of self disclosure has been undoubtedly present in my own work as a developing clinical professional. I was adopted at the age of three and have been accepted, loved and integrated into a non biological family. My interests were never to look for my biological family contrary to my adoptive sister's desires. The research I've found in my

inquiries tends to focus on mental health outcomes and “the search” of the biological family. My interests lie within the creation of my new adopted self identity specifically as a result of the adoption, and how this adoptive identity influences self disclosure. Literature suggests that individuals have several different shifting identities as a result of being in different social situations, but an acquired adoptive self identity is something always present in practice and present as being an individual; it is something I cannot escape nor leave aside (Vingnoles et al 2006). Just recently in clinical practice, there was a situation where self disclosure was appropriate. I realized in that moment, I disclosed a piece of my adoptive identity rather than the identity of my former non adopted self. Within this experience, there was a developing therapeutic relationship which is also influenced by the attachment patterns acquired both pre adoption as well as post adoption. I find it necessary to connect attachment in terms of the therapeutic relationship, self identity formation, and self disclosure, because as an adopted clinical professional, this is the context of who I am.

By exploring both attachment theory and social constructivism as it relates to identity, I will begin to gain a more clear understanding of theories and the influence on self disclosure. After the completion of this study, I hope that this information will give awareness to clinical professionals who are adopted or not adopted and continue to contribute to self disclosure and identity formation literature.

II

Literature Review

The literature review focuses specifically on the therapeutic relationship, the use of self disclosure from clinical perspectives, adoption identity and how adoption influences the use of self disclosure. These concepts inform the research question. Does adoption status influence self disclosure in the practice of licensed mental health professionals? The chapter is divided into three sections. Section one will focus on the nature of the therapeutic relationship and will present the theoretical framework of social constructivism, as the grounding theory for this research. Section two will focus specifically on the use of self disclosure in the therapeutic relationship. Section three will discuss adoption identity and the influence on self disclosure.

The Nature of the Therapeutic Relationship and Theoretical Framework

Within the therapeutic relationship, there are two individuals in the treatment room building a relationship that will be the catalyst for change to the client's development and functioning (Sommers-Flanagan & Sommers-Flanagan, 2014). Doctors Sommers-Flanagan and Sommers-Flanagan state "we began thinking and talking about the possibility that it might be the relationship between client and therapist- not necessarily the methods and techniques employed - that produced therapeutic change" (p 135). The client enters treatment with the understanding that the clinician is capable of exploring what it is that has brought the client to treatment, and if the client doesn't connect with the clinician, a transition to another provider is recommended or termination occurs. The client is an individual with his or her own history, his or her own values and own context that has shaped who he or she has become in the world. The clinician too, is a product of social exchanges with his or her own environment. Somers-Flanagan and Somers-Flanagan emphasize the importance of a clinician's self awareness, developmental awareness,

cultural awareness and psychosocial awareness when establishing a therapeutic relationship. The clinician has too, developed in response to his or her's own history, his or her's own values and own context. Paul Rosenblatt states (2009) "we may choose to label as 'therapy' only those interactions that fit within a limited model of roles, statuses, and intentions, but that does not erase the possibility that any interaction may have therapeutic consequences" (p172). In other words, the interactions between both the clinician and the client will inevitably influence both parties regardless of ethics, roles and expectations of the professions; it is as a result of basic human interaction that the relationship transforms and changes in response to the development of the relationship. There are two complex individuals within the treatment room; one clinician is not identical to another clinician just as one client is not the same as another client. The therapeutic relationship is constructed by the interaction of two separate realities (Somers-Flanagan & Somers-Flanagan, 2014).

Dr. Paul Rosenblatt describes the therapeutic relationship between a client and a clinician but with an emphasis on the client's interactions with a clinician. Rosenblatt states "in the collaborative relative system, much might affect a therapist, including how the client understands and reacts to the therapist's disposition, motivation, self disclosure and skill and what the client reveals about his or her life that may lead to the therapist to a new sense of his or her own life" (p169). This presentation of the therapeutic relationship reflects the nature of a relationship within social constructionist theory. Social constructionist theory emphasizes the development of relationships as the mutual interaction with other individuals and one's own reality (Slavin, 2013). Doctor, Malcom Owen Slavin states (2013) "the vital Otherness from which we construct a human self (a psychological identity, a subjective world) is inevitably highly colored by the experiences embedded in those others whose identities must be absorbed to shape our own- from

family to the larger culture. We must become deeply attached to- and then, in some measure, differentiate, free ourselves from and re-establish - vital connections to others” (p297). In the therapeutic relationship, individuals work together to develop the understanding of why the client has sought treatment, what the purpose of treatment will mean, what the clinician means to the client and what the client means to the therapist (Rosenblatt, 2009).

Thomas Shovholt discusses The Cycle of Caring as a continuous series of professional attachments and separations to establish a collaborative therapeutic relationship (Shovholt, 2005). He states “the quality of the counseling relationship has consistently found to have the most significant impact on successful client outcome. The particular treatment that the therapist delivers does not affect outcomes.. therapists within treatment account for a large proportion of the variance” (p83). The therapeutic relationship is constructed by the two unique individuals within the room and the ability to establish the relationship influences the client’s desire to remain in treatment and have a sense of connection with the therapist. The Cycle of Caring is defined by three stages: empathetic attachment, active involvement and felt separation. The relational process begins with the therapist’s willingness to develop a collaborative relationship with the client built upon openness and trust. Without this, there is an unspoken element of the relationship that could ultimately end in termination or the manifestations of resistance and resentment (Rosenblatt, 2009).

Other literature recognizes that empathy is vital and contains different dimensions that contribute to the therapeutic relationship. Authors Fernandes Coutinho, Olivera Silva and Decety state (2014) “the metaphor of the human brain as social organ is supported by findings from neurodevelopment and attachment, suggesting that our brain develops in the context of our

relationships and that brains regulate one another during moment-to-moment interactions. The establishment of human bonds and interactions is essential for human survival” (p541). The nature of the therapeutic relationship is influenced by the degree to which a clinician can demonstrate empathy. Fernandez Coutinho, Olivera Silva & Decety (2014) defined empathy as “the process by which one infers the affective state of another person and experience a similar state in ourselves, while at the same time keeping a distinction between the self and the other, in other words, being aware that the origin of that is experience is the other and not oneself” (p542). These authors then continue to discuss empathy and the role within the therapeutic relationship. They state that the clinician’s ability to self regulate personal states of affect, both physiologically and cognitively, in response to clients is found specifically within the therapeutic relationship. These authors argue that therapeutic relationships can produce change within the client but that the process of empathy within the clinician leads to a more clear understanding of a client’s presenting problems (Fernandez Coutinho, Olivera Silva, & Decety, 2014).

As the client begins to develop a relationship with the clinician, the clinician is also developing a relationship with the client. The clinician will be abiding by his or her own code of ethics and own modality of treatment but the clinician cannot remove personal context which is constantly informing treatment practice; context of a client is always present. There is a significant gap in the literature about the clinician in the therapeutic relationship due to expectations and historical expectations of the therapeutic relationship. Found within research, the client is perceived as the focus of research rather than the clinician. Rosenblatt (2009) states,

Much of the literature, particularly the literature from modernist or medical model perspectives, is about a detached and objective therapist with clear boundaries, working with considerable therapeutic resources to help clients.. The therapist is the observer who engineers what goes in therapy; the client is the observed for whom therapy is

engineered. Thus the literature constructs a reality in which there would be no point to looking for the effects of therapy on the therapist. During training, in supervision and the literature on how to do therapy, therapists are warned that problems may arise if therapy affects the therapist – countertransference, compassion fatigue, the breakdown of boundaries of personal reserve and the like (p 170).

Certain modalities of training do influence the therapeutic relationship and the use of self disclosure in the room. Lynda Carew discusses different theoretical frameworks and how they inform the use of self, self disclosure which ultimately impacts the therapeutic relationship. Carew discusses the historical content of Carl Rogers and his use of transparency to transform the therapeutic relationship into a positive interaction. Carew found that clinicians who practice with a more classic, psychodynamic approach were more reflective about the principles of self disclosure and how it influences the therapeutic relationship. Other modalities such as Cognitive Behavioral Therapy, Systemic and Person Centered initiated a greater flexibility using self disclosure in the therapeutic relationship. Historically, psychoanalytic practitioners have avoided the use of self because of issues relating to countertransference and transference. Authors Berzoff, Flanagan and Hertz (2011) state “All psychoanalytic models have the same conceptual base, the dynamic unconscious, although they may differ in certain fundamental ways. All deal with transference and countertransference and the use of method of free association” (p 6). All of the clinicians regardless of modality utilized stated that disclosure was used to bond with the client, to demonstrate empathy in the relationship and to recognize the power imbalances within the treatment relationship (Carew, 2009).

Author Stephanie Brody extends the discussion about self disclosure, informed by social constructionism. Brody states (2013) “we pride ourselves that our analytic instruments can rise above our own reactivities, rigidities, and resistances to explore profound tacts of affective pain, even when our patients elicit powerful emotion in us. But personal vulnerability raises a different

manner of test within the analytical dyad. Ultimately, we are no less vulnerable by our patients, however refined our powers of self reflection” (p 76). Both Brody and Rosenblatt suggest that the therapeutic relationship is a relationship that affects both the client and the clinician; a view in line with social constructionist perspective. The consequences of a clinician’s rigidity and the inability to establish the therapeutic relationship ultimately leads to misattunement or termination of the therapeutic relationship. Rosenblatt suggests that the client influence on the clinician in the therapeutic relationship could in fact be beneficial. He states “being defined by a client as deeply empathic and sensitive to others may move a therapist who has felt down, unconfident and cautious because of assumed limitations to become more aware of personal empathic and social sensitivity resources and to become more confident” (174). These perspectives suggest that the client does have influence on the clinician in the therapeutic relationship, but the influence is one grounded in the reality that the clinician is an individual, in addition to a professional.

Brody also emphasizes the impact of the therapeutic relationship on the clinician as a human person. In speaking about the experiences of clinicians Brody (2013) states

Our desire to have a powerful impact stands side by side with our helplessness. The great risk may be that in an effort to uphold the powerful identification with our analytic identity, we lock ourselves into an either/or battle. If we are human, we are not analytic; if we are analytic, we are not human. We must commit to an unshakeable belief in the principles of anonymity, a principle that reinforces a false sense of grandiosity and is a hopeless effort to preserve our sense of omnipotence (p78).

In addition to her discussion around the nature of the therapeutic relationship as a construction of both expectation and interaction, Brody elaborates further on the inevitability of countertransference and transference in the therapeutic relationship. Brody states (2013) “do not leave sufficient room for an appreciation of the unpredictable impact on the patient when the

analyst unintentionally cracks the transference by suddenly emerging as a vulnerable human being. I would hardly say that these moments are best for any patient, but enactments of all sorts of inevitable, and I believe they are often surprising both to the patient and the analyst” (p78). Brody’s discussion captures the essence of the undeniable reality of the therapeutic relationship: these two individuals have influence on one another and the influences that they do have are unavoidable.

Self Disclosure

For purposes of this research, self disclosure will be defined as “behaviors, either verbal or nonverbal, that reveal personal information about therapists themselves to their clients” (Carew, 2009, 266). Different modalities of clinical practice tend to have diverse expectations of the use of self disclosure. Despite having differing opinions about self disclosure, research has suggested that self disclosure and the use of self disclosure is beneficial to the therapeutic relationship under certain circumstances (Carew 2009).

In a study conducted in the United Kingdom, professionals were divided up into four practice modalities: Psychodynamic, Cognitive Behavioral Therapy, Systemic and Person Centered, and asked to elaborate on the use of self disclosure in the therapeutic relationship (Carew 2009). The objective of this study was to explore the perceptions of therapists practicing but to understand whether or not theoretical background influenced the use of self disclosure within the therapeutic relationship. These findings would essentially assist in developing a framework that addresses the use of self disclosure. The findings suggest that all modalities of practice fell within a spectrum of self disclosure, but if there was self disclosure across modalities, it was to build upon the therapeutic relationship. She further concluded that client

perspectives needed to be taken into consideration in order to utilize self disclosure in an appropriate manner regardless of theoretical orientation.

In addition, self disclosure has been shown to strengthen the therapeutic relationship and assists to eliminate or alleviate power dynamics in the therapeutic relationship (Anderson & Anderson, 1989). Carew has also argued that self disclosure is beneficial in the therapeutic relationship. She states, “the belief amongst all participants who used self disclosure as a therapeutic strategy was that it was a bonding, empathic, sharing quality that helped address power imbalances within the relationship. Participants were particularly concerned that disclosures did not distract from the client’s issues and become therapy for themselves “ (Crew, 2009, p 271). Andersen and Anderson (1989) contribute to this discussion by acknowledging that self disclosure contributes to the development of a positive therapeutic relationship, but that not all self disclosure is definitively positive.

In a qualitative study, nine participants were interviewed to explore therapist self disclosure and the influence on the therapeutic relationship. The study found that self disclosure from a therapist can influence the boundaries within the therapeutic relationship either positively or negatively (Audet, 2011). Audet discusses the use of immediate self disclosure and non immediate self disclosure but ultimately concludes that therapist self disclosure is viewed more favorably because it establishes a sense of support in the therapeutic relationship. In addition, Audet discusses boundaries as it relates to self disclosure and acknowledges the power dynamics in the therapeutic relationship. Audet (2011) states,

One type of boundary that is contingent on disclosure norms between client and therapist. The client is characteristically the primary discloser expected to bare all of therapy to be effective while the therapist maintains a predominantly non-disclosive stance applies his or her expertise to the issue at hand. An ethics perspective explains

that boundary concerns are identified with therapist disclosure include shifting the focus away from the client, inviting social dynamics conducive to a friendship, generating client feelings of needing to care for the therapist and in extreme cases, risking exploitation of the client and role reversal (p 87).

Audet goes on to refute the ethical boundaries by stating that it is not the use of self disclosure that may lead to exploitation, but it is the intent of the clinical professional that determines if self disclosure is warranted.

From a client perspective, Audet explores the impact of self disclosure on clients during therapy. Audet explains that there have been both cases in which clients have encountered self disclosure as unfavorable but other uses of self disclosure as favorable. Audet states (2011) “another study focusing on client experiences of helpful therapist disclosure showed that clients perceived their disclosing therapist as more real, human or imperfect, which had an equalizing effect on the on the relationship” (p91). In the study Audet conducted, findings suggest that the use of self disclosure can impact the nature of therapeutic relationship both negatively and positively but the outcome is determined by frequency and whether or not disclosure is congruent with the client’s discussion and values (Audet, 2011).

Other literature also discusses personal experiences of clients and the use of self disclosure in the therapeutic relationship. Jean Hanson conducted a studying involving eighteen clients which explored the use of self disclosure and the ethical limitations of doing so. Hanson’s findings suggest that these clients found self disclosure to be helpful in the therapeutic relationship and found that non disclosure was twice as likely to be unhelpful. Hanson organized results by the participants in categories of: helpful disclosures, unhelpful disclosures, helpful non disclosures and unhelpful nondisclosures. Hanson found that participants who have experienced

helpful disclosures found that it positively impacted the therapeutic relationship by creating a stronger alliance with the therapist and assisted with a more egalitarian relationship. Unhelpful disclosures were often found to create a sense of distrust in the therapeutic relationship and left the client feeling more negatively self reflective. Helpful non disclosures discussed the concept of transference and indicated that clients were able to develop their own sense and opinions about the therapist. Unhelpful nondisclosures directly influenced the nature of the therapeutic relationship. Clients often felt as though there was a lack of connection to the therapist which was detrimental and harmful to the therapeutic relationship. Hanson (2005) concluded this study by discussing the importance in the skill of disclosure and the timing of disclosure indicating that self disclosure may be useful with the correct intent in doing so.

Literature discussing social constructivism and identity development suggest that self disclosure and the use is influenced by individual identity within the therapeutic relationship, for both the clinician and the client. The literature suggests that individuals have different motivations to self disclose as a result of the exchanges the individual has with the external and internal self (Akrin & Hermann, 2000; Vignoles et al, 2006). Arkin and Hermann suggest that an individual's sense of self and presentation in daily life impacts multiple relationships by social exchanges which contributes to overall identity development. Arkin and Hermann (2000) state,

high impact self presentational episode in which positive therapeutic outcomes arise when clients perceive the therapist has a favorable view of them. The objective of psychotherapy is reconceptualized as the construction of a useful, productive, positive identity. This can be best achieved by selectively withholding certain (negative) information from the therapist and through a collective emphasize the positive (p 501).

Arkin and Hermann suggest that the therapeutic relationship influences and is influenced by the client's identity development. Arkin and Hermann (2000) state “ therapists offer positive feedback to their clients based on the client's self presentations, identifying identities that the

client prefers and then reinforces those identities. Newly acquired self knowledge can easily be attributed to the demands of the social situation” (p 502). Arkin and Hermann discuss the client perspective of identity development but do not necessarily address the identity development of the clinical professional. They do however, argue that all self concept is malleable and subject to change inside the therapeutic relationship. They suggest that individuals experience the external world which shapes the internal development of self in response to social situations (Arkin & Herman, 2011). These findings suggest that the development of personal identity can be applicable to both the clinical professional as well as the client considering self concept is ever changing.

Similar literature on social constructivism examines the motivations within identity development. Vignoles et al state (2006) “the processes shaping both individual and group identities are guided by motives to protect feelings of self esteem, continuity, distinctiveness and efficacy” (p 308). This suggests that the clinical professional’s identity may be influenced by the social expectations of belonging and identifying as a clinical professional. According to this literature, there are three levels in which an individual’s identity becomes defined: individually, relationally and within group levels of self representation. The study found that self esteem, motives for personal meaning, continuity had effects on different dimensions of identity (Vignole et al, 2006). Vignoles et al state (2006) “participants rated as more central and were happier with elements of identity that provided a greater sense of meaning in their lives. These findings support the influence of a motive for meaning on processes of identity construction beyond the influence of concerns for esteem” (p 324). In the concluding discussion, Vignoles et al discusses personal identity development and its influence in relationships with others which relates to self disclosure. Vignoles et al state (2006) “if identity construction is guided

simultaneously by multiple identity motives, then- over time and in an absence of external constraints - a physiologically healthy individual will likely find non conflicting ways of satisfying each motive” (p328). In other words, clinical professionals are guided by multiple identity motives simultaneously, which may ultimately impact the use of self disclosure. Somers Flanagan and Somers Flanagan (2014) suggests that self disclosure be utilized if the disclosure is in congruence to the client’s focus in treatment. Somers Flanagan and Somers Flanagan (2014) state “the ability to be congruent includes an internal dimension that involves therapists being in touch with their inner feelings or real self plus an external or expressive dimension that allows therapists to articulate their internal experiences in ways clients can understand” (p 137). Self disclosing in a meaningful and purposeful way can result in positive outcomes. Similarly, client identity development is influenced by similar motivations that assist to construct identity development which may impact motivation for self disclosure to a clinical professional.

