PSYCHOLOGIST SELF-DISCLOSURE WITH COURT-MANDATED AND SELF-REFERRED CLIENTS

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DEDICATION

This is dedicated to Joseph Chappo, Elizabeth Kline, and Hubert Kline. I know wherever you are, you are all very proud.
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PSYCHOLOGIST SELF-DISCLOSURE WITH COURT-MANDATED AND SELF-REFERRED CLIENTS
BARBARA ANN DOREMUS

ABSTRACT

Therapist self-disclosure is a topic that continues to generate professional discourse in research literature. However, no literature has considered how therapists use self-disclosure with clients who are court-mandated into therapy. The goals of this research were to: 1) identify differences in psychologists’ responses on the Self-Disclosure Questionnaire – Revised (SDQ – R) between self-referred and court-mandated clients; 2) determine whether psychologists using self-disclosure with court-mandated clients endorse similar justifications for using self-disclosure as documented in the literature; 3) understand how psychologists’ years of experience influence self-disclosure with court-mandated clients; and 4) observe whether psychologists who had graduate training/experience with self-disclosure respond differently on the SDQ – R compared with psychologists who had little or no graduate training on self-disclosure. This study found: 1) psychologists were less likely to use self-disclosure with court-mandated clients compared with self-referred clients; 2) psychologists are more likely to use self-disclosure with court-mandated clients diagnosed with acute, non-chronic mental health diagnoses compared with psychotic or personality disorders; 3) psychologists use similar justifications for self-disclosing with both self-referred and court-mandated clients; 4) self-disclosure does not increase the longer a psychologist has been in practice; and 5) although over half the participants reported receiving information about self-disclosure during graduate training, most psychologists do not generally use self-disclosure.
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CHAPTER I
INTRODUCTION

Introduction

Self-disclosure during psychotherapy refers to any statement in which the therapist shares something personal about him or herself (Hill, 1992). Therapist self-disclosures are defined as conscious, intentional verbalizations or behaviors on the part of therapists that communicate information about them to the client (Constantine & Kwan, 2003; Farber, 2006; Knight, 1997). According to some scholars, therapist self-disclosure is one of the least commonly used, yet most poignant therapeutic interventions (Hill, Helms, Tichenor, Spiegel, O’Grady, & Perry, 1988; Knox & Hill, 2001). Although the literature suggests that therapist self-disclosure is a rarely used intervention, Edwards and Murdock (1994) found most therapists (94%) in their research sample report self-disclosing at least occasionally. Clients whose therapists use self-disclosure give high ratings to the helpfulness of self-disclosure (Hill, Helms, Tichenor, Spiegel, O’Grady, & Perry, 1988). