The Criteria for Therapist Self - Disclosure: An Exploration of the Conscious Use of Self In the Practice of Psychotherapy

Judith Cohen Simon

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THE CRITERIA FOR THERAPIST SELF-DISCLOSURE: AN EXPLORATION OF THE CONSCIOUS USE OF SELF IN THE PRACTICE OF PSYCHOTHERAPY

A dissertation submitted to the
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in partial fulfillment of the requirements
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Doctor of Philosophy in Clinical Social Work

by

Judith Cohen Simon

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ABSTRACT

THE CRITERIA FOR THERAPIST SELF-DISCLOSURE: AN EXPLORATION OF THE CONSCIOUS USE OF SELF IN THE PRACTICE OF PSYCHOTHERAPY

This study explores the criteria that therapists employ in their determinations to self-disclose with their patients. It focuses on the processes that therapists use in deciding when, why, and what to reveal of their personal selves to their psychotherapy patients.

The literature review reflects a paucity of research and writing that specifically addresses therapists' processes regarding their self-disclosures.

Fifty questionnaires were sent to experienced psychotherapists representing the three main psychotherapy disciplines: clinical social work, psychiatry, and psychology. Twenty-seven were returned.

The subject group was selected by ranking the questionnaire respondents to determine the four highest and the four lowest disclosers. A semi structured interview was conducted with these eight psychotherapists. The interview was based on the respondents' questionnaires and clinical vignettes.

Analysis of the interviews suggested three themes and

five categories of criteria for self-disclosure. The themes were: the psychotherapy relationship, therapists' theoretical orientations, and therapist self-awareness. The criteria were: modeling, fostering the therapeutic alliance, validating reality, encouraging the patient's autonomy, and the therapist's satisfaction. Except for therapist satisfaction, which was reported only by the high disclosers, the criteria reported by all the subjects was the same. What differed was the frequency of revelations.

All the subjects reported some self-disclosure in their work. Most of the subject therapists disclosed demographic information during the first therapy session when it was requested. All were more likely to disclose with their adolescent and more disturbed patients.

Therapists' theoretical orientations, specifically, the conscious use or nonuse of the transference relationship, emerged as a highly significant variable in these therapists' disclosures. Therapists who do not make conscious use of the transference relationship are comfortable disclosing themselves freely with their patients. In contrast, those who do are less likely to self-disclose. Such differences governed attitudes towards the psychotherapy relationship, the curative components of psychotherapy, and therapist use of self. Divergent viewpoints about these themes emerged.

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years and have cheered me on in this achievement.

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CHAPTER I

INTRODUCTION

The psychotherapeutic relationship is unique to interpersonal relationships. It is a dyadic relationship with a specific goal, that is, the emotional growth and increased mental health of one of the participants. Roles are defined: the therapist facilitates the patient's growth, and the patient presents concerns and participates in the psychotherapeutic process. The role definition includes agreement that one person, the patient, will openly discuss his or her personal life, while the therapist will function in a manner that will further the patient's psychotherapeutic gains. That the patient employs the therapist as an agent of change implies a relationship founded on trust and confidence, within which a unique interconnection will develop. The hours spent together generate a special closeness and intensity, even though discussion is primarily of the patient's material. While the patient is clearly involved, the therapist frequently becomes personally as well as professionally invested in the relationship.

Exploration of the psychotherapy relationship raises complex questions and issues related to the numerous dimensions and techniques of the therapist's functioning and the essence of the curative aspects of the relationship. The therapist's professional and personal selves

are inextricably connected, and the ways in which the therapist enables the patient to grow reflect the therapist's whole self. Since therapists' personal revelations are frequently a component of psychotherapy, questions arise regarding when, why, and what is revealed and with which clients. How does the therapist determine whether or not to disclose personal information or reactions? This study addresses an aspect of the general issue of what therapists personally contribute to the psychotherapy process.

Inherent in any ongoing intimate relationship is each person's learning about the other. Implicit to the goal of a psychotherapeutic relationship however, is a one-way intimacy in which the patient is the primary one who is self-disclosing. Discussion of the therapist's personal life is not de rigueur. However, the therapist cannot avoid sharing some personal information with the client. For example, the ways the therapist dresses, decorates the office, and handles promptness, humor, non-verbal body language, fee management, appointments, and telephone calls all give the client clues about the therapist. Additionally, the therapist cannot avoid communicating values and beliefs. Whether or not the therapist intentionally chooses to reveal personal information, a perceptive client can discern a great deal from observations of the therapist and the environment that

the therapist creates.

Therapists of different theoretical orientations regard the psychotherapeutic relationship differently. For example, humanistic and existential therapists do not utilize the transference as do psychoanalytic therapists. Transference is also usually not overtly addressed in group and family therapy.

In psychotherapy models that do not utilize the transference, that is, when the patients' projections are not the core of the material discussed, the therapist is inclined to be more self-disclosing than in those that do. When the patient's transference projections onto the therapist are not encouraged or interpreted, the therapist need not be concerned with contaminating these projections and is therefore free to participate personally. Indeed, openness is often encouraged. (See Alger, below.) Ideally, the therapist's revelations are in the service of the patient's needs and growth, not the therapist's.

While assuming that therapists vary in their frequency of self-disclosures according to their theoretical orientations, one cannot assume that the criteria for self-disclosure follow a pattern consistent with their orientations. It is possible that all therapists utilize the same criteria, or that therapists of the same orientation differ individually in the criteria utilized.

The Questions

What are the factors in therapist's self-disclosure? What, when, why, and with whom do they consciously self-disclose? Are therapists more likely to disclose at different stages of the therapy? With what patient populations are therapists more likely to self-disclose? What sorts of information, thoughts, reactions, and feelings are disclosed? Why do some therapists regularly employ disclosure? Do some therapists decide not to disclose? Why? How do therapists from various theoretical orientations and diverse years of experience differ in their revelations of personal information and reactions? What criteria are used in therapists' determinations regarding their disclosing themselves in the psychotherapy process? Answers will derive from the questionnaire and interview data.

Background

Attention to the psychotherapeutic relationship and its ramifications began in the 1890s when Freud first discussed transference and then countertransference, acknowledging the impact of the therapist's personality and responses on the psychotherapeutic work. A neutral stance was the goal. Therapeutic neutrality, originally discussed and recommended by Freud in his

early writings on psychoanalytic practice, was defined as detached observation. The therapist was to function as a blank screen, mirroring the patient while adding nothing that did not originate in the patient (Freud, 1912). According to Freud, the components of neutrality included passivity, anonymity, and mirroring and these were free of countertransference distortion.

Countertransference, which Freud defined as the therapist's unconscious responses to the patient's transference reactions, was seen as indicative of a probable pathological response by the therapist. Clearly, countertransference was destructive to the therapeutic process. Every expressed emotion by the therapist was a violation of the rule of neutrality. Therapist self-disclosure came to be viewed as the antithesis of the detached observer.

It is important to distinguish between neutrality as a therapeutic stance and therapist self-disclosure as a therapeutic technique. They are not mutually exclusive. Freud spoke of being like a mirror but not "like an inanimate thing" (1912, p. 7). Psychoanalytic doctrine almost universally subscribes to a neutral therapeutic stance. Annie Reich said, "To be neutral in relationship to the patient ... does not, of course, imply that the analyst has no relationship at all to the patient" (1951, p. 26). She, among others, maintained that psychotherapy

is a process within the context of an intimate and caring relationship that can be warm and supportive and can either include or exclude intentional therapist disclosures.

Therapists vary greatly in how they value, define, and maintain neutrality in their therapeutic attitudes and behavior. This area of theory has remained vague. Currently, the trend is away from neutrality and toward increased activity, including intentional verbal self-disclosure by the therapist in individual psychotherapy (Weiner, 1983: Yalom, 1980). The societal trend towards a holistic approach to health care and more equal relationships between patients and their health-care providers have impacted psychotherapy relationships as well as physician patient ones in general. The human potential movement, with the popularity of encounter groups and large group trainings, has challenged as "standoffish" the manner of the traditional psychotherapist. All facets of the therapist's contribution to the psychotherapeutic relationship are under scrutiny, with studies examining therapist self-disclosure in individual therapy increasingly frequent in the literature (Bundza, 1973; Curtis, 1982; Dickenson, 1965; Flaherty, 1979; Hayward, 1973; Nielsen, 1979; Rosie, 1980; Simonson, 1976; Truax, 1971; Weiner, 1974a).

Purpose Of Study

The purpose of this study is to develop an understanding of the ways in which therapists employ intentional self-disclosure. By exploring therapists' conscious processes relating to the decision to verbally reveal ordinarily private information, I hope to learn more about how clinicians function and to increase understanding about this facet of psychotherapeutic practice.

This exploration focuses on the who, what, when, and why of self-disclosure in individual psychotherapy.

This study explores one aspect of the psychotherapeutic relationship from the therapist's vantage point. In its focus on clarifying the criteria of self-disclosure, this study aims to enhance therapists' discriminative capacities to use themselves to therapeutic advantage. In general, therapists' increased awareness and understanding about the determinants of self-disclosure may enable them to function more effectively.

Definitions

For the purpose of this study, "intentional self-disclosure" is defined as verbal behavior through which therapists consciously, sincerely, purposefully, and intentionally communicate ordinarily private information about themselves to their clients. Details about one's history, family demographics, vacations, feelings,

values, and concerns are considered private information. Intentional self-disclosure, as used here, also encompasses revelations about one's point of view on moral issues, politics, health, and religion. Such disclosures are defined as "intrapersonal." Also included within the definition of intentional self-disclosure are "interpersonal" disclosures, which reveal the therapist's personal feelings and responses to a client's behavior and material during a session.

Some therapist self-disclosures are countertransferential. In this study, I am defining "countertransference" as a response that originates in the therapist's reaction to the client. This can be distinguished from a "non-countertransferential" disclosure, which originates in the therapist, such as private information. Both the countertransferential and noncountertransferential responses, when shared, can be intentional self-disclosure interventions that aim to facilitate the client's therapy.

The conscious use of countertransference reactions must be differentiated from countertransference expressions that originate in the therapist's unconscious. The former is a self-disclosure in which the therapist notes and chooses to tell the patient about his or her reaction. The latter is an unconscious manifestation, which may be unintentionally revealed.

"Genuineness," "transparency," "congruence," "self-exploration," and a variety of other words have been used to describe the communication between client and therapist. Although there is considerable overlap in the use and meaning of these expressions, they are not synonymous with self-disclosure.

This study investigates criteria for self-disclosure by experienced therapists who practice long term intensive psychotherapy. "Experienced" is defined as having practiced psychotherapy for ten or more years. "Intensive long-term psychotherapy" is defined as weekly or more frequent sessions lasting longer than two years.

To gain insights into this facet of psychotherapy, it is necessary to study the criteria therapists use for making or withholding personal disclosures to their clients. This will be done through a questionnaire and interview, both focusing on the issue of deliberate self-disclosure.

The exploration and questioning will provide an opportunity to learn more about therapists' processes of making decisions about some aspects of deliberate self-disclosure during therapy sessions. The researcher expects that this will make a contribution to the general exploration of the context of the psychotherapeutic relationship from the therapist's vantage point. This project no doubt will raise questions as well as answer

them.

Presentation of the Dissertation

The review of the literature will trace the evolution of attention to the role of the therapist in psychotherapy. A chapter discussing the investigative procedures will follow. The research findings are presented in two chapters, the first addressing overall themes that emerged in the data, and the second presentating the data specific to criteria of therapist self-disclosure. Conclusions and discussions follow. The final chapter discusses the implications of the findings for clinical work and poses possible questions for further study. The appendix includes the questionnaire, interview schedule, outline for analysis of the data, and the form used related to preservation of subjects' confidentiality.

CHAPTER II

REVIEW OF THE LITERATURE

The history of the views on therapist self-disclosure is linked with the beginnings of psychoanalysis with the prominence of the concept of neutrality and acceptance of the phenomenon of countertransference. Self-disclosure, as one aspect of the therapist's contribution to the psychotherapeutic process, is in part a reflection of the therapist's stance. This literature review traces the evolution of therapists' thinking and attitudes about the therapeutic relationship and therapists' contribution to that relationship over the years.

Discussion of Freud's early writings, which reflect his increased awareness of the therapist's impact on the therapy, is followed by a review of the countertransference literature and the evolving attention to how therapists both use and reveal themselves in their work. Included is a brief presentation of some of the writings that, in discussing what is termed the real relationship, bridge the transition from the traditional to the contemporary viewpoints.

Specific attention to therapist self-disclosure appears in the very recent literature. These recent writings cover a variety of kinds of research including studies with simulated patient populations, explorations

with patient populations, and anecdotal material. This portion of the review represents a range of philosophical viewpoints, including traditional psychoanalytic, psychodynamic, existential, and humanistic theorists. The writings on self-disclosure based on explorations and observations from group and family therapy and research with simulated patient populations are included because of the sparse amount of material directly addressing this issue in individual psychotherapy and to allow further perspective on this topic. One can speculate that the diversity and limited amount of literature relating to this area of clinical work reflects therapist sensitivity to and/or the difficulty in delineating the issue.

Neutrality

Freud clearly stated his instructions and admonitions to student analysts in his three papers, "Recommendations to Physicians Practicing Psychoanalysis" (1912; 1913; 1914). Maintenance of a neutral stance and mirroring the patient were hallmarks of this new treatment. While acknowledging the human inclination to reveal oneself, Freud instructed the training analyst against attempting to help the patient by citing his own concerns or by giving him intimate information about his own life.

> One would expect it to be entirely permissible, and even desirable for the overcoming of the patient's resistances that

> the physician should afford him a glimpse into his own mental defects and conflicts and lead him to form comparisons by making intimate disclosures from his own life. One confidence repays another, and anyone demanding intimate revelations from another must be prepared to make them himself. But the psychoanalytic relationship is a thing apart.... Evidence does not bear witness to the excellence of an affective technique of this kind. The loosening of the transference, too, one of the main tasks of the cure, is made more difficult by too intimate an attitude on the part of the doctor, so that a doubtful gain in the beginning is more than cancelled in the end. Therefore, I do not hesitate to condemn this kind of technique as incorrect. The physician should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him. (1912, p. 7)

In "Further Recommendations in the Technique of Psychoanalysis," written in 1915, Freud stated that friendly relationships that overstep a certain boundary will work against the therapy, and he again stressed the importance of adherence to the rule of neutrality. "It is not permissible to disavow the indifference one has developed...." However, Freud's own deviations from strict adherence to neutrality played a serendipitous part in his increasing understanding of transference. Freud became involved in the personal lives of some of his patients and shared information about some of them with others. In Freud's work with the Wolf Man, 1910-1914, he revealed himself surprisingly freely, talking about his children and discussing another patient. The Wolf Man has written that "too close a relationship

between patient and doctor has ... its shadow side." (1971, p.141) From these deviations, Freud experienced confusion and complications of his role as analyst and realized that his patients' transference reactions were tainted.

The general rule at the time was that any revelation of feelings or reactions by the therapist were a hindrance to the work. The analyst was to function as a mirror. However, analysts writing during the early years (Freud, Ferenczi) increasingly noted "the individual factor" (1904) which refers to the psychotherapist as a person and the negative impact of his personality on the process. Self-analysis and, later, psychoanalytic treatment in order to increase therapist self-awareness presumably lessen this hindrance.

In 1939 A. and M. Balint explored the importance of considering the context the therapist creates, that is, his office furnishings, personal affect, personality, and tones, as part of the whole psychotherapeutic relationship. While agreeing with Freud about the importance of the therapists' role of mirroring their patients, they question his rigidity regarding neutrality.

> Returning to Freud's metaphor we see that the analyst must really become like a well-polished mirror -- not, however, by behaving passively like an inanimate thing, but by reflecting without distortion the whole of his patient. The more clearly the patient can see himself in the reflection, the better our technique; and if this has

> been achieved, it does not matter greatly how much of the analyst's personality has been revealed by his activity or passivity, his severity or lenience, his methods of interpretation, etc. (1939, p. 229)

The Balints' writings revealed evolution towards increasing participation of the therapist as a person in the psychotherapy process.

Ian Alger, primarily a family therapist, addressed some of his writings to individual psychotherapy. Alger took exception to the traditional neutral stance in his espousal of therapist self-disclosure. In 1969 he proposed that the therapist

> ...include his own behavior and personal reactions in the exchange he has with his patient, and the degree to which he can be direct and open in communicating this information will determine the freedom of his expression in the therapy. The corollary of this is that the patient will include his feelings and reactions in the same way, and indeed will be encouraged to be more free in this way himself by the example of the analyst. (1969, p. 73)

Carl Rogers (1961) discussed therapist self-disclosure and transparency in his own terms. He wrote about "congruence":

> Congruence is the opposite of presenting a facade, a defensive front to the client. If the therapist is experiencing one thing in the relationship, but is endeavoring to be something else, then the condition (of congruence) is not met....To be transparent to the client, to have nothing of one's experience in the relationship which is hidden...this is, I believe, basic to effective psychotherapy.... The therapist, by being openly and freely himself, is ready for and is offering the possibility of an

> existential encounter between two real persons.... It is these moments, I believe, which are therapeutic. (1958, p. 616)

Rogers' words are the antithesis of Freud's. While Freud stated that "the physician should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him" (1904, p. 7), Rogers advised that the therapist be "transparent to the client, to have nothing of one's experience in the relationship which is hidden." (1958, p. 616) Rogers regarded the curative components of psychotherapy as based upon a very different therapist stance. According to his viewpoint, therapist openness was to be encouraged, not avoided.

These disparate viewpoints regarding neutrality and the appropriate therapist stance underlie the various viewpoints concerning self-disclosure.

Countertransference

Early attention to the therapeutic relationship focused on transference and countertransference. This material is presented because it is the core of the initial explorations into therapists' contributions to the psychotherapy process. Freud first formulated the concept of countertransference and the importance of therapist self-awareness in his 1904 paper, "On Psychotherapy." At that time he discussed the therapist's personal awareness, labeling it "purification". Freud was aware that the analyst's personality was not a

matter of indifference and that "the individual factor will always play a larger part in psychoanalysis than elsewhere" (i.e., in other medical specialties.)

Initially, countertransference was seen as a hindrance to the psychotherapy work. An alternative viewpoint was held by Helene Deutsch who suggested that countertransference could be useful in the psychotherapy process (1953). In her article, "Occult Processes Occurring During Psychoanalysis," she wrote that the therapist-patient relationship is an intimate and intense connection in which both therapist and patient identify with each other. (p. 137)

Paula Heimann also referred to the therapeutic use of countertransference reactions. In her 1950 paper, "On Countertransference," she questioned the value of total therapeutic neutrality and recommended that therapists disclose their reactions to patients as a valuable psychotherapy tool. She was not advising revealing the dynamics of one's reactions but, rather, the use of responses as a source of insight into the patient's dynamics. Furthermore, she believed that the therapist's sharing of feelings would place a burden on the patient by de-emphasizing the patient's feelings. She stressed the importance of the analyst's analysis to clearly monitor revelation of personal reactions to patients.

Margaret Little, in her 1951 paper, "Countertrans-

ference and the Patient's Response to It," addressed the interdependence of patient and analyst. Acknowledging the power of the relationship, she presented an argument for employing countertransference responses as a valuable, if not indispensable, psychotherapy tool. She defined countertransference broadly, that is, including all of the therapist's reactions to the patient. Little's conceptualization of countertransference falls within the definition of self-disclosure as used in this study. For example, she was a proponent of therapists acknowledging and explaining their errors.

> Not only should the mistake be admitted ... but its origin in unconscious countertransference may be explained, unless there is some definite contra-indication for so doing.... Such explanation ...will have only beneficial results, increasing the patient's confidence in the honesty and good-will of the analyst. (p. 33)

Karen Horney's perspective on the psychotherapeutic relationship was consistently interactive and equalitarian. Her thoughts on countertransference, expressed in her 1939 New Ways in Psychoanalysis, stated the importance of the therapist's reactions as reflective of his/her character. She saw countertransference as deriving from the therapist's narcissistic reactions to the patient.

D. W. Winnicott discussed therapist determinations regarding the revelation of negative feelings and

reactions towards patients in an article entitled "Hate in the Countertransference" (1947). His position was that the therapists should be aware of their feelings and vigilant about professional obligations without sharing personal reactions unless therapeutically indicated. While basically adhering to a neutral stance, he acknowledged that there are times when a deviation is appropriate. The example he presented, revealing hateful feelings from early phases of treatment during the termination phase, suggests that his criterion for therapist disclosure is whether it emphasizes his patient's growth.

Winnicott (1947) viewed therapists' hating their patients as understandable and normal. Similarly, Haldipur, Dewan, and Beal (1982) wrote of the therapist's fear as an understandable and normal reaction. "Fear in the Countertransference" suggested that it can be important for therapists to reveal their feelings to the patient to protect both therapist and patient from a possible real danger or an emotion so intense as to sabotage the psychotherapy itself. The decision to discuss the fear, when present, is dependent on the reality of potential danger and the need to protect the therapist and/or the patient. If the therapist decides to delay sharing of his fear, they advise revealing it when no longer present, to validate the pa-

tient's growth. Additionally, the therapist must evaluate the usefulness and appropriateness of this information to the psychotherapy process.

Charles Chediak (1979) addressed the psychotherapy dyad from the therapist's vantage point. Dealing largely with severely disturbed patients, he discussed the importance of the therapist disclosing feelings and countertransference reactions to facilitate establishment of a working alliance. He urged the revelation of countertransference reactions and personal feelings in work with these borderline and psychotic patients. His thinking indicates that the patient's diagnosis is a criterion for therapist self-disclosure. Chediak assumed that therapists function with a very high degree of self-awareness, which enables them to continually differentiate the various components of their experiences vis-a-vis the patient. He enumerated the advantages of this vigilance of one's self in the therapy process:

> It helps clarify the role of the analyst within the therapeutic dyad, ... it establishes a rationale for limiting the analyst's self-disclosures. Although I have not found it necessary to disclose my countertransference or identification ... directly in order to make the information thus obtained useful in treatment, I do find it less objectionable to do so than to disclose my own difficulties as derivatives of intrapsychic conflicts of my own....(p. 126)

This author thoughtfully addressed the determinations that therapists use regarding disclosures of

countertransference as a potential psychotherapy tool, especially at times of therapeutic impasse, and the importance of conscious nondisclosing.

The Real Relationship

Since the very early years of psychoanalysis, analysts and therapists have discussed, argued, and studied the therapist's role in the psychotherapeutic relationship. Some practitioners (Brenner, Greenson, Ferenczi) have divided the relationship into the countertransference and the non-countertransference or "real" relationship.

A clear definition of "real" is elusive, and its meaning is especially ambigious for therapists. In describing a real relationship, the literature uses such terms as human compassion, empathy, respect, and humility amost universally. Less common are words like genuineness, truthfulness, accessibility, warmth, and vulnerability. Theorists identifying with the psychoanalytic school, for example, Freud, Greenson, and Horney, seem to view "real" as meaning the actual relationship and view respect, civility, and empathy as a priori components of the therapeutic relationship. Greenson presented an illustrative example. He was supervising an analytic candidate who related that he had greeted his patient in the waiting room and noticed that the man was bruised and his arm was in a cast. The candidate did not

want to taint the neutrality he had established and so did not comment about the injury. Greenson chastised him for not being real with his patient (1978 p. 444). For humanistic theorists such as Alger, Perls, Rogers, and Yalom, being "real" denotes accessibility, genuineness, transparency, and equality. Their stance advises moment-to-moment openness with patients.

Ferenczi (1950) addressed the importance of the "real" relationship, that is, the therapist's actual acceptance of the patient. He felt that it was important for the therapist to express his feelings towards the patient in order to be more real, human, and reachable, and therefore therapeutic.

Greenson (1971) explored the issue of the real relationship and real feelings between therapist and patient. He directly confronted the notion that therapists often put themselves on pedestals of perfection. As human beings, each participant is a whole being and is to be respected.

> All object relationships consist of different admixtures and blendings of real and transference components. The working alliance is essentially realistic, but more or less synthetic, artificial. In the analyst, the working alliance becomes part of his therapeutic character and personality, and in that sense it is genuine. But situations do arise when a strong counter-transference will make it necessary for the analyst to call forth a therapeutic attitude by a conscious act of will. (p. 435)

In response to the importance of neutrality to further the transference, Greenson maintained that there must be a basis of a real relationship in order for analysis of the transference to take place. "Real relationship" means a genuine one, that is, nonsynthetic, and realistic. This is not synonymous with self-revelation but rather suggests the importance of selective disclosure when necessary for the furtherance of the real relationship. Greenson maintained that "civility toward the patient, compassion for his plight, respect for him as a human being, recognition of the patient's achievements in therapy, and acknowledgment of the analyst's own lapses when they become visible to the patient are vital ingredients of the treatment situation." (p. 377)

Therapist Self-Disclosure

Therapist self-disclosure, that is, verbal revelation of ordinarily private information, is one aspect of psychotherapy practice that provokes disagreement and lively discussions. For a therapist to present himself or herself as a real person responding to changes in the patient's real world or acknowledging errors is different from sharing personal material with a patient.

Years ago, there were no major disagreements, because theory builders (Freud, Ferenczi) were in essential agreement about not revealing themselves to their

patients. In the last twenty to thirty years, with the development of newer therapies like Gestalt and Transactional Analysis, there is less consensus among therapists regarding self-disclosure. Strong reactions are probably related to concerns about transference and its use, disparate therapist self-awareness, the human inclination to be warm, compassionate and real, and questions regarding what is useful in the therapeutic encounter. Within the constraints of these issues, therapists strive to balance involvement and distance.

Therapists of different theoretical persuasions hold varying points of view regarding the use or non use of transference in psychotherapy and, therefore, varying points of view regarding the revelation of personal information. Some theorists feel strongly that self-disclosure interferes with the transference. Some state very strongly that therapist self-disclosure is imperative in working with psychotic and borderline patients. Some therapists have experienced personal circumstances which they felt necessitated disclosures; some, in similar situations, oppose disclosures. Some therapists divulge personal demographics.

Weiner's Studies

Myron Weiner, a psychiatrist at the University of

Texas, has been the most prolific writer on the subject of therapist self-disclosure since the mid-1960s, having published more than a dozen works on the topic. He believes there are only three absolute indications for self-disclosure: (1) when the life of either the patient or the therapist is in danger, (2) when external events in the therapist's life have significantly influenced his or her feelings and the therapeutic relationship, (3) when some aspect of the therapist's personality or conduct in the interview has disrupted the therapy and (4) to provide an interpersonal learning experience that can only be accomplished through the therapist and patient dealing with each other as real people (1983, p.112). Weiner points out that the rule of neutrality, developed in the context of the psychoanalysis of neurotic patients, is not appropriate in the psychotherapy of borderline and psychotic patients, because they generally experience difficulty knowing reality. When the therapist reveals some personal information, the patient is enabled to connect and has a context in which to differentiate self from nonself. (1978)

He has addressed the impact of therapist disclosure on the client's openness and its use as a therapy technique for expressing reassurance, fostering identification, or gratification, and for breaking impasses.

In his work "Self-Exposure by the Therapist as a

Therapeutic Technique" (1972), Weiner categorized therapist disclosures by type, level of intervention, and indications for exposure. For example, types of disclosure include feelings, attitudes, opinions, formulations, experiences, fantasies, and history. Psychotherapy interventions are divided into three types based on the psychotherapeutic approach being practiced: repressive, supportive, or evocative. (Repressive therapy aims to reinforce the repression of unconscious material to enable the patient to maintain control. In patients who are unable to deal with insights or are unstable, temporarily or permanently, repressive therapy is the therapy of choice. Supportive therapy aims to encourage healthier ego defenses. Evocative therapy stimulates the emergence of unconscious material in order to encourage insights.) The therapist should be cognizant of the developing therapeutic relationship and should be sensitive to not intruding and to not steering the content of the session off track. Weiner sees therapist self-disclosure as contraindicated when an adequate therapeutic alliance is absent and when the patient is in a state of negative transference. Therapist self-disclosure at these times can undermine the process by compounding the patient's difficulty in trusting and avoiding dealing with more important material. The importance of therapists' awareness is stressed

throughout Weiner's work.

In a 1974 paper, "Studies of Therapist and Patient Affective Self-Disclosure," Cody, Rosson, and Weiner refuted Alger's, Jourard's, and Rogers' thesis that therapist openness encourages client openness. This study investigated the impact of therapist self-disclosure of feelings on patients' openness. Four short-term psychotherapy groups were used as the basis for the study. All the patients were in concurrent individual therapy with one of the group therapists. The therapists represented the three primary psychotherapy disciplines: psychiatry, psychology, and social work. Disclosures were standardized. With the first two groups, therapists disclosed for five of the ten sessions. With the second groups, therapists disclosed during all sessions in one group and not at all in the other group. All of the sessions were videotaped, and fifteen-minute segments were scored independently by Cody, Rosson, and Weiner. Examples of scored statements were "I feel lonely," "I'm getting frustrated," and "I don't like it."

In conclusion, the authors stated the following: "These studies raise the question of the feasibility of manipulating a variable such as self-disclosure, which is strongly related to situational and unconscious intrapsychic factors..."(p. 41). They concluded that disclosure by the therapist does not necessarily facilitate

patient self-disclosure and that the number of therapist disclosures is of less value than the nature and timing as relates to the impact on the patient. The authors repeatedly emphasized the importance of therapists' awareness that the purpose of their disclosures is the patients' psychotherapeutic gains.

In another work, Weiner (1974a) addressed therapist disclosure as a response to a therapeutic impasse. He based the appropriateness of gratifying or denying his patients' requests for personal information on transference considerations and sensitivity for the psychotherapy process at the moment. Self-disclosure can be a deviation from the neutral, nongratifying stance and may be justified if the process is stuck. That is, in the classic posture, the therapist uses some criteria for deciding whether to frustrate or gratify.

> Not all requests for advice are demands for gratification. Many are legitimate requests for the therapist's expertise. To differentiate, the therapist uses his dynamic formulation, his awareness of the realities of the patient's life and his feeling reactions to the patient. He then employs his clinical judgment to decide whether to frustrate or gratify. (p. 260)

This brief paper is one of the clearest statements of criteria for self-disclosure. Presenting a broad overview, it touches on the patient's curiosity, the therapist's internal pressures to disclose, the importance of the therapist making determinations with

consideration of patient diagnosis and stage of therapy, and the actual relationship between patient and therapist. Weiner's paper, "Identification in Psychotherapy" (1982), discussed the importance of patients identifying with the therapist during psychotherapy. This is more therapeutic than insight or the learning of alternative behaviors for individuals who have lacked suitable objects for identification or who have suffered an impairment in their ability to make necessary identification at appropriate developmental stages. Further, a poorly integrated person may benefit by identifying with the therapist's positive outlook and thereby become less self-critical. A better functioning patient might be able to model himself on the therapist's introspectiveness and become increasingly capable of productive reflection. Healthier patients can grow by identifying with the therapist's higher functioning aspects thus, "some degree of identification with the therapist is a sine qua non for eventual individuation in the process of psychological development" (p. 114). Weiner emphasized cognizance of the patient's diagnosis and need for identification as a facet of the therapist's determination of appropriate self-disclosure. He further encourages admitting one's technical errors and thereby revealing oneself to foster identification and modeling.

Weiner has directly confronted the proponents of high

therapist self-disclosure. In his numerous articles and two books he has consistently acknowledged that there exists strong advocacy for high therapist disclosure. One of his early papers (1969) focused on the impact of marathon and encounter group popularity and the obvious support, in those modalities, for therapist openness. He defines the therapist's role as one of expertise, competence, and responsibility, rather than of the friendliness Rogers, Alger, and Berne recommend.

> The notion has been presented elsewhere that the therapist and patient are on an equal plane and should deal with each other as equals. It is true that both patient and therapist are equal in terms of their human rights and the complexity of their psychological make-up... but the therapist has... a body of knowledge which makes him more expert than the patient. In the realm of emotional problems and their solution, denial of this is the denial of the validity of one's own training (p. 195).

Weiner's brief paper, "Personal Openness With Patients: Help or Hindrance" (1980), summarized his position. Acknowledging "...there are strong internal pressures to disclose and patients frequently press for personal disclosures," he wrote "A physician needs to be open when events in his or her personal and professional life impinge on the relationship with patients, or when errors in treatment are detected by patients." Weiner stated that disclosure can help reinforce a patient's contact with reality and that severely disturbed patients can be helped to see the therapist as a separate object.

The negative aspects are that the disclosure may be (1) a distraction from the work, (2) an attempt to meet the therapist's emotional needs, and (3) a limitation to the use of the transference. "There is good evidence that the crucial variable in being personally open with patients is not the amount one discloses, but the nature and timing of the disclosures" (p. 2).

Weiner's work has led him to the belief that therapist disclosure is appropriate with some populations and in response to some experiences in the therapist's life (1983, p. 112). He also believes that the therapist must disclose when the patient's or therapist's life is in danger. Beyond that, he feels that disclosures are rarely appropriate and should be employed only when specifically indicated. Examples of indicated disclosures are modeling oneself during crises in the patient's life and in working with severely disturbed patients. Data from Weiner's studies led him to observe that "willingness to be known" on the part of the therapist showed no significant correlation with successful outcome of therapy. Generally, Weiner found that more experienced therapists are less willing to self-disclose.

Studies Using Simulated Patient Populations

In several research studies conducted with simulated patient populations, the authors generalized their to the

psychotherapy situation. I question such an extrapolation, because the dynamics of the psychotherapy relationship cannot be replicated in an "as if" situation. Diverse as they are, these studies are included because they comprise a significant portion of the literature on therapist self-disclosure and they do contribute to the delineation of questions for further inquiry.

Steven Nielson (1979) examined the effects of four conditions of therapist self-disclosure on several measures of therapist influence with college students and with psychiatric patients. (No definition of "psychiatric patients" was given.) The four conditions were (1) no self-disclosure, (2) demographic disclosure, (3) personal testimony about the therapist's personal use of a behavior change to resolve a common problem, and (4) personal testimony about using therapy to resolve a past problem of the therapist's identical to the patient's. (Vignettes were used, which showed patients asking for personal information of the therapist.) While looking at the vignettes presented by the researcher, subjects were asked to project themselves into the role of therapy patient. Measures of therapist influence included ratings of therapist expertise, attractiveness, and trustworthiness.

Nielson concluded that therapist disclosures emphasizing dissimilarities between therapist and client

can negatively affect clients' perceptions and experiences of their therapy. He further concluded that therapists' personal revelations have no effect on clients' behavioral compliance with therapists' recommendations, thereby seriously questioning the usefulness of therapist self-disclosure as an intervention for eliciting behavior change in clients.

Walter Dickenson's dissertation, "Therapist Self-Disclosure as a Variable in Psychotherapeutic Process and Outcome," (1965) studied different degrees of therapist disclosure, that is, from highly personal to totally neutral material. He developed a scale to measure therapist self-disclosure and tested it by presenting four-minute samples of taped therapist-patient interactions to his subjects, fellow psychology students. The subjects were asked to project themselves into the patient role and to rate and discuss their reactions to the interaction. For example, in stage 1 samples, the therapist actively avoided answering the patient's direct questions and communicated reluctance to reveal anything personal. The highest disclosing therapists, in stage 9, openly divulged intimate information with patients. Dickenson found no definitive correlation between perceived psychotherapy success and high disclosing therapists, even though clients disclosed more and earlier with the relatively more open therapists. From his examples it is

clear that therapist modeling was the main criterion used for making disclosures. I question the value of the findings, because Dickenson's subjects were not patients, and therefore no therapeutic relationship existed between the parties studied.

David Earl Nilsson studied simulated clients' perceptions and evaluations of therapist self-disclosure (1978). Two hundred and forty undergraduate subjects watched a ten-minute videotape segment of a staged client-therapist interaction. The therapists in the tape offered one of three types of disclosures: no disclosure, interpersonal disclosure, and intrapersonal disclosure. He then asked each subject to complete a multiple choice evaluation form, and from this research he drew the following conclusions: First, the type of disclosure presented to subjects significantly influenced their perceptions and evaluations of the therapists; second, subjects predicted greater likelihood of disclosing to disclosing therapists than to nondisclosing therapists.

In his discussion, Nilsson listed many possible criteria for therapist self-disclosure, for example, timing, content, depth, and gender. These were not discussed in detail. Nilsson's design seemed to overemphasize the client's liking the therapist as a person, without regard to professional competence. Expertise, and empathic ability may, in the actual therapeutic

situation, be more important than the patient's liking the therapist although it is hard to imagine a patient not liking a warm, empathic competent therapist except in transference manifestations. Studies like this suggest that therapist self-disclosure, with the purpose of promoting the client's affection, is recommended. However, therapists' behavior aimed at ensuring being liked could obscure attention to functioning as a conscientious professional.

In another simulated study, Steven G. Fox (1984) explored the impact on the therapy of the therapist's disclosing his or her own experience in therapy. He investigated 175 undergraduates' perceptions of the therapeutic relationship after the therapist's disclosure. The subjects were divided into two groups. One group was presented transcripts of therapeutic interactions, including the therapist's sharing about his own therapy. This information was withheld from the subjects in the other group. The need for the therapists' own therapy was explained to subjects as required as part of training or in response to personal difficulties. Fox concluded that this disclosure facilitated patients' openness. Patients perceived the disclosing therapist as having greater therapeutic abilities and therefore perceived the therapist as more effective. The focus in this study was on the dyadic effect, as defined by

Jourard (1971, p. 66), who said that by disclosing the personal experience in therapy, the therapist communicates greater compassion and competence.

The objective of Norman Simonson and Susan Bahr's (1974) study was to determine whether the impact of self-disclosure by a paraprofessional therapist is the same as that of a professional therapist with regard to subjects' level of self-disclosure and attraction to the therapist. By using tape recordings of segments of simulated therapy sessions, they manipulated the levels of therapist self-disclosure. The three levels were: (1) no revelations, (2) demographic disclosures, and (3) demographic and five personal revelations. Their subjects were 90 psychologically unsophisticated female volunteers. Half of the subjects' "therapists" were professional, and half were paraprofessional. The subjects were each given a questionnaire to assess willingness to discuss personal things with the intended therapist and were told that this information would be shared with the therapist. They were also questioned about their attraction to the intended therapist and were told that this information would not be shared. (In actual fact, no questionnaires were shared with the "therapists.") During the "session," each subject was asked the same questions. The interviews were recorded and rated by two blind judges.

Simonson and Bahr concluded that patients preferred

an appropriate professional role, that is, low disclosing, and that the psychological distance between therapist and patient was amplified by personal disclosures by the therapist. This increased distance discouraged client openness. Patients liked and appeared to be helped by demographic disclosure, and this reaction contributed to positive psychotherapy outcome. These researchers stressed the importance of appropriateness of therapist self-disclosure, noting that therapist revelation is not a thing apart from the therapy. However, they did not define appropriateness.

These studies utilized simulated vignettes and hypothetical inquiries and so could not replicate the impact of therapist disclosure in the psychotherapy context. These studies suggested that the subjects reacted, responded, judged, and evaluated the situation as if they were psychotherapy patients, but their capability of doing so is questionable. Lacking in these studies is any acknowledgment of the various theoretical orientations, the types of psychotherapy practiced, or different patient populations. Also lacking is an appreciation of the impact of the nonjudgmental, accepting therapeutic climate on the patient and on the patient's view of the therapist.

The focus in the above-cited studies is on the early phases of the therapeutic relationship. The researchers

did not address the significance of therapist disclosures at other stages. These studies do have merit, however, in that they question the criteria that therapists use in making self-disclosures and raise important questions about therapist disclosure with different client populations and various contents of disclosures. These studies' primary contribution is that they represent a step towards further exploration of this clinical issue.

Studies Using Real Patient Populations

In the psychotherapeutic context, Truax and Carkhuff (1965) measured the relationship between therapist transparency (fully open) and patient disclosure in samples from individual psychotherapy. They labeled what they defined as the three primary interpersonal skills of a therapist: genuineness, nonpossessive warmth, and empathy. (Genuineness they defined as being nondefensive, authentic, and not hiding behind a professional facade in sharing one's reactions and feelings with a patient. Nonpossessive warmth was defined as having a warmly receptive nondominating attitude. Empathy is the ability to perceive and communicate feelings and experiences of another person.) The authors measured the manifestations of these skills in individual psychotherapy interviews. When present, these traits produced greater patient self-exploration. Truax and Carkhuff concluded that successful psychotherapy outcomes depend

upon the presence of at least two of these three therapist attributes. They did not directly address the issue of intrapersonal therapist self-disclosure, but I surmise that they support self-disclosure as a therapeutic tool to enhance the genuineness of the relationship. It is clear that they believe that interpersonal self-disclosure is necessary for a positive psychotherapy relationship and outcome.

John Rosie's paper, "The Therapist's Self-Disclosure in Individual Psychotherapy (1980)," endorsed therapist self-disclosure. He stated that "appropriate disclosure of the therapist's self is vital to: a) enable the secure structure of the real relationship to exist, and b) foster the richness of the development of the area between the therapist and the patient" (p. 3). He individually interviewed nine experienced psychotherapists in Scotland and found a trend towards increased therapist self-disclosure in older and more experienced therapists. Most of the therapists viewed therapist self-disclosure as a useful adjunct at selected times. Rosie refers to the "I-thou" relationship of the therapist-patient dyad and sees this as central to the therapy process. He found disagreement about Freud's tenet not to disclose in order to allow analysis of the transference, with some respondents thinking the blank screen is imperative to work with the transference and

others thinking that it is not helpful. Rosie's work alludes to the therapist's process in making determinations about self-disclosure, for example, his finding that experienced therapists disclose more. His observation that most therapists view self-disclosure as a useful adjunct also suggests an intra-therapist decision-making process regarding the who, what, when, and why of self-disclosure.

The cross-cultural application of the researcher's conclusions is not clear, however, and Rosie does not detail the content or length or number of interviews with each of the therapists. He does not define self-disclosure or "experienced," and does not state the therapists' theoretical orientations. Nonetheless, this is one of the few studies that explore the issues of therapist self-disclosure by questioning the therapists.

Another study focused on therapist contribution to the psychotherapy process is Wallach and Strupp's "Dimensions of Psychotherapists' Activity" (1964), in which therapists' preferences and attitudes in their therapeutic practices were studied. Subjects were divided into two groups, one of 59 psychiatry residents at a university medical center and another of 248 psychiatrists and psychologists who responded to a nationwide random mailing. The authors then developed a scale dealing with usual individual psychotherapy practice attitudes. The

factors on the scale were intensity of therapy, maintenance of personal distance, therapist overall activity, and viewing psychotherapy as an art.

For both groups, the most distinct factor was the maintenance of personal distance. The questions which elicited this information were, for example, "I rarely answer personal questions from my patients" and "I keep all aspects of my private life out of therapy." The strict adherence to personal distance was directly correlated to theoretical orientation. Those identified as orthodox Freudians had the highest rating on the "maintenance of personal distance" scale, followed by general psychoanalytic-oriented therapists; the least distance-maintaining were the client-centered. (These three groups were equidistant on the scale.) The authors did not state if they or the subjects established the theoretical orientation categories.

The large size of this sample and the fact that the subjects were practicing psychotherapists answering questions about their own therapy practices lends credibility to the results. The clear distinction between psychoanalytic and client-centered therapists suggests strong differing theoretical positions with on the importance of analyzing the transference, negative and positive, as the curative factor in treatment and on the curative aspects of a good interpersonal relationship.

This researcher wonders if the orthodox Freudians, those who maintained high personal distance in this study, would explain their (limited) self-disclosures differently than psycho-analytically oriented or client centered therapists.