Other literature exploring self disclosure has recognized that research is often presented from a white heteronormative perspective. Authors Dennis Falk and Pat Noonon Wagner state (1985) “the present study focused on self disclosure among white, middle class Americans; some cultures react quite differently to self disclosure” (p 558). These authors support the understanding that relationships develop after individuals move from “superficial information to more personal information”. In addition, these authors discuss and describe this process of disclosing to relate to one another in a more meaningful way. They state, “ an essential aspect of healthy personality and a necessary condition for close, personal relationships. On the other hand, concern has been expressed about sharing too much too quickly” (Falk & Wagner, 1985, p558).

These authors continued to incorporate and acknowledge response styles as a positively determining factor when utilizing self disclosure. The research included attempted to address the cultural differences in responses but failed to explicitly discuss more in depth variance amongst different cultures. These authors did however, discuss egocentrism and the influence of self disclosure. Falk and Noonan Wagner (1985) state,

perspective taking is manifested by behavior that indicates an active effort to understand and incorporate the information and feeling presented by the other person without making a value judgement. Egocentrism is manifested by behavior that indicates an interest in presenting one's own feelings and thoughts and evaluating the information and feelings presented by the other person from one's own frame of reference. Perspective taking has been related to cooperative interaction. Perceiving an interaction as cooperative has been related to other positive perceptions of the interaction such as satisfaction, comfort and warmth (p 560).

More research on cultural differences has emerged examining mental health clinicians and the ways in which mental health clinicians can modify and change communication to increase the likelihood of self disclosure. The article "Extending boundaries: Clinical Communication with Culturally Linguistically Diverse Mental Health Clients and Careers" was the first article to transparently discuss the nature of mental health treatment and how this intersects with individuals of different cultural backgrounds. Authors Wendy Cross and Melissa Bloomer (2010) state "historically there have been challenges to the assumptions that cross cultural similarities in abnormality exist. Earlier, cultural anthropologists suggested that abnormality was relative and should be addressed in conjunction with cultural normals and deviations tolerated relative to that society" (p 269). This was the first article that further discussed the nature of therapeutic work and the intersection of different cultural backgrounds. This article took a more medical perspective and addressed the complications that evolve from

communication which prevent full and understanding verbal exchanges. The sample included seven focus groups of mental health professionals working with culturally diverse clients. The subthemes identified from this research suggest that respect and cultural understanding influence basic communication exchanges which limits or increases capacity to self disclose (Cross & Bloomer, 2010). This research concluded that mental health clinicians need to continuously acquire cultural knowledge to promote and increase the chance for culturally sensitive self disclosure while working with cultures different from one's own.

Other research discussing self disclosure in cross cultural counseling argue that graduate programs often only teach limited courses resulting in a deficit when working with different ethnicities. Authors Alan Buckard, Sarah Knox, Michael Groen, Maria Perez and Shirley Hess(2006) state, "Whether counseling relationship was good or tenuous, however, our participants observed that immediately proceeding the self disclosure, clients were usually discussing how they had coped with racism or oppression; relatedly, perhaps, the therapists reported being concerned about the counseling relationship and worried that their clients perceived them as racist" (p22). The authors then discuss clinical observations, "noting this sense of discomfort and hesitation, potentially an indication of client's cultural mistrust, our participants reasoned that it was important to validate clients' experiences by acknowledging the role of racism/oppression in clients' lives, or to acknowledge their own racist/oppressive beliefs. Thus, our participants had clear reasons for delivering self disclosure" (p 22). The clinicians who disclosed within this study do so not for insight but to develop the therapeutic relationship and to validate client experiences of racism and oppression, indicating that self disclosure used in an appropriate manner can be beneficial to cross cultural counseling (Buckard et al, 2006).

Further research on self disclosure discusses the use of self disclosure within a supervisor trainee relationship; a comparative relationship between a clinician and client. This research focuses on the use of self disclosure in the supervisor trainee relationship and examines how the trainee comes to self disclosure in the professional relationship. This research indicated that the type of relationship established between the trainee and supervision, how the trainee utilizes supervision and how the trainee comes to understand supervision influences self disclosure in professional relationships (Gunn & Pistole, 2012). Authors Josh Gunn and Carole Pistole describe the trainee supervisor relationship from the attachment perspective and reflect upon the reciprocity within the relationship of trainee and supervisor. Gunn and Pistole (2012) state,

In the meager attachment based supervision research; the alliance was stronger when trainees perceived the supervisor as having a secure attachment pattern and supervisor highly anxious attachment predicted lower trainee professional development.. In addition, trainee disclosure and lack thereof, is important in supervision because spoken and unspoken therapy related personal thoughts, feelings, and attitudes are vital to the supervisor's ability to monitor learning and ensure effective client services. Research indicates that more than 90% of trainees withhold some information from the supervisors. Fear of evaluation and need to appear competent can provoke intense even detrimental anxiety, failure to manage emotion effectively may hinder the trainee's ability to apply knowledge and disclose to the supervisor (p230).

The research concluded that the use of self disclosure within the trainee supervisor relationship was directly influenced by the supervisor alliance and client focus. Although the limitations of this study were "self report measures," the discussions indicated that perceptions and recall may be biased and influenced (Gunn & Pistole, 2012). This research further indicates that it is the individual's developmental of the authentic self that promotes use of self disclosure rather than the context of the relationship. Jesse Geller, of Yale University, provides further perspective on professional development, personal development and the use of self disclosure. Geller (2003) states, "therapist who have found their own voice may experience the coming

together of these conceptually distinguishable states of decision making as an organic event. One can experience the decision to self disclose as inherent in the decision to pursue a particular treatment goal. Beginners, by contrast, often find themselves trying to choose between conflicting models of realizing a particular goal, all of which feels as if they have a legitimate claim” (544). Geller describes the cognitive decision making process and discusses the variance between beginning clinicians and those who have practiced. Geller discusses the differences that arise with the use of self disclosure and emphasizes context within the therapeutic relationship. Geller (2003) states, “there are no risk free self disclosures, nor is there such a thing as just listening in psychotherapy. The commonly heard phrase implies that it is possible not to communicate when in the role of listener. Therapists convey as much comprehensible content about themselves when listening as when they are talking” (p547). Geller not only describes the use of self disclosure from a professional development perspective, he focuses on the necessity to meet the need of the client. Geller concluded by stating “I have reasoned that competent use of self disclosure in psychoanalytic existential psychotherapy depends on a therapist’s ability to flexibly accommodate his or her activity level, depth of involvement, and expressivity to meet the idiosyncratic requirements of individual patients at each phase of therapy” (p553). Geller not only suggested self disclosure as a mechanism of personal discretion but also an entity of professional development as it intersects with the professional identity. In essence, the literature is suggesting that self disclosure is influenced by personal identity, one’s theoretical orientation, the duration of experience and the use of supervision that develops professional identity.

Adoption Identity and Self Disclosure

Literature that addresses adoption identity commonly utilizes the framework of loss and unresolved grief. Identity development appears to be altered due to the termination and loss of connection with biological counterparts (Lifton, 2010) As a result, adopted individuals live with parallel identities: a previous non adopted self identity and an adopted self identity.

Understanding this parallel process of identity may be essential for adoptive professionals in clinical practice to refine and re-examine self reflection and personal identity development. In addition, adoption identity development seems relevant to current literature on how identity is defined as an individual, relationally and within a group (Vignoles et al 2006).

Betty Lifton, an adoption psychotherapist, describes the birth of these parallel identities within those who are adopted. She illustrates an adoptee along with a “ghost mother” and “ghost baby” which are symbolic representations of the biological mother and the former life of the adoptee. Lifton argues that these portions of identity are frozen in time until the adoptee reconnects or chooses to reconnect with biological counterparts. Lifton describes the parallel experience of these identities as a form of dissociation. She states (2010) “the adoptees’ ghost kingdom can be seen as the nursery where the ghost baby remains behind with the ghost mother, even as the adopted child grows up with the adoptive parents in the real world. Doubling has taken place - the splitting of the self. For in order to survive in the family in which they mysteriously find themselves, adoptees dissociate - split off the self that might have been” (p 72). Lifton describes adoptees who have sought clinical therapeutic treatment who felt as though there was something not fulfilled within them. She recalls one of these clinical encounters “adoptees often have a hard time remembering when and what they were told since so many of

their feelings were split off. But once they get in touch with the vulnerable child they were -so alone and with no one to talk to about what they were experiencing - their memory returns” (p 77). Adoption identity is described as a parallel process that may exist even if the adoptee seeks reunification with biological counterparts. As a practicing professional and with the research previous discussed regarding identity development, it may be essential for the clinical professional who is adopted to gently integrate former and present self.

Further literature addresses identity development within the framework of social constructivism and adds additional perspective to adoption identity development. Authors Penny, Borders and Portnoy (2007) describe adoption and identity as a process in which an adoptee endures for the duration of his or her life. They state, “ adoptees must integrate a cultural heritage from their adopted family as well as a genealogical and cultural heritage from a birth family, about which they probably have limited knowledge” (p 30). They further discuss the negative implications of functioning as the adoptee progresses into adulthood but with the focus on loss of a previous life. They reviewed 100 adoptee narratives written by adoptees ages 35 to 55 years of age and developed five categories as it related to adoption: phase one, limited awareness, phase two, emerging awareness, phase three, drowning in awareness, phase four, remerging from awareness and phase five, finding peace with adoption. In addition, these adoptees were asked to evaluate connectedness to other individuals and evaluate quality of life.

