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The Effects of Therapist Self-Disclosure of a Mental Health Condition on Client Perceptions of the Therapist

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THE EFFECTS OF THERAPIST SELF-DISCLOSURE OF A MENTAL HEALTH CONDITION ON CLIENT PERCEPTIONS OF THE THERAPIST

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Dissertation Approval

This is to certify that the thesis presented to us by Samantha Kaufman

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Abstract

Therapist self-disclosure is a controversial intervention that is defined in numerous ways and includes a variety of content. Little is known about how therapist self-disclosure of a mental health condition affects clients' and non clients' perceptions of the therapist. The first goal of this study was to investigate the effects of therapist self-disclosure of a mental health condition on client perceptions of the therapist on three social influence factors (Attractiveness, Expertness, Trustworthiness) and two facilitative conditions (Empathy and Level of Regard). The second goal was to investigate if client perceptions of the therapist's social influence factors and facilitative conditions varied by the type of mental health condition disclosed. This study used a survey method to investigate university students' (n = 267) reactions to vignettes depicting a client-therapist interaction in which the therapist disclosed having one of three mental health conditions (AD/HD, depression, anxiety) or did not disclose any personal information. Participants rated therapist's levels of social influence factors using Counselor Rating Form-Short (CRF-S) and perceived levels of facilitative conditions, using the Barrett Lennard Relationship Inventory (BLRI). The results of this study found that vignettes that featured the therapist who self-disclosed a mental health condition were rated as significantly more attractive and empathetic than the vignettes of the therapist who did not disclose any personal information. Ratings of social influence and facilitative conditions did not vary by the type of mental health condition disclosed. Limitations of the study are addressed and alternate explanations for the results are explored. Implications regarding the use of therapist self-disclosure of personal experience with a mental health condition are discussed.

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Chapter 1

Introduction

Mental health among university students.

In the past decade, the media has drawn a great deal of attention to the psychological struggles of college students because of various tragic incidents involving school shootings, suicide, alcohol, and sexual assaults (Castillo & Schwartz, 2013; Kadison & DiGeronimo, 2004). Surveys collected from university counseling centers report a significant rise, since the 1980s, in students with more severe mental health conditions (Erdur-Baker, Aberson, Barrow, & Draper, 2006). The Association for University and College Counseling Center Directors Annual Survey (Reetz, Krylowicz, & Mistler, 2013) indicates that the most predominant concerns among college students are anxiety (46.2%), depression (39.3%), relationship problems (35.8%), suicide ideation (17.9%), alcohol abuse (9.9%), and sexual assault (7.4%). Despite these serious concerns, it is common for university students who receive therapeutic services within a university counseling center to terminate therapy prematurely, for various reasons.

Factors such as treatment expectations, motivation, suggestibility, age, and gender are but a few of a number of variables that have been cited as contributing to therapy adherence (premature termination) both in adult (including college age students) and in child populations (Backeland & Lundwall, 1975; Edlund, Wang, Katz, Lin, & Kessler , 2002; Renk & Dinger, 2002; Thormahlen, et al., 2003). One factor of particular influence is the therapeutic relationship and alliance (Swift, Greenberg, Whipple, Kominiak, 2012). Although there are a number of definitions for the therapeutic alliance, Bordin's (1979) definition is applicable to any theoretical approach because it highlights the collaborative

relationship between the client and therapist to help the patient overcome his/her suffering and self-destructive behavior (Ardito & Rabellino). According to Bordin (1979), the therapeutic alliance is composed of the following: agreement on treatment goals, agreement on tasks, and the development of a personal bond between the therapist and the client. An increasing amount of evidence suggests a relationship between the therapeutic alliance and early termination (Barrett, et al., 2008; Mennicke et al., 1988; Sharf, Primavera, & Deiner, 2010).

Research on counselor variables such as social influence factors (counselor expertness, attractiveness, and trustworthiness) and facilitative conditions (empathy, warmth, and genuineness) that pertain to premature termination and contribute to the therapeutic alliance have not warranted definitive conclusions (Barrett et al., 2008). One strategy beginning to be examined for its role in strengthening or hindering the therapeutic relationship is therapist self-disclosure (Swift, et al., 2012). Therapist self-disclosure can be defined as statements that reveal personal information about the therapist (Hill & Knox, 2002). It is a topic that has always generated and continues to generate a great deal of controversy among mental health professionals.

Although increasingly accepted among mental health professionals for its potential therapeutic benefits to clients, therapist self-disclosure is one of the most controversial clinical interventions within psychotherapy (Sando, 2014). Arguments for and against the use of self-disclosure focus primarily on how it affects the therapeutic alliance (Audet, 2011) and how it affects ethical concerns related to beneficence, non-maleficence, fidelity, and justice (Peterson, 2002).

The classical position on therapist self-disclosure, proposed by Sigmund Freud was to advise against it. According to Freud, therapist self-disclosure would likely result in resistance that is more difficult to overcome, transference that becomes more difficult to resolve, clients who find it more interesting to analyze their analyst than themselves, and clients who have an insatiable desire to know more about their therapists (Freud, 1912/1958a). Additional arguments against the use of therapist self-disclosure posit that it is a violation of therapeutic boundaries (Brodsky, 1989; Epstein, 1994), is unprofessional and counterproductive by taking the attention away from the client (Peterson, 2002).

Alternatively, other theoretical orientations such as humanistic psychology, feministic psychology, and existential psychology encourage the use of therapist self-disclosure. Advocates in favor of therapist self-disclosure claim that it has positive effects on the therapeutic relationship and contributes to positive treatment outcomes (Horvath & Bedi, 2002). Some of the beneficial effects of therapist self-disclosure that are frequently mentioned in literature include: normalizing the patient's problems, equalizing the therapeutic relationship, facilitating the client's own self-expression and gaining insight from a new perspective (Barrett & Berman, 2001; Bloomgarden & Mennuti, 2009; Knox, Hess, Peterson, & Hill, 1997; Nyman & Daugherty, 2001).

Some forms of therapist self-disclosure are considered more beneficial than others to the therapeutic alliance. Generally, immediate self-disclosure (self-involving disclosure) is considered more acceptable and ethical than non-immediate therapist self-disclosure. Immediate self-disclosure (self-involving disclosure) refers to the immediate reactions of the therapist and countertransference in the here and now. In contrast, non-

immediate self-disclosure refers to personal information about the therapist outside of the therapeutic dyad (past experiences, opinions, and beliefs). It has been suggested that immediate self-disclosure promotes a strong therapeutic alliance (Bugental, 1965; Jourard, 1971; Kaiser, 1965; Traux & Carkhuff, 1967; Rogers, 1951), primarily because the counselor is focusing on the client's needs and is attempting to understand the client's perspective (Wachtel, 1993). Additionally, when counselors' disclosures involve immediate information it allows the clients to gain feedback about how he/she may be perceived and experienced by others (Casement, 1988). Furthermore, there is evidence to suggest that counselors who disclose immediate information are perceived as more professional than counselors who disclose non-immediate information (Reynolds & Fischer, 1983).

The research findings on non-immediate self-disclosure are mixed. Non-immediate self-disclosure has been criticized for taking the focus away from the patient and placing it onto the therapist, violating boundaries, and creating a role reversal between the therapist and patient (Edwards & Murdock, 1994; Geller & Farber, 1997; Lazarus & Zur, 2002; Simon, 1990). Other studies that have investigated non-immediate self-disclosure have reported positive effects such as perceiving the therapist as being more human; developing a more equalized relationship between therapist and client; and creating normalization of feelings (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Hill, Mahalik, Thompson, 1989; Knox et al., 1997). Additionally, non-immediate therapist self-disclosure can provide insight, and can model methods of coping (Knox et al., 1997; Farber, 2006). Research on the effects of non-immediate self-disclosure on perceptions of professional attractiveness (competency, expertness, credibility) as well as

warmth, trustworthiness, empathy, willingness to disclose information remain unclear; return to therapy also remains unclear because some results are positive, but others are negative or mixed.

There are various ways in which a therapist self-discloses information. Self-disclosures can be verbal or nonverbal, direct or indirect, conscious or unconscious. Although most clinicians report using at least some self-disclosure during their careers (Edwards & Murdock, 1994; Pope, Tabachnick, and Keith-Speigel, 1987), self-disclosure remains one of the least frequently used interventions (Hill & Knox, 2003). Because therapist self-disclosure is not without its risks and because eliminating all self-disclosure is an impossible task, researchers have attempted to make guidelines that address issues regarding its use; these include content, appropriate timing, rationale, and to whom to self-disclose (Peterson, 2002).

It is common for those working in the mental health profession to have had direct and/or indirect experiences with psychiatric conditions, as well as physical and learning disabilities. Many therapists are driven to pursue a career in the mental health profession because of their own psychological wounds and painful experiences (Barnett, 2007; Farber, Manevich, Metzeger, & Saypol, 2005). The concept of an individual's capacity to heal others through the process of accessing his or her own pain and struggles is referred to as the *wounded healer* (Guggenbuhl-Craig, 1971; Nouwen, 1972; Sedgwick, 1994). Therapist disclosure of this kind of information is quite controversial because of the mental health stigma that it is present within general society and the mental health profession as well (Zerubavel & Wright, 2012). Rehabilitation research that has investigated disabled and nondisabled persons' perceptions of therapist self-disclosure of

a physical disability, as well as client preferences for disabled counselors, has produced mixed results. How counselor disability status affects client perceptions of the therapist's credibility as well as other aspects related to the therapeutic alliance remains unclear (Leirer & Strohmer, 1996).

Wounded healers have experiential knowledge that can provide a human dimension to the therapist-client relationship; this involves hope, insight, perspective, and empathy both on a cognitive and on an emotional level (Fisher, 1994; Kottsieper, 2009). The wounded healer as well as therapist self-disclosure is appreciated in the treatment of substance abuse (Jackson, 2001; Priester, Azen, Speight, Vera, 2007; White, 2000) and eating disorders (Bloomgarden & Mennuti, 2009a; Costin & Johnson, 2002). For example, alcohol rehabilitation settings in the 1930s utilized of a buddying system between peers with alcohol and other substance abuse problems. This program later became Alcoholics Anonymous (Conchar & Repper, 2014). In this program, recovering alcoholics who have completed the 12-steps provide support to other alcoholics (Alcoholics Anonymous, 2001). In 1959, men and women who had recovered from alcohol and/or other drugs were being paid to help others with similar problems. These people were known as "paraprofessionals" (White, 2000). There is evidence to suggest that experiential knowledge of having recovered from an Eating Disorder makes the wounded healer more appealing to a client with similar issues because the client may perceive the therapist as more empathetic, sympathetic, and more able to offer useful advice; the therapist would also offer a positive role model of success (Costin & Johnson, 2002; Johnston, Smethurst, Gowers, 2005). Mental health professionals who reveal personal experience with a mental health condition are not immune to the negative effects

of mental health stigma. Not all deviances are considered to be equal. Variables such as visibility, treatability, dangerousness, and the extent to which relationships are disrupted contribute to how seriously stigmatized a mental health condition may or may not be (Day, Edgren, & Eshleman (2007). Currently there is little research in the area of therapist self-disclosure of a mental health condition or learning disability on clients' perceptions of the therapist's expertness, professional attractiveness, trustworthiness, empathy, and regard.

It is extremely difficult to understand clearly, the effects of self-disclosure. Varying definitions and treatments labeled therapist self-disclosure make clarifying its effects and generalizing across studies challenging. Furthermore, research on the effects of therapist self-disclosure on client perceptions of therapists' professional attractiveness and levels of competency are limited; they have yield mixed results, and most contain samples consisting of nonclients. The results from most of the early studies investigating therapist self-disclosure on client perceptions found that clients rated self-involving (immediate self-disclosing) therapists and low disclosing therapists as more expert than those who disclosed personal information and were highly-disclosing (McCarthy, 1979; McCarthy & Betz, 1978; Merluzzi, Banikiotes, & Missbach, 1978; Myers & Hayes, 2006). In contrast to these negative findings, the results of a recent review of the research conducted by Henretty and collegues (2014) has suggested that counselor self-disclosure that reveals the similarity between the client and counselor is related either to intra or to extra therapy experiences (especially extratherapy experiences) and has a more favorable impact on clients, when compared with counselor nondisclosure. It also results in more favorable perceptions of the therapist's professional attractiveness. Other studies

report mixed results (Audet, 2011; Audet & Everall, 2010; Goodyear & Shumate, 1996) or have found no evidence that disclosing therapists were perceived as less competent (Nilsson, Strassberg, & Bannon, 1979).

Purpose of the study.

The purpose of this study is to investigate the relationship between non-immediate therapist self-disclosure of a mental health condition on college students' (client and non-client) perceptions of the therapists' levels of social influence factors (expertness, attractiveness, and trustworthiness) and facilitative factors (empathy and level of regard). This study seeks to clarify how the therapeutic relationship and alliance may be influenced by a therapist who reveals a mental health condition to a client, thereby helping counselors make an informed decision about whether or not they wish to disclose this type of information; the study also investigates the types of clients that would be most receptive to this kind of self-disclosure.

This study seeks to answer two research questions: (1) Is there a relationship between therapist self-disclosure of a mental health condition on client's perceptions of the therapist's facilitative and social influence factors? (2) Do perceptions of the therapist's facilitative and social influence factors vary by type of mental disorder disclosed?

Is there a relationship between therapist self-disclosure of a mental health condition on client's perceptions of the therapist's facilitative and social influence factors?

    - Hypothesis I: Therapist self-disclosure of a mental health condition will result in higher ratings of the therapist's facilitative conditions and social influence factors.

- Do perceptions of the therapist's facilitative and social influence factors vary by type of mental disorder disclosed?
    - Hypothesis I: The therapist who discloses Attention Deficit Disorder will receive higher ratings from clients on facilitative and social influence factors than the therapists who disclose Depression or an Anxiety Disorder.
    - Hypothesis II: Therapist self-disclosure of an Anxiety Disorder will result in higher ratings on facilitative and social influence factors than self-disclosure of Depression.

Chapter 2

Review of the literature

Although therapist self-disclosure has progressively become more acceptable within the mental health field, it still remains one of the most controversial therapist behaviors. The topic continues to incite debates on ethics as well as on other, varying perspectives regarding its use as a clinical intervention. Furthermore, there are contrasting opinions about what is acceptable for a therapist to reveal. Many people within the mental health profession are drawn to the field because of their own personal struggles and wounds. The notion that the ability to heal is aided by an individual's psychological pain and personal struggles is referred to as the *wounded healer*. The wounded healer is another contentious topic among those within the mental health profession, especially when it involves the therapist self-disclosing a mental health condition. Some schools of thought have embraced the concept of the wounded healer, asserting that it facilitates empathy, acceptance, understanding, and provides clients with hope (Fisher, 1994; Kottsieper, 2009). Others question the wounded healer's competency to deliver adequate mental health services. This review will begin by discussing the primary mental health concerns among university students, the barriers to seeking treatment, the process variables that account for treatment outcomes, and premature termination. The next section will define therapist self-disclosure and explain its historical and theoretical underpinnings. The main arguments for therapist self-disclosure, as well as some concerns and ethical considerations will be explored. Finally, findings and limitations of relevant empirical literature regarding self-disclosure will be reviewed. The second half of the literature review explains the concept of the wounded

healer, and discusses the advantages and disadvantages of being a wounded healer within the mental health profession. Client perceptions of counselors with disabilities are explored and the stigmatization of mental illness is discussed.

Mental health among university students.

A considerable number of mental disorders have their onset between the ages of 18-24 (Kessler, et al., 2005). Therefore, it is not surprising that the prevalence of certain mental illnesses is particularly high among college students. Academic pressures, irregular sleep patterns, and living away from home are aspects of college life that increase the risk of mental illness (Said, Kypri, & Bowman, 2013). Research has compared college students seeking treatment from college counseling centers with those that do not seek treatment, suggesting that those who seek treatment are more distressed, especially in the area of relationships and mood (Erdur-Baker, Aberson, Draper, & Barrow, 2006; Krumrei, Newton, & Kim, 2010; Schwartz, 2006). Although data collected from counseling center administrators report increases in psychopathology among university students (Barr, Krylowicz, Reetz, Mistler, & Rando, 2011; Locke, Bieschke, Castonguay, & Hayes, 2012; Watkins, Hunt, & Speer, 2011), the evidence to support this claim is not sufficient. The majority of survey data has been generated from counseling administrators and not from the clients themselves. Additionally, most samples have come from a single university (Locke, et al., 2012).