Special Circumstances

Special circumstances in a therapist's personal life can push one to confront the question of self-disclosure. The literature cited in this section consists of discussions of therapists' experiences in managing extenuating personal circumstances in their psychotherapy work. The way these situations are handled has implications for countertransference responses and the therapist's self-disclosure behavior. A therapist's pregnancy, for example, cannot be withheld, however, its management raises questions relevant to the self-disclosure issue. For example, does the therapist reveal her feelings about motherhood in order to model to her patients? Should the depth of revelation vary with patients at different developmental stages and/or stages of psychotherapy? How early in the pregnancy should details be disclosed? To what degree should the patient's questions be answered truthfully?

Issues such as health problems, marriage or divorce, death of a loved one, a professional achievement, and a

lengthy vacation give rise to the preceeding question.

Sander Abend (1982) wrote a paper on his experience with illness. He was anticipating treatment for a medical condition that would necessitate his being hospitalized for a few weeks and convalescing at home for a month. He described his approach as "common sense," individually assessing his patients, but generally he withheld all factual information about his illness in order to not taint his role as analyst. On his return, he shared some information when patients specifically asked. His conclusion, based on his personal observation and assessment, was that disclosure of illness information is unnecessary and serves unconscious needs in the analyst. Abend noted the ease of falling into countertransferential errors when confronted with this kind of occurrence. Looking for reassurance about his competence, denying his illness, and needing nurturing himself are possible reasons for sharing more than might be therapeutic for the patient. Also, he pointed out that it is easier on the therapist to disclose his personal plight than it would be to deal with the patients' expressed fantasies and feelings. He raises some thought-provoking questions. What is the beneficial effect of revealing anything more informative than the facts of the interruption? What is the basis for deciding that specific information relieves unnecessary

anxiety? Abend clearly alludes to his cognizance of patient-focused and therapist-focused determinants in his revelations. His patients were curious, interested, and anxious about losing him. His task was to balance their needs for specific information with his professional judgments about appropriate degree of disclosure. His attention to his patients' treatment was clear in his discussion of the importance of individual evaluation. Less clear, but certainly suggested, was the narcissistic need of the therapist himself and how this affected his willingness to reveal, perhaps excessively.

Another analyst, Paul Dewald, (1982) wrote about his experiences with a serious illness in a paper entitled "Serious Illness in the Analyst: Transference, Counter-transference, and Reality Responses." Dewald suddenly became ill with acute meningo-encephalitis and was unable to practice for ten weeks. When he returned to work, he looked visibly thinner and had to wear an eye patch for several months. Dewald wondered how much to reveal to his patients, when, and for whose gratification. He acknowledged his patients' needs for factual information when sessions were cancelled abruptly and saw that such information could overburden the patients' adaptive capacities.

Dewald thought that he did not give this process as much thought as would be optimal for his patients'

therapy, acknowledging the difficulty of managing a sudden personal crisis. He noted that the amount of information he disclosed varied with patients' diagnoses, stage of the psychotherapy, and type of treatment, e.g., psychotherapy vs. psychoanalysis. He observed that the more information he revealed the less free and uncontaminated the transference distortion of the patient was likely to be. Consistent with his psychoanalytic orientation, Dewald recommended minimal personal disclosure, so that the therapy focus remained on the patients' projections, distortions, and reactions.

Frances Goldberg, in "Personal Observation of a Therapist with a Life Threatening Illness" (1984), related her experiences sharing specific information about her illness with her clients. She felt she could not continue to work without sharing the information, because it was so present and overwhelming for her. To exclude such important information would contaminate the genuineness of the therapy relationship. Unlike Dewald, she did not feel that disclosure interfered with the therapy process but rather augmented it. She believed that she and her clients needed knowledge in order to deal with the anticipated loss. Her conclusion was that sharing such information about a therapist's illness and allowing time and opportunity to deal with the resultant material provided the clients a real-life chance to confront their

feelings about death and abandonment.

Joseph Flaherty's paper, "Self-Disclosure in Therapy: Marriage of the Therapist" (1979), discussed the scarcity of literature on the subject and his experience in revealing his marriage to his patients. He hypothesized that "anonymity is such a traditionally accepted rule that therapists feel any digression from it is in error and therefore should not be reported." In response to his disclosure, he observed that most patients had some reaction, and that their reactions were related to the therapeutic situation at the time. That is, patients who were involved in a transference relationship produced material that was transference related. Borderline patients reacted by struggling to discern what was real and what was irrational. Flaherty wrote

> that in more borderline and schizophrenic patients there is more of a need to allow the patient to discover you as a real person; in this type of patient the need for a real relationship is greater in order for the patient to tolerate the intense feelings he or she may have about the therapist. (p. 450)

Flaherty, Chediak, and Weiner, in their separate writings, stated that diagnosis is an important criterion for therapist self-disclosure, and they agreed that disclosure is indicated for severely disturbed patients. The latter patients, with their difficulty in establishing and maintaining object relationships, can benefit from a reality-oriented relationship.

Universal agreement about the management of special

circumstances within the context of psychotherapy does not exist. Those therapists who view the therapeutic relationship as primarily a transference relationship are much less likely to recommend sharing a personal crisis with their patients, since personal information is understood to interfere with projections and distortions. In contrast, those who regard the therapeutic relationship from a humanistic viewpoint generally feel that openness and full disclosure is consistent and indicated because it encourages openness and trust in the patient.

It is clear that personal crises in the therapist's life often make it impossible to remain nondisclosing, whether or not the therapist sees his disclosing as therapeutic. All the writers reviewed do agree that the impact of these disclosures has to be addressed at some time.

As noted, attention has been paid to therapeutic outcomes as related to therapist revelations and to therapist self-disclosure in critical circumstances. Much of the literature alludes to the need to question the criteria that therapists employ in making determinations about revealing personal information to patients.

There has been increasing attention to the therapist's participation in the psychotherapy process, but I have found no references that specifically address the

criteria therapists utilize in making determinations about revealing themselves. While there is almost universal agreement regarding the importance of client self-disclosure in psychotherapy, these studies reach diverse conclusions as to the value or advisability of therapist self-disclosure (Simonson, 1976; Wallach and Strupp, 1964). Several studies have concluded that clients liked therapists who disclosed, but that this does not correlate with successful therapy outcomes (Jourard, Bundza and Simonson, Dies.) (1971, 1973, 1973.) Most of the research on therapist self-disclosure has focused on therapy outcomes, impact on patients' openness, and behavior change. These studies only allude to the therapists' processes of making these determinations and to the importance of conscious self-disclosure as a psychotherapy tool.

The divergence of viewpoints among psychotherapists persists. There is no denying the presence of the therapist as a person in the psychotherapy relationship. Therapists continue to question the ways to strike a balance between being maximally therapeutic and being warm, real, and professional.

CHAPTER III

METHODS AND PROCEDURES

This study explores one facet of the therapist's contribution to the psychotherapy relationship. A questionnaire and subsequent interview were given to experienced therapists to elicit information about criteria for self-disclosure.

The Questionnaire

Pilots

A questionnaire was developed (Appendix A) based on the literature, clinical and consulting experiences, and input from colleagues. To refine the questionnaire, a two-wave pilot pre-test was conducted. Subjects for both of the pilot questionnaires were chosen from the researcher's colleagues and fellow students. Therapists' willingness to participate was the only standard for selection in the pilot phase of the research.

First, twelve experienced psychotherapist colleagues with differing theoretical orientations completed the questionnaire as if they were subjects. The aims were to clarify the crucial questions, and to ascertain that they elicited the nature of responses sought. Feedback solicited on this preliminary draft was used in the revision.

The second wave of questionnaires was administered to

fourteen experienced psychotherapists. Their responses were used to ensure that the questionnaire worked, to establish an interview schedule, to establish tentative categories, and to confirm that responses would enable the researcher to scale high to low dislosers.

The Sample

The sample selection was based on the desirability of therapists representing diverse viewpoints regarding therapist self-disclosure. The selection of experienced therapists, that is, more than ten years experience, was based on Weiner's (personal correspondence, 1986) observation and on pilot responses which suggest that more experienced therapists are more reflective, thoughtful, and conscious about their decisions to self-disclose in their work.

Potential research subjects were selected from lists of psychotherapists provided by the three local professional associations, clinical social work, psychiatry, and psychology. The actual selection was done by choosing those therapists with the lowest license numbers, assuming that that indicated the greatest experience. There was some attempt at an even male/female ratio, to ensure diversity of data, since it was thought that gender might prove a factor in self-disclosure. Geographic accessibility was also a

criteron, simply for convenience and economy in conducting the interviews.

Because this is a qualitative study, for the purpose of describing how therapists perceive their use of self-disclosure in their practices, the selection of a sample was not based on randomization but on how useful the sample would be in uncovering and describing a pattern (Polkinghorne, p. 237).

The refined questionnaire was sent to fifty experienced clinicians representing the three main psychotherapy disciplines, namely, clinical social work, psychiatry, and psychology. A return date was given, and the researcher contacted the non respondents by letter two weeks after that date. The original proposal stated that if fewer than 25 replies were received, a second round of questionnaires would be mailed to a new sample. (This was not necessary.) Those respondents who were available for an interview were asked to include their names and phone numbers. The questionnaire's cover letter assured all participants of confidentiality. (See Appendix A.)

Contents and Scaling

Seven questions in the instrument were specifically developed to gauge the levels of disclosure usually employed by the respondents. For example, the questionnaire asked, "Some theorists strongly recommend therapist

disclosure. What is your reaction to that?" (See Appendix B for full explication of the questionnaire.) Each returned questionnaire was scaled. The response to each question was ranked on a scale from one, no disclosure, to ten, total disclosure. Each questionnaire's ranking numbers were summed, and the respondents were then all ranked on a scale from low to high disclosing based on their responses to these target questions. Those four respondents falling at both of the extremes were selected as the eight interview subjects.

The Interview

Eight experienced psychotherapists were selected to be interviewed in depth; the four most self-disclosing and the four least self-disclosing, as determined by the ranking described above. At this point, the two subject groups were identified and each group treated as an entity.

One interview, lasting approximately 1 1/2 hours, was conducted with each therapist. (The interview schedule is given in Appendix A.) All were tape-recorded. The researcher suggested that the interviews be conducted in the subjects' offices but one subject preferred to be interviewed at his home. The semi-structured interviews explored both the obvious and subtle determinants of therapist self-revelation.

The interview was constructed in the following manner:

1. Starting with the respondent's returned questionnaire, the researcher asked for elaboration of the written responses. If subjects had indicated conscious self-disclosure, the researcher asked them to explicate their thinking process. In the discussion, the researcher noted subjects' comments that related to the process of deciding whether or not to disclose and asked them to attempt to label criteria used in making reported self-disclosures. Subjects were encouraged to share examples from their work.

2. Four clinical vignettes were presented to each therapist. Subjects were asked how they would handle the having just received the good news of becoming a grandparent, how they would manage coming to work with a black eye, and how they might deal with their own technical errors during treatment. (An example of a technical error would be an incorrect interpretation revealed by the patient's reaction.) Lastly, they were given a vignette in which a patient had recently returned from a trip to a place that the therapist wishes to go. What, if anything, would be said? Discussion was elicited about the management of these situations with respect to therapist self-disclosure in the therapy session.

3. Examples of conscious self-revelation and con-

scious non disclosure were sought and observations were made. Subjects were asked for elaboration from their questionnaires. For example, the researcher inquired, "Why did you reveal that?" and "When would you not disclose that?" regarding specific responses. The therapists were asked to give examples from their own clinical work of intentional self-disclosure and intentional use of their emotional reactions.

4. Inquiry was made about different determinants with different client populations, at different stages of treatment, and in response to different events and ages in the life of the therapist. Additionally, information was sought about how each subject determined the depth of self-disclosure in these instances. The researcher questioned the extremes of each subject's point of view, that is, the high disclosers were asked to present an example in which they would not disclose, and the low disclosers were asked to present an example in which they would.

In general, discussion was encouraged about theoretical orientation, thoughts about the psychotherapy relationship, the value of therapist self-awareness, and especially the criteria for self-disclosures.

The subjects were not anonymous. They were assured that their identities were held in confidence and that only the researcher would know their names. Participants

were told that the tapes would be transcribed by a secretary and that they could choose to have the tapes and transcriptions destroyed or returned upon completion of the study. A signed statement regarding the researcher's commitment to strict adherence to confidentiality was given to each interview subject. (See Appendix A.)

Data Analysis

The questionnaire responses provided the initial data on the therapists' viewpoints about self-disclosure. The questionnaire elicited information about level of experience, theoretical orientation, attitude towards revelation of self in the psychotherapy process, and experiences with therapist self-disclosure. The responses were used to identify the interview population and as material for exploration in the interviews and were also used to categorize tentatively the criteria for self-disclosure.

The interviews yielded the main body of data and further delineated the therapists' feelings, theoretical orientations, viewpoints regarding the psychotherapy relationship, and clinical styles. After the transcription of the interviews, the material was carefully reviewed. The transcripts from each group of subjects, that is, the high disclosers and low disclosers, were treated as separate entities, and the

findings are presented in this manner.

The interviews were analyzed as a whole. No distinction was made between the portion that focused on subjects' questionnaires and the portion that discussed the vignettes. The initial reviewing established several categories of responses, which were the psychotherapy relationship, theoretical orientation, therapist self-awareness, and criteria for self-disclosure. The criteria for self-disclosure were grouped: modeling and fostering identification, furthering the therapeutic alliance, validating reality, encouraging patients' autonomy, and therapists' satisfaction.

The transcripts were then reviewed again and the material coded, with most material falling into at least one of the above categories. Some material fell into multiple categories and was coded within those categories. For example, several therapist self-disclosures served both to foster the therapeutic alliance and to encourage the patient's identification with the therapist. Some of the interview material did not fit the categories. This consisted of casual chatting, extensive elaboration of content, and subjects' questions about the research itself.

After coding the transcribed interviews, the researcher organized the data within the two subject groups, that is, the high disclosers and low disclosers,

to permit comparisons within the above categories. For example, the material from all the transcripts that was coded as pertaining to the therapeutic relationship was consolidated. This provides the format for the presentation of the findings.

Limitations

Questionnaires were sent to clinicians in independent practice only, thereby excluding those who work in agencies and institutions. The reason for so limiting this sample was the assumption that agency clinicians might be limited by constraints imposed by their organizations. It was assumed that the independent clinicians' criteria for self-disclosing would reflect only their own personal/professional decisions, rather than actual restrictions or limits imposed by their institutions. Institutions impose restraints which would render it unlikely that the research would be exclusively addressing the clinicians own determinations about self-disclosure.

This researcher chose to limit this study to private practitioners in order to avoid this complication.

The researcher was concerned that the findings might be skewed by the self-selection of the respondents to the questionnaire, that the subjects who responded might be biased toward more self-disclosure than those who did not

respond. However, the respondents represented a range from very high disclosing to very low disclosing.

Selection of individuals to interview was made from those willing to participate. It was not known why some respondents declined to be interviewed. This situation could have introduced an unintended bias into the subject population that will remain unexplained. The study is further limited by the fact that the interview data is subject to the researcher's inferences and interpretations.

CHAPTER IV

FINDINGS, PART 1

This chapter presents the procedures used in the data analysis, followed by a discussion of the overall themes that emerged.

The Questionnaire

Subjects

Subjects were drawn from the researcher's local professional communities of clinical social workers, psychiatrists and psychologists.

To the fifty questionnaires that were sent, twenty-seven responded, including eight psychiatrists, ten psychologists, and nine social workers. Sixteen were men, eleven were women. Of these, twenty-four were potential interview subjects. (Two did not qualify as experienced and one was unwilling to be interviewed.) All of the respondents included their names and phone numbers. None expressed concern about confidentiality.

The researcher had anticipated that the preponderance of respondents would be social workers, since that is her profession. The heterogeneity of respondents was seen as an acknowledgment of professional interest in the research question. See "Description of Questionnaire Respondents", Figures 1 - 5, pages 61 - 66, for a breakdown of population relative to age,

gender, years of experience, professional degree, and theoretical orientation.