The results found that 55% of adoptees were exploring adoption related issues and concerns related to adoption. One of the specific adoption related concerns focused on the ability to disclose to family members personal conflict regarding adoption. Results found that 75% of respondents felt that they could openly discuss adoption with family members, but 29% of phase

three and 38% of phase four selected this statement (Penny, Borders and Portnoy 2007). In other words, one's own personal process of adoption, and how it relates to identity, is influenced by a new acquired identity of non adoptive family, new values and expectations of the non adoptive family and the ability to for the adoptee to maintain the previous identity. Other findings explored connection with adoptive family and the self disclosure to search for biological counterparts. Respondents felt that they would hurt their adoptive parents due to a false sense of loyalty and did not have the conversation regarding the search because the adoptees felt the biological parents made the right decision giving up parental rights. All aspects of these findings suggest that identity development may have influenced adoptees disclosure to the adoptive parents. In addition, these findings indicated that there are varying experiences of adoption identity development and how individuals integrate former non adoptive selves with current adoptive selves. Overall, these phases did not necessarily address the varying contexts of the adoptive families but did address adoptees willingness to disclose searching for biological counterparts and general discussion of adoption (Penny, Borders & Portnoy, 2007). Literature has discussed that individual identity is arranged relationally; therefore, disclosure within a safe relationship has led to disclosure relating to adoption. If the practicing clinician identifies as being adopted, self disclosure may occur in response to a client, which supports the clinician's continuity of an adoptive self rather than the previous non adoptive identity.

Other literature grounded in social constructivism suggests that American values construct adoption loss and contribute to identity formation. Author Irving Leon (2002) states, "so much of kinship and family in American culture is defined as being nature itself, required by nature or directly determined by nature that is quite difficult, often impossible, in fact, for Americans to see this as a set of cultural constructs and not biological facts themselves" (p 652).

Leon describes adoption stigma and its influence on individual self esteem. He states, “ a developmental study of younger children’s beliefs about adoption indicated significantly more negative attributions of adoptees by nonadopted children than adopted children themselves” (p 656). This suggests that social interactions, social norms and societal expectations in America influences identities of those who are not adopted but interact with adoptees. Leon continues to address cross cultural findings in other countries as it relates to adoption and found that biological basis for the construction of personal meaning did not exist, the formation of what is ‘real’ did not exist but instead the connection within the parent child relationship endured. Adoptees are influenced by the societal constructions of adoption which may also influence sense of identity individually, relationally and within a group. Clinicians may choose to withhold this aspect of their identity and choose not to disclosure because of societal stigma related to adoption.

Authors Howe, Shemmings and Feast (2001) discuss adoptees’ feelings of difference as it relates to identity, feelings of belonging as it relates to identity, age at placement and gender differences associated with the willingness to discuss adoption. Howe, Shemmings and Feast (2001) state “ being adopted was felt to be an important and relevant difference that had to be acknowledged and addressed by adoptive parents. Adopters who did not acknowledge the difference- who rejected difference were denying a relevant and potentially important aspect of their child’s origins and identity” (p339). They continue, “the task of integration (adoptive family) does not sit comfortably with that of accepting that adopting and being adopted is relevant difference that has to be acknowledged by both parents and adoption children. The resolution of these potential tensions is a test of the parents’ abilities to handle the complex nature of the child-parent relationships implied in adoption” (p339). The age of adoption has

been a noted factor in an adoptees identity within an adoptive family. Howe, Shemmings and Feast developed a model in responses to adoptees identity development as it related to being adopted in a new adoptive family. There were significant gender differences within this study, which found that female adoptees were more likely to discuss adoption than male adoptees. In an article relating to self disclosure and gender, women were also more likely to self disclose due to projected boundaries in a supervisor-student relationship (Heru et al, 2006). This literature highlights and mirrors the therapeutic relationship. The supervisor must maintain certain boundaries within supervision which compares to the therapeutic relationship of a professional maintaining certain boundaries with clients. Both genders were found to disclose elements of their identities as it related to adoption within relationships, but females were more likely to self disclose in general. There were specific times in which the adoptees' chose to disclose elements of their adoption which could be accurate in describing how clinicians choose to disclose with clients.

Other literature by authors, Mary Jago Kreuger and Fred Hanna (1997), emphasize an existential perspective as it relates to adoptive identity and parallel identities of the former self and adopted self. Additionally, these authors acknowledge and discuss the development of identity by acquiring a sense of belonging in a non biological family but offer additional perspectives as to why adoptees search for biological counterparts in the frameworks of loss, meaningless, isolation and death. In addition, these authors speculate about the new acquired identity as a result of what has been openly discussed with the adoptee and what is unsaid creates assumptions and beliefs by the adoptee.

The existential perspective is essentially an individual's ability to make meaning of one's self in the world. Adoption literature often cites that adoptees have a lack of continuity in identity and is often described as problematic for future development into adulthood (Jago Kreuger & Hanna, 1997). Jago Kreuger and Hanna state "the primordial phenomenon of disclosing the truth of one's being offers a sense of grounding in one's own authentic being. It is through authenticity that one genuinely experiences being in the world. For the adopted individual, the uncovering his or her own truth begins with the awareness of the desire to search" (p 197). For those adoptees who remain conflicted about their sense of being in the world are expected to have difficulties in disclosing themselves and presenting themselves as authentic beings. This literature speaks directly to previously discussed literature regarding identity formation. Vignoles et al (2006) describe the continuity motive and the distinctiveness motive as ways in which individuals maintain continuous identity and differentiation from others. In addition, Vignoles et al argue that those who are motivated to maintain certain aspects of identity such as continuity and distinctiveness often describe and rate elements of those identities as central components of identity (2006).

Individuals who identify, acknowledge and have come to terms with adoption may be more inclined to self disclose. They will have developed the self-reflection and self-awareness to disclose this as a central component of his or her identity. More specifically, clinicians who do identify as being adopted, may be more likely to disclose because identifying as adopted is an effort to maintain self-continuity, a way in which the adoptee can relate to others by having a sense of meaning in the world. The use of self-disclosure and what the clinician decides to disclose will be influenced by the clinician's identity and life post adoption. The clinician may have refined skills related to self-disclosure and self reflection because he or she has always

questioned his or her own identity; making his or her ability to empathize with clients more possible in the nature of the therapeutic relationship. The nature of the therapeutic relationship with his or her clients will allow for the use of appropriate self-disclosure, but what the clinician discloses may ultimately be a product of an adopted identity.

III

Methodology

The purpose of this qualitative study is to explore the following question “Does adoption status influence the use of self disclosure in clinical practice?” One of the intentional purposes of this study is to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with concentration on adopted clinical professionals. In order to begin to explore this particular research question, a phenomenological framework is most appropriate for the research question. According to John Creswell (2013) a phenomenological qualitative study is, “an emphasis on a phenomenon to be explored, phrased in terms of a single concept or idea.. a philosophical discussion about the basic ideas involved in conducting a phenomenology” (p 78). A qualitative study would complement this research approach because “qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2013, p44). A qualitative study would allow for exploration of these particular research topic. With this particular research question, social constructivism has been utilized as the theoretical framework to explore identity and the use of self disclosure in the therapeutic relationship.

In order to begin to understand the experiences of the participants, semi structured interviews have been conducted and have been broken down into questions pertaining to adopted clinical professionals and non adopted clinical professionals. The semi structured interview is constructed to first establish an understanding of the participant by discussing prior experience, age, racial identification and a screening question specifically to address self disclosure. These questions described are as follows: “how old are you?”, “how would you define self

disclosure?” and “how do you identify racially?” The beginning of the structured interview are screening questions to establish clinical experience and explore clinical experiences. These questions used are as follows: “Where did you go to school to obtain your degree?” “Could you tell me a little bit about your role there?” These questions were included to determine whether or not the participant had the educational capacity and experience to discuss and articulate about self disclosure with clients. The questions then touch upon the nature of the therapeutic relationship which is to again, assess the participants understanding and perceptions of the relationship which may be used for data analysis. These questions are as follows: “how would you define clinical work?” , “what makes this work clinical?” and “would you say your relationship with clients is relatively the same across differing populations?”. Additional questions were developed in response to the participants statements regarding self disclosure, identity and adoption. Some are as follows, “are there any areas of identity that you feel as though I did not discuss and would like to discuss further?” As the interviews continued, new areas of focus have been developed in response to participants to include in additional interviews. These are as follows: “use of supervision and discussing self disclosure?” and “educational experiences around self disclosure and adoption”.

Sample

The goal was to recruit 16 participants evenly divided between clinicians who were adopted and non adopted. However because of limitations further described below, the sample consisted of 11 non adopted clinicians and 1 adopted clinician. The inclusion criteria included clinical professionals that are obtaining their BSW, be obtaining their MSW, have an LMSW, have an LCSW, have a PSYD, be a LMFT, be a behavioral specialist or a case manager that must be involved in clinical practice, at least two years clinical experience paid or non paid. The

inclusion criteria utilized focused on clinical professionals that have established a therapeutic relationship with clients in a professional mental health setting. Professions such as nurses or doctors were excluded from the study because although they have relationships with clients involved in a clinical setting, but they do not have therapeutic relationships.

The sampling strategy for the research question “does adoption status influence the use of self disclosure in clinical practice?” was convenience sampling. This strategy was used to connect to professional and personal networks in addition to snowball sampling. According to Creswell (2013) snowball sampling is, “identifies cases of interest of people who know people who know what cases are information rich” (p158). In order to I reached out to fellow colleagues and former colleagues who then referred me to more possible participants, which is a reflection of the snowball sampling methodology. Some of these colleagues have worked with individuals who have been adopted and may have networks for additional participants. A combination of convenience sampling and snowball sampling were useful to find research participants.

Due to the small number of clinicians who define themselves as adopted, I utilized my research supervisor as a means to reach out to Department of Children and Families in Massachusetts, reached out to my field supervisor through Smith College and reached out to Department of Children and Families in Connecticut and Adoptions from the Heart in Connecticut. The recruitment process has been substantially difficult because of the inability to find an adoptive community, which will be further addressed in the discussion portion. In addition, recruitment has been significantly difficult due to agency policies. In the beginning of the recruitment process I had reached out to Rushford, a mental health and addiction services agency to recruit clinicians, but was unable to utilize this as a recruitment agency due to policies

in place. Convenience and snowball sampling were the only successful ways to recruit participants but I encountered barriers despite my persistence.

After receiving the approval, social media was utilized in order to reach out to colleagues and individuals in my social networks. Some of the individuals that responded were prior colleagues and were interested in participating. Some of the other individuals that “commented” on the post stated that they were adopted, but were unable to participate due to the focus of the therapeutic relationships in the thesis. This response in itself was surprising because some of these individuals were not previously identified as adopted. Unfortunately, these individuals cannot participate in the study because of the credentials I have specified which has left out individuals that are not practicing clinically but are adopted. Social media was utilized because of the accessibility, but the use of Facebook specifically, excludes those who are not utilizing Facebook to connect with others. When considering this, I have also utilized Instagram and posted a picture of the thesis approved recruitment document. One individual reached out and wanted to participate, but this participant was not adopted.

One of the ways I attempted to gain adopted participants was by reaching out to local and community run support groups for adoptees. One of the respondents contacted me via telephone to discuss participating in my thesis study. I contacted three support groups held locally in the town of West Hartford, Connecticut. The group facilitator responded and provided me with individuals that could be possible participants. The facilitator forwarded my thesis information to those who attend the group and were open to participation. One respondent discussed the process of reunification with her biological family and then inquired the status of my personal reunification with my biological family. The conversation concluded with me self disclosing to the clinician that I was not pursuing a connection with my biological parents.

Despite multiple outreach phone calls to this potential participant, she never returned my calls and therefore did not participate in the study. This has prompted me to consider the different subgroups within the adoptee community. With the understanding of different adoption stories, it is only safe to assume individuals are at different places of acceptance and awareness and because of these differences; adoptees do not share a unified experience of “adoption” and may in fact, feel different from adoptees within in different stages. Further exploration of subgroups within adoption would be beneficial to explore and will be further discussed in the discussion. Another participant, who identified as adopted through the support group, also responded via email. This participant did not necessarily meet the criteria for participating in my study but provided similar services comparable to a clinician, specifically with the adopted community. This mental health professional came to understand her role from a different perspective, which has allowed me to consider the different perspectives that individuals hold of their professional jobs. Although she was not definitively a clinician, she was providing services that would be comparable to the therapeutic relationship, but this participant did not identify as such and did not participate in the study.

Interestingly enough, the individuals who participated in the study were individuals I have had prior relationships with or who I have had personal face to face connection with. This experience reflects the theoretical orientation of social constructivism and emphasizes the importance of relationships, another significant component to my thesis. As I was recruiting many of the individuals who responded to me were adopted but they did not meet the criteria for participating. The only participants that inevitably discontinued or did not follow up for a second appointment were adopted clinicians. The one adopted clinician who did participate was a clinician who had years of psychotherapy to address adoption. Future research may include

exploration of how adoption status influences relationships later in life. This part of the results was not something I had anticipated, but allowed space for me to consider that different people engage with adoption status in different ways.

Of those who are participated, I did not anticipate a definitive number of male clinicians or definitive number of females, but the entire sample were females limiting the male perspective. I had anticipated a much more diverse sample and only interviewed three clinicians of color. The sample that I have used will not be generalizable due to the number of participants and strategy to recruit. There were not a significant amount of participants to completely understand the experience of being adopted and a clinician in order to reach a saturation of data.

Ethics and Safeguards

After constructing the semi structured interview, I had to determine what type of interview is most appropriate to accommodate the needs of the research being conducted and the interviewers themselves. In the beginning of the research study, most the interviews occurred in person but I have left the interview structure itself up to the interviewee and telephone was also available if necessary. In addition, participants who agreed to participate reviewed the consent in the beginning stages of recruitment. The participants were encouraged to sign whether or not they would like to be recorded and video recorded. This was an option left up to the participants. In addition, the consent form included the possibility of additional information to obtained by the researcher. This section was included to either clarify statements that had been made or to gather additional information.

In order to ensure confidentiality of participants, no use of real names is within the documentation. When transcribing the interview, I have utilized pseudonyms that will assist me to remember the participants, but are not actual identifies for the participants. As of right now,

interview notes and the interviews themselves are locked in drawer I only have access to. In order to conduct these interviews, I had to receive an IRB approval from Smith College School for Social work and have all of the participants sign informed consent.

Data Collection and Data Analysis

In the tradition of qualitative research, data analysis and data collection happened concurrently. Due to financial limitations, I have decided to transcribe my own interviews. I have typed the interviews and have printed the written transcripts. I have highlighted significant phrases or commonly stated phrases among the participants. In order to organize the data, phenomenological data analysis utilizes horizontalization or “highlighting significant statements, sentences, or quotes that provide an understanding of how the participants experienced the phenomenon” (Creswell, 2013 p82). After locating finding these significant statements, I began to organize the data by textural description or themes, or structural description, which is context associated with the experience (Creswell, 2013). The semi structured interviews have produced new areas of focus, which has led to the development of new questions to be discussed upon interviewing. This is reflective of the terminology Creswell (2013) utilizes bracketing or “suspending our understandings in a reflective move that cultivates curiosity” (p 83). In order to explore the professional and personal experience of mental health professionals, I had to step away from assumptions that have been informed by my own personal experience to explore topics that have emerged from the interviews.

Upon any confusion, or the researchers inability to fully comprehend an experience, I contacted participants for further clarification and member checking. Creswell (2013) states, “triangulation is when researchers make use of multiple and different sources, methods, investigators and theories to provide corroborating evidence. Typically, this process involves

corroborating evidence from different sources to shed light on a theme or perspective” (p 251). By contacting participants and discussing current findings, the participants can offer feedback about experience or about previous themes that have been developed to maintain validity. The audio recordings that I have utilized have been substantially helpful when transcribing the interview. After conducting of the interviews, codes have been developed to focus upon the actual words of the participants and general experiences relating to certain questions of the semi structured interviews. A code by themes has been developed as well as a code for words to assist with reliability.

IV Findings

Table 1

General Demographics of Participants Who Confirmed Participation

<u>Demographics</u>	<u>%</u>
Age	
20-25 years	33.3 %
25-30 years	33.3 %
30 + years	33.3 %
Race	
White Non Latino	75%
Latino	8.3%
Asian	8.3%
African American	8.3%
Education	
BSW	25%
Obtaining MSW/MSW Licensed	58.3%
PhD	16.6 %
Biological Sex	
Female	100%
Male	0%
Gender Identified	
Female	100%
Years Clinically Practicing	
1-2 years	16.6%

3-4 years 58.3%

5+ years 25%

N=12 total participants

TABLE 2

General themes of self disclosure and statements of participants

THEMES		QUOTATIONS
Client focused self disclosure		“Redirected it back to the purpose of treatment” “a way to connect” “depends on the setting”
Therapist identity focused	Clinicians discussed personal identities that influenced their practice with clients	“racially insulting me” “I have anxiety too” “sarcasm and humor” “I can’t say it has entered the room” “I think, well I’m a mom too”
Therapist theoretical orientation focused	Clinicians reflected upon their theoretical orientations and style of practice	“Is it going to help the client?” “a way to connect to someone in relation to something they are going through”
Therapist experience/use of supervision	Clinicians discussed influence of educational institutions and reflected upon professional development	“should really be discussing it in supervision” “What I learned so far stay away from it” “It changed from what I learned in school to how I do practice”

TABLE 3

Adopted themes parallel identity process to non adopted clinicians

THEMES	QUOTATIONS	
Identity as a therapist and as an individual	Adopted clinicians had similar experiences	<p>“It’s one of my many identities but it’s not my main identity anymore”</p> <p>“I felt I was a whole person after reconnecting with my biological family”</p>
Connection and isolation	Clinicians, non adopted and adopted discussed connection and isolation; further exploration and understanding adoption and adoptees experience	<p>“I felt alienated growing up”</p> <p>“she realized that I understood”</p> <p>“I considered adopting with my partner”</p> <p>“I took a class on it in school”</p> <p>“ I feel like the system needs to do more”</p>

RESULTS:

Identified below are themes that emerged from 12 interviews of clinical professionals regarding the use of self disclosure, identity and adoption: 1. Client focused self disclosure; 2. therapist identity focused self disclosure; 3. therapist theoretical orientation focused self disclosure; 4. duration of experience and use of supervision as an influence on self disclosure; 5. identity as a therapist and as an individual; 6. the need for connection and the isolation as it relates to identity. The themes that have emerged as a result of interviews do not however fully address the initial research question of “does adoption status influence the use of self disclosure?”

Client focused self disclosure

All of the interviewees that participated identified that they have encountered the pressure to self disclose or were called upon by clients to self disclose. The operational definition of *self disclosure* will be as follows: “interactions in which the therapist reveals personal information about him/herself [self revealing] and/or reveals reactions and responses to the client as they arise in session [self involving]” (Hanson 2005 p 96) All participants identified professional boundaries and the strategic use of self disclosure. The participants that had just recently graduated with their MSW or had their BSW, would often reflect upon the nature of the treatment relationships. Often, these participants redirected the questions clients asked back to the nature of the work as one participant stated “I would redirect the question back to the purpose of treatment”. Other participants that had identified as using client focused self disclosure described it as “a way to connect with their clients” and often reflected the nature of the therapeutic relationship rather a space to disclose personal information. One of the participants discussed context as an important factor in the use of self disclosure. This clinician stated “I think it depends on the setting” and reflected upon the characteristics of the clients that she interacts with. This clinician then went on to explain that the therapeutic relationship and context of the relationship with mandated clients as considerably different than with those receive services because of personal choice. Of the twelve participants, two worked directly with mandated clients and both discussed the context of the relationship as a factor that influences client focused self disclosure.