Watkins and Colleagues (2011) administered semi-structured interviews to counseling center administrators from various institutions and found that directors reported an increase in severity of mental health concerns among university students. The administrators ascribed the rise in severity of mental health problems to the growing

psychosocial influences that university students face such as societal pressure of excellence, increased availability of medication, and decreased stigma for seeking treatment, as well as an overdependence on technology. Another study (Barr et al., 2010) also reported that 77% of counseling directors that responded to a survey believe there has been an increase in the number of students with severe psychological problems on campus.

College students' treatment seeking. According to the American College Health Association National College Health Assessment (2008), about 1.8 million college students pursue help from their college counseling centers annually. The Association for University and College Counseling Center Directors Annual Survey (2013) reported that anxiety is the most predominant concern among college students (46.2%), followed by depression (39.3%), relationship problems (35.8%), suicidal ideation (17.9%), alcohol abuse (9.9%), and sexual assault (7.4%). Of some interest is the fact that, despite a wealth of research that suggests an increase in psychopathology, most college students with mental health problems do not receive treatment (Blanco et al., 2008). The Healthy Minds Study conducted in 2007 and 2009 surveyed college students from 26 campuses nationwide. Of the college students surveyed, 32% reported symptoms in accord with a psychiatric diagnosis; 64% of those did not receive services (Eisenberg, Hunt, Speer, & Zivin, 2011). Results from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions found that almost half of college-aged individuals had a psychiatric disorder in the previous year and 25% of those individuals sought treatment in the year prior to the survey (Blanco et al., 2008). Researchers have examined the correlations between help seeking and factors regarded as barriers and as facilitators to

treatment in order to understand the under-utilization of mental health services among university students (Eisenberg, Hunt, & Speer, 2012). These factors include: stigma, perceived need, access to services and close relationships with individuals who have used treatment, and cultural competence.

Barriers to treatment seeking. One barrier that has gained a significant amount of attention within the literature is stigma. Stigma can be divided into two categories: self-stigma (negative attitudes about one-self) and public stigma (negative attitudes held by others) (Corrigan, 2004). One study (Eisenberg, Downs, Golberstein, & Zivin, 2009) found that public stigma was not significantly associated with help seeking. However, research conducted by Vogel, Wade, and Hackler (2007) found that these two types of stigma (public stigma and self-stigma) interact with each other. Specifically, perceptions of public stigma influence self-stigma, in turn, influencing help seeking behavior. Significant negative relationships have been found between personal stigma and perceived need, the use of psychotropic medication, therapy, and nonclinical sources of support. Lower help seeking behavior and higher personal stigma were reported among students who were Asian who grew up in a poor household; this was recorded in the Healthy Minds Study (Eisenberg et al., 2012). Another study (Masuda, Anderson, Twohig, Feinstein, Ying-Yi, Wendell, & Stormo, 2009) found that African Americans and Asian Americans had less favorable attitudes on a variety of help-seeking attitudes, compared with European Americans. Additionally, the authors found that more European Americans sought psychological help than did African and Asian Americans; they also found that stigma was higher among blacks and Asians, compared with white undergraduate psychology students (Masuda et al., 2009). Stigma is one of the most

common reasons cited for the fact that medical students report reluctance to seek mental health services. Other common reasons reported by medical students are: lack of time, and fear that revealing a mental illness may negatively affect their academic records and careers (Givens & Tjia, 2002; Tjia, Givens, & Shea, 2005). The perceived need for professional help has one of the strongest relationships with intentions of help seeking (Celluci, Krogh, & Vik, 2006) and actual help seeking (Eisenberg et al., 2011). Students with untreated mental health problems often report that they do not seek help because they prefer to handle their problems on their own; they question how serious their problems are; they believe that stress is normal in college; they believe the problems will get better on their own, and they cite the lack of time (Czyz, Horowitz, Eisenberg, Kramer, King, 2013; Eisenberg et al., 2011). University students have also reported pragmatic barriers to accessing services. These services include: long waiting periods, financial issues, not knowing where to go to get help, doubt that professional help would be beneficial and negative past experiences with help seeking (Czyz et al., 2013). Additionally, cultural competence may be another important barrier to mental health seeking among university students. Further, among the individuals with untreated mental health problems in the Healthy Minds Study, 9% of nonwhite students and 23% of students whose sexual orientation was not heterosexual reported lack of cultural competence as an important reason for not receiving services (Eisenberg et al., 2012).

In conclusion, help seeking behaviors among university students are influenced by a number of factors such as: stigma, knowledge, perceived need for help, social networks and cultural competence. Furthermore, the gravity of these factors differs across subgroups. Stigma and knowledge are the traditional barriers that have been emphasized

in the literature and have been the target of help-seeking interventions with university students; however, research suggests that other factors should be investigated and incorporated into future interventions (Eisenberg et al., 2012).

Premature termination.

Premature termination refers to clients leaving treatment before their counselors believe they should (Mennicke, Lent, & Burgoyne, 1988), dropping out before a significant reduction in symptoms before returning to a nonclinical level of functioning (Swift & Greenberg, 2014). A great deal of research reports that early terminators have poorer treatment outcomes and more dissatisfaction with therapy than those who complete therapy (Swift & Greenberg, 2014). Research has identified a number of clinical, client, counselor, and interaction variables that are related to premature termination (Mennicke et al., 1988). This section will briefly cover client factors and emphasize counselor variables (social influence characteristics and facilitative conditions) as they relate to premature termination.

Backeland & Lundwall's (1975) review of the literature indicated that client variables associated with higher rates of premature termination include: being female, being socially isolated, low SES, being less anxious and depressed, exhibiting paranoid symptoms, sociopathy, alcoholism, low psychological mindedness, need for high approval suggestibility, and poor motivation. Although a small relationship between age and gender of the client has been shown in the majority of the research regarding premature termination, evidence from two recent studies (Edlund et al, 2002; Thormahlen et al., 2003) has indicated that younger clients (younger than 25-30 years of age) are more likely to drop out than older clients (Barret, Chua, Crits-Christoph, Gibbons,

Casiano, & Thompson, 2008). Therapist characteristics related to premature termination include: dislike or disinterest in clients, low expectation of client improvement, ethnocentricity, and inexperience. Additional factors associated with high rates of premature termination are: low client similarity on dimensions such as sex, race, socioeconomic status, delay in case assignment, interruption in therapeutic relationship, and treatment expectations (Mennicke et al., 1988). Furthermore, a growing amount of research has found that poor and weak alliances have been associated with increased dropout (Barrett et al., 2008).

Social influence factors (attractiveness, expertness, and trustworthiness) have been linked to initial client satisfaction (Mennicke et al., 1988). Of some interest is the fact that there is evidence to suggest client satisfaction to be predictive of premature termination (Larson, Attkisson, Hargreaves, & Nguyen, 1979; Zamostny, Corrigan, Eggert, 1981). One study (Zamostny et al., 1981) found satisfaction to be predictive of premature termination rather than social influence factors. Larsen and Collegues (1979) found that the Client Satisfaction Questionnaire correlated with early drop out rates and have suggested using client satisfaction as a predictor in early termination. Expertness and trustworthiness have been found to be related to clients returning following intake; however, this appeared true to the extent that they correlated with satisfaction (Kokotovic & Tracey, 1987; Mennicke et al., 1988). Another study (McNeill, May, & Lee, 1987) found that early terminators rated their therapists lower on all three social influence variables (expertness, attractiveness, and trustworthiness) than did those who were successful terminators. There is also evidence to suggest that attitude variables such as

involvement, respect, and openness are related to treatment duration (Saltzman, Leutgert, Roth, Creaser, & Howard, 1976).

In a study focused on college students, Hynan (1990) investigated early terminators and late terminators in a university counseling center and found that later terminators rated their counselors higher on levels of warmth and competency than did early terminators. Additionally, late terminators reported higher levels of belief that their therapists respected them; these late terminators were also more likely to stop therapy due to improvement attributed to treatment. Early terminators dropped out of therapy more often than late terminators because of discomfort with services and situational constraints. In general, higher levels of a client's perceptions of facilitative conditions, relevant verbal responses, and beliefs about the therapist have resulted in longer treatment durations.

In summary, premature termination is a complex and multifaceted issue. Research on variables related to premature termination are often conflicting, contradictory and consist of different operational definitions of premature termination, thus making it difficult to draw clear conclusions (Mennicke et al., 1988). There is evidence to suggest the working alliance, client satisfaction and expectations, client likeability and pretreatment preparation may aid in prevention of premature termination (Reis & Brown, 1999). Therefore studying various therapist behaviors and interventions as well as therapists' effect on these variables could lead to a clearer understanding of the variables related to premature termination, thus finding ways to prevent it.

The therapeutic alliance.

Counseling process variables are elements that are common to counseling regardless of theoretical approach (Locke et al., 2012). The therapeutic alliance is a process variable that is consistently associated with treatment outcomes. Baldwin, Wampold, and Imel (2007) conducted a study with the goal of determining relative contribution of patient and therapist variability in the alliance, as related to outcome. The study used Consortium data from 45 centers that examined 331 clients. The results indicated that therapists' variability in alliances significantly predicted outcome. Patient variability as well as the interaction between therapist and client was not significantly related to outcome. Clients who had therapists who were, on average, better at forming strong therapeutic alliances with their clients had better outcomes than clients who had therapists that did not, on average, form strong therapeutic relationships with their clients (as cited in Locke et al., 2012, p. 236). Research on the therapeutic alliance indicates that therapist self-disclosure can influence client perceptions (positively and negatively) that are necessary to build a strong therapeutic alliance (Curtis, 1981).

Definitions of self-disclosure.

Broadly defined, therapist self-disclosure refers to statements that reveal personal information about the therapist (Hill & Knox, 2001). Although the majority of the literature on therapist self-disclosure focuses primarily on verbal statements provided by the clinician, therapists can disclose and communicate personal information in various other ways such as: nonverbal communication (body language); office décor, arrangement and location, as well as physical characteristics and attire (Zur, 2007; Peterson, 2002).

Therapist self-disclosure is an intricate intervention that can be defined and categorized along various different dimensions (Watkins, 1990). Research on the topic is inundated with inconsistent definitions and distinctions between types of verbal self-disclosure, making it difficult to generalize across studies (Hill & Knox, 2001). Categories of self-disclosure are differentiated according to the process by which the action occurs and the content of the disclosure (Sando, 2014). Other models of self-disclosure discuss parameters of self-disclosing behavior such as time spent disclosing, the amount, and the intimacy level of the disclosure (Cozby, 1973).

The process by which disclosure occurs can be deliberate, accidental, or unavoidable. Verbal disclosure of personal information or other deliberate actions is referred to as deliberate self-disclosure. Unintended interactions that reveal personal information about the therapist such as unplanned encounters outside of the office or spontaneous reactions fall into the category of accidental self-disclosure. Unavoidable self-disclosure refers to aspects of the self over which the therapist may not have full control such as tone of voice (Zur, 2007).

A greater amount of research has been conducted on the content of self-disclosures, particularly on the distinction between immediate and non-immediate self-disclosure. Immediate therapist self-disclosure (also known as self-involving or interpersonal self-disclosure) focuses on the client in the "*here and now*" and on the personal dynamics between the therapist and client (Audet, 2011, p.86). Its primary function is to address the process within the therapeutic relationship, in order to promote insight into the impact of the clients' behaviors, as well as to help clients identify, experience, and integrate dissociative parts. Immediate self-disclosure, for example, would occur if a therapist were

to explain to his/her client about how he or she feels when the client does not show up for a scheduled therapy session and does not inform the counselor that he or she will be not be attending. Non-immediate self-disclosure (also known as self-revealing or intrapersonal self-disclosure) is disclosure of information about the therapist's personal life outside of therapy, such as personal experiences, beliefs, attitudes, and life circumstances (Audet, 2011; Watkins, 1990). For example, if a therapist were to disclose to his or her client an experience he/she had over the weekend with a friend, this would qualify as a type of non-immediate self-disclosure. The function of non-immediate self-disclosure is to build rapport between therapist and client, reveal the humanity and fallibility of the therapist, equalize the relationship, and model behaviors, such as authentic self-disclosure (Audet, 2011; Ginot, 1997; Hill et al., 1989).

Researchers have made distinctions between positive versus negative disclosures and the level of intimacy of self-disclosing statements. Disclosure of experiences that reflect favorably upon the counselor and/or are parallel with the client's experiences is referred to as positive self-disclosure (Anderson & Anderson, 1985; Hoffman-Graff, 1977; Watkins, 1990; Watkins & Schneider, 1989). Negative self-disclosure involves sharing experiences that do not reflect favorably upon the counselor and/or are not parallel with the client's experiences (Anderson & Blake, 1985; Doster & Brooks, 1974; Hoffman & Spencer, 1977; Watkins, 1990). Therapist self-disclosure can be divided according to the level of intimacy. Anderson & Anderson (1985) suggest dividing therapist self-disclosure into six levels of intimacy: demographic information (general characteristics and facts about the counselor such as age, marital status, and residence); emotional reactions of the counselor (responding affectively to clients thoughts or behaviors);

therapist's professional identity (professional standing of the therapist, expertise, and training); the therapist's world view (the merging of the philosophical, cultural, professional and personal identity of the therapist that makes up the therapist's schema for dealing with the world); personal experiences of the counselor (experiences outside of the therapist's professional life), and counselor fantasies (images and fantasies that creatively communicate information not amenable to verbal descriptions or as a way to describe feelings that the client or counselor may have). Similar versus dissimilar self-disclosure is another dimension of disclosure that is discussed within literature. Similar self-disclosure refers to counselor experiences that are parallel with the client's experiences. Dissimilar self-disclosure refers to counselors' experiences that are not parallel with the client's (Murphy & Strong, 1972). Additionally, authors have differentiated between present disclosure that refers to revealing a problem that is currently taking place and past disclosure that refers to revealing a problem that has taken place in the past (Dowd & Boroto, 1982). Other distinctions have been made between reassuring and challenging disclosures. Reassuring disclosures support, reinforce, or legitimize the client's perspective, way of thinking, feeling, or behaving; challenging disclosures confront the client's perspective, thinking, or behavior (Hill et al., 1989).

Therapist self-disclosure within different theoretical orientations.

Perspectives and opinions regarding the ethics and usefulness of therapist self-disclosure vary across therapeutic orientations (Peterson, 2002). Yalom (1985) asserts that the nature and degree of therapist self-disclosure differentiate the schools of therapy more than any other single characteristic. This section will briefly summarize how major theoretical orientations perceive and use therapist self-disclosure.

Classic psychoanalysis. Classic Psychoanalysis emphasizes the importance of the therapist's anonymity, equanimity and abstinence (Freud, 1915/1958b; Goldstein, 1997). Freud believed that therapist self-disclosure creates an interpersonal void between the patient and therapist and leads to the emergence of unconscious conflicts and urges that the patient then tranferentially projects onto the analyst as well as to the therapeutic alliance (Ziv-Beiman, 2013). Ultimately, therapist self-disclosure could distort transference and prevent the client from the resolution of that transference (Edwards & Murdock, 1994); it is perceived as a symptom of the therapist's countertransference (Lane & Hull, 1990; Peterson, 2002, p. 22). Many psychoanalytic clinicians view self-disclosure as a boundary violation, and believe that it derails therapy by taking the focus from of the client (Zur, 2004). Although Freud is responsible for founding a movement that imposed a taboo on therapist self-disclosure (Ziv-Beiman, 2013), research indicates that he failed to follow his own rules in his clinical work (Lynn & Vaillant, 1998).

Not all of Freud's colleagues and students agreed with his stance on disclosure. Ferenczi (1932/1988) contends that a neutral and anonymous stance would likely re-enact trauma in the treatment of childhood trauma. According to Freneczi, the relationship between psychoanalyist and patient should be open and mutual in order to ensure free communication and the challenging of hierarchies. More recent literature suggests that psychodynamic therapists have become and are continuing to become more accepting of self-disclosure (Geller, 2003; Goldstein, 1997; Lane & Hull, 1990).

Ego psychology directly followed the psychoanalytic movement and shares the same perspective on therapist self-disclosure (Ziv-Beiman, 2013**).** *Object Relations* theory believes that the therapist's examination of his/her own countertransference can

provide a window into the object relation patterns that the patient brings into therapy (Mitchell & Black, 1995). Contemporary object relations theorists encourage disclosure of the therapist's countertransference to help the patient see how others experience him/her as well as learn about the parts of him or herself that have split off or have been projected onto the therapist (Casement, 1988; Ziv-Beiman, 2013).

Humanistic psychology. Humanistic Psychology grew tremendously in the 1960s and was considered to be a psychological movement by the 1970s. The person-centered approach strongly emphasizes and values authenticity and congruence. According to the humanistic paradigm, self-disclosure is a way to facilitate growth and establish an authentic and therapeutic bond (Bugental, 1987; Rogers, 1957). Humanists maintain that therapist self-disclosure serves the purposes of demonstrating the humanness of the therapist and equalizing the relationship between the therapist and client (Stricker & Fisher, 1990). Therapist self-disclosure is important in the development of the therapeutic alliance and the client's self-actualization (Goldstein, 1994; Ziv-Beiman, 2013). *Existential Psychology* shares a similar view of self-disclosure. The therapist is encouraged to disclose his/her manner of coping with existential questions, thereby serving as a model to inspire clients to find his/her authentic answers (Ziv-Beiman, 2013).

Feminist psychology. Feminist Psychology is a paradigm very much influenced by the humanistic movement of the 1970s (Brown & Walker, 1990). This paradigm advocates for judicious use of immediate and non-immediate therapist self-disclosure (Ziv-Beiman, 2013). The core principal of feminist psychology is an egalitarian relationship between the client and therapist (Brown & Walker, 1990). According to this

perspective, self-disclosure regarding personal feelings, opinions, and values (especially ones that pertain to social and political issues) help the client in making an informed decision when choosing and evaluating a therapist. Therefore, self-disclosure allows the client to become an active participant in his/her treatment and equalizes the relationship by deconstructing the positions of power within the therapeutic dyad. (Simi & Mahalik, 1997)

Cognitive behaviorists. Cognitive Behaviorists advocate for the use of therapist self-disclosure; however, they emphasize examination of the therapists' intentions of using the intervention. Cognitive Behaviorists believe that immediate and non-immediate self-disclosure can achieve many different goals such as strengthening the therapeutic relationship; normalizing the patients experiences; challenging negative interpretations of intentions and behavior; enhancing positive expectations and motivations for change, and modeling and reinforcing desired behaviors (Ziv-Beiman, 2013). Immediate and non-immediate self-disclosure has different therapeutic effects on clients. Immediate self-disclosure is used for reinforcement and non-immediate self-disclosure is used for modeling (Goldfried, Burckell, Eubanks-Carter, 2003).

Multicultural psychology. Multicultural Psychology is another theoretical orientation that advocates the use of therapist self-disclosure as a way of building trust when the client is from a sociocultural background that is different from that of than the therapist (Hill & Knox, 2002). Other researchers disagree with this stance. Lee (2014) asserts that therapist self-disclosure may negatively impact the client and cause him or her to disengage. The reason for this is that self-disclosure involves asserting the therapists cultural norms affecting the power dynamics of the therapeutic relationship.

This is a particular concern for cross-cultural dyads in which the therapist is white and additional dynamics of power and privilege may be enacted. Therapists must reflect on their cultural biases and discuss mistakes with their clients (Lee, 2014).

Why disclose?

Therapist self-disclosure serves multiple purposes. Lane, Farber, and Geller (2001) found that the most common reasons given by therapists for using self-disclosure are normalizing the patient's experience, strengthening the therapeutic alliance, and providing the client with different ways of thinking. Other research in this area has found similar results (Anderson & Mandell, 1989; Chelune, 1979; Knox et al., 1997; Simon, 1988). This section will address the primary arguments for the therapeutic usefulness of therapist self-disclosure.

Modeling. Therapist self-disclosure can serve the purpose of modeling (Curtis, 1981). In a study conducted by Simon (1988), therapists reported that they served as models for their patients by demonstrating coping skills and problem solving strategies, self-acceptance and assertiveness. Therapist self-disclosure models open communication and encourage healthy attitudes for clients (Edwards & Murdock, 1994; Goldfried et al., 2003; Hill & Knox, 2001). If a therapist self-discloses, the patient will in turn imitate the behavior (Curtis, 1981).

Eliciting self-disclosure. Eliciting self-disclosure is critical to a therapist because client disclosure has been found to have a positive relationship to therapy outcome (Carkhuff & Pierce, 1967; Jourard, 1964; Rogers, 1961; Strassberg, Anchor, Gabel, & Cohen, 1978; Truax, 1968; Truax & Carkhuff, 1965). The "dyadic effect" of self-disclosure, proposed by Jourard (1971), states that disclosures offered by the first party in

a dyadic interaction serve as a stimulus for increased disclosures in the second party. In other words, self-disclosure on the part of one person elicits similar self-disclosure from another (Jourard & Jaffe, 1970). Self-disclosure has also been found to lead to a better understanding of the self as well as to establish interpersonal closeness (Jourard, 1971).

Demystification of therapeutic process. Therapist self-disclosure establishes the therapist as more real and human (Hill et al., 1989; Knox & Hill, 2003). The clients' anxieties are reduced through the therapist revealing vulnerabilities and personal information, thereby demystifying the therapeutic process (Bugental, 1965). Therapist self-disclosure has been recommended to mitigate the problem of excessive defensiveness in the client and breaking through an entrenched impasse in treatment (Maroda, 1999; Simon, 1988).

Fostering the therapeutic alliance and therapeutic relationship.

Therapist self-disclosure is often used to build rapport and foster the therapeutic alliance (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Hill & Knox, 2001; Wells, 1994). A number of studies have indicated that therapist self-disclosure favorably influences perceptions necessary to the development of a strong therapeutic alliance (Curtis, 1981). It has been suggested that therapist self-disclosure encourages the development of trust by establishing a relationship based upon reciprocity (Jourard & Friedman, 1970). Bugental (1965) indicated that when the therapeutic relationship is a reciprocal interpersonal encounter, self-disclosure equalizes the relationship and promotes therapeutic growth. Current literature on therapist self-disclosure supports its use for the equalizing power relationships in the therapeutic relationship (Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Simi & Mahalik, 1997; Wells, 1994), encouraging

self-exploration, self-reflection, and growth (Bridges, 2001). Furthermore, some researchers have suggested that therapist self-disclosure of his/her personal reactions and experiences to the patient will promotes a strong therapeutic alliance (Bugental, 1965; Jourard, 1971; Kaiser, 1965; Truax & Carkhuff, 1967; Rogers, 1951).

Additional reasons cited for the use of therapist self-disclosure includes increasing the similarity between the client and therapist (Edwards & Murdock, 1994); and confirming a client's reality (Hill et al., 1997; Hill & Knox, 2001).

Ethical considerations of self-disclosure.

Very few papers have been published specifically on the ethics of therapist self-disclosure; rather, researchers have focused on whether or not therapist self-disclosure is a helpful intervention (Audet, 2011). Although the decision to disclose is recognized as an ethical one by most authors (Peterson, 2002), a few clinicians would contend that therapist self-disclosure is always unethical (Gutheil & Gabbard, 1993). Therefore, researchers have focused on the several elements; these are, the content, the reasons, to whom, and under what circumstances an ethical therapist should disclose (Peterson, 2002). This section will discuss the ethical concerns raised about the use of therapist self-disclosure as an intervention and clinical tool.

Two of the most frequently mentioned ethical principles addressed within self-disclosure literature is non-maleficence (do no harm to clients) and beneficence (the goal of the psychologist should be to help others). According to the principles of non-maleficence and beneficence, therapist self-disclosure is deemed ethical when it is considered a highly useful tool that is intended to benefit the client in a given situation and unethical when it impedes the therapeutic process. Additional ethical principles that

may be related to therapist self-disclosure in particular situations include: autonomy, fidelity, and justice (Koocher & Keith-Spiegel, 1998).

Boundary violations and boundary crossing are major concerns discussed from the ethical perspective on therapist self-disclosure (Audet, 2011). Therapist self-disclosure is a boundary violation when it is used especially to serve the therapists needs. Disclosure in this situation can impede the therapeutic process and harm the client, thus violating the ethical principles of non-maleficence and beneficence (Peterson, 2002). In contrast, boundary crossing refers to 'a departure from commonly accepted practice that may or may not benefit the client' (Smith & Fitzpatrick, 1995, p.501). Therapeutic boundaries serve a number of functions: they distinguish therapy from other social events in the client's life (Smith & Fitzpatrick, 1995); provide a framework that can manage client expectations of the therapeutic encounter, and define behavior that is acceptable in therapy (Audet, 2011). Boundary concerns that are related to the ethical principles of beneficence and non-maleficence and are identified as such in the literature include: shifting the focus away from the client, inviting social dynamics conducive to friendship, generating client feelings of needing to care for the therapist, and risking exploitation of the client and role reversal (Gutheil & Gabbard, 1999; Wachtel, 1993; Zur, 2004).

It has been argued that relaxed boundaries can be ethical as long as they are indicated as such and have therapeutic intent (Lazarus & Zur, 2002). Some researchers contend that strict boundaries are intended to protect the therapist and are often at the expense of the client (Lazarus & Zur, 2002; Williams, 1997). It has been suggested that strict boundaries can function as a way of maintaining a professional distance between the therapist and client and in doing so objectify the client in the process (Dineen, 2002;

Tomm, 2002). Singer (1977) states that everything a therapist does could be considered self-disclosing. Therapists' reluctance to self-disclose and to be known to their patients comes from a fear of not being accepted (Singer, 1977) and idealized (Renik, 1995) by their patients. Some contemporary therapists have cautioned against restricted use of therapist self-disclosure. When therapists hold back their thoughts or feelings in therapy, both the therapist and patient become frustrated (Farber, 2006). Therapists who inhibit their feelings are depriving patients of models for disclosing risky material, and also for feedback regarding how the client presents to others, making it difficult for clients to express negative feelings about their therapists (Hill, Thompson, Cogar, & Denman, 1993). Similarly, Geller (1994) states that the inability to speak openly about difficult feelings, especially avoidance of discussing conflictual parts of a relationship can lead to stalemated therapies. This restricts expression and growth (Farber, 2006).

Epstein (1994) states that the reason for not disclosing personal information is to focus on the patients' problems; another reason is that extensive disclosure on the part of the therapist could be indicative of the inability to comprehend and maintain the professional role. Wachtel (1993) cautions that therapists' personal disclosures beyond the therapeutic relationship (non-immediate self-disclosure) are exploitative because they undermine the clients' needs and distract from the clients' experiences. Barnett (1998) stresses that therapist self-disclosure can blur and threaten clearly defined roles and rules necessary to maintain a professional relationship.

As a way to aid clinicians in determining the ethical appropriateness of a self-disclosure, authors have established four basic elements that should be considered: the

clinicians' intentions in disclosing, the content of the disclosure, the clients' traits, and special or rare situations impacting treatment (Sando, 2014).

Therapist intention. The therapist's motivation and intention for disclosure is one of the most important determinants of the ethicality of therapist self-disclosure (Peterson, 2002). It is considered exploitative if the motivation behind a therapist's disclosure is to have his/her needs met by the client (Gutheil & Gabbard, 1993). It is not always easy to determine if the desire to disclose is based on the therapist's needs or the client's needs (Brown & Walker, 1990; Goldstein, 1994).

Content. Researchers have varying opinions regarding the content that is considered appropriate and ethical. Wachtel (1993) argues that non-immediate disclosure (personal information about the therapist outside of therapy) is selfish, exploitive, and ultimately unethical because it diverts attention onto the therapist instead of focusing on the patient and undermines the appreciation for the client's needs. Other authors assert that personal information may overburden clients (Peterson, 2002). In contrast, immediate self-disclosure about reactions to the client is considered to be beneficial because the therapist is demonstrating attention to the client's experience and is working to obtain a better understanding of his or her client's perspective (Wachtel, 1993). Disclosure of training, style, and orientation are mandated for informed consent because they are directly related to the ethical principle autonomy (Peterson, 2002). Similarly, mental health professionals of a feministic orientation posit that non-immediate content such as religious, political, and personal beliefs, sexual orientation, and ethnicity should be disclosed to clients because it allows the individual to make informed decisions about the person whom they wish choose as a therapist (Simi & Mahalik, 1997).

Client traits. Certain types of individuals may more likely be harmed by self-disclosure than others (Peterson, 2002). It has been suggested that clients who put others needs before their own are poor candidates for therapist self-disclosure because the client may respond to the disclosure by attempting to heal the therapist (Epstein, 1994; Goldstein, 1994). Additionally, clients with poor reality testing and poor boundaries may not benefit from therapist self-disclosure because they may adopt the characteristics of the therapist (Goldstein, 1994). Similarly, Epstein (1994) advises against therapist self-disclosure with clients who are impulsive and have poor boundaries, asserting that this type of client may use therapist self-disclosure as an excuse to act out aggressively or sexually with the therapist. Goldstein (1994) believes that therapist self-disclosure may not be beneficial with clients who are self-absorbed, fear closeness with their therapist, and are trying to avoid strong emotions.

Age is a patient variable that should be considered when making the decision to self-disclose (Peterson, 2002). Arguments have been made for the use of self-disclosure with children and adolescents. Papouchis (1990) states that children and adolescents often ask their therapists personal questions as a way of identifying their places in the world and by avoiding these questions, the therapist could impede a child's ability to master reality. Additionally, therapist self-disclosure is a way of developing trust and modeling authenticity and openness. Greenberg (1990), however, strongly advises against the use of self-disclosure with elderly patients. Therapist self-disclosure with the elderly is perceived to be a violation of boundaries. The reason for this is that the elderly are often socially isolated, and self-disclosure could lead to social rather than professional interactions.

Special circumstances. There are particular situations that present complex ethical questions regarding the use of therapist self-disclosure (Sando, 2014). An example of this is a time when a therapist has a significant illness, or has experienced a death. These topics are important because bereavement or illness can interrupt therapy and compromise treatment. Therapists are encouraged to disclose terminal illness to their patients and prepare them to continue therapy elsewhere. Furthermore, therapists experiencing illnesses and loss should seek help managing their own emotions because if the therapists own emotional needs are not being tended to, they can spill into therapy and affect clients' treatments. Although full disclosure of illness can burden patients, and can result in role reversal, inhibiting discussion of their own problems, it can also greatly benefit both parties. Some patients of deceased therapists have reported that disclosure of terminal illness helped them deal with existential issues such as: the fear of their own mortality, the meaning of life, and dealing with past losses and abandonment issues (Farber, 2006).

Another special circumstance involves therapist disclosure of sexual orientation. A therapist's nondisclosure of personal sexual orientation can profoundly impact a gay client, especially if the client is having difficulty" coming out". Nondisclosure may be perceived as discouraging the client's disclosure of being gay (Taylor, 1993). Furthermore, if the patient thinks the therapist is straight he or she may feel that the therapist will lack the ability to empathize with a gay patient and may fear that the individual has homophobic attitudes. If the patient suspects that the therapist is gay, nondisclosure communicates the idea that being gay is shameful. It is possible that patients find out their therapists' sexual orientations though external sources and patients

can assume that nondisclosure was due to shame; this can affect the clients' ability to be honest and open about sensitive topics in therapy, thus damaging the therapeutic relationship and hindering therapy (Farber, 2006). Ultimately, nondisclosure can be interpreted as shame, disapproval, indifference, and hinder the alliance and therapeutic process (Cerbone, 1991; Farber, 2006).

Factors that influence therapist self-disclosure.

A variety of factors have been identified as influencing a therapist's self-disclosure. These factors include: Theoretical Orientation, Experience Level, Personal Comfort, Setting of Practice, the relationship of the therapist with the disorder being treated, and patient variables. This section will briefly summarize how each of these factors influences therapist self-disclosure.

Theoretical orientation. As stated previously, theoretical orientation is one of the most frequently highlighted factors in self-disclosure research that has been found to influence a therapist's self-disclosure. A few studies have found that humanistic/existential therapists disclose more than psychoanalytic therapists (Farber, 2006). Considering the classic psychoanalytic position asserting that self-disclosure interferes with the development of transference, it is not surprising that psychoanalytic clinicians report less disclosure than any other theoretical orientation (Edwards & Murdock, 1994; Goldstein, 1997; Lane & Hull, 1990). Simi & Mahalik's (1997) study found that feminist therapists are more likely than psychodynamic therapists to promote the use of self-disclosure, disclose in order to equalize the power in the therapeutic relationship, and disclose personal background information (sexual orientation, race, political and religious beliefs; Farber, 2006). Henretty & Levitt (2010) concluded in their

review of qualitative research that it appears that psychoanalytic and psychodynamic therapists disclose less, but the difference may not be as significant as theorized.

Experience level. There is a great deal of clinical evidence suggesting that therapists' experience levels may influence the type and process of disclosures (Farber, 2006). Geller (1994) believes that therapists who are inexperienced and insecure may avoid confronting patients with aspects of their self-representation that may repel interest. Alternatively, a study conducted by Simon (1990) found that the frequency of disclosures was not affected by experience levels.

Personal comfort. A therapist's tendency toward self-disclosure can be influenced by his or her personal comfort. Therapists differ in their levels of comfort with the connection, tension, tone, and affect that disclosures create in the room (Farber, 2006).

Setting of practice. The setting of a therapists practice may influence the nature of therapist self-disclosure. The reason for this is that therapists who practice in their homes are far more visible than those who practice in typical private or institutional practices. A patient that goes to a therapist, who has a practice in his or her own home, is privy to wide variety of personal information such as: data about home furnishings, cars, neighbors, and have at least some knowledge of the therapist's family (Farber 2006). Farber (2006) mentions that as a result of practicing therapy in his home, patients have inadvertently met his wife, know what kind of car he drives, music he listens to, books he has read, as well as knowing other personal pieces of information. Therefore, setting of practice can result in inadvertent therapist self-disclosure.

Familiarity with the disorder. Some therapists feel inclined to disclose their own personal experiences with patients dealing with similar experiences. This is a common in the areas of childhood victimization, eating disorders, as well as drug and alcohol abuse (Farber, 2006). Research on this particular type of self-disclosure yields mixed results. Clinicians who have recovered from an eating disorder are often better than others to establish rapport, model recovery, and challenge self-centeredness and denial (Costin & Johnson, 2002). However, therapists with the same disorder as their clients may assume that they already know all about how the patient thinks and feels; therefore, the therapist may not be listening very attentively (Farber, 2006). Some researchers have suggested that therapists with the same disorder as their clients may be putting themselves at risk for relapse because the therapist may over-identify with the patient and take on the responsibility of the patient's recovery (Costin & Johnson, 2002; McGovern & Armstrong, 1987).

Patient variables. As discussed previously, patient variables that influence therapist self-disclosure include: impulsivity, poor reality testing, poor boundaries, self-centeredness, fear of closeness with the therapist, avoidance of strong emotions, and age. Although there is evidence suggesting that therapists are more likely to self-disclose to patients with greater symptomology (Hills & Knox, 2002), there are authors that recommend an opposite stance (Kelly & Rodriguez, 2007). According to McWilliams (1994), psychotic people need more emotional self-disclosure because they will stew in their own fantasies. Furthermore, McWilliams states that she avoids self-disclosure with healthier patients so that the patient can explore what his or her fantasies are about the therapist's affective state. Therapists surveyed in a study conducted by Kelly and

Rodriguez (2007) revealed that therapists self-disclosed more frequently to clients with lower initial symptomology and to female clients, just as people in general self-disclose more often to women (Collins & Miller, 1994).

Effects of therapist self-disclosure.

The impact of therapist self-disclose has been assessed primarily through client perceptions of the counselor via ratings on counselor variable scales, client's level of disclosure to the counselor, allegiance to the counselor, and measuring levels of symptoms in a control and experimental group over the course of the intervention (Henretty et al., 2014). Client perceptions of interpersonal variables such as expertness, attractiveness, trustworthiness, empathy, congruence, and warmth are primary ways in which the impact of therapist self-disclosure is assessed because research suggests that these variables have been positively linked to satisfaction with therapy, changes in the clients' self-concepts, achievement of pre-therapy goals, decreases in distress symptoms, as well as other measures of therapy outcome (Henretty et al., 2014). Research has suggested that different types of self-disclosure affect client perceptions more positively than others. This section will highlight empirical findings on how clients' perceptions are affected by various types of self-disclosure. Furthermore, there will be an emphasis on how different types of self-disclosure affect the therapeutic relationship as well as social influence factors and facilitative conditions.

Disclosure vs. nondisclosure. A wealth of research suggests that clients respond more favorably to therapists who self-disclose than to those who do not. Furthermore, disclosing counselors have been rated as more nurturing, trustworthy, and empathetic than are non disclosers (Reynolds & Fischer, 1983). However, there is some evidence

that suggests that non disclosers are seen as more psychologically healthy and more professional than disclosers (Dies, 1973).

A meta-analysis conducted by Henretty and Colleagues (2014) reviewed 53 studies examining counselor self-disclosure versus non-disclosure, all of which were experimental and quasi-experimental designs. Henretty and Colleagues found that clients who had counselors that self-disclosed rated themselves as more likely to disclose and rated their counselors more favorably. Similarly, in a qualitative literature review of therapist self-disclosure, Watkins (1990) found that counselors who disclose in a moderate or non-intimate fashion in the initial interview tend to be viewed more favorably by subjects and elicit greater subject disclosure than counselors who did not disclose at all, disclosed a lot, or counselors who disclose personal, intimate material. Therefore, it appears that there is more evidence to support the use of self-disclosure versus non-disclosure. Clients report that disclosure during therapy results in relief from physical and emotional tension and they feel as though lack of disclosure to therapist inhibits therapy (Farber et al., 2004).

Self-involving vs. non-immediate. The effects of self-involving and non-immediate disclosure have received a great deal of attention within self-disclosure literature and have generated an ongoing debate of its usefulness and effects on clients. A number of studies have found self-involving disclosures to be more helpful than non-immediate disclosures (Curtis, Field, Knaan-Kostman, & Mannix, 2004; McCarthy & Betz, 1978; Watkins & Schneider, 1989). Hill and colleagues (1989) separated therapist self-disclosure into four categories: self-involving (thoughts and feelings regarding the client in therapy); disclosing statements (information about the therapist's life);

reassuring (statements that reinforce or legitimized the client's experience), and challenging disclosures (statements that confront the client's perspectives or behavior). Therapists and clients rated reassuring disclosures as the most helpful; however, disclosure that was both reassuring and self-involving was considered to be helpful by both groups. The studies included within a qualitative literature review (Henretty & Levitt, 2010) suggested that immediate self-disclosures were perceived more positively than non-immediate disclosures. Similarly, Watkins (1990) reviewed 16 studies that contrasted positive and negative self-involving statements, positive with negative self-disclosing statements, or a combination of the two. Consistent results were found for the studies contrasting positive with negative self-involving statements; positive self-involving statements were perceived more favorably.

The results were mixed for the studies that contrasted positive with negative self-disclosure. In the remaining studies that used a combination of positive and negative self-involving and self-disclosing statements, the results suggested that, generally, positive self-involving statements have been regarded more favorably by subjects than negative self-involving or self-disclosing statements. No definitive conclusion was found for positive versus negative information; however, positive self-involving disclosures were regarded more favorably than negative self-involving disclosures, positive self-disclosures, or negative self-disclosures (Watkins, 1990).

In contrast to these findings, Ramsdell and Ramsdell (1993) surveyed former clients who rated therapists' sharing of personal information as having a beneficial effect on therapy. A review of analogue studies on therapist self-disclosure suggests that non clients liked therapists who moderately disclosed personal information (Hill & Knox,

2001). Furthermore, results from qualitative studies with clients suggest therapeutic benefits of non-immediate self-disclosure. For example, clients in one study (Knox et al., 1997) described helpful therapist self-disclosures as ones that were made in the context of the clients' self-disclosure of personal issues and contained past, non-immediate information (i.e. family, leisure activities, similar difficult experiences) rather than immediate information (information that pertains to the therapy relationship). The client reported that they believed these types of disclosures were intended to normalize their feelings. Fox, Strum, and Walters' (1984) study that investigated client perceptions of therapists' prior self-disclosing history of going to therapy versus no disclosure found that the disclosing counselor was viewed as having more favorable personal and therapeutic abilities and as more facilitative of the therapeutic relationship than the non-disclosing counselor. Similarly, Somers and colleagues (2014) assessed reactions to psychotherapists revealing their own psychological problems to clients with similar problems. The study used vignettes that either disclosed psychological problems or did not disclose at all. Participants were randomly assigned to one of three disclosure conditions (Depression, PTSD, Alcohol Dependency) or to no disclosure at all. Psychotherapists who disclosed were rated as having a higher level of favorable personal qualities, as more likely to establish strong working relationships with clients and achieve success in therapy. Interestingly, no significant difference was found between the types of psychological condition disclosed (Somers, Pomerantz, Meeks & Pawlow, 2014).

Similarity/dissimilarity. Research from social psychology suggests that people are more attracted to others who have similar attitudes and beliefs as they (Byrne, 1961). In general, research supports the concept that counselor disclosure revealing a similarity

between the counselor and client has a more positive impact on client perceptions (Barrett & Berman, 2001; Giannandrea & Murphy, 1973; Mann & Murphy, 1975; Murphy & Strong, 1972; Peca-Baker & Frielander, 1989).

Henretty and colleagues' (2014) meta-analytic review of experimental and quasi-experimental research found that therapist self-disclosures that contained negative content, revealed similarity between the counselor and client, and was related to intra- or extra-therapy experiences resulted in more favorable perceptions of the counselor, particularly in the area of professional attractiveness. Counselor disclosure that revealed similarity between the client and the counselor had a favorable impact on the clients' willingness to return to disclosing counselors. Giannandrea and Murphy (1973) investigated similar counselor disclosures with varying levels of frequency. The authors found that a moderate number of similar self-disclosures affected more return behavior than either low or high levels of disclosure. Similarly, Murphy and Strong (1972) found that similar self-disclosures increased perceptions of warmth, friendliness, as well as willingness to be known, and understood. Similar counselor self-disclosures were viewed more favorably than non-disclosing counselors; however, four disclosures were considered to be disruptive.

Intimacy and frequency. Watkin's (1990) review of self-disclosure literature included three studies comparing demographic disclosures versus personal disclosures, and four studies contrasting high-low or high-medium low counselors disclosures. Generally, participants regarded demographic disclosures more favorably than personal disclosures, and high or medium disclosing counselors were perceived the most favorably by subjects. One study that compared personal versus demographic disclosure versus no

disclosure found that a moderate amount of demographic self-disclosure from a warm therapist elicited the greatest client self-disclosure, in comparison with personal disclosure or nondisclosure (Simonson, 1976). Interestingly, Simonson and Bahr (1974) compared personal disclosure versus demographic disclosure versus no disclosure, and disclosures from professionals versus disclosures from paraprofessionals; they found that paraprofessionals who used personal disclosure rather than demographic disclosure, elicited greater attraction and disclosure from subjects. Professionals elicited greater attraction and disclosure when they used demographic disclosures. In other words, the effects of different disclosures varied as a function of status (Watkins, 1990). Cash & Salzbach (1978) found that a moderate number either of demographic or of personal counselor disclosures eliminated the effect of counselor attractiveness on subjects' evaluations.

Barrett and Berman (2001) examined varying levels of therapist self-disclosure on therapy outcome. Treatment was provided by 18 doctoral students with 2 years of clinical experience, each with 2 clients (adults over 18) that had requested individual therapy at a university counseling center. The therapist increased the frequency of reciprocal self-disclosure (disclosure of personal information in response to similar information revealed by the client) with one client and refrained from self-disclosures with the other. Clients in the heightened therapist disclosure condition reported lower levels of symptoms distress and greater liking of their therapist than clients who experienced limited therapist self-disclosure. In Hill and Knox's (2001) review of analogue research on therapist self-disclosure, no relationship was found between the frequency of therapist self-disclosures and client, therapist, or observer judgments of

treatment outcomes in six studies. One study in the review (Braswell, Kendall, Braith, Carey, & Vye, 1985) found a negative correlation between frequency of therapist self-disclosure and therapists' ratings of client improvement.

Mediating variables. Mediating variables investigated in various studies include the effect of client preferences, anticipations, expectations about counselor self-disclosure, race, culture, need for approval and sex-role orientation (Watkins, 1990). One study (Derlega, Lovell, & Chaikin, 1976) found that the material disclosed by subjects varied as a function of the appropriateness of the counselors' disclosures. Subjects who perceived high self-disclosure appropriate disclosed more intimate information to a high disclosing counselor rather than to a low disclosing counselor. Peca-Baker and Friedlander (1985) found counselor self-disclosure, subject preference, and subject anticipation to be interactive variables. Similarly, another study by Peca-Baker and Friedlander (1987) found that self-disclosing counselors were viewed more positively than non-disclosing counselors, regardless of the participants' expectations. VandeCreek & Angstadt (1985) found that subjects viewed counselors who disclosed as favorable, and that preferences and anticipations affected subject ratings.

Cultural factors may also influence how therapist self-disclosure is perceived. For example, Berg and Wright-Buckley (1988) indicated that African American subjects disclosed more to White interviewers who used intimate disclosures. Cherbosque (1987) found that Mexicans and Americans differed in how they perceived counselors who self-disclosed. Mexicans rated counselors who did not self-disclose as more expert and trustworthy; Americans did not indicate a clear preference. In conclusion, the results

from these studies suggest that mediating variables affect an individual's responsiveness to therapist self-disclosure (Watkins, 1990).

Social influence variables and facilitative conditions. The process of a person influencing another's attitudes, feelings, or actions is referred to as the interpersonal influence process. Strong (1968) regarded therapy as an interpersonal influence process and infused social psychology concepts (such as opinion-change variables) into counseling, resulting in the birth of the social influence theory. A number of variables have been identified as crucial to promoting behavior change: sources characteristics (e.g. expertness, trustworthiness); message variables (e.g. message discrepancy, incongruity), and recipient characteristics (e.g. authoritarianism, locus of control) (Heppner & Dixon, 1981). In general, the literature on interpersonal influence and therapist self-disclosure suggests that counselor self-disclosure increases perceptions of counselor attractiveness (Merluzzi et al., 1978; Nilsson et al., 1979). Increased ratings of perceived counselor attractiveness and warmth have been found for counselors who disclose similar experiences, feelings and attitudes as subjects (Hoffman-Graff, 1977; Nilson et al., 1979; Schmidt & Strong, 1971).

According to Carl Rogers (1957), effective therapeutic relationships consist of the following qualities: warmth, positive regard, congruence, and genuineness. These qualities are referred to as facilitative conditions. According to a review (Kirschenbaum & Jourdan, 2005), most of the recent psychotherapy outcome research demonstrates that "common factors" (warmth, respect, empathy, genuineness or self-disclosure, positive, relationships, and trust) rather than therapeutic technique or orientation account for therapeutic outcomes and change. In general, clients show positive gains with therapists

who demonstrate high levels of these facilitative conditions, especially when the client perceives these qualities even to a minimum degree. Similarly, another review (Klein, Kolden, Michaels, & Chrisholm-Stockard, 2002) of 77 studies examining the relationship between congruence or genuineness and outcome and other therapy change processes found that 34% of the studies showed a positive relationship to outcome; none was negative. In summary, the value of therapist self-disclosure or genuineness as one of the main factors in effective individual therapy is strongly and consistently supported by the literature (Forrest, 2010).

Research conducted by Myers & Hayes (2006) found that disclosures affected client perceptions of the therapist's expertness but not of attractiveness or trustworthiness. When the therapeutic alliance was positive, participants rated the session as deeper and the therapist as more expert when the therapist made general disclosures versus no disclosures. Sessions were rated as shallower and therapists as less expert when the therapeutic alliance was negative and therapists made general or countertransference disclosures, compared with no disclosures. In other words, clients rated self-disclosing therapists as more expert in the context of a strong therapeutic alliance. In Henretty & Levitt's (2010) review, the authors concluded that therapist self-disclosure had no reliable effect on client perceptions of trustworthiness, level of regard, empathy, congruence, and unconditionality; however, a positive relationship has been found between therapist self-disclosure and client perceptions of therapists' levels of warmth. Results were not reliable for the effect of therapist self-disclosure on client perceptions of professional attractiveness and expertness. The authors concluded that therapist self-disclosure has no effect on client perceptions of expertness, and if it does, it is a negative one.

Furthermore, therapist self-disclosure had a positive effect or no effect on therapist ratings of attractiveness. Dowd & Boroto (1982) found that past and present oriented self-disclosures, as well as self-involving statements were perceived as more attractive than interpretive and summarizing disclosures from counselors. Another study, McCarthy & Betz (1978), found that clients rated counselors using self-involving statements higher in trustworthiness and expertness than self-disclosing counselors. Additional studies present promising evidence on the benefits of therapist self-disclosure. These studies have found that client perceptions of credibility and unconditional positive regard were higher when the counselor used self-disclosure (Hoffman & Spencer, 1977) and that those clients' levels of self-disclosure as well as their willingness to interact with the counselor increased with increasing self-disclosure (Mallinkchrodt & Helms, 1986). Greater therapist self-disclosure has been directly associated with clients' reports of liking their therapist as well as with symptom reduction (Barrett & Berman, 2001).

There is also evidence that clients have described and rated counselors that self-disclose as less professional, less emotionally stable, less sensitive, less relaxed, less competent, and weaker (VandeCreek & Angstadt, 1985). In one study (Curtis, 1981) clients rated high-self-disclosing counselors significantly less competent and empathetic than non-self-disclosing counselors. However, Merluzzi et al., (1978) found that lower disclosing therapists were perceived as significantly more expert than high disclosing counselors. Conversely, another study (Nilsson et al., 1979) found that disclosing counselors were perceived to be just as competent as nondisclosing counselors. Dies (1973) found that self-revealing therapists were rated by clients as more friendly, disclosing, trusting, intimate, helpful, and facilitating; however, they were also judged to

be less relaxed, less strong, less stable, and less sensitive. Similarly, the results from Weigel, Dinges, Dyer, and Straumfjord's (1972) study indicated that group members perceive therapist self-disclosure as a negative indicator of mental health. Subjects in another study (Reynolds & Fischer, 1983) rated counselors who gave self-involving statements as more professional than counselors using self-disclosing statements.

Thus, the literature on therapist self-disclosure is full of contradictory findings, making it difficult to draw any definitive conclusions about the effects of therapist self-disclosure on client perceptions and therapeutic outcomes. However, results from studies have shed some light on the benefits and consequences of therapist self-disclosure.

Research suggests that therapist self-disclosure is perceived positively when it focuses on the client, is attuned to the clients needs, is not too lengthy or detailed, is made in response to client material and is made in context of a positive therapeutic relationship at the time the disclosure is made. Furthermore, clients report that positive effects of therapist self-disclosures fostered the therapeutic alliance, enhanced the feeling of therapist involvement, early connection and mutuality, made clients feel validated, reassured, and understood, equalized power relations, increased comfort, trust, and safety, elicited client disclosure, encouraged and facilitated self-reflection and insight, and helped the client see situations from another perspective (Audet & Everall, 2010; Hanson, 2005; Hill et al., 1989; Knox et al., 1997; Wells, 1994). Additionally, there is evidence that disclosure begets disclosure (Jourard, 1959; Renik, 1995; Simonson, 1976; Truax & Carkhuff, 1965). These findings are important because there is a great deal of evidence that supports the idea that greater client self-disclosure is related to positive therapy outcomes (Farber, Berano, Capobianco, 2004). This is not surprising because counselors

rely on client disclosure in order to give proper diagnosis and appropriate treatment (Forest, 2010).

Clients have been found to respond negatively to therapist self-disclosure that is misattuned to the client's needs, is irrelevant and not given in response to the client's disclosure (Audet & Everall, 2010; Hanson, 2005; VandeCreek & Angstadt, 1985; Wells, 1994). For example, some authors (VandeCreek & Angstadt, 1985) have found that clients had less favorable perceptions of therapists when the disclosures were not matched to the client's situation. Research also suggests that clients respond negatively to disclosure that is poorly timed, lengthy and detailed, is given in the context of a weak therapeutic relationship, shows low trust and rapport, elicits the feeling of being judged and fails to expose the client's reactions and responses (Audet & Everall, 2010; Hanson, 2005; Wells, 1994). Negative effects of therapist self-disclosure as reported by clients include: damage to the therapeutic relationship, violation of therapeutic boundaries, lowered level of trust, safety, and confidence in the therapist's competency, shifts the focus onto the therapist, makes the client feel as though he or she needs to care for the therapist, causes client inhibition in or disengagement from the therapeutic process, and elicits negative or uncomfortable emotions in the client because of the intimacy that can be fostered by therapist self-disclosure (Audet, 2011; Audet & Everall, 2010; Hanson, 2005; Peterson, 2002; Wells, 1994).

The research findings on the effect of therapist self-disclosure on social influence variables and facilitative conditions appear to be mixed and contradictory, thus making it difficult to draw any definitive conclusions. A wealth of evidence supports the value of genuineness or self-disclosure as an essential component in effective therapy. Generally,

the literature on interpersonal influence and therapist self-disclosure suggests that counselor self-disclosure increases perceptions of counselor attractiveness (Merluzzi et al., 1978; Nilsson et al., 1979). The literature suggests that therapists who self-disclose are perceived as warmer than those who do not, and disclosures that reveal personal information, experiences, beliefs or attitudes similar to those of the clients are perceived to be more attractive. It appears that the strength of the therapeutic alliance is a variable that influences whether counselors that self-discloses are perceived to be more expert. Additionally, counselors who use self-involving statements may be perceived as more professional than counselors who self-disclose. The reason for this may be that people have preconceived notions about how therapy should be, as well as preconceived ideas that therapists should be the ideal model of mental health.

Limitations of research on therapist self-disclosure.

It is very difficult to have a clear understanding of the effects of therapist self-disclosure on clients because of a myriad of limitations within the research on this topic. Across studies, therapist self-disclosure has been defined in various ways, and is often poorly operationalized, thus making it difficult to compare the results of different studies (Audet, 2010; Hill & Knox, 2001). Hill & Knox (2001) suggest that future researchers should clearly define self-disclosure and use definitions that are consistent with ones found in previous research. Another important limitation pointed out by other authors is that most studies use an analogue design or survey design (Farber, 2006; Henretty & Levitt, 2010; Hill & Knox, 2001; Knox et al., 1997). When using an analogue or survey design, the evolving context and relationship between therapist and client is lost (Audet, 2010; Farber, 2006; Hill & Knox, 2001. Therefore, analogue designs are not

representative of the actual counseling experience. Farber (2006) points out that the problem with the analogue and survey designs is that it "decontextualizes a situation in which context exerts a great deal of influence" (p. 147). Hill & Knox (2002) shines light on the fact that most research within the area of therapist self-disclosure has focused on frequency of self-disclosure. This ultimately implies a linear relationship between frequency of disclosure and therapeutic outcome when there is no reason to draw this conclusion (Farber, 2006; Hill & Knox, 2002). Hill & Knox (2002) assert that other situational variables have been left out of research such as: type, content, timing, and client readiness to receive disclosures.

Finally, most studies lack generalizability because they have small sample sizes, consist of nonclients, and lack cultural diversity (Constantine & Kwan, 2003; Farber, 2006; Hill & Knox, 2001). Constantine & Kwan (2003) have pointed out that majority of studies have therapists and clients that are female, white, and American. A therapist's cultural or racial background can affect the nature as well as the impact of therapist disclosure. Furthermore, lack of racial and cultural diversity within samples results in data that maybe affected by important biases and limitations based upon race, culture and gender experience.

The wounded healer.

There is an apparently high prevalence of psychological disturbance among therapists. Studies have suggested that approximately 75-85% of therapists have taken part in therapy, compared with 25% of the general population (Bike, Norcross, & Schatz, 2009; Norcross & Conner, 2005; Orlinsky, Schofield, Schroder, & Kazantzis, 2011). Therapists most frequently report pursuing therapy for anxiety, depression, and marital

conflicts (Bike et al., 2009; Norcross & Conner, 2005). Across studies, approximately 73% of therapists have experienced anxiety, 58-62% have experienced severe depression, and 11% have experienced substance abuse (Deutsch, 1985; Gilroy, Carroll, & Murra, 2002; Sherman, 1996; Sussman, 1992).

The concept of the wounded healer suggests that a healer's wounds can carry curative power (Zerubavel & Wright, 2012). The origin of the wounded healer lies in Greek mythology; however, Jung was the first psychotherapist to reference this archetype (Jackson, 2001). At first, Jung thought of therapists' personal struggles as something that was negative but later changed his stance, asserting "only the wounded physician heals" (Jung, 1963, p. 134). The wounded healer paradigm suggests a duality; i.e., that there is both a healer and patient within each therapist and client. It is the activation of the wounded healer's duality that facilitates the healing process (Guggenbuhl-Craig, 1971; Miller & Baldwin, 2000; Sedgwick, 2001). Healing potential is generated through the process of recovery and not simply as a result of the individual's being wounded (Zerubavel & Wright, 2012).

Mental health clinicians are idealized as paragons of health and maturity (Sussman, 1992). However, therapists have cited childhood experiences of woundedness as a primary motivation for becoming a therapist (Barnett, 2007; Sussman, 2007). Furthermore, many psychotherapists arrive at their profession through a journey of pain and suffering (Barnett, 2007; Farber, Manevich, Metzger, & Saypol, 2005). Therapists that overcome these psychological wounds are wounded healers; those who are wounded and whose personal distress negatively impacts their work are impaired professionals (Jackson, 2001). Therefore, in order to prevent the therapist's wounds from interfering

with therapy, the wounds must be understood, processed, or be healed sufficiently (Gelso & Hayes, 2007).

Some areas of mental health treatment embrace the wounded healer. For example, in alcohol and substance abuse treatment, the wounded healer plays a distinctive role as service provider (Zerubavel & Wright, 2012). It is common and usually preferred for a therapist to have had a history of alcohol or substance abuse (Jackson, 2001) because these therapists are perceived as having higher credibility regarding the therapy process and a deeper empathetic connection with clients going through similar struggles (White, 2000). The problem of eating disorders is another mental health area that has begun to embrace the concept of wounded healer. One study (Bloomgarden, Gerstein, & Moss, 1999) surveyed 150 staff members at a treatment program regarding self and/or family history of eating disorders, and found that 29% themselves struggled with an eating disorder and that 14% had a family member with an eating disorder.

Advantages and disadvantages. Studies that have investigated the under-researched area of the wounded healer have found that many wounded healers perceive their experiences as transformative, leading to growth both personally and professionally (Zerubavel & Wright, 2012). Mental health workers with wounds report that their emotional issues and experiences inform their practices and give them greater empathy towards their clients (Gilroy et al., 2002). Gilroy, Carroll, and Murra (2001) surveyed women psychotherapists; most of the respondents that reported experiencing depressive disorders also reported that these experiences had a positive effect on their clinical work. Moreover, the women in the study reported enhanced empathy with depressed clients,

more patience and tolerance when progress in therapy was slow, a heightened appreciation for how difficult therapy can be, and greater faith in the therapeutic process. Similarly, another study (Gilroy et al., 2002) surveyed 425 licensed psychologists and asked them to indicate whether or not they had experienced depressive symptoms while working and if they had received treatment for these symptoms. Of the respondents surveyed, 62% self-identified as depressed and 38% as nondepressed. The respondents reported that the emotional issues gave them more empathy for their clients; however, they also indicated they had lessened energy and ability to concentrate on their relationships with clients. Respondents also reported that they felt isolated from colleagues. Eating disorder research has recently highlighted possible benefits and challenges of disclosing personal recovery from an eating disorder to this client group (Bloomgarden & Mennuti, 2009a; Costin & Johnson, 2002). For example, clinical advantages of staff with recovery of an eating disorder include: understanding, hope, and motivation; enhanced empathy and trust; shame abatement; challenging narcissism and grandiosity (Costin & Johnson, 2002).

A number of negative effects of woundedness in clinical work has been reported within the literature; these include decreased ability to be emotionally present, poorly managed countertransference, overidentification, projection, having a personal agenda regarding the therapy process, as well as boundary confusion or violation, and in some cases the possibility of relapse (Briere, 1992; Gil, 1988).

In summary, those who have shown significant recovery regarding mental health issues and/or severe emotional difficulties bring insight and understanding to the helping role, and the model recovery, providing a sense of hope for clients (Specht, 1988).

However, when an individual's wounds are not properly tended to, the negative consequences can harm both therapist and client. Although it is clear that the wounded healer has positive and negative effects on clients, the impact of the wounded healer is not well understood due to lack of research (Zerubavel & Wright, 2012). A large amount of literature on therapist self-disclosure and experiential knowledge of a mental illness focuses primarily on competency issues. There is a dearth of articles that address the benefits of self-disclosure or experiential knowledge of a mental illness of the professional for his or her clients (Kottsieper, 2009).

Counselors with disabilities.

It has been suggested that clients from special populations will perceive counselors from similar populations as more credible and attractive because of group membership similarity (Heppner & Claiborn, 1989, p.370). Some branches within the independent living movement assert that individuals who have a physical disability relate more readily to a counselor with a physical disability than to one who does not have a disability (Nosek, Fuhrer, & Hughes, 1991). Counselors with disabilities are thought to have certain advantages relative to able-bodied counselors because of their disabilities (Mallinkcrodt & Helms, 1986). For example, some authors (Brearley, 1980; Grantham & Joslyn, 1981) suggest that counselors with disabilities have unique life experiences and coping strategies that increase their ability to function as role models for clients who are able-bodied and disabled. Other authors (Bicardi, Helms, Harren, 1979) have suggested that clients may believe that having a disability would enhance an individual's ability to empathize. This section will review the empirical literature on how counselor disability status affects client preferences and perceptions of counselors with disabilities.

Client preferences for counselors with disabilities. Client preferences for counselors with particular characteristics may significantly influence factors that relate to the counseling process such as: help seeking, duration of counseling, subsequent evaluations of counseling, and certain aspects of the counseling interaction (Strohmer & Leierer, 1996). One study also found that matching clients with counselors according to preference produced slight but consistent effects on client and counselor evaluations of outcomes (Ziemelis, 1974). In some studies, clients have been shown to prefer counselors of the same sex, same socioeconomic status, and as a function of the type of problem the client reports during the counseling session. It is important to realize that society's stereotypical expectations and beliefs about individuals with disabilities can influence counseling outcomes (Strohmer & Leierer, 1996). Some research suggests that the physical disability of a counselor has been shown to be a significant variable in the perception of the individual's therapeutic ability and in client preferences (Brabham & Thoreson, 1973; Mitchell & Allen, 1975).

A literature review by Strohmer and Leirer (1996) examined the effects of counselor disability status on counselor preferences and perceptions (expertness, attractiveness, and trustworthiness) of individuals with and without a disability. The authors concluded that "preference for counselors who are disabled is, at best a weak effect and at worst an artifact of designs with limited external validity" (p. 4). Of the nine studies that examined preferences for counselors with a disability, four had results supporting the idea that counselors with a disability are preferred; two of these used clients with a disability. The remaining five did not support the idea of a preference. When counselor disability was preferred, it was inconsistent across disabilities and

counseling problems. Also, an effect was found for type of counseling problem in all of the studies that indicated counselor preference. One of the studies (Brabham and Thoreson, 1973) investigated the effects of an obvious physical disability of a counselor on preferences of clients that were both able-bodied and disabled. Results from this study suggested that disabled individuals are preferred as counselors over able-bodied individuals. Subjects consisted of undergraduate university students that were both able-bodied and disabled. The participants were shown three slides: a counselor in a wheelchair, a counselor in crutches, and a counselor with no apparent physical disability. They were then asked about hypothetical counseling situations. Interestingly, the counselors with a physical disability were selected more often than able-bodied counselors for discussing hypothetical counseling situations. Subjects that were disabled preferred counselors with a disability, rather than one without a disability for personal problems; however, no differences were found for vocational or educational problems. In all problem areas, the able-bodied sample most frequently chose the counselor that was shown in a wheelchair; least frequently, he or she chose the counselor in crutches. Therefore, all sample subjects tended to choose, with the greatest frequency, the disabled counselor for discussing problems. These findings are in contrast to literature suggesting prejudice toward those with disabilities. For example, Allen and Cohen (1980) explored preferences for a counselor across three problem areas: vocational, sexual, and personal. The results of this study indicated that able-bodied participants preferred an able-bodied counselor and disabled persons preferred a disabled counselor. Furthermore, disabled persons preferred to discuss sexual problems, and nondisabled persons preferred to discuss vocational concerns. Another study (Strohmer & Phillips, 1985) investigated the

influence of similarity in counselor age, race, gender, socio-economic background, and disability status on the counselor preferences of students with disabilities, who were economically disadvantaged. Interestingly, neither disabled nor disabled students differed in their preferences for a counselor of the same age, sex, or race for academic – vocational concerns versus personal-social problems. Disabled participants and disadvantaged students showed a greater preference for a disabled counselor when discussing educational-vocational concerns versus a personal-social concern. Haley & Dowd (1988) found that students with hearing impairments did not indicate a preference for a counselor with a hearing impairment; however, they did prefer a counselor who used sign language or they preferred the presence of an interpreter.