DESCRIPTION OF QUESTIONNAIRE RESPONDENTS

FIGURE 1 – AGE

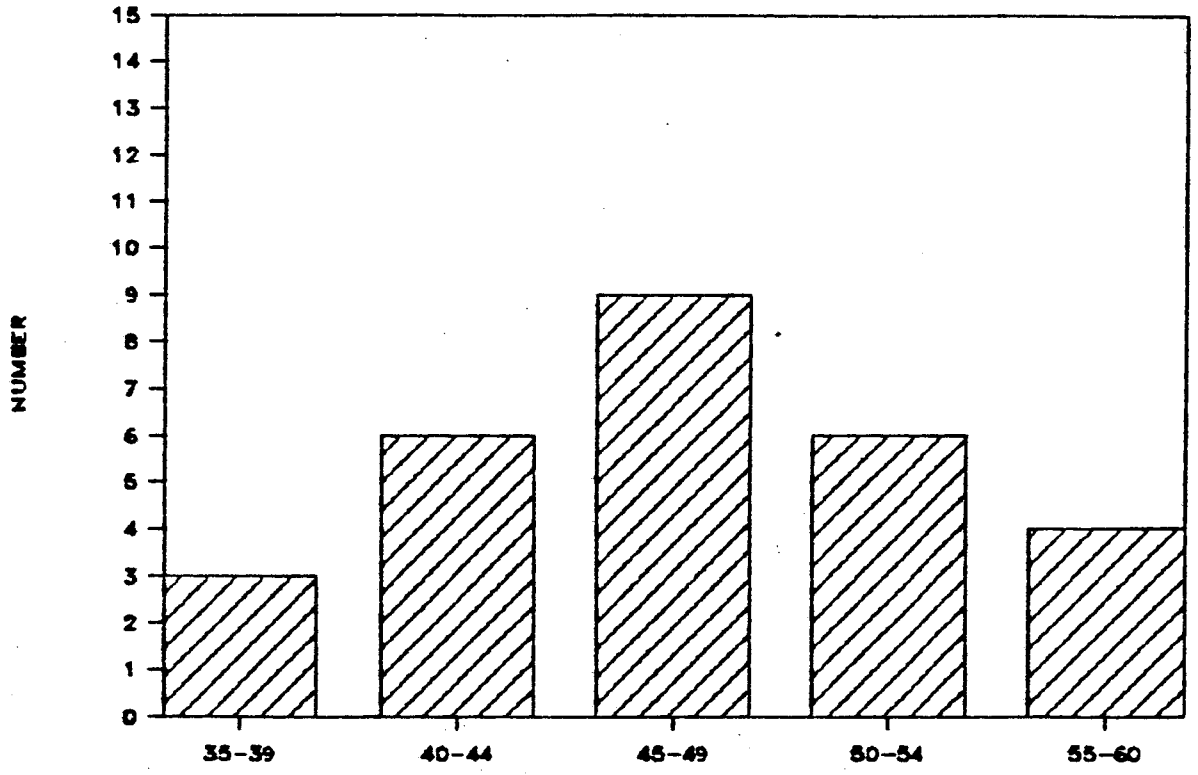


FIGURE 2 – GENDER

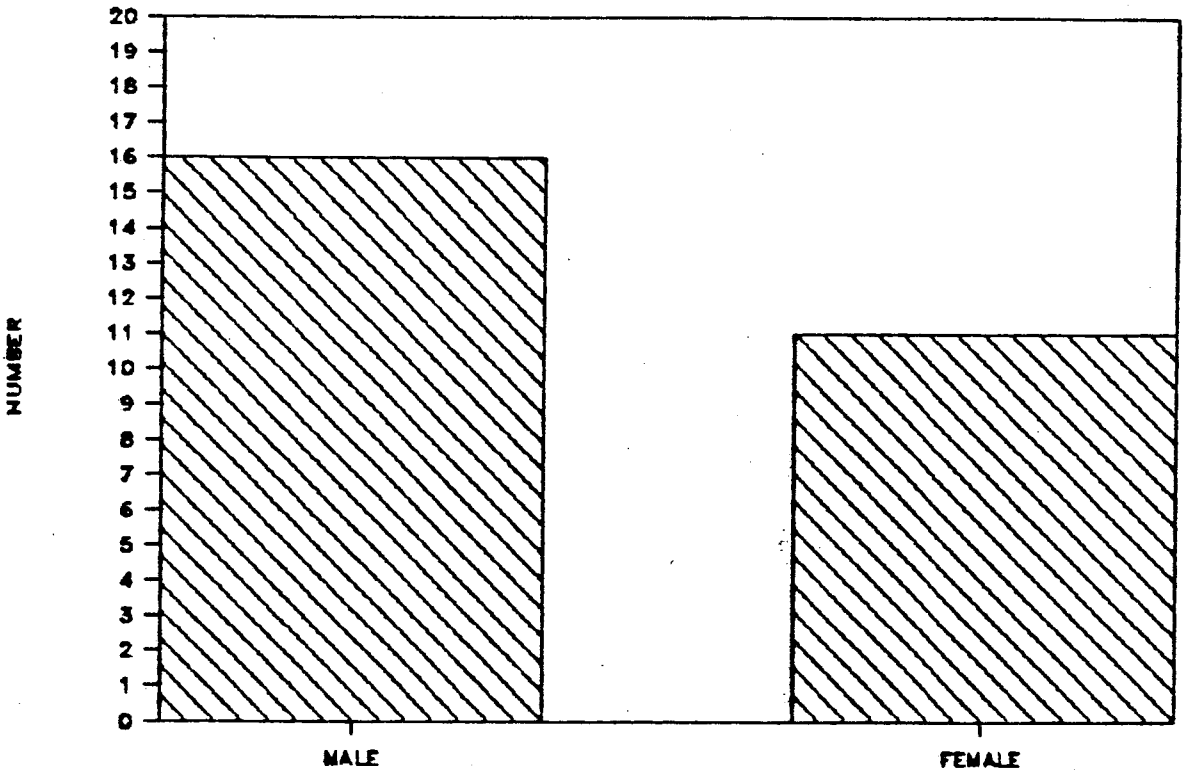


FIGURE 3 – YEARS OF EXPERIENCE

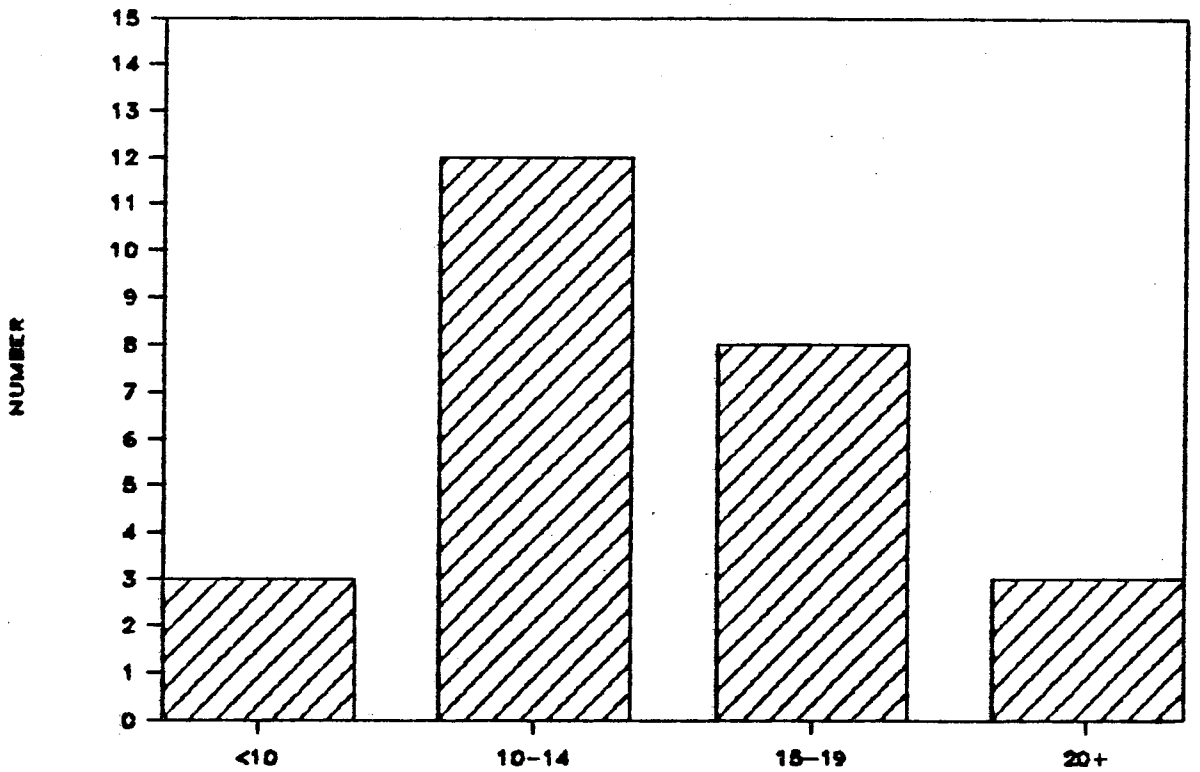


FIGURE 4 – PROFESSIONAL DEGREE

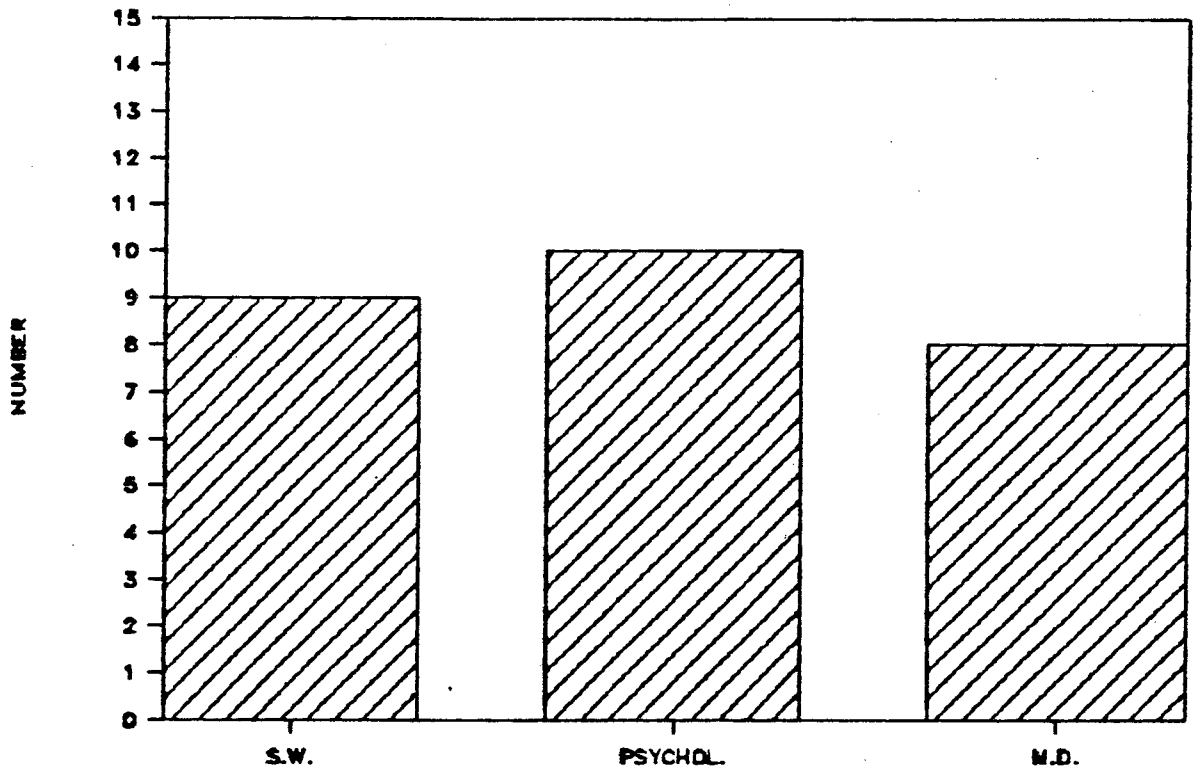
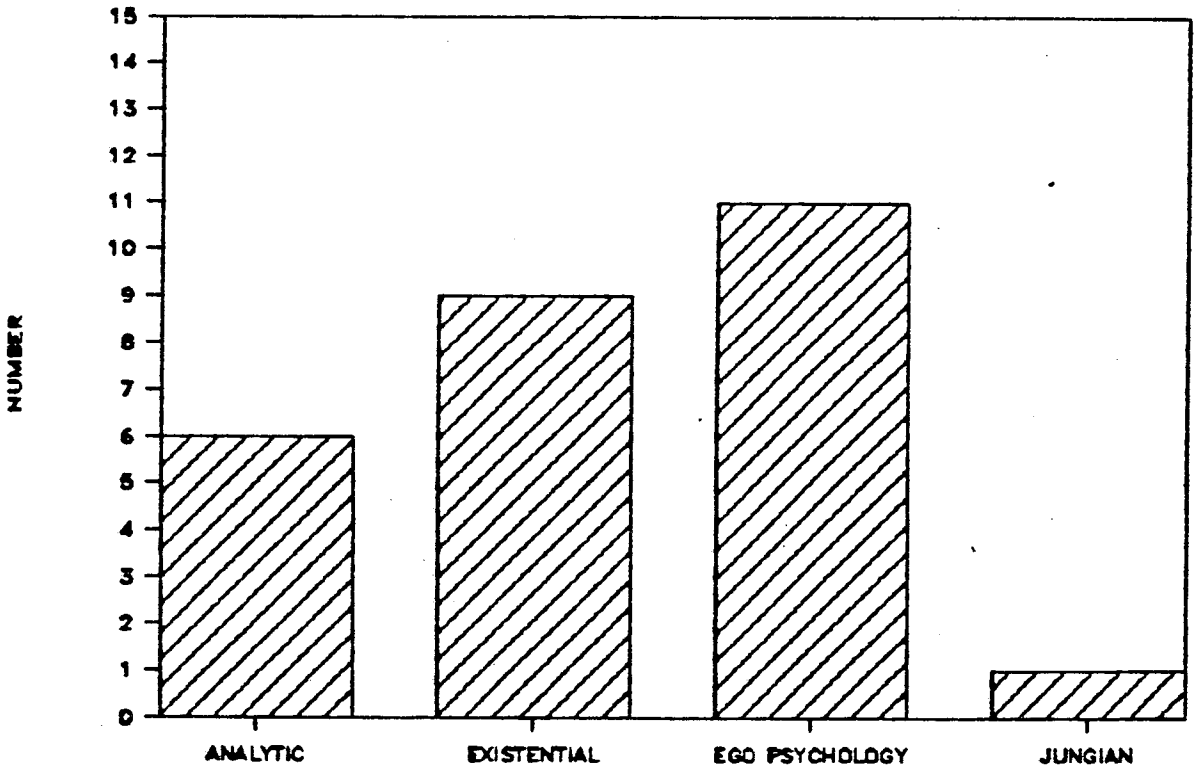


FIGURE 5 – THEORETICAL ORIENTATION



Questionnaire Responses

The questionnaire responses suggested that these experienced therapists give considerable thought to their participation, including disclosures, and have strong opinions about this issue. Discernible criteria of therapist self-disclosure was reported: to model, to validate their patients' perceptions, and to enhance the psychotherapy relationship.

The researcher expected to find a correlation between theoretical orientation and self-disclosure and between years of clinical experience and readiness to self-disclose. Four categories of theoretical orientation emerged in the responses: 1. psychoanalytic, 2. existential/humanistic, 3. psychodynamic/ego psychological, and 4. Jungian. The years of experience groupings fell into three categories: 1. ten to fifteen years, 2. fifteen to twenty years, and 3. more than twenty years. Theoretical orientation as a variable for therapist self-disclosure did, indeed, prove highly significant. All but two (17) of the respondents who labeled their theoretical orientation psychodynamic or psychoanalytic were low disclosers, as scaled by the researcher. (See "Data Analysis of Questionnaire" in Appendix B.) Those two and one of the respondents who was existential/humanistic were moderate disclosers. The

other eight respondents were high disclosers.

No discernible relationship between self-disclosure and length of experience emerged, but it nust be remembered that no therapist in the sample had less than ten years' experience. The researcher had also speculated that there might be a gender-related pattern, but none emerged.

Seven questions were developed specifically to identify the criteria that therapists employ in deciding to self-disclose. For example, subjects were asked, "When do you share aspects of your current personal life with a patient and why?" Responses included, "When we are stuck," "When something is going on in my life that's impacting the therapy," and "When I've had a similar experience to my patient I can model it for him." (See "Data Analysis of Questionnaire" in Appendix B.)

Responses referring to criteria of self-dislosure fell into five categories: (1) modeling and fostering identification, (2) management of personal crises, (3) enhancement of the therapeutic alliance, (4) narcissistic needs expressed as wanting to be liked and to be real, (5) enjoying the sharing aspects of being a psychotherapist. Some of the labels came from the respondents themselves, as they described their criteria for self-disclosure. For example, all the respondents used the word "model." Three talked about wanting to be liked,

and one of those labeled this "my narcissistic needs."

Criteria for non disclosing were commitment to furthering the transference, not burdening the therapy with irrelevant material or with the therapist's values or needs, and judgments that therapist self-disclosure is contra-indicated with some populations. Cognizance of patients' diagnoses, age, and stage of therapy were apparent variables.

The Interview

Subjects

The four highest disclosers and the four lowest disclosers were selected for the interview. As noted above, the returned questionnaires were scaled from high to low disclosing. The ranking was based on questions developed to generate this scale. See "Questions Developed for Ranking of Respondents" in Appendix B.)

Three of the eight subjects were psychiatrists, three were psychologists, and two were clinical social workers. Six were male, and two were female. All were experienced, as defined in this study as having ten or more years clinical experience. All were private practitioners in the Palo Alto, California, area.

The four high disclosers were two psychiatrists and two psychologists. The four low disclosers were one psychiatrist, one psychologist, and two clinical social workers. Each subject group consisted of three men and

one woman. See "Description of Interview Population" Figures 1 - 5, pages 71 - 76.

All of the subjects were cooperative, accessible, and willing participants in this project. Each thanked the researcher for the opportunity to explore this issue and expressed curiosity about the other subjects. All wanted to receive an abstract of the results of the study; one wanted to read the completed dissertation. None requested the return of the interview tape.

Analysis of the interview transcripts showed recurrent themes in all the subjects' discussions. The researcher noted that the subjects intertwined their discussions of their criteria for disclosing with their viewpoints on the psychotherapeutic relationship, their theoretical groundings, and their own self-awareness. The findings are presented first in relation to these three identified themes and then, in the following chapter, in relation to the criteria for self-disclosure.

Themes

Several overall themes emerged in the interviews. The researcher observed that much of the discussion focused on the therapeutic relationship and the type of psychotherapy being practiced.

As anticipated, therapists' theoretical orientations and viewpoints regarding the psychotherapeutic relation-