Therapist Identity Focused

All of the clinicians that participated discussed personal attributes reflecting identity but clinicians discussed identity under different circumstances. Two clinicians identified their ethnicity and race as influencing interactions with clients. One clinician of color specifically referenced a client that “was racially insulting me” based upon her physical presentation. In addition, this participant explained “the client asked if I was capable of doing the work because of my age? But the race part came up initially. The client claimed that I was young claimed that I was young, but also stated oh, you’re just a young Indian. I knew she was in crisis, but some part of me felt compelled to answer to that but I chose not to”. Three of the twelve participants were clinicians of color and the rest were non latino females. None of the white clinicians discussed an intersection of personal racial identity with interactions with clients. One participant stated “I can’t say that it has entered the room”. Three white clinicians expressed pieces of their personality as it relates to personal identity. These participants stated “I have anxiety too” and “I usually am sarcastic and use a lot of humor”. Three clinicians identified as having children of their own and utilizing personal roles of being a mother as an influence of self disclosure and personal identity; one participant specifically this as a way of connecting and self disclosing. This participant stated “well, it was difficult because I am a mother too”. It was evident that clinicians of color spoke more openly about racial identity as it intersects with self disclosing to clients, whereas white clinicians very rarely stated that their racial identity influenced self disclosure.

Therapist style as an influence on self disclosure

All participants referenced theoretical orientation or style of practice as a factor that influenced the use of self disclosure with clients. Four of the participants that graduated with their MSWs reflected upon the nature of the therapeutic relationship and goals of treatment by voicing some variation of the statement: “I thought, is it going to help the client?”. Other participants identified situations in which they used self disclosure as a way to connect to their clients. One clinician reflected upon an interaction with a young male student who recently lost his dog and self disclosed the loss of her dog when she was a child as well. All of the participants referenced self disclosure and the appropriate use of self disclosure as a way to connect to someone in relation to something that they were going through. Different contexts of therapeutic relationships often changed the depth of personal self disclosure. One participant who worked with court mandated clients stated “well, I knew what she was talking about and acknowledged that, but when she asked how I knew, I had to somewhat lie. I didn’t want her knowing that I went to that store too”. This is a direct reflection of what these participants had identified throughout the interview as boundaries of the therapeutic relationship, and also a reflection of varying contexts that may influence the use of self disclosure. Many clinicians referenced their personalities and styles such as: personal centered, relational, psychodynamic, strength-based which impacted the foundations and development of the therapeutic relationship. One participant, who identified as using a relational approach stated: “sometimes I do it more in the beginning when engaging with the client to let them know that I am genuinely interested”.

Number of years with experience and use of supervision

The use of self disclosure was often influenced by the number of years of clinical experience of the interviewees. The majority of those interviewed had been practicing 3-4 years and the experience had been related to school based internships. Three of the participants had been practicing for more than 5 years. Duration of experience often influenced the understanding and reflections upon self disclosure. One more experienced clinician stated “well, in school they teach you things, especially with using self disclosure. When I was going through school they said absolutely not and that was when psychotherapy really had established itself in the late 70s, very Freudian (laughing). I still am meaningful when I use self disclosure but I have come to understand it as a tool not just something you do casually”.

All of the participants who had recently graduated had a more rigid response to self disclosure and often stated “no I do not use it” but when further explored referenced times in which they had disclosed to clients. One MSW recent graduate explained that “we were basically told to stay away from it” but later identified that she had disclosed to a client. Duration of experience often reflected a comfort in the use of self disclosure and understanding self disclosure as a tool rather than something that should not be used. One more experienced clinician stated “ it changed from what I learned in school to how I do practice” and further explained that self disclosure and the use of self disclosure is a tool of practice that assists in the reciprocal relationship with the clients she sees. Of the participants that recently graduated with their MSW, four clinicians discussed the use of supervision as a space to discuss clinical decision regarding self disclosure but could not determine specific times in which they had directly discussed situations with their supervisors. One participant stated “well, I definitely bring that up in supervision” and yet later stated, “sometimes I have so much to discuss in supervision and I do forget”.

Adoption themes parallel process: identity as a therapist and as an individual

One clinician identified as adopted and participated in the interview process. This clinician had similar conceptualizations of the use of self disclosure as those participants who were not adopted. Additionally, this participant reflected upon many aspects of her personal identity, considering adoption status both personally as a therapist and as an individual identity. This participant stated “it is one of my many identities but its not my main identity anymore”. This clinician discussed that she had been adopted at birth but felt disconnected to her adopted family because of her adoption status. The clinician then went onto discuss her journey connecting with her biological family stating, “I felt I was a whole person after reconnecting with my biological family”. She stated that after this experience, her adoption status no longer was the center of who she perceived herself to be. This clinician utilized self disclosure which was directly related to her adoption status with a client who was also adopted as a means of “connection”. This participant was the one of two participants that indicated a significant identity shift. The other clinician later identified in life as lesbian but did not consider sexual orientation as an influence on self disclosure, but rather just personal identity.

Connection and Isolation

Found within almost all interviews were themes of connection and isolation to clients professionally, personally and in relation to adoption. The one clinician who identified as adopted, found herself “alienated” growing up an feeling set aside in her adoptive family. This clinician discussed that her adoptive family was in support of reunification due to the nature of adoption and she found discomfort in peer relationships. This clinician discussed that her closest friend in childhood was also adopted and that this relationship helped her through childhood.

This clinician explained that she often felt disconnected from her family and felt different than her peers, who were not identified as adopted. The participants who were non adopted clinicians never made reference to alienation or that their identity had been compromised unless they were considering pieces of their identity in marginalized populations. One participant reflected upon the nature of defining herself as a lesbian and considered sexual orientation as a piece of her identity. This participant did not consider her sexual orientation as an influence on self disclosure, but through out the interview identified that this aspect of identity, may influence the therapeutic relationship and self disclosure.

This adopted clinician also discussed a self disclosure to a client who also was adopted and stated that there was a change in relationship for the better. The clinician had stated “she felt like no one understood her or knew where she was coming from. She was just there and felt as though because she was adopted she wasn’t able to connect with anyone”. The participant continued to state “it was a changing point in our relationship. I had to think about timing and consider whether or not my personal disclosure would benefit her. It did significantly and from then on our relationship changed positively. It was almost as if I knew where she was coming from because of that shared disclosure”. Some of the other participants indicated that they had disclosed and it positively impacted the nature of the therapeutic relationship, but none referenced adoption status because they had not experienced it or facets of their identities in childhood.

At the same time, participants who were not adopted also found the need to connect with clients in a different manner other than adoption or birth status. One participant stated “well, I was working with a younger boy who lost his dog. I couldn’t help but to think of my own loss of

a pet when I was younger. I disclosed that I had lost an animal too growing up.” This statement reflected a shared personal experience relating to loss and the clinicians decision to self disclose to establish connection, similarly but yet different than those identified as adopted. After discussing further this clinician concluded “this self disclosure wasn’t harmful and probably was the reason why he kept coming back. He felt safe and supported in that”. The nature of this disclosure was in fact a personal self disclosure, but not one of which reflected personal identity to form connection. In the disclosure used by the adopted clinician, the use of her self disclosure was to establish connection to a client who felt misunderstood and alienated. Although these disclosures both emphasize the connection between the client and clinician; both expressed a shared experience but one expressed adoption identity. Another clinician referenced a relationship with her client who was a young adult. She stated “well, I know that this person would come in and talk about all of the wrong choices that she made over the weekend or at least that is what I anticipated because that’s what she always does, but surprisingly she didn’t. She ended up making a different decision and not socializing with the people I thought she would be with over the weekend. Couldn’t help but feel a certain way”.

Despite differences in identity, seven out of the twelve participants discussed adoption and the need for connection and isolation. At the end of the interview, the interviewees were asked to reflect upon the current word of “adoption.” Seven out of twelve participants discussed their interest in adoption but the need for change within the current system. One clinician specifically stated “I feel like the system needs to do more” and further discussed her experience in working with a client who was adopted and currently in middle adulthood. She described her client and stated “he still feels that everyday” and “it’s hard to help him” indicating that his adoption has shaped his life experience. Three non adopted clinicians stated that they were

considering adoption and have considered it before. One clinician who identified herself as lesbian is considering adoption instead of alternative means to have children. Both non adoptive and adopted clinicians discussed the need to further explore this area of research and life experiences of adoptees. Two participants stated that there needs to be further education and a foster care system change. One participant stated that she had taken a class on it as an elective while in school and still feels underprepared working with this population. One participant discussed the process of aging out and its impact on children who are not legally adopted. Seven out of twelve participants indicated that the adoption and foster care system have a lack in resources for foster and adopting parents. Despite the differences, both non adopted participants and adopted participants suggest that further research is necessary and essential for children in the foster care system or pending adoption. The participants indicated the necessity to support individuals who are looking to adopt such as continuing education to support children who will become adopted to enhance the relationships post adoption. As a result, families who are integrated into a family post adoption, will have the resources to support children integrating into families. In addition, these participants identified individuals who are not adopted and “age out” of the foster care system as a current concern which is a factor that proceeds isolation and diminishes connection.