It should be noted that the studies indicating preference used photographs and verbal descriptions of the counselors, but studies that did not indicate a preference for a counselor with a disability used a real-life counselor or a videotaped presentation of the counselor and client (Strohmer & Leierer, 1996). Researchers that have studied the construct of preference have found an abundance of literature suggesting that preferences are unstable and easily manipulated (Slovic, 1995).

Client perceptions of counselors with disabilities. Theoretically and empirically, client perceptions have been tied to more effective counseling interventions and outcomes (Strohmer & Leierer, 1996). According to Strong (1968), a counselor's influence potential with a client is affected by the degree to which the client perceives the counselor as expert, attractive, and trustworthy. It has been asserted by Strohmer & Biggs (1983) that counselors with disabilities may be perceived as more expert, trustworthy, and attractive to clients with disabilities because the client and counselor

share group membership. Additionally, counselors with disabilities may be perceived as more attractive and expert to clients with disabilities because of perceived knowledge and similarity. Interestingly, the results from studies have generated mixed results.

Ten studies examined in the Strohmer and Leierer (1996) literature review investigated the effects of client disability status on client perceptions of counselors with disabilities. Seven of the ten studies did not find a main effect for counselor disability status; one found a positive main effect; one found a negative main effect, and one did not report main effects. In the six of the ten participants with disabilities one had a negative main effect, four found no main effects, and one did not report main effects. Ultimately, the authors concluded that counselor disability status is not a major factor influencing perceptions of a counselor's social influence, either for individuals with or without a disability. Leon (1988) found that an average of 1 year after their incidents, individuals with mobility disabilities preferred a counselor without a disability and gave significantly higher ratings on expertness, attractiveness, and trustworthiness to the counselor without a disability. Mallinckrodt & Helms (1986) found a significant main effect for disability status. The authors recruited 169 university students without disabilities who did not have disabled friends or relatives. The participants viewed one of four tapes that depicted a counseling session involving: (a) able-bodied or no disability and no self-disclosure of a disability, (b) obvious disability (individual in a wheelchair) with no self-disclosure of disability, (c) obvious disability (individual in a wheelchair) who disclosed and discussed his or her disability, (d) non obvious disability (visually impaired with contact lenses) who was able-bodied and who disclosed his or her disability. The results indicated that disabled counselors were rated equivalent to or more

positive than able-bodied counselors. However, self-disclosure did not have a positive or negative effect on ratings. The counselors in wheel chairs who self-disclosed were rated as significantly more expert and attractive than the able-bodied counselors with no apparent disability who did not disclose. Counselors in wheelchairs who self-disclosed received significantly higher ratings for expertness and attractiveness, compared with counselors that were able-bodied with no apparent disability who did not disclose. There were no significant differences in ratings of counselors in wheelchairs who disclosed and those who did not disclose. Counselors with the non-obvious disability who disclosed were rated significantly more attractive than the able-bodied, or those with no apparent disability and no self-disclosure. Another study (Nosek et al., 1991) examined the influence of counselor disability status, counselor professional reputation, and counseling content on counselor credibility by persons with physical disability. Each of the 71 volunteers viewed four photographs of male counselors; two had visible disabilities and two did not; they read a biography that included each counselor' professional credentials and listened to an audiotape containing a counseling problem, one that was disability related and another that was not. Each participant rated the counselors on experience, expertness, interest, understanding, and ability. Overall, counselors with disabilities were rated more favorably than counselors without disabilities, particularly when the counselors were portrayed as nonprofessionals and the counseling problem was disability related.

Interaction of counselor disability status and other factors. Interaction effects were found with counselor disability status and another variable in five of the eight studies reviewed by Strohmer and Leierer (1996). No interactions were found with

disability status in two of the five studies. In two additional studies, counselors with a disability had higher ratings when the content of counseling was a disability-specific issue, thus suggesting an interaction between disability status and session content (Strohmer & Leierer, 1996).

One study that used participants without disabilities indicated an interaction with disability (Strohmer & Leierer, 1996). Mallinckrodt and Helms (1986) found an interaction effect of counselor self-disclosure and counselor disability status. Clients rated counselors who had an obvious disability, who self-disclosed about this disability higher on trustworthiness. Another study (Strohmer & Biggs, 1983) investigated the influence of client-counselor group membership similarity, counselor reputational cues, and counselor attending behavior on disabled subjects' perceptions of a counselor's attractiveness and expertness. The subjects were 40 physically disabled adults that looked at a series of vignettes portraying a counselor-client interaction. After viewing each vignette, the participants were asked to rate the counselor's attractiveness and expertness. Higher ratings were given to the counselor without a disability in the attending behavior condition, whereas the counselor with a disability received higher ratings in the non-attending condition. Regardless of disability status, counselors who used appropriate attending behavior were rated highest.

In conclusion, if counselor disability status has an effect on social influence factors (expertness, trustworthiness, and attractiveness), it is at best a weak effect. If counselors have an advantage it may be only when they are discussing an issue that is related to shared disability status (Strohmer & Leierer, 1996).

Limitations in research. The theoretical underpinning of most of the research on the perceptions of counselors with disabilities is based on Strong's (1968) social influence theory. Strohmer & Leierer (1996) highlight the idea that perceptions research has seen little replication and is made up of cross-sectional designs rather than longitudinal designs. Furthermore, the research is full of inconsistency in instrumentation, in inadequate statistical analysis, and in lack of methodological rigor and external validity. It is important to address the concept that the types of disabilities used in all of the studies on counselors with disabilities are limited. It is unclear how the type, the severity of a disability, the cause and the stigma may contribute to perceptions of expertness, trustworthiness, and attractiveness (Strohmer & Leierer, 1996).

Stigmatization of mental illness.

Mental health stigma is one of the primary challenges faced by individuals who are diagnosed with a mental illness. Common stigmatizing attitudes held by society toward those who have a mental illness contribute to social intolerance; these include the beliefs that that individuals with mental health conditions are dangerous and should be avoided; that they are to blame for their conditions; that they are weak in character, and are incompetent and need oversight and care (Day, Edgren, & Eshleman, 2007; Smith & Cashwell, 2010). Furthermore, individuals who have mental illnesses are frequently portrayed in the media as unpredictable, violent, and dangerous, thus perpetuating negative attitudes and stigma toward those with psychiatric illnesses (Stuart, 2006). Furthermore, current biological explanations for mental illness have reinforced that idea that the mentally ill are defective and genetically tainted (Arboleda-Florez & Stuart, 2012). A number of consequences have been associated with mental health stigma; these

include lower self-esteem and self-efficacy, unemployment, and strained interpersonal relationships. Furthermore, mental health stigma negatively impacts treatment seeking, and can worsen mental health symptoms and the ability to cope (Sickel, Seacat, Nabors, 2014). One main consequence frequently mentioned in the literature is that people do not seek treatment for their illnesses because of fear, shame, and anxiety (Zerubavel & Wright, 2012). The mentally ill often internalize these stereotypes, leading to decreased self-esteem and self-efficacy (Watson, Corrigan, Larson, & Sells, 2007).

Mental health professionals are influenced by widely held social beliefs, and interestingly, have been rated by those who seek their services as one of the most stigmatizing of all groups (Thornicroft & Mehta, 2010). Mental health professionals who suffer from mental illnesses are also subject to the negative effects of mental health stigma, especially because it is assumed that they can fix their own problems and are at the pinnacle of mental health (Schulze, 2007; Sussman, 1992). Professionals often fear that disclosing mental illness or distress will lead others to question their competency and could result in being fired. In fact, most professionals hide their wounds because they do not want to be thought of as an impaired professional (Sherman, 1996). It is not uncommon for people to assume that the wounded healer cannot provide effective care to patients (Forrest, Gizara, & Vacha-Haase, 1999, O'Connor, 2001).

Furthermore, awareness of the stigma associated with one's mental illness within society and the mental health profession often causes feelings of shame, humiliation, and disgrace (Hinshaw & Stier, 2008). Society stigmatizes some disabilities and mental health conditions more so than others, based upon the specific characteristics of the wound. In other words, not all deviances are equal (Feldman & Crandall, 2007). Factors

that have been found to be related to the social stigma of mental illnesses are: visibility, treatability, dangerousness, and the extent to which relationships are disrupted (Day et al., 2007).

For example, an individual who discloses that he or she has schizophrenia will probably be stigmatized to a greater degree than another person who discloses that he or she has depression. This occurs because of the association between schizophrenia and psychosis. Psychosis is considered to be dangerous. Furthermore, psychologists may respond differently to a therapist who discloses anxiety or depression rather than to one who has a personality disorder because personality disorders carry poorer prognosis (Zerubavel &Wright, 2012). One study (Feldman & Crandall, 2007) had participants (281 undergraduates) read case histories depicting individuals with 40 mental disorders. The participants were then asked to rate those individuals on 17 dimensions and indicated how willing they were to reject these individuals on a social distance scale. This ultimately resulted in a ranking of mental disorders by degree of stigmatization. Participants' social distance ratings were highest for Antisocial Personality Disorder and lowest for Narcolepsy, Female Sexual Arousal Disorder, and Posttraumatic Stress Disorder. Interestingly, out of Dysthymia, Major Depression, Panic Disorder, Bipolar Disorder, Attention Deficit Disorder, and Social Phobia—ranging from most rejected to least rejected, Dysthymic Disorder was the most highly stigmatized followed by Major Depression, Panic Disorder, Specific Phobia, Bipolar Disorder, Attention-Deficit Disorder, and Social Phobia.

In summary, mental health stigma has many negative effects on self-esteem and self-efficacy, employment, housing, and interpersonal relationships. Mental health

stigma is associated with increases in mental health symptoms, decreases in treatment compliance and treatment seeking in young adult (college age) and in older adult populations, as well as in reduced coping efforts. Because all deviances are not equal, some mental illnesses are more seriously stigmatized than others. Therapist self-disclosure of a mental health condition may help in breaking the stigma of mental illness. In conclusion, although the effects of therapist non-immediate self-disclosure are unclear, there is some research to support positive effects of therapist self-disclosure on aspects of the therapeutic alliance. The therapeutic alliance has consistently been linked to positive therapy outcomes and clients who report a strong alliance with their therapists are less likely to terminate therapy prematurely. Therefore it is important to investigate ways that therapists can help strengthen the therapeutic alliance among those who attend college because this population appears to be particularly vulnerable and could benefit from the psychological support.

Chapter 3

Method

This study utilized a quantitative research design consisting of four written vignettes and an anonymous survey. Each written vignette contained a single scenario involving a client-therapist interaction during a therapy session and therapist self-disclosure of one of the following mental health conditions: Depression, Anxiety, ADHD, or no self-disclosure. The survey consisted of 12 questions from The Counselor Rating Form—Short (CRF-S) that make up three subscales: Attractiveness, Expertness, and Trustworthiness; 34 questions from The Barrett-Lennard Relationship Inventory (BLRI) that make up the Empathy and the Level of Regard subscales, and eight demographic questions asking the participant's age, the region of the United States in which he/she resides, gender, race/ethnic and gender identities; if the participant has ever attended therapy, and if so, for what reason(s); if he/she has a clinical diagnosis and an identification of the diagnosis.

The online survey for this study was created and distributed through SurveyMonkey. All participants were informed that their answers were anonymous. As an additional precaution, SurveyMonkey's capacity to track internet IP addresses was disabled, so that there was no way of tracking the specific IP addresses of individuals who access the survey.

Participants.

Participants consisted of 130 males (48.7%), 135 females (50.6%), 2 other (.7%), totaling 267 subjects. All participants ranged from age 18 thru age 29. The vignettes which compose the primary independent variable depict a 21 year old patient old and a

30 year old therapist. Participants exceeding the therapist's age were excluded. Seven participants ranging from age 30 through age 64 from the original 274 respondents were excluded from the study as being outside the targeted age group. The majority of the final 267 participants classified themselves as White (56.9%). The remaining individuals identified themselves as African-American (12.4%), Hispanic (16.1%), American Indian (1.5%), Asian (8.6%), Multiple Races (3.7%), and Other (.7%). Geographically, (21.0%) participants reside in the Pacific, (21.3%) in the South Atlantic, (16.9%) in East North Central, (13.5%) in the Middle Atlantic, (7.5%) in the West South Central, (7.1%) in the Mountain, (5.2%) in New England, (4.1%) in the West North Central, and (3.4%) in the East South Central. Of the 267 participants, 132 (49.4%) reported exposure to therapy. Participants indicated the following reason(s) for entering therapy: Depression (79), Anxiety (69), Family and/or Friends (50), Romantic Relationships (25), Academic Difficulties (24), Attentional Problems (19), Problems Adjusting (16), Sexual Assault (15), and Substance Abuse (9).

Recruitment.

SurveyMonkey sent survey materials to college students 18 years and older in the United States. The email indicated that the name of the survey was titled "Therapist Opinion Survey." A link that took the participants directly to the survey materials was embedded within the email.. As part of the introduction to the survey, participants were informed that they would be presented with a scenario depicting an interaction between a therapist and a client in a therapy session. After reading the scenario, participants were asked to read a series of questions that took approximately 10-15 minutes to complete. Participants were asked to give their honest opinions and were told that their answers

would be kept anonymous. Additionally, participants were informed that completion of this survey was voluntary and that they could choose to stop at any time.

Measures and materials.

Dependent variables. The Counselor Rating Form—Short (CRF-S) (Corrigan & Schmidt, 1983) is a brief version of the Counselor Rating Form (CRF; Barak & LaCrosse, 1975) that measures social influence variables. The measure consists of 12 items (attributes), that when summed, make up three subscales: Attractiveness (4 items), Expertness (4 items), and Trustworthiness (4 items). The respondent is asked to rate the extent to which they feel their therapist possess an attribute on a 7-point Likert scale that ranges from 1 (not very) to 7 (very) (see Appendix A). Subscale scores range potentially from 4 to 28. Larger subscale scores are indicative of greater levels of a perceived attribute. Corrigan and Schmidt (1983) found that the reliabilities for Attractiveness, Expertness, and Trustworthiness to be .86, .87 & .76. Reliability was not calculated for the total score. Tracey, Glidden, and Kokotovic (1988) found reliabilities of .93, .92 & .92 for the 3 subscales and .95 for the total scale. Cohen's Alpha for the subscales in this study was found to be .87 for Attractiveness, .89 for Expertness, and .85 for Trustworthiness.

The Barrett-Lennard Relationship Inventory (BLRI) (Barrett-Lennard, 1962) is a 6-point Likert-type measure of perceived facilitative conditions (regard, empathy, and genuineness). The BRLI consists of 92 items that comprise five subscales: Level of regard; Empathetic understanding; Congruence; Unconditionality of regard; and Willingness to be known. This study uses the Empathy subscale (16 items), and the Level of regard subscale (18 items) (see Appendix A). Empathy is defined as "the extent

to which one person is conscious of the immediate awareness of another" (Barrett-Lennard, 1962 p.3). Level of regard is defined as "the affective aspect of one person's response to another…respect, liking, appreciation, affection" (Barrett-Lennard, 1962, p.4). In the original version respondents are asked to "read each item and rate each statement as if you were Kelly" on a scale ranging from -3(definitely not true) to +3 (definitely true). Potential scale scores range from -48 to 48 on the Empathy subscale and -54 to 54 on the Level of Regard subscale. Larger subscale scores are indicative of greater levels of perceived Empathy and Level of Regard. Some of the items are positively worded, others negatively worded, with scoring adjusted accordingly. The split-half reliabilities for the Empathy and Regard scales are .86 and .93, respectively (Barrett-Lennard, 1962; Klein & Friedlander, 1987).