DESCRIPTION OF INTERVIEW POPULATION

FIGURE 1 – AGE

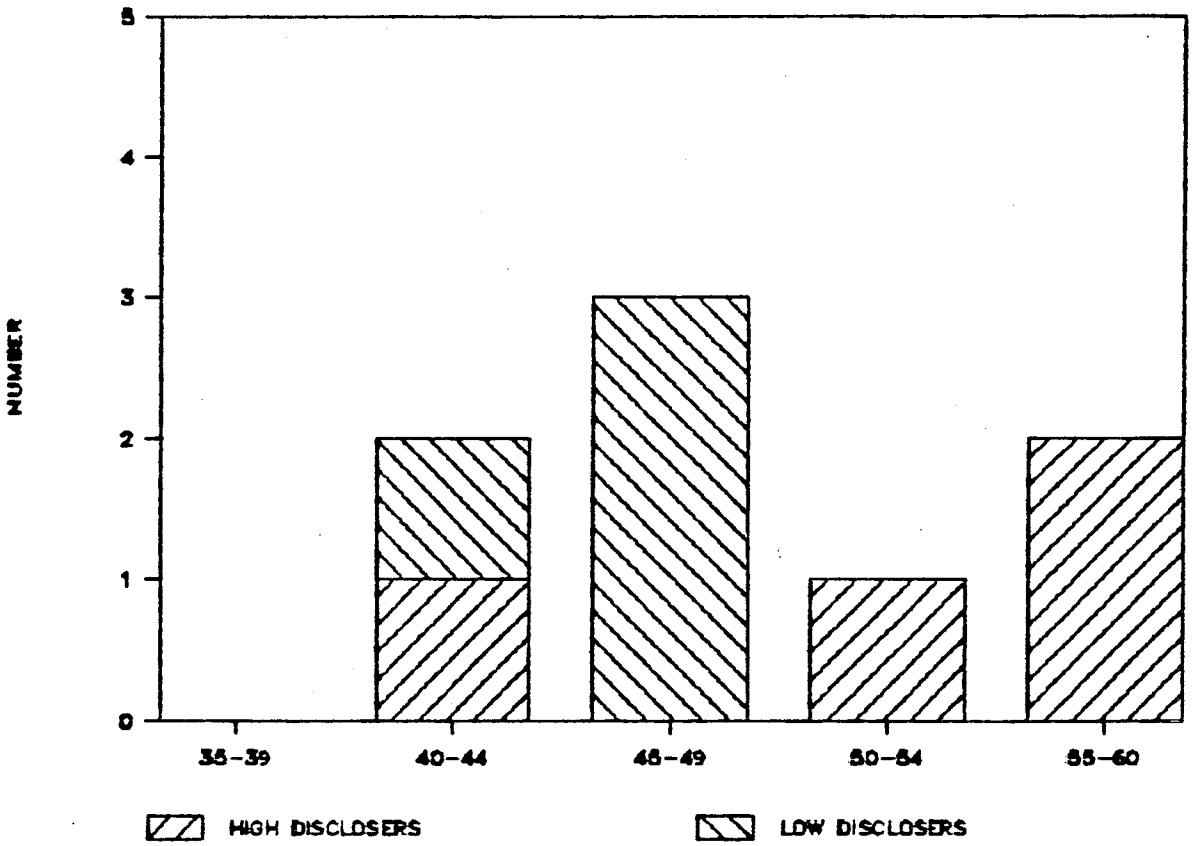

NUMBER
5
4
3
2
1
0
35–39
40–44
45–49
50–54
55–60
HIGH DISCLOSERS
LOW DISCLOSERS

FIGURE 2 – GENDER

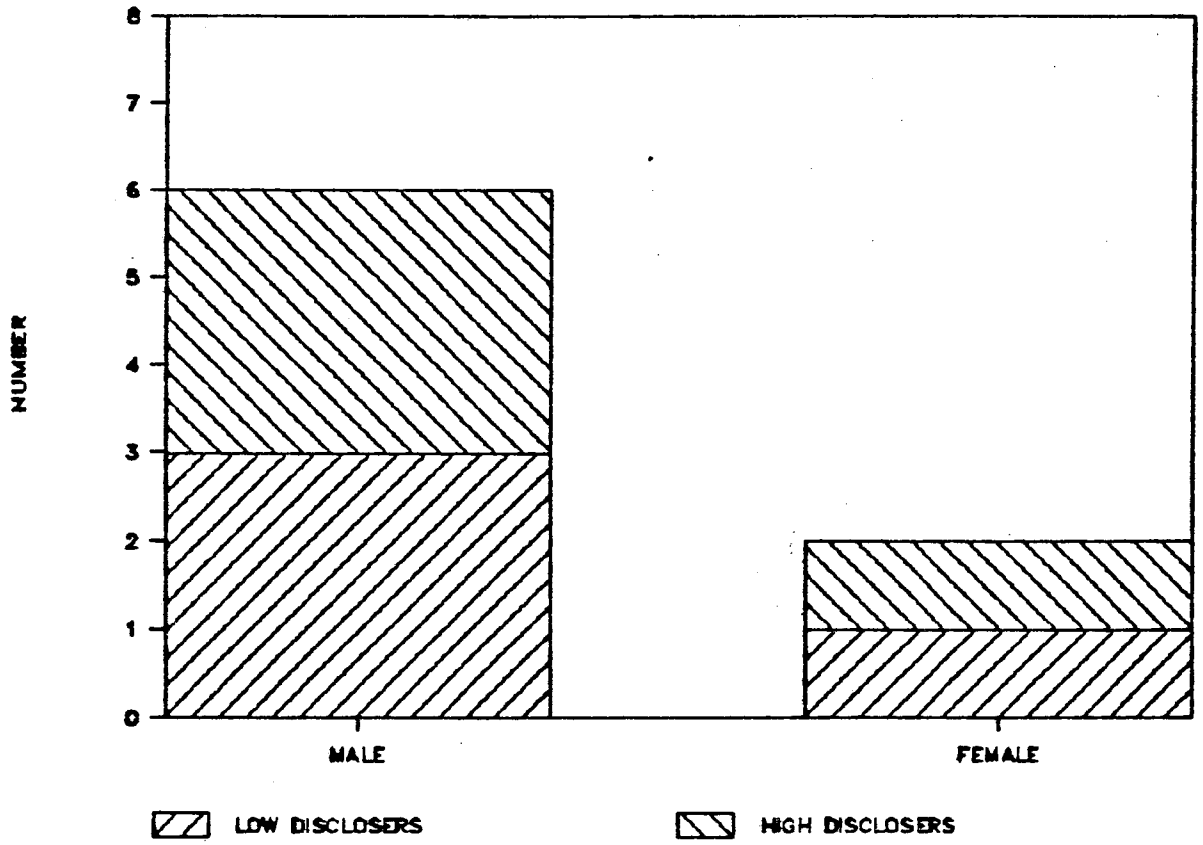


FIGURE 3 – YEARS OF EXPERIENCE

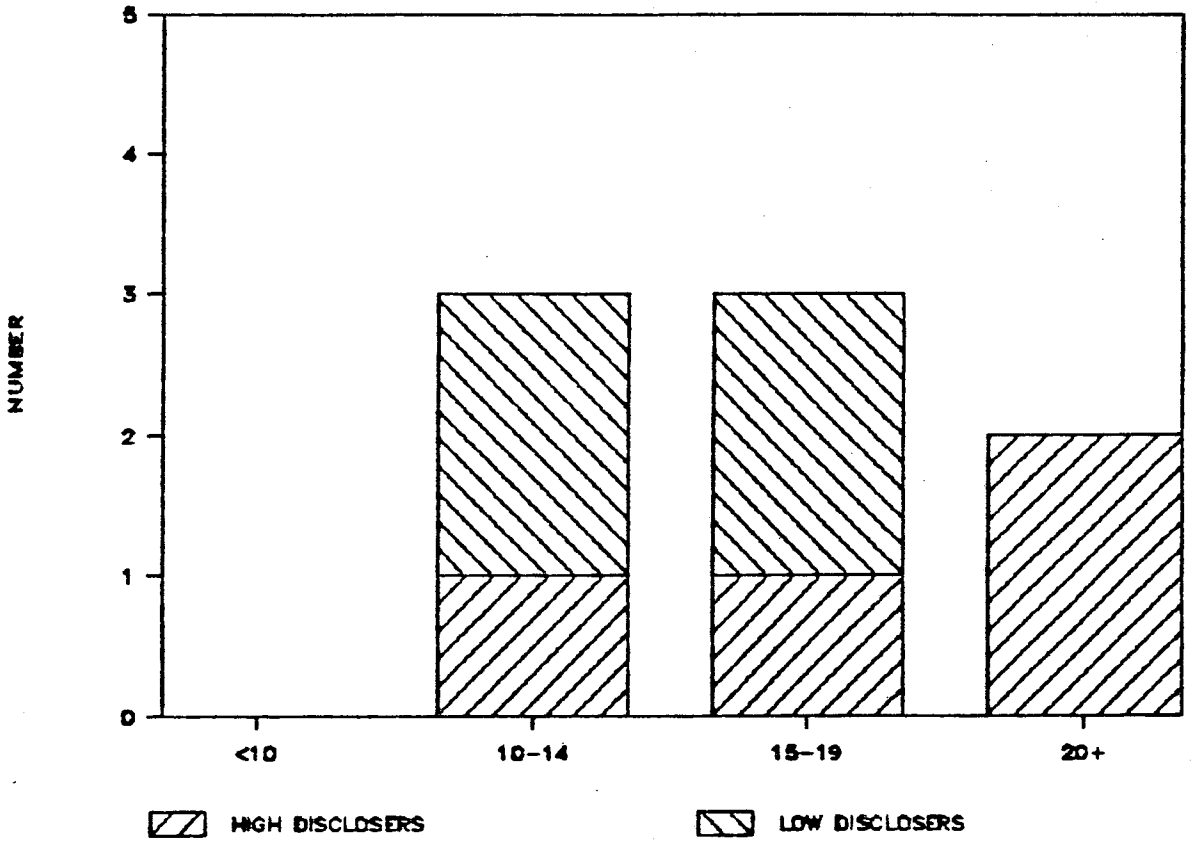


FIGURE 4 – PROFESSIONAL DEGREE

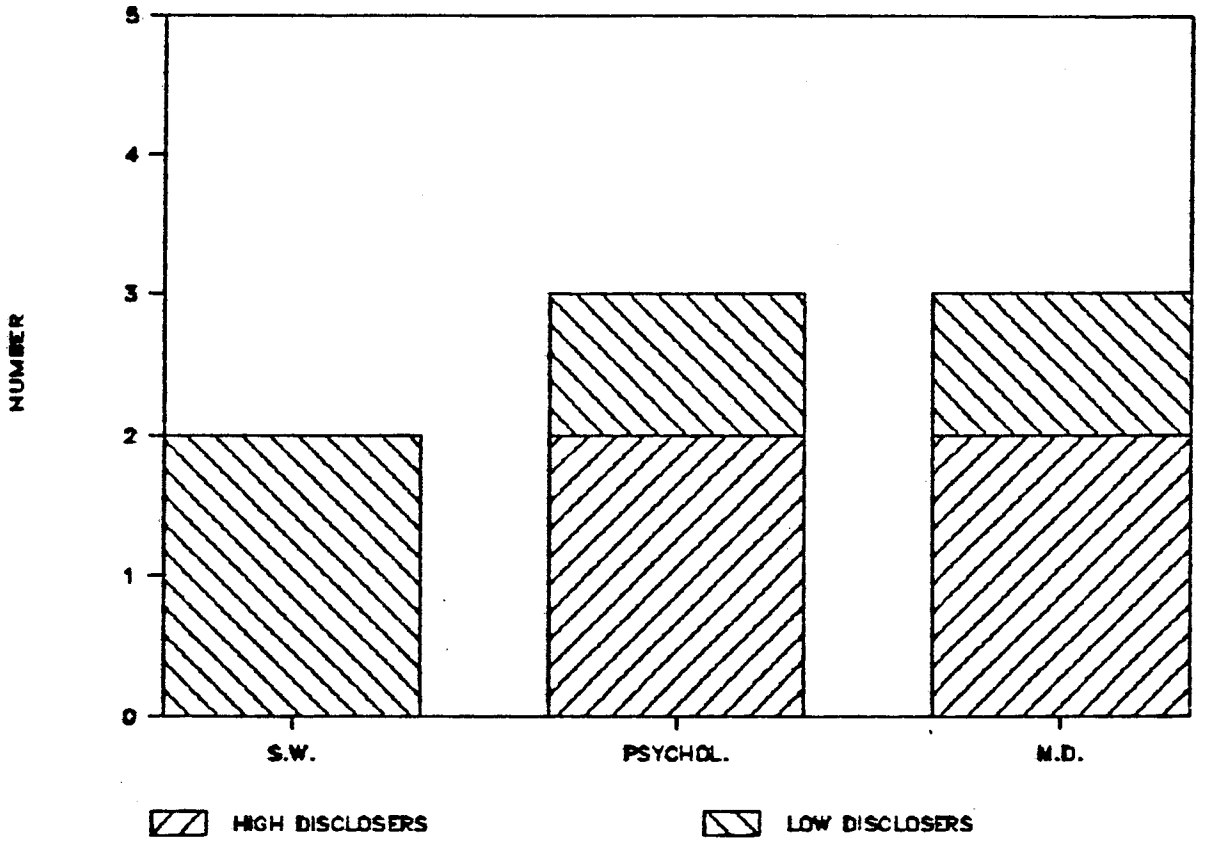
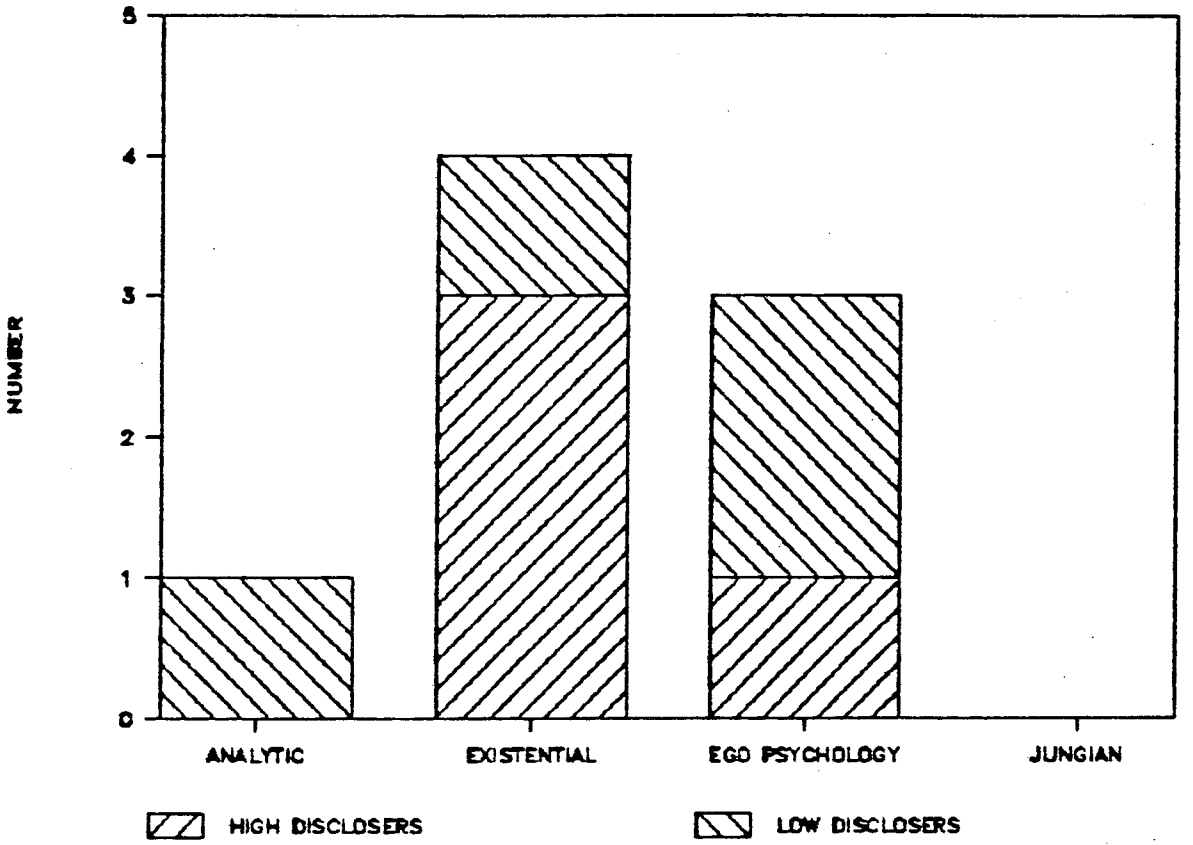


FIGURE 5 – THEORETICAL ORIENTATION



ship did correlate with self-disclosing. Three themes, the psychotherapeutic relationship, theoretical orientation, and therapist self-awareness, provided a context in which the subjects discussed criteria for therapist self-disclosure. These motifs served as an overall frame within which the therapists explored their use and non-use of self-disclosure.

The Psychotherapeutic Relationship

The interview explored therapists' viewpoints about the psychotherapeutic relationship, including the curative components and the purpose of psychotherapy. The questionnaire asked, "What do you think are the curative components in psychotherapy?" Both groups of respondents (high disclosers and low disclosers) viewed the purpose of the psychotherapy relationship as the improved mental health of the patient. The goals were increased self-esteem, decreased depression, improved ability to cope with and respond to reality factors, and greater sense of satisfaction. All agreed that the therapist is an agent of change and a facilitator of their patients' growth. All also agreed that they use themselves towards this end, and that their personalities and styles are facets of their psychotherapy relationships. Both groups talked about respect, empathy, compassion, and realness as essential components of the psychotherapy relationship. Thereafter, differences in the definition of "realness"

and in views on the therapist's role and the relationship emerged.

The Psychotherapeutic Relationship as Viewed by the High Disclosers

The intent of the therapists in this group was to create a connection with the patient to provide a context for growth. They saw their work as based on a real and human relationship. They aimed to be "real," which they defined as not creating illusions and being genuine and honest, fully open, and personally involved. These therapists spoke about the therapeutic relationship as a human exchange with mutual personal sharing. "This being together, openly sharing together, connecting, the relationship, that's what therapy is!" said one subject. Another commented, "What really heals in therapy is the truth." One said, "I believe that there's more value in being real with the patient than fostering any transference." One talked about therapy as the offering of his total self to the healing process.

Two of them felt that the therapist becomes a compensatory object for earlier deprivations, and that the healing comes from a corrective emotional experience rather then "working through" in the psychoanalytic sense. Therapist disclosures foster a trusting closeness and quasi-friendship, according to each of their psycho-

therapy models. Two of the subjects said, for example, that not being truthful and open about something personally upsetting would adversely impact the "space." (By "space" they meant the total therapeutic environment.) They viewed their commitment to being real as empowering their patients and helping them to deal with reality. Being human and sharing his humanness was the way one subject expressed this.

These subjects were critical of the traditional psycho-analytic model for its hierarchial implications and its encouragement of patient projections as the context for the work. They valued equality in the relationship. One referred to Freud's writings as having taught him to be respectful, caring, and equal, which he interpreted as encouraging free disclosure. "Freud was very helpful with his patients. He talked with them, walked with them. He was interested in their family problems and revealed some of his. He was real."

This group presented divergent opinions regarding boundaries in the therapeutic relationship. One of the subjects discussed his sensitivity to not being intrusive to his patients. As much as he believed in truthfulness and openness, he felt it was important to respect his patients' cues regarding their psychological borders. Another subject felt that all boundaries are open when patient and therapist meet. He felt that it was impor-

tant to treat each other as fellow human beings and that "withholding self-disclosure is clumsy and hostile."

All four of these subjects were clear that they would not socialize with current patients. "My job is to teach how to socialize, but not to do it with them," said one. Three felt that there is not much difference between the psychotherapy relationship and a close friendship. One stressed that the therapist is like a friend, but the purpose of the relationship is not friendship, and "I tell them that straight. I'm not primarily a friend. We are together to work." All four subjects have connected socially with former patients. Two have had relationships with former patients develop into personal friendships. This is compatible with their view that when psychotherapy terminates, the psychotherapy relationship ends, and the two people are then free to develop another kind of relationship, if both so desire.

These subjects agreed with Jourard's concept of the dyadic effect, that is, that the therapist's disclosures encourage the patient's disclosures. (1971, p. 66) Equality, truthfulness and genuineness are the relationship hallmarks for these therapists.

The Psychotherapeutic Relationship as Viewed by the Low Disclosers

All the therapists in this group also saw themselves as "real," but in a different sense. Their definition was being respectful, warm, attentive, empathic, and "not dishonest," that is, honest but not fully open. For them non disclosing is not dishonest but rather reflective of the commitment to neutrality as the appropriate therapeutic stance.

Two of these therapists made a distinction between sympathy and empathy, stating that they thought the two were frequently confused. One stated it this way: "Empathy is a mode of perceiving on the part of the therapist. Sympathy is being sympathetic with the patients' view of things, you know, commiserating with them." Empathy communicates understanding and a state of feeling with the patients. Both stated that empathy belongs in therapy, sympathy does not. Note that there is a divergence in definition. The low disclosers were as clear as the high disclosers that these traits were essential therapist characteristics, but used themselves differently. One of the subjects discussed this in detail, revealing a discriminatory and analytical attitude towards the words that describe "real."

> What people want is warmth and genuineness, but they may or may not want genuineness depending upon what you're being genuine about. I'm here as a therapist. If I'm

> being genuine, I'm going to be trying to help the patient look at some things that they don't want to look at. So, often genuineness on that level is not that appreciated by the patient. If you mean genuineness in the sense of some kind of emotional visibility of the therapist, the therapist sort of being sincere in conveying the feelings that he or she is experiencing, that I think makes sense.

One subject discussed the therapeutic relationship as a complementary relationship, saying that therapist and patient complement each other, and "that cannot be denied as a factor in psychotherapy. I think, therefore, that it's important to be able to meet the needs of whoever he or she is seeing." He went on to say that being genuine is an important part of his work, "letting them know that I'm able to respond to what they're talking about and who they really are. That's being genuine." He stated that he reveals as little as possible without being artificial.

These subjects consistently stated that, with minimal exception, the psychotherapy relationship was not a place for them to share their personal selves. Their roles demanded neutrality and a clear frame to which patients agree when undertaking psychotherapy. Quoting a subject:

> There is an agreement that we will look at what happens in here as though it is real. It is real, but only within the confines of this arrangement. If you have to break the arrangement, it's sort of like the theatre --- the roof leaking in the theater. Then

> you refund people their money, or tell them the roof is leaking. But you don't say, 'this is part of the play.'

Equality in the psychotherapy relationship was mentioned spontaneously by three of the subjects. They noted that they were often criticized for presenting themselves as superior to their patients but insisted that equality inequality was not the issue. When the patient understands that the therapist is being supportive and empathic while encouraging transference, there is not an implied hierarchy or power play but rather a sense of teamwork. Two of them were amused by this criticism of their work and felt that they were often not understood by their high disclosing colleagues. One said, "I guess it reminds me of the sixties, with 'We'll all share and we'll all be equal and everybody will be happy together.' But it blurs the therapy, it blurs the boundary, and the boundary is critical to the work."

All of the low disclosing subjects were opposed to socializing with current or former patients. They disagreed with the high disclosers' viewpoint that the relationship ends when the therapy ends. As one said, "They may want to come back, and socializing would interfere with that. Also, when patients leave, they carry with them an introject of their therapy experience. If I socialized, that would mess up what they've taken with them."

The therapist's satisfaction emerged as one criterion for self-disclosure in the high disclosing subjects. Most of the low disclosers discussed their satisfaction in terms of their viewpoint about the relationship and not as a criterion for disclosing. A brief discussion of therapist satisfaction as a criterion in the low disclosers is presented in Chapter 5, but most of the material is presented here, as a facet of their views about the relationship.

Two of the low disclosers derived much of their satisfaction from the intellectual challenge of their work. These two discussed their pleasure in making technically correct interventions and offering interpretations that facilitated their patients' insights. One of these subjects said that he enjoyed the intellectual problem-solving component of the process. Another enjoyed "being real without revealing." The satisfaction from the relationship was described as a "special kind of intimacy." As one said, "I feel so privileged to be trusted and confided in. That affirms me!" When the researcher inquired how he felt when he did disclose, one therapist said, "In that moment when we are directly acknowledging that we're both human beings with feelings encountering each other, it doesn't matter if the feelings are warm or hostile." The experience of reflecting their reactions to their patients enhanced the sense of

connectedness, a source of satisfaction for these subjects. One said, "I often feel a tug to be closer, when it's a very intense hour. I might feel my need to connect and feel needed. I would like to reach out. I try to remember to stop and think, "Is this for me or for the patient?'"

One spoke of the self-affirmation he experienced when he offered himself as a model. "It's a chance to remind myself how far I've come."

Theoretical Orientation

As anticipated, therapists' theoretical orientations did correlate with self-disclosing. In addition to self-labeling of their professional identities and their schools of thought, the subjects communicated their orientations in their discussions of how they do therapy. Transference, its use or non use, was clearly the core of the matter. The distinction was reduced to whether one viewed the psychotherapy process as focused on working through patients' projections or as focused on the interconnection between therapist and patient.

Each subject in this study had a clear model of his/her approach to psychotherapy practice. Each had a clear sense of professional identity in terms of teachers, idols, and respected schools of thought.

They conversed about how they define their work, that is, whether they are doing supportive or evocative

psychotherapy, and they discussed their work in general terms. They saw the kind of therapy they practiced as the significant determinant for the way they interacted with their patients.

Theoretical Orientation of the High Disclosers

These subjects used many terms to describe their theoretical orientations. Among them were: eclectic, humanistic, existential, and "here and now." One said, "I am a neo-contextualistic, Jungian, Buddhist, Gestalt, realist, Rogerian, humanist, transpersonal behavior therapist with a psychoanalytic twist." Their mentors were Ellis, Perls, Rogers, and Werner Erhard. One of the subjects, a Hasidic Jew, leaned heavily on his religious beliefs and spiritual orientation in his work. Two had been active participants in EST and utilized much of that material in their work. (Erhard Seminars Training was a large group growth experience presented in major urban areas during the 1970s.)

These subjects talked at length about the kind of work they do, focusing on the human connection and reality. They reported that the stance of friendliness, openness, and personal connectedness they espoused was consistent with their theoretical conception of what made for quality psychotherapy. They stated that the curative factors in their work included truth, love, communica-

tion, understanding oneself, and the human bond.

In response to the inquiry about the comparison of their point of view with traditional psychotherapy, one response reflected the group's thinking. "I'm not an analyst. I didn't want to be one. What the analyst is doing is evoking primary process behavior of dreams, fantasies, slips, whatever, to try to get into an unconscious architecture, so he can build models of what the person is, his unconscious. The idea is that insight and interpretation leads to change. That's fine. I don't work that way. I want to connect." Another subject also expressed respect for transference-focused work and said simply, "It's just not the way I want to be. I can see that it makes sense though."

One subject talked about her rejection of transference work.

> I'm trying to think if I've ever addressed a transference issue. I think the only time I ever did -- and I didn't to the patient, it was only in my head or with colleagues -- is a welfare patient who would come three or four times, get super mad at me, and quit. And six months later, would come, get mad, and quit. There was some discussion about that sort of thing being a transference psychosis, I don't know. I didn't think it was useful to think in those terms.

Three of these subjects had family photographs on display. Asked for the resaon, one replied "Why not?" Another volunteered that she sends family photo Christmas cards to her patients in order simply to be real and not

hide.

Two of these subjects were very critical of traditional psychoanalysts' unwillingness to self-disclose. They labeled them "uptight," "unaware," and "stupid." One criticized with anger and the other with respect. One laughed and said, "I acknowledge personal enlightened superiority."

Theoretical Orientation of the Low Disclosers

Two of these subjects labeled their orientation as psychoanalytic. One said "psychodynamic with overtones from family therapy and feminist thought." One said "reality oriented and behavioral psychodynamic." Their teachers were Freud, Fromm-Reichman, Greenson, and Horney. One also mentioned Skinner and Rogers.

The findings show that the low disclosing therapists viewed use of the transference as the integral aspect of their work and were therefore generally opposed to therapist self-disclosure. Much of their therapy hours are spent working through the patients' projections on them which they see as clearly the primary curative component in the process. One discussed this in terms of creating a context of deprivation:

> The deprivation is important in the treatment, especially with neurotic patients, because that mode encourages their projections, so I don't want to answer their questions too quickly, it's more valuable to help them to explore. 'Deprivation' is a a

> bad word, but that's the one Freud used. It conveys harshness. I don't mean that.

One talked about sharing enough to not be artificial "but not revealing so much as to structure any more than necessary and risk getting in the way of the patient's projections." One of these subjects discussed at great length his process of appraising what kind of therapy he is doing, that is, crisis intervention, supportive, or insight- oriented psychotherapy. With supportive work, he was less concerned about monitoring his disclosures, since that kind of psychotherapy is not dependent on exploring transference. "You see, my appraisal of what kind of therapy I am doing or may be doing with the patient -- If it's -- if it looks like it's going to be a more supportive therapy I'm less concerned about disclosure -- It's a clinical, therapeutic assessment more than a diagnostic."

Cognizance of the therapist's personal style was mentioned by all of these subjects. For example, "I'm generally not effusive -- so working in a neutral way fits for me." One of the subjects expressed this:

> I think there are people who either in their personality style or their theoretical orientation can weave greater disclosure into their work in a way that's consistent with what they're doing. But it's less consistent [for me] so I do very little of it. I think in general it tends towards a kind of collaboration of avoiding a more transference-oriented kind of relationship [sic].

Another criticized self-disclosure by saying: "It reinforces the social quality of the relationship, thus adding to the patient's resistance, and it increases information for the patient to process along with fantasy." Consistent with emphasis on transference, these four subjects aimed to avoid a quality of friendship in their therapy relationships.

The questionnaire asked about personal photos in the therapist's office. These subjects did not have any displayed. As one subject said, "I feel strongly about pictures of family in the office. Pictures are too concrete. Why do they need them? Gets in the way of transference."

One subject expressed confusion, which reflected his struggle with the issues of genuineness and warmth and empathy in his psychotherapy model:

> To give them limited information allowed them to work on their own material, rather than leaving the therapist as only an object to project upon. Because if the therapist remains just blank, that doesn't fit well against the patient's demands for some information, particularly against research showing that therapists who were more genuine and more warm and more empathic are more effective.

This quote reflects the researcher's observation that this subject was theoretically committed to a neutral, transference psychotherapy model while being personally drawn to a more open and sharing way of functioning with his patients.

The researcher noted that this group used many fewer words in their discussions of their theoretical orientations than did the high disclosers.

Therapist Self-Awareness

One question inquired about personal psychotherapy experience as an aspect of gaining self-awareness. The responses suggested different viewpoints regarding the value of therapist self-awareness. The range for all the questionnaire respondents was from no personal psychotherapy experience to fifteen years. The type of therapy ranged from crisis intervention to psychoanalysis. It is noteworthy that there is clear distinction between the two subject groups and their own psychotherapy.