V

Discussion

The operational definition of *self disclosure* will be as follows: “interactions in which the therapist reveals personal information about him/herself [self revealing] and/or reveals reactions and responses to the client as they arise in session [self involving]” (Hanson 2005 p 96) . The clinical professionals that participated perceived self disclosure both negatively and positively, but all identified using self disclosure in the therapeutic relationship and treatment context. Other uses of self disclosure in treatment specifically reflected the identities of clinicians as they practiced with clients. These participants discussed personal aspects of their identities as well as theoretical orientations as an influence on the use of self disclosure. Several of the newer clinicians, who have just recently graduated, indicated the use for supervision to continue to explore self disclosure as a mechanism in the therapeutic relationship. All clinicians referenced and discussed educational institutions as an influence on the use of self disclosure, but only the more experienced clinicians identified self disclosure as a source of professional development to be integrated into clinical repertoire. Of the twelve participants, one identified as adopted. Analysis of the data from this individual interview suggests that there is a parallel process in the use of self disclosure and the intersection with professional and personal identity. In analyzing data from the adopted participant’s interview, themes emerged related to the use of self disclosure and identity that were distinct from non adopted participants. However, these themes must be interpreted cautiously, as they emerged from a singular interview.

Many of the interviewees shared personal experiences related to their own identities within the context of the therapeutic relationship. One participant discussed her own personal

reflections of her identity, stating that race was a core concept of her identity. The research discussed in the literature review highlighted how individuals hold different aspects of their identity, but the ones that are most core to the individual, are held most central. Vignoles et al(2006) state, “if identity construction is guided simultaneously by multiple identity motives, then- over time and in an absence of external constraints - a physiologically healthy individual will likely find non conflicting ways of satisfying each motive” (p328). Research focusing on identity supported and reflected the clinician of color who expressed that her identity was reflective of her racial identity, but that her identity was questioned by a client or external constraints. This reflection is a direct result of unconscious racism which was explicitly inquired about regarding the clinician’s race.

In this study, individuals who identified themselves as white rarely considered their race as a factor influencing the therapeutic relationship or other aspects of clinical practice. This suggests that individuals of color hold their race central to their conceptualization of personal identity and individuals who identified as white did not necessarily consider race within the room. Many of the white clinicians did however; highlight aspects of their identities in which they found most dominate. For example, one clinician had stated “I have anxiety like you too” or “I considered me being a mother”. Clinicians utilized these aspects of their identities to connect with clients whether through personal self disclosure, and use of self and use of empathy while working with clients. Although these clinicians did not necessarily address race in clinical practice, these individuals made reference to these aspects of their identities as the core ways in which they established and nurtured ongoing connections with clients.

Clinicians who identified as white displayed limiting understandings that a white identity has influence and power over their clients. Inevitably, these clinicians acknowledged the power in the relationship but failed to address and be held accountable for such. Research reflected in the literature review discussed the influence of egocentrism and the influence upon self disclosure. Falk and Noonan Wagner (1985) state, “perspective taking is manifested by behavior that indicates an active effort to understand and incorporate the information and feelings presented by the other person without making a value judgement” (p560). These authors continue to include egocentrism within the research and how self disclosure is influenced from a place of power. Of these clinicians who identified as white, none considered this perspective, but acknowledged their power in the therapeutic relationship.

Adoption Identity

The adopted clinician also identified as a white female. This clinician expressed alienation throughout childhood due to her adoption status with social connection and referenced a relationship in childhood that encouraged social connection; another adopted friend. The clinician that was interviewed shared the importance of processing her biological family as a part of her story. After reunifying with her biological family, the participant stated that she then considered her status as an adoptee just another aspect of her multifaceted identity. This clinician discussed disclosing to a client about her adoption status after an ongoing struggle with a client in a therapy session. After disclosing her personal adoption status the client reacted differently to the clinician. Interestingly, this clinician doesn't identify adoption as a core or central component of her identity but rather something that she has processed through years of psychotherapy before clinically practicing. This identity process is similar to the presenting literature suggesting that there was a reduction of external constraints (Vignoles et al, 2006).

Of the other clinicians interviewed, the non adopted clinicians did not reference portions of their identity that had radically shifted except those who identified in a marginalized population. One clinician discussed how her sexual orientation had been more considered as she identified as a lesbian during adolescence and how this influenced her immediate and personal life, but did not consider this while working with clients. As she became to understand her sexual orientation, her considerations of this portion of her identity changed personally but not professionally.

Self Disclosure

There was a general consensus and saturation of data indicating the interviewees understood self disclosure. Some clinicians identified this as “personal facts relating to historical history..anything personal relating to yourself as the clinician”. The articulation and details related to self disclosure varied based upon age and amount of years clinically practicing. Of those who described self disclosure, the more general definitions were given by those who had recently graduating and just had started to practice. Those who felt ambivalent about the use of self disclosure were individuals currently obtaining their Masters in Social Work or who just graduated. Many of these individuals also referenced the need for supervision and the use of supervision regarding self disclosure. The literature however, indicated that like a therapeutic relationship, there are boundaries that are established which may influenced by the nature of the relationship. Gunn and Pistole (2012) state, “Fear of evaluation and need to appear competent can provoke intense even detrimental anxiety, failure to manage emotion effectively may hinder the trainee’s ability to apply knowledge and disclosure to the supervisor” (p230). These findings suggest there are factors which influence ability to disclose in supervision. When asked in further detail, most of the newly graduated clinicians made general statements about the use of

supervision. These statements also support this research indicating that the use of supervision and what was disclosed was based upon perception, bias and the supervisor trainee relationship (Gun & Pistole, 2012). The clinical professionals who had been practicing for a longer period of time arrived at their own understanding and used self disclosure in relation to their authentic therapeutic self. Some of these individuals referenced their education received at an earlier stage of professional development but then shared that they developed their own use of self disclosure over time.

Therapeutic Relationship as Reciprocal

Of the interviewees that described this professional development of self disclosure, these individuals also discussed a personal and professional self within the room. They identified that they are a person aside from being a clinician and that these are not necessarily mutually exclusive. This new perspective of the person within the therapeutic relationship has been found within the literature (Gellar, 2003; Rosenblatt, 2009; Shoholt, 2005). Despite the time individuals had spent practicing, both newly graduated and experienced clinicians identified some elements within the therapeutic relationship and how both therapist and client establish the relationship; trust, empathy, ability to listen and boundaries. Almost all of the clinicians discussed therapeutic sessions with their clients that indicated that clients impacted them professionally or personally. These exchanges support the view that that the nature of the therapeutic relationship is reciprocal and by definition, is evolving.

Limitations and Recommendations

The information obtained in these thesis interviews did not necessarily address the initial research question because of the difficulty in sampling adopted clinicians and instead has given

direction to new areas of research. These new areas would further explore adoptees in general and non adoptees as relating to the construction of identity. The research findings that came from this research study emphasize the importance of social constructivism and the relationships individuals develop with others.

In order to obtain participants for my research study, a convenience sampling method was used to recruit. Interestingly enough, the participants who responded, were individuals I have had prior relationships with or who I have had personal face to face connection with. Personal connection appeared to be the common factor as to whether or not participants followed through with participating; all but one participant I had prior interactions with. This experience reflects the theoretical orientation of social constructivism and emphasizes the importance of relationships, another significant component to my thesis. As I was conducting my research, many of the individuals who responded to me were adopted but they did not meet the criteria for participating. Some of the professionals that I interviewed did not have the clinical relationship with clients that that study required. If I were to replicate this study, I might consider a broader understanding that the type of relationships differ rather than understandings of self disclosure. Due to the perceptions of the professionals as well, it may be beneficial to broaden professional titles considering individuals define themselves professionally in different ways.

Research may want to examine adoption from a more general perspective considering there is limited research pertaining to adoptees. This research may want to explore adoption disclosure from those who do not clinically practice. Some individuals were public about their adoption whereas other individuals were not. Further exploration regarding disclosure of adoption status may help future practice with adoptees to gain an understanding of personal

experience of adoption. From the experience I gained an understanding of the different experiences of adoption and the broad understanding of “being adopted” is not a shared experience. Future projects may wish to support that a clinical professional in approaching an adoptee with this understanding of differing experiences which lead to different feelings towards adoption.

In addition, this research has indicated the necessity for adoptees to have community aside from online connection; a fundamental need for a human is connection with others. The difficulties in finding this sample population may be a parallel process and experience of adoptees; they are in existence but have limited connections to other adoptees. Other considerations related to adoption may include, what motivates individuals to adopt? Many of the clinicians that I had interviewed were interested in adopting children and many clinicians stated that they understood the hardships that may come from doing so. Of the individuals I interviewed, all but the adopted clinician expressed interest in adopting. Future research may look to explore whether or not the nature of the helping profession influences desires to adopt because we are “in the helping profession”. What personal characteristics or motivations do individuals have to adopt?

More research is needed to develop a clearer understanding of racial identity development for white clinicians and how it influences clinical practice. This research may be beneficial in the creation of workshops that encourage the discussion of privilege and encourage the discussion of what being white means. Many of the interviewees were white clinicians and had graduated from programs in which they received their Bachelor’s in social work. These clinicians recognized areas in which they held power over their clients but could not identify that

race had influenced the nature of therapeutic relationships. Some clinicians felt mistrusting of clients in different settings ie. Probation or transitional housing which could be helpful in future research as well: understanding stereotypes informed by context and racial identity development.