There are many versions of the BLRI; therefore, it is important to mention that the basic other-to-self form was used. For the purposes of this research the two BLRI scales that were used (Level of Regard and Empathy) were modified. In order to conform to the vignettes, *he* was substituted with *she*. In addition to this item 3, "She disapproves of me" was changed to "She approves of me" so that the number of positive items was equal to the number of negative items for the Level of Regard subscale. The reliability for BLRI subscales together (Level of Regard and Empathy) is .89, suggesting that items have high item to total correlation with the exception of the item, "She tolerates me." A possible explanation for this may be that it is unclear if that statement is supposed to be positive or negative. The reliability for the Level of Regard and Empathy subscales are .84 and .77, respectively. It should be noted that 2 items on the Level of Regard subscale had low item to total correlation. These items were "She tolerates me" and "She has deep

affection for me". On the Empathy subscale, 1 item "She tries to understand me from her own point of view" also had lower item to total correlation. In conclusion high reliabilities were found for the total sample as well as for each of the therapy and no therapy subsamples.

Independent variables. The four written conditions were designed by the researcher and were guided by empirical research findings on therapist self-disclosure (see Appendix B). The therapist's disclosure came after the client's disclosure; it was similar in content and brief so that it would not take up too much time from the therapy session. Furthermore, the vignette indicates that the client has established a good relationship with the therapist and has known the therapist for two months. Four written vignettes were created depicting a 21 year-old female client and a 30 year-old female therapist interacting in a therapy session; it also involves therapist self-disclosure of Attention Deficit Hyperactivity Disorder, Anxiety, Depression, or no self-disclosure. The rationale for the diagnoses chosen for the vignettes is that these are common concerns and diagnoses found in university counseling centers.

Two additional independent variables (Gender and Therapy) were examined. Gender was utilized because the vignettes involved a female therapist and gender may affect perceptions of self-disclosure. An indicator of exposure to therapy was included because an individual's ratings may be affected by his or her personal experience or lack thereof in the therapeutic process.

Research design.

This study is a Quantitative design that utilizes a survey method. A 3 Between (condition, gender and therapy) Analysis of Variance design (ANOVA) was conducted

using the statistical software SPSS package on each of the five subscales (attractiveness, expertness, trustworthiness, empathy, regard) to determine if client perceptions of the therapists' levels of facilitative and social influence factors differ between disclosure and no disclosure, males and females, and experience with therapy versus no experience with therapy. An Analysis of Variance (ANOVA) was conducted using SPSS software on each of the five subscales to determine if client ratings of the therapist on social influence factors and facilitative conditions vary by the type of mental health conditions disclosed. If a factor is found to be statistically, significantly different, means will be examined to determine the nature and degree of the difference.

Procedure.

The online service, SurveyMonkey, distributed emails to college students in the United States who were 18 years and older, who were members of their respondent bank. Embedded within the email was a link that took the recipient directly to the survey materials that were titled, "Therapist Opinion Survey". The introduction to the survey informed participants that they would be presented with a scenario depicting an interaction between a therapist and a client in a therapy session. After reading the scenario, participants were asked to read a series of questions that took approximately 10-15 minutes to complete. Participants were asked to give their honest opinions and were told that their answers would be kept anonymous. Additionally, participants were informed that completion of this survey was voluntary and that they may choose to stop at any time. Each participant was randomly assigned to one of the four conditions (vignettes): therapist self-disclosure of ADHD, Depression, Anxiety, or no disclosure. After reading a vignette, the participant was asked to fill out 12 questions from the

Counselor Rating Form-Short (CRF-S), 34 questions from the Barrett-Lennard Relationship Inventory (BLRI), and eight demographic questions inquiring about the participant's age, in what region of the United States the individual resides, gender, race/ethnic and gender identities; if he or she had ever participated in therapy, and if so the main reason(s) for entering therapy; if the individual had been given a clinical diagnosis as well as any clinical diagnosis he/she has been given.

Chapter 4

Results

Two hundred sixty-seven university students between 18 and 29 years of age responded to the survey. Subjects' age by vignette is provided in Table 1; data on subjects' history of being in therapy is presented in Table 2. The first research question examines whether or not there is there a relationship between therapist self-disclosure of a mental health condition on client's perceptions of the therapist. Specifically, it was hypothesized that therapist self-disclosure of a mental health condition will result in higher ratings of the therapist's facilitative conditions and social influence factors. This hypothesis was tested using five 3 Between Factor ANOVAs, one on each of the subscales (Attractiveness, Trustworthiness, Expertness, Empathy, and Regard). On the CRF-S subscales, therapist disclosure proved significant on the Attractiveness subscale $F(1,257) = 4.668$, $p = .032$. The group that received disclosure yielded a higher therapist attractiveness rating ($x = 22.74$) than the nondisclosure group ($x = 21.25$) (see Table 3).

Table 1.

Subjects' Age by Vignette

	ADHD		Depression		Anxiety		No Disclosure		Total	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Age	21.9	2.66	21.0	2.30	21.2	2.48	21.7	2.40	21.5	2.48

Table 2.

*Subjects' Therapy History by Vignett*e

	ADHD Vignette	Depression Vignette	Anxiety Vignette	No Disclosure Vignette	Total
	n (%)	*n (%)*	*n (%)*	*n (%)*	*n (%)*
Therapy					
Yes	36 (13.5%)	29 (10.9%)	37 (13.9%)	30 (10.9%)	132 (49.4%)
No	30 (11.2%)	35 (13.1%)	33 (12.4%)	37 (13.9%)	135 (50.6%)
Total	66 (24.7%)	64 (24.0%)	70 (26.2%)	67 (25.1%)	267 (100.0%)
Problem					
Depression	22 (27.8%)	20 (25.3%)	20 (25.3%)	17 (21.5%)	79 (100.0%)
Anxiety	21 (30.4%)	14 (20.3%)	18 (26.1%)	16 (23.2%)	69 (100.0%)
Family and/or friends	15 (30.0%)	11 (22.0%)	14 (28.0%)	10 (20.0%)	50 (100.0%)
Romantic relationship	6 (24.0%)	7 (28.0%)	4 (16.0%)	8 (32.0%)	25 (100.0%)
Academic difficulties	6 (25.0%)	8 (33.3%)	4 (16.7%)	6 (25.0%)	24 (100.0%)
Attentional problems	4 (21.1%)	6 (31.6%)	5 (26.3%)	4 (21.1%)	19 (100.0%)
Problems adjusting	5 (31.3%)	3 (18.8%)	4 (25.0%)	4 (25.0%)	16 (100.0%)
Sexual assault	2 (13.3%)	3 (20.0%)	6 (40.0%)	4 (26.7%)	15 (100.0%)
Substance abuse	4 (44.4%)	2 (22.2%)	2 (22.2%)	1 (11.1%)	9 (100.0%)

Note. Subjects could report multiple problems

Table 3.

Mean Subscale Ratings and Standard Deviations as a Function of Disclosure, Gender, and Therapy Experience

			CRF-S		BLRI		
			Attractiveness	Expertness	Trustworthiness	Regard	Empathy
Disclosure	Gender	Therapy	Rating *(SD)*	Rating *(SD)*	Rating *(SD)*	Rating *(SD)*	Rating *(SD)*
Yes	Male	Yes	22.32 (4.68)	21.47 (4.63)	22.58 (4.36)	9.77 (15.77)	3.22 (11.60)
Yes	Male	No	22.56 (3.54)	20.84 (4.17)	21.76 (3.66)	13.43 (12.96)	5.36 (10.35)
Yes	Female	Yes	23.04 (5.05)	21.87 (5.25)	23.36 (3.99)	19.00 (15.67)	9.24 (13.84)
Yes	Female	No	23.01 (4.21)	22.30 (4.66)	23.17 (4.17)	16.84 (15.12)	8.00 (12.34)
No	Male	Yes	21.64 (4.01)	19.64 (4.03)	21.57 (3.85)	6.21 (7.74)	-2.00 (7.00)
No	Male	No	21.23 (5.05)	21.17 (5.10)	21.64 (4.80)	10.47 (12.16)	1.41 (6.25)
No	Female	Yes	21.46 (4.62)	20.66 (4.57)	22.40 (4.71)	17.13 (15.92)	6.53 (12.89)
No	Female	No	21.00 (5.18)	20.94 (4.49)	21.36 (4.43)	12.94 (18.88)	6.57 (13.15)

On the BLRI Empathy subscale, disclosure proved to be significant on the BLRI Empathy subscale than did non-disclosure $F(1,257) = 3.892$, $p=.05$. The group that received disclosure yielded more positive empathy ratings (x = 6.44) than the nondisclosure group (x = 2.94). Disclosure proved non-significant for the CRF-S Expertness $F(1,257) = 2.298$, $p = .131$, CRF-S Trustworthy $F(1,257)=2.644$, $p=1.05$, and BLRI-Regard $F(1,257) = 2.062$ $p=.152$ Report subscales. The 3 Between Factor ANOVA did not produce Gender effects for the CRF-S nor for the CRF-S subscales. However, there were Gender effects for both BLRI subscales. Gender differences were statistically significant on the BLRI Regard subscale at the .003 level F(1,257)=9.252,

p=.003, with females rating the therapist higher (*x*=17.1) than males *(x*=10.8). Similarly, Females therapist ratings on the BLRI Empathy subscale were higher (*x*=13.0) than males (*x*=10.3) *F*(1,257)=10.963, *p*=.001. There were no significant differences based on a subject's history of experience in therapy *F*(1, 257) = .416, *p*= *.519* > .05). No interaction effects were found for condition x gender *F*(1,257) =.560 , *p* >=.455 .05 , condition x therapy *F*(1, 257) = .144, *p* =*.705*, gender x therapy *F*(1, 257) = 1.00, *p* =.318 , and Condition x Gender x Therapy *F*(1, 275) = .001 *p* =.997.

Research question II attempted to examine the differences between the types of disclosure. Two hypotheses were presented: Hypothesis I: The therapist who discloses Attention Deficit Disorder will receive higher ratings from clients on facilitative and social influence factors than the therapists who disclose Depression or an Anxiety Disorder. Hypothesis II: Therapist self-disclosure of an Anxiety Disorder will result in higher ratings on facilitative and social influence factors than on disclosure of Depression.

A one-way ANOVA yielded no significant condition effects for the CRF-S subscales nor for the BLRI subscales. The *F* values range from 0.815 to 1.844 for the CRF-S subscales and from 1.435 to 1.866 for BLRI subscales with *p* values ranging from 0.14 to 0.487 for CRF-S subscales and from .136 to .233 for BLRI subscales (see Table 3.). Mean subscale ratings by condition are provided in Table 3.

Table 4.

ANOVA for Subscale Ratings

	ADHD Vignette		Depression Vignette		Anxiety Vignette		No Disclosure Vignette				
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*df*	*p*
CRF-S											
Attractiveness	22.6	4.35	22.7	3.95	22.8	4.87	21.25	4.69	1.844	3,263	.140
Expertness	21.6	4.39	21.5	5.20	21.8	4.56	20.7	4.51	.815	3,263	.487
Trustworthiness	22.7	3.98	22.9	3.82	22.6	4.46	21.4	4.67	1.636	3,263	.181
BLRI											
Regard	12.6	15.49	16.5	14.99	15.1	15.31	11.7	14.61	1.435	3,263	.233
Empathy	5.0	12.44	6.9	12.07	7.2	12.32	2.9	10.96	1.866	3,263	.136

Chapter 5

Discussion

This study examined the effect of therapist self-disclosure of a mental health condition on client perceptions of the therapist's social influence and facilitative factors. It was hypothesized that therapist self-disclosure of a mental health condition, rather than no disclosure, would result in higher ratings of the therapist's facilitative conditions and social influence factors. The results of this study partially support this hypothesis. Specifically, therapist self-disclosure of a mental health condition, as opposed to no disclosure, resulted in significantly higher (more positive) ratings of the therapist on attractiveness and empathy. There were no significant differences between the disclosure and no disclosure groups on the CRF-S Expertness and Trustworthy subscales as well as on the BLRI Regard subscale. Results of this study are similar to Somers and colleagues' (2014) research that found, in the vignettes, that psychotherapists that self-disclosed personal problems similar to those of the client's were perceived as possessing a higher level of favorable personal qualities and would be more likely to establish strong working relationships with clients and achieve success in therapy. Additionally, this study supports research that found clients rated disclosing counselors as more empathetic (Reynolds & Fischer, 1983) and more attractive (Merluzzi et al., 1978, Nilsson et al., 1979) than non-disclosing counselors. The current findings also support Henretty and colleagues' (2014) meta-analytic review of experimental and quasi-experimental research which found that therapist self-disclosures containing negative content, thus revealing similarity between the counselor and client, and was related to intra- or extra-therapy

experiences resulted in more favorable perceptions of the counselor, particularly in the area of attractiveness.

Counselors who disclose a mental health issue may appear more empathetic and attractive than counselors who do not disclose because the therapist is communicating that he or she is human, and with faults and also that it is acceptable to receive help, thereby normalizing the individual's experience. Moreover, the experiential knowledge coupled with academic knowledge of the therapist may be more appealing to some people because in addition to the therapist being viewed as the expert, he or she is perceived to be more relatable. The therapist in each of the disclosure vignettes revealed personal information that was similar to the client disclosure. There is some research that has demonstrated increased ratings of perceived counselor attractiveness and warmth for counselors who disclose similar experiences, feelings and attitudes as subjects (Hoffman-Graff, 1977; Nilson et al., 1979; Schmidt & Strong, 1971). Therapist self-disclosure of a mental health condition may facilitate or enhance the therapeutic relationship through sharing similar experiences. Sharing this type of non-immediate information may validate client or non client's experiences as well as provide individuals with hope of recovery from a similar mental health condition or from mental health conditions in general. Enhancing a therapist's perceived level of empathy and professional attractiveness may assist in strengthening the therapeutic relationship, thereby helping to prevent premature termination and instead lead to positive therapeutic outcomes. The results of this study support previous research that did not find therapist self-disclosure to have a significant effect on perceptions of trustworthiness and level of regard (Henretty & Levitt, 2010; Myers & Hayes, 2006).

Interestingly, the current findings contradict previous research that found that clients rated self-disclosing counselors as less professional, less competent, less empathetic, less sensitive, less stable, and weaker than non-disclosing counselors (Curtis, 1981; Dies, 1973; VandeCreek & Angstadt, 1985). It is possible that no significant differences were found between disclosure and non-disclosure because the therapists in the vignettes self-disclosed in ways suggested by the literature. The disclosure was similar to what the client had revealed, occurred after client disclosure, was not lengthy, and was attuned to the client's needs. Additionally, participants may have assumed a positive therapeutic relationship between the therapist and client because the client had been receiving the therapist's services for two months. In Myers & Hayes' (2006) study, clients rated self-disclosing therapists as more expert in the context of a strong therapeutic alliance. Therefore, it is possible that participants' perceptions of the strength of the therapeutic relationship influenced ratings. In each of the four conditions the therapist validated the client's feelings. An individual's feeling of validation by his/her therapist may influence ratings of the therapist on trustworthiness and level of regard. This study provides additional evidence that supports the concept that a counselor's perceived level of expertness or competency is not necessarily compromised when he/she self-discloses a mental health condition (Nilsson et al., 1979).

The current study also examined if perceptions of the therapists' facilitative and social influence factors vary by type of mental health condition disclosed. It was hypothesized that therapist self-disclosure of ADHD would be rated more favorably than Anxiety and Depression on social influence factors and facilitative conditions. Additionally, it was hypothesized that disclosure of Anxiety would be rated more

favorably than Depression on social influence factors and facilitative conditions. The results of this study did not indicate significant differences in participant ratings of the therapist on social influence factors and facilitative conditions by the type of mental health condition disclosed. Therefore, the current findings did not support the two hypotheses pertaining to differences in ratings of the therapist by type of mental health condition disclosed.

These results are similar to Somers and colleagues' (2014) research, which found that vignettes depicting therapists who self-disclosed their own histories of psychological problems to clients with similar issues were perceived more positively than vignettes depicting therapists who did not disclose, and that perceptions of the therapist did not vary between the mental health conditions disclosed. Therefore the type of mental health condition disclosed may not be as influential as is the similarity of the therapist's psychological condition, issue or experience to the clients. This is a plausible explanation because, as stated previously, there are studies that have found that counselors who disclose similar experiences, feelings and attitudes as those of the subjects are perceived more positively in various ways (Hoffman-Graff, 1977; Nilson et al., 1979; Schmidt & Strong, 1971).