Therapist Self-Awareness in the High Disclosers

The high disclosers averaged 2.75 years of personal psychotherapy experience. None was currently in therapy. The findings suggest that the high disclosers have had less personal psychotherapy than the low disclosers. The responses to questioning about their own therapy showed that this group valued personal psychotherapy and self-awareness less than the low disclosers. The high disclosers saw the therapy relationship as mutually satisfying for therapist and patient. Whose material was being discussed was less significant than that patient and therapist were interacting in what they considered a

deep and meaningful way. One stated that the expectation of personal psychotherapy by the other schools made no sense to him, since he had not had a traumatic life.

Therapist Self-Awareness in the Low Disclosers

These subjects had an average of 6.2 years of personal psychotherapy, and three were currently in therapy. As a group, these subjects felt that therapists must have extensive personal psychotherapy. One statement reflected the sentiment of the group: "I have to know what's mine and what's the patient's." There were several examples in which these therapists discussed their self-questioning before revealing themselves. One described to the researcher her personal joy after having given birth to her son and her personal wish to share details with any interested person. "But it wasn't my place to discuss that with patients, that was my wish, my need, and I had to be able to contain it. I was sufficiently aware of my personal need and the conflict it caused in me when I went back to work... I returned to my therapist for help." Another talked about the importance of being unselfish while working and knowing how to take care of himself in general. "I go elsewhere to meet my needs."

One subject discussed his viewpoint that his transgressions with self-disclosures provide an opportunity

for personal growth. He shared with the researcher an experience in an initial interview in which a patient asked him numerous personal demographic questions, and "I couldn't keep my mouth shut. I didn't know what was happening, but I wasn't handling anything right." He knew that he reacted personally to some aspect of this patient and used his inappropriate reaction as material for exploration in his personal psychotherapy.

In response to the researcher's question, "How would you respond if a patient said, 'You look ill'?", one subject demonstrated his self-awareness:

> This gets very caught up in some of the feelings I have toward my therapist. In fact I can feel tears at this point. He died right at -- there were a number of times when he was wearing a neck brace and he pushed my questions aside and I just accepted it and said "Okay. I'm going to be a good patient and not ask any more." And this happened a number of times. And then, four months after I terminated, he died. And I was furious!

He went on to say that this issue is difficult for him, and that his orientation against disclosing would probably be overridden by his personal experience "unless I get it worked out."

The researcher concluded that therapists who utilize their patients' projections as the main material believe that they have to be maximally self-aware to minimize distortions. In contrast, therapists who value the interpersonal connection view the psychotherapy process as the context for their own growth, along with that of

their patients.

Summary

The two subject groups clearly use different models, viewpoints, and paradigms in their psychotherapy practices. Internal consistency within each group was high as they discussed their concepts of the psychotherapy relationship, their theoretical orientations, and personal self-awareness. This consistency persists in the findings specific to the criteria utilized in therapist self-disclosure.

CHAPTER V

FINDINGS, PART 2

Criteria for Self-Disclosure

This chapter presents the findings that specifically relate to the criteria for self-disclosure. Discussing this material separately from the themes in the data, presented in Chapter IV, is not meant to suggest that these topics are mutually exclusive. Therapists' viewpoints about the psychotherapy relationship, their theoretical orientations, and their attitudes regarding therapist self-awareness are, in fact, interconnected with the utilization of self-disclosure in their work.

The researcher reviewed the interview transcripts, seeking examples of criteria for self-disclosure and categorizing major portions of each interview. (As noted above, some interview content was irrelevant chatting.) All eight subjects utilized the same criteria for self-disclosure. The differences emerged in the therapists' individual determinations regarding when, what, and why to self-disclose. These decisions were based on their theoretical orientations, or what several stated as "the way I do therapy."

The high disclosing subjects were quick to share themselves. Their orientation prescribed that the indications for self-disclosure were ever-present and they

were not as contemplative of their criteria for disclosing as the low disclosers were.

This same phenomenon was observed in the interviews. When asked why they might disclose something, the high disclosers frequently responded quickly by saying "I just do," whereas the low disclosers paused, thought, and gave a response such as "I do that because it furthers the patient's sense of reality." One initially said he had no criteria, that he was 100 percent open. In contrast to the low disclosers, none of the high disclosers labeled therapist self-disclosure as a psychotherapy technique, although they clearly sometimes utilized it as one technique. All the subjects were more inclined to disclose with adolescent patients than with adults, and all reported some self-disclosing.

Specific questionnaire contents sought the initial categories of therapists' criteria for self-disclosure and non disclosure. The interview subjects were asked to explain their thinking leading to disclosures, for example, "Why would you tell her you were ill?", and "How do you decide with which patients to share information about your family?", and "When would you not share information about your vacation plans?" The interviews provided similar labeling of the categories of criteria, with elaboration and refinement. These were: to model and educate, to foster the therapeutic alliance, to validate

reality, to encourage the patient's autonomy, to reduce the patient's sense of alienation, and therapist personal satisfaction. There was consistency across the subgroups regarding the criteria for self-disclosure, with the exception of "therapist's personal satisfaction." "Therapist personal satisfaction" as a criteria was expressed in responses like "I sometimes need to share important things in my life" and "Part of why I became a therapist was to be able to truly be with people."

The findings will be presented for each category of criteria. The discussion of each criterion addresses the material first from the high disclosing subjects and then from the low disclosers.

Modeling

Therapists in this study reported that they often served as models of adult behavior by demonstrating problem-solving approaches, coping skills, self-acceptance, assertiveness, and other attributes. By presenting examples of desired behavior from their lives, they taught patients alternate ways of coping. Identification with the therapist was viewed as helping patients face life and was fostered by the therapist's appropriate self-disclosures.

The researcher explored the subjects' questionnaire replies that suggested modeling as a criterion for self-disclosure. Elaboration of modeling as a criterion was

sought in the exploration of the vignettes and in specific inquiries regarding when the therapists shared some of their own experiences. Throughout the interviews, modeling emerged as one of the primary criteria for therapist self-disclosure. All the subjects said that they used self-disclosure to model more frequently with adolescent patients than with adults because of the adolescent's need for help with the developmental task of becoming more autonomous.

Modeling Among the High Disclosers

These subjects were quick to share their own experiences and ideas with their patients. They especially saw value in sharing experiences that were similar to their patients'. One subject wanted to model someone who was open and who could demonstrate a way to live without fear or secrets, a stated psychotherapy goal of his. "I want to show them how I am with people and let them know that honesty and openness makes for good relationships. So I model that for them by being who I am." The four subjects labeled these interventions modeling, teaching, and fostering identification. "We can set some sort of modeling figure, which all good therapists are doing." By revealing in this manner they communicated to their patients, "You can do these things, too." Such behavior also tells patients that that they

aren't so different from someone they perceive as "having it all together."

Revelations were readily offered to adolescent patients because, as one subject explained, "It really makes sense to do it with people who don't know anything about family dynamics, about experiencing good parenting." By sharing his experiences of growing up and his career evolution, for example, he tells his young patients that they are capable too. "I think therapists need to use modeling with adolescents. We are all doing some kind of reparenting."

In working with adolescents, one subject said she was more likely to share more personal material. For example, "If an adolescent was trying to get a feel for who makes how much money, then I might be quite specific." She also stated that she would share almost any personal experience that paralleled that of a teen aged patient.

The researcher explored use of therapist self-disclosure when there are extenuating circumstances in the therapist's life. Subjects were asked if they'd ever experienced a serious illness, and how they did or would handle that with patients. The high disclosing subjects all felt that it would be very important to share this with patients. Modeling was the main rationale: "Teach them how to deal with it, including what you did that

helped and what you did that didn't help." In the same vein, two of these subjects felt that they would reveal information about any personal crisis or significant occurrence in order to model a way to cope. "I might even reveal that I fight with my wife. That would teach that it's okay to get angry, have fights, and that even someone as together as his therapist fights with his wife."

The researcher asked what the therapists would discuss about a black eye received since the last appointment. In response to the researcher's query, "Suppose you got the black eye because you'd gotten into a fight?", one subject said: "Yes, I'd tell, and I would tell the circumstances, because I would assume that there would be a lot of learning in that. Like about anger, intimacy, embarrassment. I'd share it all."

Modeling Among the Low Disclosers

Fewer examples of modeling were presented by these therapists than by the high disclosers. The four subjects reported that they sometimes self-disclose in order to model with their adolescent patients and hardly ever self-disclose with reasonably healthy adult patients. They expressed that modeling to young patients can provide an identification object and can be ego building. "I might tell a story about when I was their age. I'd be offering myself for identification. It's ego building.

Adolescents idolize the therapist, sometimes, and then I could use that to good purpose." These subjects felt that modeling themselves with this population was an appropriate deviation from their usual non disclosing mode. "Some of these kids haven't had decent adults to look up to. If I can provide that, I'm not going to withhold because I'm a Freudian."

Three felt that they would model with more disturbed patients to show them ways of coping with specific situations. The emphasis was on specific. They did not present themselves as over all objects of identification. Examples included social skills like dining out and interactions with co-workers. One woman felt that, without saying much, she was modeling her own pregnancy and femininity to a disturbed young woman. She related that she shared some of her frustrations of early parenting to a patient who was experiencing considerable anxiety about her performance as a mother. One subject, a former cigarette smoker, shared that information with patients who were confronting their own smoking habits. He did this to model, hoping that they would imitate that behavior and be able to stop smoking. "I figure if that's a mistake in terms of countertransference, and we pose that against seven years of life, we can afford it."

One therapist said that he sometimes shared a personal experience that showed his bad judgment to model

that "even the idealized therapist is not a perfect person."

All four subjects related that they have shared their own intense reactions to specific difficult personal situations in order to sanction and model for their patients that it was okay to be responding intensely. One example, from two subjects, was the sharing with a grieving patient some of their own emotional reactions to a parent's death.

In addition to sharing reactions to the patient during the session as feedback or validation, one of these subjects said that he sometimes shared his emotions to model that emotional reactions were appropriate sometimes. The emotion noted was anger. He often said to patients, "That would make me angry, too."

One subject said that he employed modeling only when he was doing supportive psychotherapy, as contrasted to his more usual mode of insight work. Within that frame, he sometimes shared details about his family and education.

Two of these therapists felt that universalizing was a successful tool to reduce some insecurities, and that they included themselves as models in this respect. "Sometimes we're just at the mercy of the powers that be" was a common phrase for one subject.

In responding to the question regarding how the

subject would handle an error made with a patient, one reported that he thinks it's important to be able to say "I'm sorry" to communicate respect and also "to model the ability to goof and to then aplolgize."

All but one therapist reported modeling as a criterion. She thought that that kind of information puts a burden on patients to do whatever it was the way she did, and that "it cuts off their own explorations, their own feelings, their own discovery."

Fostering The Therapeutic Alliance

The therapists in this study expressed sensitivity to their patients' anxieties about the process of psychotherapy and to the importance of establishing a trusting working relationship. All the subjects reported that they were more inclined to disclose early in the psychotherapy process for these reasons. They all noted that it wasn't uncommon for patients to ask for specific personal information during the first or second interview, and this was universally viewed as revealing the patient's anxiety and need to assess the trust potential with the therapist. The manner in which the subjects responded to these kinds of questions differed in the two subject groups. Utilization of self-disclosure to reduce alienation and to help establish the working alliance was expressed frequently in the interviews with the high

disclosers and occasionally in the interviews with the low disclosers.

Fostering the Therapeutic Alliance Among the High Disclosers

The four therapists in this group willingly shared whatever information patients requested during the early phase of treatment. The therapists saw this as critical for the building of trust and communicating to the patients that they were genuine, human, and real. One stated: "I think people are particularly anxious when they come to a therapist ... wanting to know who they are dealing with." Three of these subjects expressed a strong commitment to being truthful and honest in every situation and stated that the therapeutic alliance depends on this absolute honesty. These four subjects felt that they would be more cautious, at this stage of therapy, about disclosing themselves with severely disturbed patients, out of concern that that could lead to insatiable requests. The criterion in those instances was "Will it help reduce anxiety?"

Responding to patients' curiosities was seen as a criterion for self-disclosure. "Curiosity makes sense" was a common theme. Several said they could see no reason not to reveal anything that was asked. These four subjects felt that not to answer questions would be offensive to patients and increase rather than reduce anxiety.

The Hasidic therapist acknowledged that his office is a self-disclosure, because of its religious objects, and that he voluntarily says something right away to disarm patients' anxiety. "I just can freak out a patient, if they're scared and looking for a certain kind of person for their therapist. I often say something disclosing right away that shows them I'm a regular guy, even though I look strange." He stated that he views this kind of disclosure, during an initial session, as enhancing trust and respect and laying the groundwork for the therapeutic alliance.

Understanding and empathy were viewed as facets of the working alliance. These subjects agreed that they wanted to communicate these feelings as part of establishing the alliance, and they reported that they therefore disclosed specific personal experiences. Included are patient experiences which the therapist had also had, for example, an experience in jail and reactions to serious illness and death. The purpose of these disclosures was to say "I know" and to give permission to patients to express a broad range of emotions. They all felt that such disclosures deepened the relationships with their patients and facilitated the treatment. Some disclosures were offered specifically to foster a closeness and to strengthen the relationship with their patients.

Two of these subjects said that they sometimes shared having had a similar experience to their patient's to help the patient feel more connected. The enhanced connection, in their model, furthered the alliance. They both went on to emphasize the importance of being clear whose needs were being satisfied by these kinds of disclosures.

Similarly, self-disclosures were discussed as a tool to end impasses. In the above example of the therapist's jail experience, he felt that the patient's material about jail stirred up too much reaction in the therapist for him to continue without processing it with the patient. Additionally, he felt that the depth of the understanding from this unusual shared experience enabled the patient to let go of his "no one can understand me" way of thinking. A subject related to the researcher his frustration with a woman patient who had been dating a man for years and couldn't make a decision about marriage. He revealed that his son had just married a young woman he'd known for six months. The subject said that he shared that "to get her off her ass." He related that he wanted to confront her with an opposite situation to make her think. The researcher questioned if a non-personal comment could have had the same impact. He said, "That's the example that came to mind. It worked fine."

All four of these subjects speculated that their handling having a black eye would reflect their fostering the therapeutic alliance. "I'd be embarrassed... but honesty is ' very important. It's a matter of them believing me or not, and they must believe me and my honesty. I'd tell the truth." These comments were typical. When asked if they might lie about the details with any patient, they all hesitated and concluded that they would have to be truthful.

All the high disclosers were asked for an example of when they would not disclose something. The determination to not disclose was reported as sometimes being in the interest of maintaining and/or furthering the therapeutic alliance. Three reported specifically withholding personal information for this reason. For example, two said that they wouldn't share their news of prospective grandparenthood with a woman who was experiencing fertility problems. They explained that that sort of disclosure would be insensitive and cause pain. Three were clear that they would not reveal personal sexual information, because such disclosures are inappropriate to most social interactions. Allowing an invasion of their privacy would alter their objectivity with their patients and interfere with the therapist-patient connection. (One subject was unable to think of an example when he would not disclose.) One shared that he

sometimes has sexual feelings about his patients that he would not share. "I don't want to do numbers on my patients."

Fostering the Therapeutic Alliance Among the Low Disclosers

Self-disclosing interventions to further the therapeutic alliance were less frequent for these subjects. However, like the high disclosers, these subjects were more inclined to disclose during the early sessions. In the interest of not adding to their patients' anxiety at the outset of therapy, all of these subjects stated that they would probably answer demographic questions during the first session. Three were clear that they would rather not answer these questions but acknowledged that they usually did. One presented this in terms of the patient's need to feel secure and comfortable. "I think of this more like a character analysis of the person and then what type of information that person will need to feel secure." One said that he would answer these questions for courtesy, stating that, until the therapeutic alliance and agreements were set, the usual social manners were necessary. One saw patients' need to know demographics as a way of settling into the process.

For these therapists, the way in which they refused to respond to inquiries would lay the groundwork for establishing the therapeutic agreements. "I might use a

patient's question, straight away, as an opportunity to show him that I won't readily reveal, and that non-revealing is an aspect of the process." Another said, "I would answer if somebody was just finding out..., but I would make a mental note of the question, the context, and hopefully use it as grist for the mill later on."

In general, patients' curiosity was seen as an opportunity for further exploration. One expressed a common feeling: "I don't think there's any point in being mysterious for its own sake." They all felt that if the material was fully explored and still seemed very important to the patient, that they would briefly share it. This applied to inquiries about their personal data and to observations about their state of health.

Furthering the therapeutic process when there is an impasse was reported as a criterion for self-disclosure by three subjects. In this regard, one said, "I share only if the patient's progress is being totally hampered by something related to my personal life." One subject said that he might share that he'd had good news, if the patient seemed sidetracked by his good mood. "It would probably get me back on track too. It would discharge it in the moment and get us both back to work." Another subject shared that he might self-disclose "when I feel that the patient somehow got me in a corner and I can't think, you know, I'm addled and so I can't think my way

therapeutically out of the situation." He stated that he would do that to "get on with it."

One subject discussed his work with disturbed patients who sometimes "needed" personal information "to maintain a state of homeostasis within the therapeutic hour." This therapist said that he usually gives the information and sometimes regrets it later. He mused, "maybe it's my need to maintain homeostasis...." He was open to giving information in these situations but questioned whether that was the best action. The researcher was unable to obtain clarification of his term "to maintain homeostasis."

Establishing and maintaining the alliance with low functioning patients was discussed as an aspect of the determination to self-disclose. The subjects talked about these patients' need to merge. One stated that his task was to help them with boundary issues, and that he would "gently and minimally disclose and inquire why they needed to know and what if they didn't know." He felt that to be strict about non disclosing with this population could threaten the working alliance.

Sometimes the patient's not asking for a disclosure was viewed as significant to the alliance. Two subjects brought up the experience of the patient who refuses to know anything about the therapist. Examples included the research vignette of the therapist's black eye, a thera-

pist's broken arm, and patients who, over years, never asked anything. Both of these subjects saw these examples as appropriate times to explore why the patients didn't want to know. In these instances, the subjects felt that they probably would reveal some information.

The four subjects felt that the more common way for them to be self-revealing towards the furtherance of the alliance would be by informing patients of their emotional impact on the therapist. One said that he sometimes asked a patient, "How do you think I feel about this?" and then he'd disclose how he really felt. "I think this enhances them in some way. It furthers the work."

This group presented examples of avoiding self-disclosures when revelations would interfere with the work. Because maintenance of the therapist-patient boundary was an aspect of the alliance, they talked about being careful not to burden and not to intrude. Subjects were asked how they would handle having received good news about becoming a grandparent just before a session. None of these subjects felt that they would share it. The lowest discloser said, "If I became a grandparent, I might be too happy to contain myself. It's possible I might just violate my own practice out of sheer emotional ebullience." Then he added, "I don't think I should bring it into the treatment though." All of them felt

that sharing their own good news was at best a distraction and a waste of the patients' time and, at worst, a narcissistic need of theirs and an interference with the working alliance. Three of these subjects commented that they were very good at "putting on a neutral face" when they greeted their patients. They felt that it wasn't relevant to the therapy and that the information would distract both parties from their work. Such a disclosure was labeled intrusive, insensitive, or narcissistic.

Responding to the researcher's vignette about the black eye, one of the low disclosers said, "I think that that is exactly the kind of situation where there's the most payoff in not disclosing. Because once you disclose it, it will really close it off as an issue. I'd hope that the patient's fantasies would be the primary thing that would be focused on there."

Validating Reality

One of the goals of psychotherapy, as reported in this study, is the enhancement of the patient's ability to cope with and respond appropriately to reality factors. However differentiated the psychotherapy relationship may be from the outside world, the impact of reality factors on the psychotherapy process cannot be ignored. Both groups reported therapist self-disclosure as a technique to enhance patients' abilities in this regard. Special reality circumstances do arise in the therapist's

life during the course of psychotherapy that demand some response by the therapist. This could be a cold, or a personal joy or crisis.

Validating Reality Among the High Disclosers

This group, in their particular view of "truthfulness" in psychotherapy, felt that validation of the patient's reality was a continuous facet of the psychotherapy process. Two reported that this was the context of psychotherapy, clearly consistent with the high disclosers' concept of the therapeutic relationship. By being open and truthful they were always facilitating the patient's grasp of reality. One subject said that such disclosures help "patients to be able to validate their perceptions of what's going on with me. If they're wondering --- the more feedback I can give them, the more accurate they can be about 'that's my stuff and the other stuff is her stuff'."

The subjects were asked how they would respond to a patient's comment, "You look ill. Are you okay?" These four subjects said that they would answer directly to confirm their patients' perceptions. Three reported that they would answer with "enough detail to make it real for the patient." For example, one said that he would say, "Yes, my kid was sick last night," or "I am worried about my mortgage payment." If they were not indeed feeling

ill, two of them said that they would then explore the meaning of the query for the patient. The other two felt that the question confirmed that the patient was sensing something awry, and they would say something like, "I didn't get enough sleep," or "I guess I am sluggish today," again to confirm the patients' perceptions.

Subjects were asked how they would handle a patient's comment that the therapist seemed to be especially happy today. They all reported that they would validate this and provide some detail about their good news. Responses ranged from a simple "Yes, I am feeling good" to extensive discourse about the source of the good feeling. All responses were seen as assisting the patient in his sense of reality and enhancing the relationship. One communicated ambivalence and a discriminative process with regard to sharing details of his personal good news:

> For example, if my wife just had a baby and I was working with this lady with a infertility problem. That's too painful a reality, that wouldn't be kind to share. But it's reality. And babies are getting born, and even if she's not having a baby, she's got to deal with other women having babies. I would be protecting her by not telling her.