Although I did not receive the turnout of adopted clinicians that I had desired, there was a lot of rich information I received whether it be from adopted or non adopted clinicians. While conducting my thesis, I have reconsidered connecting with my biological sister who was adopted as well. My adoptive family has been in support of connecting with biological counterparts and has been since my childhood. Interestingly, I have reconnected with my oldest brother after finding out I had a biological nephew; which was the central reason for him reaching out, the social connection to the biological counterpart. In addition, my middle brother and I have lost touch through the years. Our lives grew distant as we entered adolescence. He had a child with a female who recently contacted me. The woman wanted her son to know his biological aunt. The original research regarding adoption emphasized an existential perspective to make meaning of one belonging in the world and I find this existential desire within each individual not just adoptees. Social connection and the desire for biological connection are found within individuals who are not necessarily adopted. Future research may want to examine and further examine those considering reunification with biological counterparts in general because there is something significant about biological counterparts who have been socially disconnected. This was reflective in the responses given by the adopted clinician and the adopted clinician who inevitably withdrew from the study. This was an aspect of other interviews that were not considered before and may indicate the need for future research: the reunification stages with a biological family post adoption. The adopted clinician discussed conflict with her adoptive family while wanting to reunify with her biological counterparts, “ my sister actually had a really

difficult time. If anyone were going to work with a family wanting reunification, know that it is emotional and it can stir up a lot of things”. These statements indicate that the reunification process and different stages of reunification may be an area of focus for those working with adoptees who want to reunify but also for the clinical professional to understand that adoptees may not want reunification. This portion of my thesis went unexplored because the participant that was officially interviewed, desired reunification. The interviewees that withdrew also desired reunification but even within these experiences, there is the alternative experience of why individuals choose not to reunify, which may be beneficial for clinical practice.

Future research may want to further examine this complex understanding of the clinical professional, a more intricate look within the co-existing selves which appeared to be a parallel process for those who identified themselves as adopted. The clinician that identified herself as adopted utilized self disclosure with an adopted client to connect within the therapeutic relationship but stated that she does not consider doing so with other clients. This emphasizes that adoption status may influence self disclosure but context is considered. While conducting some of the interviews, some interviewees disclosed pieces of their historical background that I did not know prior to the interviews. Most of these interviewees, I had relationships with and the disclosure within the context of the thesis interview was surprising. One individual disclosed that she had a trauma history and another who was unable to work with divorced clients because of their own experience. The degree of involvement or degree of relationship would be interesting to examine to consider whether or not these influence the use of self disclosure in addition to context.

In conclusion, there is emerging evidence to suggest that self disclosure may be influenced by adoption status but this study failed to answer the initial research question however, this research has illuminated considerations for future research. The one adopted clinician that did participate in the study confirmed that there was an identity shift from pre-adoption to post adoption where she felt disconnected and then a whole individual. The general participants indicated the need to explore and continue to develop an understanding of the adopted community and the societal implications of societies disconnect or lack of awareness. The inability to find participants who identified as adopted may indicate that this population could be hidden and disconnected. The individuals who initially desired to participate and then retracted, felt compelled for unidentified reasons. Furthermore, the experience of adoption varied and should be understood person to person identified as adoption. The majority of these participants were newly graduated and have identified that self disclosure is controversial yet beneficial in the context of the therapeutic relationship. Additionally, this study suggests that newly graduated clinicians who identify as white, have limited understandings of racial identity within the context of the therapeutic relationship. The lack of awareness has the potential to wound clients of color by continuing to create oppressive dynamics within clinical practice and unconsciously promote racism in practice.

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APPENDIX A : HSR REQUEST TO REVISE LETTER



School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

October 28, 2015

Heather Smith-Jackson **A16**

34 Hillside St,

Newington, CT 06111

Dear Heather,

Thank you for the effort you have put into your Human Subjects Review (HSR) application. Our job as a federally mandated human subjects review committee is to make sure that all research projects which we approve follow federal guidelines for research with humans, including informed consent, protection of vulnerable participants, the ability to withdraw from projects, appropriate storage and collection of data, and other items discussed in the HSR manual.

Part of our job is to ensure that the research results are worth the risks and costs to the participants. The actual benefits to the researcher, participants, and the field of social work, must be worth the time and energy participants will put into being a part of the study. Projects that are unclear in their questions and methods may lead to results that are not beneficial to the participants or to the field.

Attached you will find your proposal with our required changes in **MS Word Track Changes** and our requests for revisions marked as *New Comments* in the margins. These comments will provide guidance to make substantive changes in accord with HSR federal guidelines for research.

Please make all changes to your research proposal with **MS Word track changes** or indicate changes in another way (e.g. bold type or highlighted type) so they are easily read in order to

speed the return of your revision. If you feel we have misunderstood your study and there are changes you do not wish to make, please explain in the margins with a *Comment/s*. Sometimes we ask for changes that do not make sense to applicants because something was unclear to us and your explanation can clarify these issues.

Please understand that we function with a collaborative model- we want to help all applicants learn from their research while protecting all human subjects. Should you have any concerns about committee comments, please review with your thesis advisor, who may follow up with a contact to the Chair, HSR Committee.

Please return your application to Laura Wyman at lwyman@smith.edu. Please label each document you send with **your name, the term "HSR," the term "Revision", and the number of the revision**. As an example, if your name is Sara Jones, we should receive an application revision document like this: "SaraJones HSR Revision1.docx".

Please label the subject line of your email as HSR Revision.

Please note that most of your correspondence will come from me through Laura.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten', with a small circular mark above the 'E'.

Elaine Kersten, EdD
Co-Chair, Human Subjects Review Committee

CC: Julie Berrett-Abebe, Research Advisor

APPENDIX B: HSR RESUBMISSION APPROVAL LETTER



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

November 8, 2015

Heather Smith-Jackson

Dear Heather,

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,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

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

CC: Julie Berrett-Abebe, Research Advisor

APPENDIX C: INFORMED CONSENT

October 10 2015

Dear Potential Research Participant,

My name is Heather Smith-Jackson and I am a graduate student at Smith College School for Social Work. I am conducting a study on how adoption influences the use of self disclosure from a clinical perspective. The data that is found will be used in my master's thesis. You were selected as a possible participant because you are a practicing clinical professional and may have been adopted. If you are interested in participating in this study, you must have a MSW, LMSW, LCSW, PSYD or MD who has two years of clinical experience either paid or non paid. If you choose to participate, we ask that you read this form and ask any questions that you have before agreeing to be in the study.

One of the intentional purposes of this study is to expand upon the limited research that is offered from a clinical perspective regarding self disclosure, but with concentration on adopted clinical professionals. This study is being conducted as a research requirement for my master's in social work degree. Ultimately, this research may be published or presented at professional conferences.

If you agree to be in this study, you will be asked to do the following things: after accepting role of participant, there will be a 45 minute in person interview session. I will be asking questions specific to identity, self disclosure and adoption. I will ask for you to provide demographic information about yourself. The interview will be tape recorded and I will be taking notes reflecting body language. I may contact you by telephone to gain a more clear

understanding of your responses or to contact and discuss whether or not my own observations are accurate.

This study has the following risks. There is the possibility that discussing material may resurface unsolved feelings regarding adoption. There is a possibility that there will be feelings regarding adoption that may trigger me, the interviewer. In addition, those clinical professionals who are not adopted may be triggered discussing adoption as well. If these professionals discuss emotional distress, I will provide them with a list of providers in the town that the professional lives in. The benefits of participating in this study include: adopted clinical professionals sharing experiences that are not discussed in common scientific literature which directly influences the knowledge students are offered and knowledge about marginalized populations, specifically, clinicians who are adopted. The benefits to social work practice include a more clear understanding of the marginalized population of adult adoptees without focusing on the outcome or mental health. This study would contribute to literature that views clinical professionals as human beings with conscious decisions to self disclosure and personal reasons for doing so.

Your participation will be kept confidential. With the exception of my research advisor and myself knowing demographics, the interview and results, will be kept anonymous. After I transcribe the interview, I will utilize pseudonym instead of your actual name. In addition, I will lock consent forms, audio tapes and interview notes in a locked room only I have access to. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage

period. We will not include any information in any report we may publish that would make it possible to identify you.

You will receive a 5.00 gift card for Starbucks for participating. The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study 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 up to the point noted below. 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 by 12/31/2015. After that date, your information will be part of the thesis, dissertation or final report.

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, Heather Smith-Jackson, hsmithjackson@smith.edu or by telephone at xxx xxx xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. 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.

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. You will

also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

1. I agree to be [audio or video] 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: _____

Please return this consent form to me by 2 weeks within receiving to indicate intention of participating in the study (I suggest that you keep a copy of this consent form for your records).

If I do not hear from you by then, I will follow up with a telephone call.

If you have any further questions about this study, participation, rights of participants, or this consent form, please feel free to ask me at the contact information below.

Thank you for your time, and I greatly look forward to having you as a participant in my study.

Sincerely,

Heather Smith-Jackson

XX XXXXXX XXXXXX

XXXXXXXXXX XX XXXXX

XXX XXX XXXX

hsmithjackson@smith.edu

APPENDIX D : INTERVIEW GUIDE

This information will be utilized during the analysis of the data to determine if there were variations within these specific categories to discuss further in my reflective portion of this paper. My questions are broadly defined as :

1. Feelings and thoughts about the use of self disclosure in general (to both adopted and not adopted clinical professionals)
2. Personal accounts of what is and what is not appropriate with clients and with what specific clients (to both adopted and non adopted clinical professionals)
3. Feelings and thoughts about adoption (relationship with adopted families : for those adopted) Feelings and thoughts about adoption (personal reflection/feelings about childhood: not adopted)
4. Experiences negative and positive regarding adoption (both groups)
5. Past experiences of the use of self and adoption as a means of disclosure/reactions/thoughts while doing so (for those adopted) past experiences of the use of self and family as a means of self disclosure/thoughts/reactions while doing so (for those not adopted)
 - a. Outcome of that treatment relationship
 - b. Personal reflections between disclosure and clinical relationships
6. Reflections about self identity (both adopted and not adopted individuals)
7. Thoughts and feelings about self disclosure of individual administering the interview

With these questions, I believe that I can thoroughly conducted semi structured interviews and to begin to explore the question “How does adoption influence the use of self disclosure in clinical practice”