In addition, college students' perceptions of Anxiety, Depression, and ADHD may have impacted therapist ratings. An individual's knowledge, familiarity, and experience with a mental health condition can influence how it is understood and thus perceived. For example, Depression may be perceived by one individual as the result of an unpleasant experience, yet another person views it as neurochemical imbalance. Previous findings from Feldman & Crandall's (2007) research suggest that Anxiety,

Depression, and ADHD may be less stigmatized than other conditions among college students. Therefore, another conceivable explanation for the lack of significance found between the types of mental health condition disclosed could be that the three conditions in the vignettes are perceived to be more treatable and less dangerous than other disorders. It is important to note that the vignettes did not specify the particular kind of Depression or Anxiety that was being experienced either by the client or by therapist and ratings of the therapist may differ by a participant's perceived subtype of the condition disclosed.

The current study also investigated the impact of client gender and previous experience with therapy. Findings indicate significant gender effects and non-significant effects for previous experience with therapy. Females rated significantly higher than males on the regard subscale and on the empathy subscale. These ratings could be the result of female participants identifying with the female client or with the therapist in the vignette. Additionally, females may be more comfortable with discussing mental health concerns and with being the recipient of this type of disclosure. Expectations and preferences of therapist behaviors may differ between the genders. Another explanation may be that males perceive disclosure of a mental health condition as revealing a weakness. However, disclosure of a mental health condition may be more acceptable if disclosed by females. Sex differences have been reported in the receipt of self-disclosures. Women may perceive the role of the recipient of self-disclosure as more rewarding because of sex-role stereotypes suggesting that women are more concerned with issues of intimacy. Unsolicited disclosure may be more threatening to men (Collins & Miller, 1994). Another important factor to consider is that the conditions portrayed in

the vignettes may not have been relatable to male participants. Evidence from previous research suggests that treatment seeking is higher among females than among males in the college population (Eisenberg et al, 2012; Eisenberg et al., 2011; Mackenzie et al., 2004; Nam et al., 2010; Reetz et al., 2013; Thomas, Caputi, & Wilson, 2014) and that females are more likely than males to seek help for depression and anxiety (Said, Kypri, & Bowman, 2013). Females may have identified with the issues being discussed by the female client and/or therapist and may be more comfortable with self-disclosure of a mental illness. Significant gender differences in ratings of the therapist on empathy and regard may be due to disparate reasons for entering therapy, for personal experience with particular disorders, for relatability of the disclosed mental health condition, and for perceptions of particular mental health conditions. The lack of significance found for experience with therapy may be that this demographic question did not inquire about the length of time spent in therapy. In other words, an individual who has been in and out of therapy for 3 years may have different expectations of therapist behaviors as well as perceptions of therapist self-disclosure than someone who attended a single therapy session.

Limitations.

A number of limitations should be considered when reviewing the results of this study. Primarily, the current study made use of written vignettes in lieu of authentic or simulated therapy sessions. Therapy is a unique experience for each individual. Written vignettes do not capture the client's actual experience of the dynamics of therapist self-disclosure in a real therapy session (Knox et al., 1997). Therapist self-disclosure is very much influenced by context. Therefore the situation is being decontextualized (Farber,

2006). The vignettes did not specify the type of anxiety or depression that was experienced by the client or therapist. Therefore participant interpretations of the condition's cause or subtype could have influenced ratings. It is important to note that the therapist in the vignette self-disclosed in the ways outlined by the literature and provided validating statements. In other words, the vignette depicted a situation that was the ideal self-disclosure scenario. It is unclear if the disclosure would be received as positively if the disclosure was not made after the client's disclosure, and if it contained dissimilar content and more details. It is possible that the self-disclosure would not have been as well received if the therapist had not provided validating statements.

The current study did not investigate participants' preferences on self-disclosure nor did it provide qualitative information about the reasons why participants felt the way they did about the counselor and the counselor disclosure in the vignettes. Qualitative information inquiring about the reasoning behind participants' ratings of the therapist may provide an understanding into how clients and non clients perceive counselors who reveal this particular type of non-immediate information as well as beliefs pertaining to certain mental health conditions.

This study asked participants if they had ever participated in therapy; however, it did not ask about the length of the therapy. There may be differences in perceptions between individuals who have been in therapy for a particular amount of time. Finally, more than half of the sample in the current study consisted of Caucasian college students. The sample lacked cultural diversity and did not take into consideration how cultural differences may affect perceptions of therapist self-disclosure and mental health conditions.

Future directions.

One of the most significant problems with the research on therapist self-disclosure is the plethora of definitions across the literature. Researchers have defined therapist self-disclosure into immediate (self-involving; intratherapy) and non-immediate (self-disclosing; extratherapy) and others have differentiated between high and low intimacy, positive and negative information, high and low frequency. These differing definitions make it challenging for researchers to come to any clear conclusions about therapist self-disclosure. Various definitions exist within non-immediate, self-disclosure literature. Future researchers are encouraged to contribute to the literature by clearly defining what non-immediate self-disclosure he or she is attempting to measure. Particular types of non-immediate information can vary in emotional weight and level of intimacy. Therefore it would beneficial to gain a greater understanding of how different types of non-immediate information affect client perceptions of the therapist by investigating critical aspects of the disclosure event such as depth, breadth, duration, and emotional content (Altman & Taylor, 1973; Cozby, 1973; Omarzu, 2000). As suggested by Henretty and Levitt (2010), researchers should investigate how and why therapist self-disclosure of past struggles that are similar to the clients may affect perceptions of the therapist as well as the therapeutic relationship, alliance, and treatment outcomes.

Another issue present within the literature on therapist self-disclosure is the use of analogue studies. In many ways analogue studies have little applicability to authentic therapeutic situations (Henretty & Levitt, 2010). This is true, primarily because these studies fail to capture the dynamics of therapy genuinely (Henretty & Levitt, 2010); therefore, a situation in which context exerts a great degree of influence is being

decontextualized (Farber, 2006). Future research should use real clients and real therapists in natural settings.

A third problem, noticeable in research on therapist self-disclosure, and present in the literature on the wounded healer, including perceptions of counselors with disabilities, is how therapists who disclose particular mental health conditions are perceived by clients and colleagues and also if these perceptions differ across the type of condition. This type of information is valuable because it can inform mental health professionals of certain perceptions, stereotypes, and overall stigma attached to diagnostic labels and can educate the public on such issues.

A great deal of research fails to account for mediating variables: similar vs. dissimilar, positive vs. negative, frequency, timing, therapeutic relationship, client's expectations, preferences, personality characteristics, culture, and cognitive factors that may influence how clients and non-clients perceive non-immediate therapist self-disclosure. Current research lacks studies that investigate clients' preferences for a therapist with a disorder similar to theirs and also with the content that a client is willing to discuss with a therapist who has a certain mental health condition.

Conclusions.

In conclusion, non-immediate therapist self-disclosure is one of the most highly contentious topics among professionals in the mental health field. Therapist self-disclosure of a mental health condition and of experiential knowledge has become increasingly more acceptable in the treatment of substance abuse, eating disorders, sexual abuse, and gender identity. However, little is known about how therapist self-disclosure of different mental health conditions may be perceived by clients. The current study

aimed to contribute to greater knowledge in the literature about client perceptions of counselors with disabilities, therapist self-disclosure of a mental health condition, and the under-researched area of the wounded healer. The results of this study provides evidence suggesting that when implemented according to guidelines outlined in research, experiential therapist self-disclosure of a mental health condition enhances client perceptions of the therapist's level of empathy and professional attractiveness versus therapist non disclosure. The current findings lend additional support to previous research that suggests counselors' perceived levels of expertness or competency are not necessarily compromised by disclosure of a mental health condition. A growing amount of research suggests that increased client perceptions of a therapist on social influence factors and facilitative conditions can strengthen the therapeutic relationship and alliance. This is essential because many studies have found that the therapeutic relationship and alliance are strongly related to treatment outcomes. Therefore, it is important for researchers to find therapeutic methods that help facilitate and enhance the therapeutic relationship, as well as the therapeutic alliance. Non-immediate therapist self-disclosure or experiential knowledge of a mental health condition could be a therapeutic tool that can aid in accomplishing this task by making the therapist appear more attractive and empathetic to clients, and also possibly enhance the female clients' perceptions of a therapist's levels of empathy and regard. The therapist self-disclosure may help the therapist appear more relatable and human to clients as well as provide hope to those with similar conditions or experiences. Therefore, it is crucial for researchers to develop a deeper understanding of how and why different types of non-immediate therapist self-disclosure (particularly experiential knowledge of a mental health condition) as well as

various mediating variables positively and/or negatively affect the therapeutic alliance and relationship.

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Appendix A

Online Survey Questions

Counselor Rating Form – Short (CRF-S)

We would like you to rate several characteristics of your therapist. For each characteristic on the following page, there is a seven-point scale that ranges from "not very" to "very." Please mark an "X" at the point on the scale that best represents how you view your therapist. For example:

FUNNY

X

not very _____:_____:_____:_____:_____:_____:_____ very

WELL DRESSED X

not very _____:_____:_____:_____:_____:_____:_____ very

These ratings might show that the therapist does not joke around much, but dresses wisely.

Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences.

Corrigan, J. D., and Schmidt, L. D. (1983). Development and validation of revisions in the Counselor Rating Form. *Journal of Counseling Psychology, 30*, 64-75.

FRIENDLY

not very _____:_____:_____:_____:_____:_____:_____ very

EXPERIENCED

not very _____:_____:_____:_____:_____:_____:_____ very

HONEST

not very _____:_____:_____:_____:_____:_____:_____ very

LIKABLE

not very _____:_____:_____:_____:_____:_____:_____ very

EXPERT

not very _____:_____:_____:_____:_____:_____:_____ very

RELIABLE

not very _____:_____:_____:_____:_____:_____:_____ very

SOCIABLE

not very _____:_____:_____:_____:_____:_____:_____ very

PREPARED

not very _____:_____:_____:_____:_____:_____:_____ very

SINCERE

not very _____:_____:_____:_____:_____:_____:_____ very

WARM

not very _____:_____:_____:_____:_____:_____:_____ very

SKILLFUL

not very _____:_____:_____:_____:_____:_____:_____ very

TRUSTWORTHY

not very _____:_____:_____:_____:_____:_____:_____ very

The Barrett-Lennard Relationship Inventory

BLRI

Below are listed a variety of ways that one person could feel or behave in relation to another person. Please consider each statement with respect to whether you think it is true or not true in your present relationship with your therapist. Mark each statement in the left margin according to how strongly you feel it is true or not true. Please mark every one. Write +1, +2, +3; or -1, -2, -3 to stand for the following answers:

+1: I feel that it is probably true, or more true than untrue.

+2: I feel it is true.

+3: I strongly feel that it is true.

-1: I feel that it is probably untrue, or more untrue than true.

-2: I feel it is not true.

-3: I strongly feel that it is not true.

___1. She respects me.

___2. She tries to see things through my eyes.

___3. She approves of me

___4. She understands my words but not the way I feel.

___5. She is curious about “the way I tick,” but not really interested in me as a person.

___6. She is interested in knowing what my experiences mean to me

___7. She likes seeing me.

___8. She nearly always knows exactly what I mean.

___9. She is indifferent to me.

___10. At times she jumps to the conclusion that I feel more strongly or more concerned about something than I actually do.

___11. She appreciates me.

___12. Sometimes she thinks that I feel a certain way, because she feels a certain way.

___13. She is friendly and warm toward me.

___14. She understands me.

___15. She cares about me.

___16. Her own attitude toward some of the things I say, or do, stop her from really understanding me.

___17. She feels that I am dull and uninteresting.

___18. She understands what I say, from a detached, objective point of view.

___19. She is interested in me.

___20. She appreciates what my experiences feel like to me.

___21. She just tolerates me.

___22. She does not really care what happens to me.

___23. She does not realize how strongly I feel about some of the things we discuss.

___24. She seems to really value me.

___25. She responds to me mechanically.

___26. She dislikes me.

___27. She is impatient with me.

___28. She feels deep affection for me.

___29. She usually understands all of what I say to him.

___30. She regards me as a disagreeable person.

___31. At times she feels contempt for me.

___32. When I do not say what I mean at all clearly she still understands me.

___33. She tries to understand me from her own point of view.

___34. She can be deeply and fully aware of my most painful feelings without being distressed or burdened by them herself.

Demographic Questions

1. What is your age?

2. What is your ethnicity?

3. What is your gender?

4. Have you ever participated in therapy?

    If yes…

    5. What was the main reason for entering therapy?

6. If you were given a diagnosis, what diagnosis were you given?

Appendix B

Written Vignettes

Vignette 1

Kelly is a 21-year old college student who has been to therapy on and off over the past 5 years. She recently decided to go to therapy at her university counseling center because of a breakup with her boyfriend of 1 year. Kelly has been going to therapy at her university counseling center 1x a week for 2 months and has established a good relationship with her therapist, Dr. B. Dr. B. is a female psychologist in her early 30's. During a session with Dr. B., Kelly expresses that the recent breakup with her boyfriend of 1 year has caused her to feel depressed and anxious lately. In addition to this, Kelly tells Dr. B. that she been having a difficult time paying attention and getting her academic work done.

Dr. B. responds by acknowledging how difficult and painful it is dealing with a breakup and how it is not uncommon to experience anxiety and depression in this type of situation. Dr. B. also mentions that anxiety and depression can make it even more difficult for Kelly to focus and get her work done. For about five minutes, Dr. B. explains she can relate and understand Kelly's state of mind. Dr. B. reveals to Kelly this is because she has experienced painful breakups in the past and because she has ADHD.

Vignette 2

Kelly is a 21-year old college student who has been to therapy on and off over the past 5 years. She recently decided to go to therapy at her university counseling center because of a breakup with her boyfriend of 1 year. Kelly has been going to therapy at her university counseling center 1x a week for 2 months and has established a good relationship with her therapist, Dr. B. Dr. B. is a female psychologist in her early 30's. During a session with Dr. B., Kelly expresses that the recent breakup with her boyfriend of 1 year has caused her to feel depressed and anxious lately. In addition to this, Kelly tells Dr. B. that she been having a difficult time paying attention and getting her academic work done.

Dr. B. responds by acknowledging how difficult and painful it is dealing with a breakup and how it is not uncommon to experience anxiety and depression in this type of situation. Dr. B. also mentions that anxiety and depression can make it even more difficult for Kelly to focus and get her work done. For about five minutes, Dr. B. explains she can relate and understand Kelly's state of mind. Dr. B. reveals to Kelly this is because she has experienced painful breakups in the past and because she has Depression**.**

Vignette 3

Kelly is a 21-year old college student who has been to therapy on and off over the past 5 years. She recently decided to go to therapy at her university counseling center because of a breakup with her boyfriend of 1 year. Kelly has been going to therapy at her university counseling center 1x a week for 2 months and has established a good relationship with her therapist, Dr. B. Dr. B. is a female psychologist in her early 30's. During a session with Dr. B., Kelly expresses that the recent breakup with her boyfriend of 1 year has caused her to feel depressed and anxious lately. In addition to this, Kelly tells Dr. B. that she been having a difficult time paying attention and getting her academic work done.

Dr. B. responds by acknowledging how difficult and painful it is dealing with a breakup and how it is not uncommon to experience anxiety and depression in this type of situation. Dr. B. also mentions that anxiety and depression can make it even more difficult for Kelly to focus and get her work done. For about five minutes, Dr. B. explains she can relate and understand Kelly's state of mind. Dr. B. reveals to Kelly this is because she has experienced painful breakups in the past and because she has Anxiety.

Vignette 4

Kelly is a 21-year old college student who has been to therapy on and off over the past 5 years. She recently decided to go to therapy at her university counseling center because of a breakup with her boyfriend of 1 year. Kelly has been going to therapy at her university counseling center 1x a week for 2 months and has established a good relationship with her therapist, Dr. B. Dr. B. is a female psychologist in her early 30's. During a session with Dr. B., Kelly expresses that the recent breakup with her boyfriend of 1 year has caused her to feel depressed and anxious lately. In addition to this, Kelly tells Dr. B. that she been having a difficult time paying attention and getting her academic work done.

Dr. B. responds by acknowledging how difficult and painful it is dealing with a breakup and how it is not uncommon to experience anxiety and depression in this type of situation. Dr. B. also mentions that anxiety and depression can make it even more difficult for Kelly to focus and get her work done.