Special circumstances do arise during the course of therapy that necessitate direction by the therapist. The subjects were asked how they would handle their illnesses, vacations, and special occasions in their lives. These four subjects have shared and believe that therapists should disclose fully about their own illnesses and

absences from work. Consistent with their orientations that the truth heals, and that experiencing reality with the therapist enhances the patient's ability to react to personal reality, these therapists have disclosed children's weddings, toothaches, marital problems, surgery details, and deaths of parents. One female therapist shared considerable details during a pregnancy and in general discloses "whatever they want to know."

Within the open frame valued by these therapists, encouraging patients to deal with reality is ever present. Sometimes, via specific therapist self-disclosures, it is clearly brought into focus.

Validating Reality Among the Low Disclosers

It was one of the low disclosers who used the metaphor of the theater's leaking roof in his discussion of the relationship. (See page 81.) The point he was making, which is relevant to the material in this section, is that even if a therapist is practicing psychoanalytic psychotherapy, with its emphasis on the transference and the patient's projections, reality sometimes intrudes. These subjects felt that to pretend that reality is a facet of the projections is to confuse and betray the patient. As noted above, the kinds of realities that the subjects enumerated related to therapists' illness, losses, joys, and accomplishments.

The low disclosing therapists were in agreement that they had to validate their patients' reality when they made observations that were accurate. "To ignore their observations undermines their ability to trust themselves in relationships." Therefore, in response to the researcher's questions about handling a patient's inquiry, "You look ill. Are you okay?", these subjects all agreed that they would first explore the patient's experience behind the question and then share truthfully if, indeed, they were feeling less than well. They would not volunteer any details. Likewise, when a patient noted that the therapist seemed happy, these therapists wanted to acknowledge the validity of what the patients sensed. All of them would say something like "Yes, I had some good news," and be clear that they didn't want to elaborate. The point to this disclosure was explained succinctly as "All I'm doing there is validating their perceptions, so that's all I need to say."

The researcher inquired about a serious illness in the therapist, and how they would recommend handling this. These subjects felt that the information needed by patients related to their needs to know what was going to happen regarding their appointments and the therapist's expected return to practice. As one said, "I'd recommend disclosure of enough to allow the patient to deal with it realistically. When you're sick you're going to have to

violate the contract, the frame, involuntarily, and that's different from a patient wanting to have information." Additional information was reported to be an interference with the therapy work. Another subject also discussed a therapist's illness as a break in the therapeutic frame and felt that stating this helped patients cope with the reality and kept the psychotherapy relationship defined.

An noted above, a patient's not asking about the therapist's obvious injury was viewed as an avoidance of reality. One of these subjects said that he would reveal some information in these kinds of circumstances to push the patient to confront reality.

These finding show that therapists' self-disclosures can enhance the patients' ability to deal with reality. Even therapists who generally withhold personal information are not unwilling to disclose when doing so assists patients in this regard.

Encouraging The Patient's Autonomy

The questionnaire responses and interview content affirmed that enhancement of the patient's sense of self is a goal of psychotherapy. Even though not specifically sought by the researcher, material suggesting the intent of supporting the patient's autonomy did emerge as a criterion. An example from the questionnaire was the response to : "Some theorists strongly recommend thera-

pist disclosure. What is your reaction to that?" Six of the questionnaire respondents stated something like, "I feel that clients should be treated with respect and like fellow humans." Several of the interview subjects talked about some therapist self-disclosures specifically intended to increase a patient's autonomy or sense of self. Although not as frequent as modeling or fostering the therapeutic alliance, enhancement of the patient's autonomy was a reported criterion for some revelations.

Encouraging The Patient's Autonomy Among the High Disclosers

Consistent with their commitment to openness and being with their patients as a whole person, these four subjects reported that their frequent disclosures communicated to their patients a respect for the patient's autonomy as well as their own. Communicating a sense of equality to patients was reported as an important aspect of their work and was accomplished by self-disclosures, primarily regarding demographics. One said, "I want to let my patients know that we're peers. He's as good as I am." Another said, "When I tell a patient about my life, I am telling him 'I like you, I trust you, I respect you.' That's got to make him feel like a mensch!" ("Mensch" is a Yiddish word meaning "a real person.")

One subject stated that he thinks it's important to be receptive to patient's concerns as a way to convey

respect. He discussed this: "For example, there's the lady who said 'You don't look well.' If I just pooh-poohed that, I'd be putting her down, making her feel like a fool. I don't want to do that. My task is to help people feel bigger, not smaller."

Three of these subjects discussed a segment of their patient population who are in therapy because they haven't been loved or acknowledged adequately by their parents. As one said, "It's healing to be receptive to their personal questions."

In response to the researcher's question about a patient's recent trip, one of these subjects said that he would be inclined to show his personal interest to reflect to the patient acknowledgment of her competence and success in completing a wonderful and expensive trip.

Two of these subjects discussed their decisions not to disclose in terms of respecting the patient. One talked about not being intrusive with revelations that could be painful, for example, not sharing about having just become a parent with an infertile woman. Another talked about not doing much disclosing with a borderline patient, because "they've got enough load. I think people can't take too much if they're having that kind of trouble." When the researcher asked for explication of this comment, the subject said, "Sometimes I show respect for the patient's fragile autonomy by not overloading him

or her."

The decision to disclose or, particularly for the high disclosers, not to disclose, was reported to be frequently based on therapists' determinations that their disclosures could interfere with their patients' autonomy.

Encouraging The Patient's Autonomy Among the Low Disclosers

Respecting patients was important to all the subjects in this study. As noted above, the high disclosers often used self-disclosures to communicate this respect to their patients. The low disclosers reported that respect for patients was communicated in their demeanor, commitment, and attentiveness. Their respect for their patients was reflected in the interviews by their caring attitudes and attention to maintaining patients' confidentiality when they shared examples of their interactions.

The researcher's inquiry about the subjects' handling of an error elicited a response that reflected encouraging the patient's autonomy as a criterion for disclosing. One subject said: "If I feel that what I did or said was really blowing it, I will indicate that, or even say 'I'm sorry.' First of all, I'm not infallible, and second, that tells the patient that he or she isn't a dumbo and is entitled to the courtesy of an apology." Another explained his handling of as error as

follows: "The purpose of how I work is to help the patients get better at understanding themselves, and I know I have a kind of power in my position about defining what's real and what's true and so forth. So I think it's very important to undo, if it's very clear, any error."

Diagnosis was a major factor in these therapists' determinations to disclose with the purpose of enhancing patients' autonomy. In this group of subjects, all the examples given referred to patients labeled "low functioning" or "borderline." One subject discussed a client who has difficulty with separations and explained why she shared her vacation plans with him. "If he can picture me in a certain place, that helps him cope while I'm away. He feels less whole when the important people in his life are away. So I think it's right to disclose information like that with patients who really feel supported and more intact by knowing." Another talked about his work with low functioning patients who need to merge as a part of the psychotherapy process. "Sometimes that's manifest in wanting to know a lot about you. And I would probably gently help them with those boundaries. I would tell them stuff, briefly, and inquire why they felt they needed to know."

"Sometimes patients just need some kind of reassurance of the stability of the therapist as a whole

object, in order to feel whole himself," one subject stated. "By being a trusting person and communicating by your wholeness that the patient is too, we can further their sense of autonomy." This therapist said that, with this purpose in disclosing, it was less significant what was being revealed. The timing was the more important variable. Another also talked in terms of being a whole object to some patients. "Sometimes I think we need to show that we're somebody who's real and has reason to feel good, alive."

Enhancing their patients' senses of autonomy and wholeness was often reported to be a reason for disclosing specific personal information. The information shared was limited to the details deemed relevant for the therapeutic purpose.

The Therapist's Satisfaction

The therapist's personal satisfaction as a criterion for self-disclosure was suggested in the questionnaire responses and emerged again in the interviews. The questionnaire asked subjects to describe their feelings and reactions when they share personal information with a patient. Some of the responses that suggested satisfaction as a criterion interfaced with the therapists' views of their roles and how they function and therefore relate to the findings' on the therapeutic

relationship. (See Chapter IV.)

The researcher wanted to explore this area to gain insight into possible narcissistic satisfaction derived from therapist self-disclosure. The findings suggest that therapists' satisfaction originates in the relationship and for some subjects, it originates specifically in their connections with their patients. All the subjects reported that they obtain satisfaction from their own growth, which flows from their work. The fulfillments derived from practicing psychotherapy were presented differently by the subjects in the two groups.

The Therapist's Satisfaction Among the High Disclosers

The high disclosers were very clear about the pleasure they derive from their connections with their patients. They have chosen orientations that support therapist openness, and it is the mutuality of openness that provides them some of their professional satisfaction. These therapists acknowledged their own enjoyment of their friendly relationships with their patients.

Two of the high disclosing therapists clearly stated that they enjoyed the bond with their patients. "It feels good to share with patients, just like it does with good friends. We are good friends. And we both grow from the relationship," as one subject put it. Two of the subjects said concisely, "I like to talk about myself." The researcher asked the subjects what their

thoughts were about some disclosures. One said, "It went with the flow. Both of us got nurtured out of them."

Two subjects talked about their satisfaction stemming from the gratification of seeing patients' growth and from the intellectual stimulation of the process.

The subjects were asked if they would pursue a discussion with a patient about a recent trip the patient took to an interesting destination. This question was directed at eliciting possible disclosure for the primary purpose of information for the therapist. All these subjects reported that they would encourage some discussion because of their interest. As one said, "If I'm simply curious, I'd be curious. For just a few minutes." They all said they would reveal that the place was of interest, and two felt that they would ask specific questions about the trip to satisfy their own curiosity. One said he would spend a long time talking about it, asking questions about hotels and sightseeing "if the patient didn't seem to have anything special to discuss."

Two subjects volunteered that they would pursue discussions with patients about most topics of interest to the therapist. With respect to one patient who was a theologian, the therapist related that "I'd like to chat with him about that. As long as he understands that it's not therapy but a man-to-man chat... which he doesn't have to pay for."

One subject addressed an aspect of non disclosing in terms of it taking too much energy for her. She felt that the work was easier and more satisfying for her when she was open with her patients. "There'd be more emotional drain in not talking about something, to holding up a wall. I don't want to work so hard."

The questionnaire asked if the subjects had family photographs on display in their offices. One stated in the interview, "I've got the pictures there. I'm proud of my kids, and it's a way of sharing them with the world."

Personal satisfaction from the connections with their patients was a by-product of the high disclosers' manner of practicing psychotherapy. Being open and sharing was consistent with their theoretical orientations, and therefore self-disclosing was seen as appropriate to the psychotherapy process.

The Therapist's Satisfaction Among the Low Disclosers

The relationship was reported as the source of satisfaction by this group also. However, therapist satisfaction was not a criterion for self-disclosure for these subjects. It was less the openness of the relationship and more the psychotherapy process and relationship that provided fulfillment for the low disclosing subjects. Discussion of the satisfactions that this

group derived from their work is presented above, under the therapeutic relationship.

In order to explore this issue with the low disclosing group, the same question was asked about expressing interest in a patient's recent trip to a place of interest. One said, "I don't think I'd say anything." Another said, "I think I have done that. I don't think that's good. I'd be more likely to focus it back on what the experience was like for them. I don't close my ears to tips on good restaurants though!" Another said that he wouldn't ask anything unless "if the client's real negative and talks about the trip in negative ways, I might reframe it and say 'Well, there are people who would love to go to China or whatever.' But in general, I wouldn't. It's my stuff." Another said that he probably wouldn't share that it was someplace of interest but might say, "Oh, that must have been exciting." He then acknowledged that he might fish a little. "But that's it. Just touch it, if they don't go with it, drop it."

With regard to the therapist's satisfaction, the high disclosers were as consistent with their theoretical orientations as the low disclosers were. However, they acknowledged occasional difficulty in adhering to their neutral stance when something sparked their personal interest.

Summary

There were notable similarities and notable differences in the criteria for self-disclosure between the two subject groups. Except for the high disclosers' revelations for the therapist's satisfaction, the criteria for each group were the same. To reiterate, the criteria for disclosure that emerged in all the subjects' data were: modeling, fostering the therapeutic alliance, validating reality, and encouraging the patient's autonomy.

It was also revealed that there were certain categories of patients with whom all the subjects were likely to self-disclose, that is adolescents and low functioning adults.

The frequency and extent of the disclosures varied considerably. All the subjects disclosed sometimes.

Chapter VI

DISCUSSION AND CONCLUSIONS

This chapter begins with an overview of the dissertation and then discusses the limitations of the study and the relation of the findings to the literature survey. Further discussions of the findings and of related material that emerged in the study follow. Implications for clinical practice and suggestions for further study conclude this dissertation.

Overview

The purpose of this study was to explore therapists' criteria for self-disclosure with their patients. This was achieved through in-depth interviews with experienced psychotherapists who represented high and low disclosers. The literature review traced the evolution of attention to the therapists' contribution to psychotherapy as well as pointed out the consideration that has been given to therapist self-disclosure. This research explored the relationship of therapists' theoretical orientations and experience with their criteria for self-disclosure. Five categories of criteria emerged: (1) modeling, (2) fostering the therapeutic alliance, (3) validating reality, (4) encouraging the patient's autonomy, and (5) therapist satisfaction. Three related themes were

evident. The findings presented extensive discussion of therapists' theoretical orientations and their views about the psychotherapeutic relationship as well as some discussion of therapist self-awareness.

Limitations of the Study

This study addressed therapists' conscious intentional self-disclosure in the practice of individual long-term psychotherapy. It did not include spontaneous or unconscious unintentional therapist disclosure. Group and family therapy practice were beyond the scope of this study. Physical touching, which can be viewed as a therapist self-disclosure to communicate feelings and/or thoughts, was not addressed although some of the subjects mentioned it.

Because this study was limited to experienced clinicians, a bias towards less therapist self-disclosure in the responses was anticipated. (Weiner, 1986). This did not appear to be the case. The researcher observed that experienced therapists have thought about therapist self-disclosure as a clinical issue and have some awareness of both self-disclosure and countertransference. It was assumed, from consultation with colleagues and supervision of interns, that relatively inexperienced therapists disclose more frequently and with less intentionality. However, by not including less experienced thera-

pists, this assumption was not tested.

By not interviewing therapists other than those at the extremes of self-disclosure, the researcher cannot know how these other questionnaire respondents would explain their disclosures. It is possible that they might have different therapeutic frames, theoretical orientations, and viewpoints about the use or nonuse of transference. The questionnaires provided limited data.

Conclusions reached in this study cannot be extrapolated to the therapist population at large because of the sample's small size. Since those respondents whose questionnaire responses ranked between the two extremes were not included, there is no data describing therapists in this middle range. Data is limited to the responses of those eight subjects who fell at the extremes.

The Literature and the Findings

This research attempts to further the study of the psychotherapy relationship by its focus on therapist self-disclosure. The literature review surveyed the evolving attention to the therapist's contribution to this process, starting with Freud's early work on psychoanalysis and the development of the concepts of neutrality, transference, and countertransference. Helene Deutsch and Paula Heimann, whose works on using countertransference laid the groundwork for exploring the therapists' active participation in psychotherapy, are

acknowledged by this researcher for having questioned therapist use of self.

Included in the review were writings addressing the therapist's reactions to special circumstances, with discussion highlighting the diversity of recommendations for therapist management of these instances. This study's findings confirm diversity of recommended clinical management.

Several studies that specifically addressed therapist self-disclosure were included, many of which utilized simulated patient populations. The studies cited primarily focused on the impact on the patient of the therapists' revelations. Very few references were found that addressed therapist self-disclosure from the therapist's point of view (Abend, 1982; DeWald, 1982; Goldberg, 1984; Rosie, 1980; Weiner, 1974, 1978, 1983).

The preponderance of writings specific to therapist self-disclosure were Myron Weiner's. It is curious that one author so dominates a clinical issue and the scarcity of literature is also puzzling. Perhaps this is a little attended issue because consideration requires therapist self-exploration and self-disclosure, both of which can be uncomfortable. In the process of developing the proposal for this project, some colleagues advised against doing a study that used therapists as the subjects. They felt that it would be difficult to find therapists who

would be candid about their personal participation in their work. This reasoning probably parallels the above observation regarding the paucity of literature.

The research subjects cited the established body of literature for clarification and substantiation of their own styles of psychotherapy. Two subjects, representing each group of the respondents, quoted the same paper of Freud's (1912) to support their use and nonuse of self-disclosure. One subject from each group referred to Jourard's dyadic effect as a model for self-disclosing.

This study serves as an initial exploration into the criteria for therapist self-disclosure. The bibliography, developed for its specificity to therapist self-disclosure, could be valuable for further researchers.

Discussion of Findings

The original question, "What are the factors in therapist self-disclosure?", can be answered concisely. The main factor is therapist theoretical orientation. At the same time, it is clear that this concise answer, while accurate, is limiting. Numerous other components impact therapist disclosure. Theoretical orientation, the psychotherapeutic frame, the psychotherapeutic relationship, the therapist's personality, and therapist self-awareness all emerged as themes associated with

therapist self-disclosure.

Theoretical Orientation

The four high disclosing therapists defined their orientations similarly: they agreed on loose boundaries between themselves and their patients; they opposed therapeutic neutrality; they espoused equality; and they were active participants in the interchange between themselves and their patients. The four low disclosing therapists also defined their orientations consistently: they agreed about defined boundaries; they valued neutrality; and they believed in being fairly inactive in interactions with their patients to encourage transference.

The difference in attitudes about transference both exemplified and was crucial to their overall differences. This fact impressed the researcher as both obvious and so simple as to be profound. That is, if a therapist believes that transference work is the crux of the psychotherapy process, that therapist will self-disclose minimally. On the other hand, if a therapist rejects transference work, that therapist will not hesitate to self-disclose.

The Psychotherapeutic Frame

Two distinct frames representing very different views of the psychotherapeutic relationship and process

emerged from the subjects' discussions of their work. The frame includes attention to the core issue of theoretical orientation. As found in this study, the therapist's orientation determines boundary issues, neutrality, the focus of the sessions, the language employed in discussing the work, and the overall use of the therapist's self.

The interview data suggested that the low disclosing therapists were more contemplative about their roles in the psychotherapy process. Indeed, during the interviews, the low disclosers were frequently silent for several moments, obviously thinking about their responses. A few of those silences were prefaced by "Let me think a minute." The researcher assumed that such behavior reflected their general manner and concluded that the low disclosers were more thoughtful about their approaches, their stances, and their decisions to self-disclose. In contrast, the more spontaneous responses of the high disclosers was seen as being congruent with their stances, their less self-reflective styles, and the way they do psychotherapy.

The Psychotherapeutic Relationship

The question of the therapists' viewpoints about the psychotherapeutic relationship emerged as an important component of the findings. Discussion about realness and

genuineness surfaced in the interviews. The researcher could not avoid addressing the question of the real relationship within the context of the psychotherapeutic relationship. The two groups used the terms "real" and "genuine" differently. For the high disclosers, "real" meant total openness, honesty, and equality between patient and therapist. ("Equality" to these therapists meant an absence of hierarchy and minimal role distinction.) A therapist who is real adheres to a code of genuineness and truthfulness. Such a therapist freely uses him or herself and freely discloses personal information. This conception of the real relationship was valued by the high disclosers. In contrast, the low disclosers did not readily use the word "real" in discussions about their work. To them, "real" meant the actual person-to-person relationship, and genuine meant being direct, attentive, respectful, and responsive to patients without self-disclosure. "Equality" meant equal value as a person while acknowledging a role distinction.

Whether or not therapists directly discuss their own reality in the therapy, some aspects of real life do impact the psychotherapy dyad. Personal circumstances, for example, affect therapists' involvement with their patients. None of the therapists in this study suggested denial of the real world. However, the data showed that the managing of reality within the psychotherapy context

presents a challenge. These subjects did not express confidence in handling these situations. They communicated their frustrations regarding knowing what to do and acknowledged that intense personal stresses could upset their professional composure.

The therapists in this study defined the kind of therapy they practice. This was not necessarily a conscious process, but its manifestations were clear, often with a reflection regarding "the way I work." Early in treatment, therapists make assessments and decisions about their modus operandi based on their preferred styles of working and on diagnostic impressions. Distinctions are made between counseling, supportive therapy, and in-depth psychotherapy. The therapist's stance is at least partially determined by this assessment, and it impacts the therapist's determinations for on use of self and level of activity.

Equality as an aspect of the psychotherapy relationship was specifically mentioned by three of the subjects and alluded to by all. In the early stages of the formulation of this study, the researcher heard several colleagues accuse low disclosers of being "uppity," implying that those therapists put themselves on a pedestal by non-disclosing. That particular question, "Is the therapist suggesting his or her own superiority by being neutral?", was at the core of the researcher's interest

in this project.

My thoughts, at the completion of this study, are that the high disclosing therapists see their use of self-disclosure as an important way to communicate their care and respect to their patients. According to their thinking, therapists who do not share themselves are withholding respect and care and elevating their own status. In answer to the above question, the low disclosers in this sample are not attempting to establish superiority. They are no less committed to communicating care and respect to their patients but feel that this is accomplished by their undivided attention and adherence to a professional style that they see as the most facilitative of the patient's growth.

The Therapist's Personality

Therapists' personal styles affect the way individual therapists use themselves in their work. The researcher's impression is that self-disclosure is an extension and/or reflection of the therapist's individuality. The researcher found the four high disclosers to be very interactive and congenial. Three were unusual and colorful persons. For example, the Hasidic therapist shared that he philosophizes and lectures his patients on spiritual issues. Another, who had eight clocks in her office, numerous family photos, new-age posters, and many trinkets, boasted that she "lets it all hang out." One

subject was wearing a partially open shirt, blue jeans, and cowboy boots, and his office was cluttered. This man said repeatedly, "I'll tell you whatever you want to know." They talked much more than the low disclosers; the transcipts of their interviews were pages longer. They laughed and quipped more. Three of them offered the researcher a beverage. The interviews with the four high disclosers were entertaining and lively. These subjects appeared to be extroverts who enjoyed sharing themselves, and this outwardness seemed consistent with their clinical styles. They were quicker to share personal anecdotes and to elaborate on the researcher's questions. Perhaps this suggests a parallel to the way they feel about their work.

In contrast, the low disclosers' interviews were briefer and more focused. These four generally answered questions concisely and with attention to being clear and thoughtful. They were more formal and restrained (neutral?) in their manner and dressed relatively conservatively. (Two of the men wore suits.) These interviews were less lively and more intellectually provocative. It was easy for the researcher to grasp their professional style from the interactions with them. That these interviews were shorter and that there was less laughter and a general tone of seriousness seemed to reflect these subjects' personal styles.

The findings might suggest that more experienced therapists are more disclosing, since the two most experienced subjects were high disclosers. The researcher declines to draw this conclusion because of the small sample size. Furthermore, their self-disclosure seemed to be a reflection of the finding that orientation and personal style are more closely associated with self-disclosure than years of experience. They were probably equally as disclosing ten years ago.

Therapist Self-Awareness

Therapist self-awareness was assessed by the researcher's questions regarding personal psychotherapy experiences. There appeared to be a relationship between valuing self-awareness and working with transference. When a therapist works within a neutral frame and encourages the patients' transference projections, knowing oneself is important. Neutral therapists are often asked to listen to material that could sound accusatory while attending to facilitating a patient's growth. As one of the subjects stated, "I need to know what's my stuff and what's my patient's." Personal therapy was seen as a central experience in their development as therapists.

The high disclosing therapists did not have as much personal therapy as the low disclosers. Self-awareness was not viewed as directly related to their professional

functioning. Its purpose was personal, and one subject explained his noninvolvement in psychotherapy by stating, "I haven't had a traumatic life." Their discussions about the way they practice and their commitment to openness as a critical component of the psychotherapy process make clear that for them, personal self-awareness is not at all necessary.

Criteria

The facts that all the subjects utilized similar criteria for therapist self-disclosure and that all the subjects did self-disclose lead to the conclusion that intentional therapist self-disclosure is a psychotherapeutic tool for both high disclosing and low disclosing therapists.

Appropriateness of self-disclosure is an underlying criterion for these subjects. The subjects' clarity on and definition of appropriateness varied, but all expressed sensitivity to patients' strengths and weaknesses and needs.

The similarity in the purposes of therapist self-disclosure expressed by all the subject blurs some of the striking differences between the two groups. The findings show that high disclosing therapists do not think through their processes in making disclosures because they value overall openness. They are not concerned about being too revealing since self-revelation

is an integral component of the therapy process as well as their personal styles. When the researcher asked the most disclosing therapist for an example of nondisclosing, He was unable to provide one. (It was up to the researcher's imagination to create the limit.) The low disclosers do think about their use of self. For them, intentional self-disclosure demands thought. It was the thinking-through process and the readiness to self-disclose that differentiated the two subject groups.

The researcher inquired about diagnosis as a facet of therapist self-disclosure. All the subjects gave less attention to it than to the other criteria. This discussion did not require elaboration, because there is agreement about the definition and about its significance for therapist self-disclosure. Examples included: "Psychotic people are so preoccupied with their own stuff that they can utilize very little reality from me"; "Self-disclosure is desirable with most patients except acting out, character disorders, and adolescents with acute anxiety crisis"; "If a disturbed person needs information, I'd share to get on with the hour"; and "Borderline folks need to know where I am on vacation." There was no noted difference in the responses to this question given by the two subject groups.

The researcher concluded, from this small sample, that diagnosis had minimal impact on therapists'

decisions to disclose, and that both the high and low disclosing subjects viewed diagnosis as a minor criterion.

Stage of therapy also emerged as a criterion across the categories of therapists, and, like diagnosis, merited scant attention from the subjects. The high disclosers reported being at the beginning stage of therapy as a criterion for free disclosing. In contrast, the low disclosers found themselves disclosing early in psychotherapy in spite of judgments to the contrary. Indeed, all the subjects reported that they are more likely to disclose in the early phases of psychotherapy either to further the alliance, relieve the patient's stress, or to be courteous. The mention of courtesy, by several respondents, suggests that there is a period of adjustment to the psychotherapy process to which these therapists are sensitive. (Is the adjustment for the patient only? Perhaps the inclination to be courteous reflects some of the therapists' process of acclimation also.)

The researcher had expected that stage of therapy, the patient's age, and diagnosis would emerge as more important facets of these therapists' determinations to disclose than was found. The criteria of modeling, fostering the therapeutic alliance, validating patients' reality, encouraging autonomy, and therapist satisfaction

were shown to be the primary factors.

Comments on the Questionnaires

All the respondents reported utilizing similar criteria for self-disclosing. They varied along a continuum regarding their readiness to reveal. Their stated theoretical orientations were similar to the responses given by the respondents selected for an interview, except that six said "eclectic." These ecclectic therapists wrote down very few absolutes on their questionnaires, as contrasted to the subjects who expressed their strong positions and fell at, or closer to, the extremes.

Related Material

Material related to the issue of therapist self-disclosure emerged in the study. This was not unexpected. In the formulation of the research project, the author debated addressing some of these areas. Clearly, the issue of frequency of disclosure is closely related to the issue addressed in this study. Physical contact between patient and therapist was mentioned by three of the subjects. It was anticipated that the therapists' individual offices would reflect their work in a manner consistent with the verbal interview material.

Subjects' Offices

The researcher made note of differences in the therapists' offices. (Some of this material is included above in the discussion of therapists' personal styles.) The offices were decorated in manners consistent with the orientations and ways of doing therapy reported in the findings. Specifically, three of the high disclosers had personal photographs on display, as well as numerous artifacts that clearly revealed their personal interests and values. For example, one had African artifacts and one had Jewish objects. Two of the offices of the high disclosers appeared cluttered. In one such office were several coffee cups and many photos of the therapist himself at various vacation spots. One office had many clocks. These offices were larger than the low disclosers'. One possible explanation is that they have more desire to share. Another possibility is that, paradoxically, they do not want to be physically close to their patients. The researcher thought that their furniture was similar to ordinary living room furniture. (It will be recalled that one of the high disclosers requested that the interview be held in his home. The researcher was introduced to his wife and children. Perhaps this behavior reflected his interest in maximally disclosing to the researcher and/or his general desire to present an open and warm manner.)

The low disclosers' offices were more modern and simpler in decor. The colors were more neutral. The art consisted of landscape photographs, oriental prints, and ceramic objects. Two had Picasso prints. There were no personal photographs. The researcher did not think that these were personal objets d'art. As noted above, these offices were smaller. The furniture was more functional than cozy. One office felt barren to the researcher. The subjects' psychotherapy stances did, indeed, seem to be reflected in the physical environments they created in their offices.

Touch

The researcher had originally wondered about exploring the issue of physical touch between therapist and patient. Although this was excluded from the study, three of the interview subjects mentioned it as an aspect of self-disclosure.

Several of the subjects spontaneously mentioned their use or nonuse of touch as a self-disclosure. Three of the low disclosers said that they never have physical contact with their patients. The high disclosers volunteered that they often hug a patient on leaving and, consistent with their styles, if they feel like making physical contact, they do. (There was no suggestion that any of this physical contact went beyond socially acceptable casual touch.) Three subjects shared their

experiences in using touch with patients.

Patients Liking Therapists

The issue of patients liking the therapist is a thread that was occasionally evident in this research and in the surveyed literature. It is possible that an aspect of the high disclosers' friendly, open style is founded in wanting to be liked by the patients.

A variation of this may be that some early patient inquiries regarding the therapist's demographics are based on the patient's wondering if he or she will be understood. The inquiries may be based on the assumption that, if the therapist has had similar experiences (such as parenting, divorce, or a close death), the patient will be understood better. Several subjects alluded to these kinds of revelations in their discussions of disclosing to further the therapeutic alliance.

Implications for Clinical Practice

Aspects of these findings have implications for psychotherapists: the clarity of the criteria used for disclosing, the attention to the style of therapy being practiced, and the significance of theoretical orientation.

The researcher has concluded that there is clinical value in therapists becoming more aware of the early

process of assessment presented in these findings. The distinction between counseling and psychotherapy suggests a very different use of the therapist self-disclosure. The counseling process suggests briefer, less in-depth exploration with more emphasis on coping skills and environmental manipulation. Modeling, a frequent criterion for self-disclosing, is a very successful technique in this kind of work. Psychotherapy, on the other hand, is usually more insight-oriented, and therefore self-disclosure to foster the alliance is the more relevant criterion.

The lack of confidence in utilizing therapist self-disclosure might be addressed by a clearer conception of the kind of therapy being practiced. The low disclosers, with their basic anti-disclosure viewpoint, might be excluding a useful psychotherapy tool in their supportive or counseling work with some patients.

Whether or not the therapist chooses to intentionally self-disclose, a client can discern much about his or her therapist over time. One of the low disclosing subjects addressed this non verbal aspect of disclosure: "I think that I disclose a great deal to all of my clients, about who I am and what I think and what I believe, because of the way that I work and the questions that I ask, the things that I say about feelings and about how people work on things. And also in my office.

This room reflects me; it couldn't not."

The therapist's attention to the physical environment created is important, whether it be a clear reflection of the therapist as a person or an aspect to support the therapist's professional stance.

This study has addressed the varied ways in which therapists have handled their own personal circumstances during the course of psychotherapy. The researcher notes that these findings, as well as the literature, suggest that therapists handle these situations in a style consistent with their overall psychotherapeutic style. However, the material does suggest that most of the subjects had questions about the best way to address this issue. They all acknowledged difficulty staying focused on "what makes sense for the patient?". The researcher suggests that this question should be asked by any therapist confronted with a similar situation. Concurrently, therapists should acknowledge the difficulty in balancing their own needs and those of their patients during times of personal crisis.

Therapist self-disclosure is and can be a useful psychotherapy tool. It can also be irrelevant or counter productive. More awareness of its merits and its drawbacks can enhance therapists' effectiveness.

The researcher was uncomfortable with the criticism expressed by one therapist towards those of a different

orientation. Clearly, there is no best way to practice psychotherapy, and there is no universally right kind of therapist for all patients.

Suggestions for Further Study

Several of the cited studies addressed the patients' liking a therapist who discloses freely. How does this correlate with successful therapy outcomes? How do and how should prospective patients go about the process of selecting a therapist?

In recognition of the apparent importance of therapists' personal styles, the researcher suggests further study into what motivates individual therapists to chose to be high or low self-disclosers.

Further study might contrast experienced therapists with beginners. The researcher assumes that, in a population of less experienced therapists, the range of high and low disclosers would be weighted towards greater disclosure. It is also assumed that less experienced therapists have not clearly conceptualized their theoretical orientation and that this would therefore be a less important variable than was found in this study, with its exclusive attention to experienced practitioners.

Exploration of other therapist population groups would be interesting. She wonders about therapist use of self in other geographic areas of the United States as well as in other countries. Do therapists from ethnic

minority groups employ disclosure differently, and if so, why? Although gender was not identified as a variable for therapist use of self in this study, the researcher suggests further study on this.

As noted, touch emerged in the data as a facet of therapist self-disclosure. This could be a direction for additional exploration of use of self in psychotherapy, specifically, how touch could be employed as a psychotherapy technique.

While the author has mentioned a few of the possible questions for further study, it is hoped that this study has piqued interest in numerous facets of the issue of therapist self-disclosure and the broader issue of the therapist's contribution to the psychotherapy process.

APPENDIX A

APPLICATION FOR THE CONDUCT OF RESEARCH PROJECT

INVOLVING HUMAN SUBJECTS

Title of Research Project: The Criteria for Therapist Self-Disclosure: An Exploration into the Conscious Use of Self in the Practice of Psychotherapy

Investigator: Judith C. Simon, M.S.W.
Principal Investigator: Elinor D. Grayer, Ph.D.

I have read the Policy and Procedures on the Participation of Human Subjects in Research Projects of the California Institute for Clinical Social Work and I will comply with their letter and spirit in the execution of the research proposal. In accordance with this policy and my best professional judgement, the human subjects participating in this study are not "at risk".

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

2/7/86	Elinor D. Grayer, Ph.D.
Date	Elinor D. Grayer, Ph.D., Principal Investigator
1-18-86	Judith C. Simon
	Judith C. Simon, M.S.W., Investigator
2-4-86	Frances Brown MSW
	Frances Brown, M.S.W., ICSW evaluator
2-26-86	Rosemary Lukton D.S.W.
	Rosemary Lukton, D.S.W., Dean

April 23, 1986

Dear Colleague:

I am a doctoral candidate at the California Institute for Clinical Social Work and am requesting your assistance in my research. My dissertation will be a study of the determinants of therapist use of self. In the process of doing this work I hope to increase our understanding of the ways in which we use ourselves as persons in the process of psychotherapy. My exploration will focus on the who, what, when, and why of self-disclosure.

This questionnaire is being sent to fifty psychotherapists. The pilot respondents reported that the process of completing this questionnaire, although time consuming, was valuable. I hope that you find that to be true for you also. It takes about 45 minutes to complete. Returns are requested by May 16. I would like to do a follow-up interview with some therapists.

By exploring this facet of the therapist's participation in psychotherapy, I hope to learn more about how we function, and how to better help our patients.

Enclosed with this questionnaire is an informed consent form. Confidentiality will be assured by coding of all responses and names of respondents will be discarded as soon as possible. I would be pleased to answer any questions.

A stamped return envelope is also enclosed. If you are available for an interview, please include your name, address, and phone number. (The interview would be at a time and place of your convenience.) Please feel free to add any additional comments, using extra paper if necessary. Also, if you are interested in receiving results of this study, add a note to that effect.

I want to thank you in advance for your cooperation.

Sincerely yours,

Judith C. Simon, MSW
Doctoral Candidate

Enclosures: Questionnaire
Informed consent form

Therapist Questionnaire

Gender_____ Age_____

Do you practice long term individual psychotherapy? (That is, once a week or more frequent sessions for a period of eight months or longer.)_____

How long have you been in practice?_____

How many hours a week do you spend in direct service (excluding supervision)? _____

Percent of patients seen once a week: _____

Percent of patients seen twice a week:_____

Percent of patients seen more than twice a week:_____

How many minutes is each session?_____

What is your highest earned degree?_____

Name of degree granting institution._____

Do your patients have access to your home telephone number?_____

Do you supervise therapists in training? _____

1. Please describe how you are likely to handle the following inquiries from a patient.

a. Do you have children?_____

_____

_____

_____

b. Where are you going on your vacation? _____

_____

_____

_____

c. You look ill: are you okay? _____

_____

_____

_____

d. Can we go out for a drink together sometime? _____

_____

_____

_____

****

2. Please list the three most frequent diagnoses of your patients. _____

_____

_____

3. Some theorists strongly recommend therapist disclosure. What is your reaction to that? _____

_____

_____

_____

4. When do you share aspects of your current personal life with a patient and why? _____

_____

_____

_____

5. When or why would you not disclose something personal?_____

_____

_____

_____

_____

6 Have you have had a personal psychotherapy experience? If so,

a. What recollections do you have from your own therapy when your therapist disclosed personal material? What was your reaction/response? _____

_____

_____

_____

b. What was the frequency and duration of your therapy?_____

_____

c. If you have had more than one therapist, how did your experiences differ with your therapists' self-disclosure?

_____

_____

_____

7. Please describe your feelings and reactions when you share personal information with a patient. _____

_____

_____

_____

_____

_____

8. Are there some clients with whom you are more likely to disclose than others? Please describe._____

_____

_____

_____

a) Please give examples of what you have shared? _____

_____

_____

_____

b) In retrospect, what are your thoughts about these disclosure(s)? _____

_____

_____

_____

9. Has a serious illness ever interrupted your practice? _____

If so, how much did you share with your patients?_____

_____

_____

_____

What would you recommend to other therapists confronted with this experience? _____

_____

_____

_____

10. Some theorists are opposed to any sharing of oneself. What are your thoughts about that?_____

_____

_____

_____

_____

11. Has your viewpoint about self-disclosure changed over the years? How? _____

_____

_____

_____

12. What do think are the curative components in psychotherapy?

_____

_____

_____

13. Do you have any family photographs on display in your office?

14. Please list three persons or references that have had a strong influence on you and your work._____

15. What is your theoretical orientation?_____

16. What do you recall as your primary motivation for becoming a therapist?_____

****

Do you have additional comments?_____

Are you available for an interview?_____

If so, Name_____

Address_____

Phone_____

Best time_____

INFORMED CONSENT FORM

I, _____, hereby willingly consent to participate in the Criteria for Therapist Self-Disclosure research project of Judith C. Simon of the Institute for Clinical Social Work.

I understand the procedure to involve the completion of a questionnaire and possible participation in an interview conducted by Ms. Simon. I understand that I may withdraw at any time, that this study will be published and that my anonymity will be protected.

Date_____

Signature_____

LETTER SENT TO NON-RESPONDENTS

May 21, 1986

Dear Colleague:

About a month ago I sent you a questionnaire, requesting your assistance in my doctoral research. You may recall that my study is an exploration of the criteria therapists use in making self-disclosures.

To date I have not received the questionnaire that I sent to you. I do know that it takes some time to complete. The pilot respondents all felt that it was a worthwhile experience, causing them to think about an aspect of our work that is often not addressed. I would very much appreciate your completing it, if possible.

Thank you very much.

Sincerely,

Judith C. Simon, M.S.W.
Doctoral Candidate

LETTER SENT TO QUESTIONNAIRE RESPONDENTS

Name
Address
Address

Dear Name:

May 6, 1986

Thank you very much for responding to my request for assistance in my doctoral research exploring therapist self-disclosure. I very much appreciate your completing the questionnaire and your willingness to participate in an interview.

At this time I am working with the returned questionnaires and I will soon be ready to conduct the interviews. It is not yet clear to me if I will be needing to interview you but I very much appreciate your availability.

Thank you again for your assistance in this project.

Sincerely,

Judith C. Simon, M.S.W.
Doctoral Candidate

INTERVIEW SCHEDULE

1. Acknowledge subject's participation.

2. Reiterate confidentiality.

3. Reiterate purpose of study: to understand the criteria that therapists use in making decisions to disclose to their patients, including the who, what, when, and why.

4. Explain that "This study is not aimed at judging the rightness or wrongness of disclosing or the amount of disclosing you do. It is not relevant, for this study, whether you are inclined towards a neutral or open stance. I am interested in how you decide when, why, what, and with whom you share ordinalriy personal information with your patients."

5. Examples from this subjects questionnaire. I will ask for elaboration to responses which suggested a conscious thought process in determining whether to disclose some information. With this, I will explore thoughts and feelings.

6. Present three vignettes to each subject, asking with whom would you share, e.g., diagnosis, gender, your attraction and/or identification with the patient. What would you share? Why? When would you share? E.g., stage of treatment, your personal life issues.

a. Suppose that you <u>just</u> found out that you're going to become a first time grandparent: Do you share anything? What? With whom? What if your client says "You seem happy!"?

b. Suppose that you got a black eye two days ago from walking into a door. Clients ask what happened. How would you handle it. different clients, times, etc.

c. If you realized a moment too late that you made a technical error, how would you handle it, if at all.

d. If a patient just returned from a vacation someplace that you'd love to go, would you ask about it? How much? Can you think of an example?

7. Present the opportunity for further elaboration and or questions from the participants. I will also ask if results of the study are desired.

8. Ask how the participant wants me to dispose of the tape after use.

APPENDIX B

QUESTIONS DEVELOPED FOR RANKING OF RESPONDENTS

Questions seeking ranking

A. Do your patients have access to your home phone number?

1. Please describe how you are likely to handle the following inquiries from a patient.
   a. Do you have children?
   b. Where are you going on your vacation?
   c. You look ill: are you okay?
   d. Can we go out for a drink together sometime?

3. Some theorists strongly recommend therapist disclosure. What is your reaction to that?

5. When or why would you not disclose something personal?

8. Are there some clients with whom you are more likely to disclose than others? Please describe.

10. Some theorists are opposed to any sharing of oneself. What are your thoughts about that.

13. Do you have any family photographs on display in your office?

DATA ANALYSIS OF QUESTIONNAIRE

Questions seeking criteria

3. Some theorists strongly recommend therapist disclosure. What is your reaction to that?
4. When do you share aspects of your current personal life with a patient and why?
5. When or why would you not disclose something personal?
6. Have you had a personal psychotherapy experience?
7. Please describe your feelings and reactions when you share personal information with a patient.
8. Are there some clients with whom you are more likely to disclose than others? Please describe.
9. Has a serious illness ever interrupted your practice?

Questions seeking viewpoint about therapeutic relationship

6. Have you had a personal psychotherapy experience?
7. Please describe your feelings and reactions when you share personal information with a patient.
11. Has your viewpoint about self-disclosure changed over the years? How?
12. What do you think are the curative components in psychotherapy?
14. Please list three persons or references that have had a strong influence on you and your work.
16. What do you recall as your primary motivation for becoming a therapist?

Questions seeking information about theoretical orientation

How many minutes is each session?

1. Please describe how you are likely to handle the following inquiries from a patient.
    a. Do you have children
    b. Where are you going on your vacation?
    c. You look ill: are you okay?
    d. Can we go out for a drink together sometime?
4. When do you share aspects of your current personal life with a patient and why?
7. Please describe your feelings and reactions when you share personal information with a patient.
10. Some theorists are opposed to any sharing of oneself. What are your thoughts about that?
11. Has your viewpoint about self-disclosure changed over the years?
12. What do you think are the curative components in psychotherapy?
15. What is your theoretical orientation?

Questions to rank disclosing

Do your patients have access to your home phone number?

1. Please describe how you are likely to handle the following inquiries from a patient.
   a. Do you have children?
   b. Where are you going on your vacation?
   c. You look ill: are you okay?
   d. Can we go out for a drink together sometime?

3. Some theorists strongly recommend therapist disclosure. What is your reaction to that?

5. When or why would you not disclose something personal?

8. Are there some clients with whom you are more likely to disclose than others? Please describe.

10. Some theorists are opposed to any sharing of oneself. What are your thoughts about that?

13. Do you have any family photographs on display in your office?

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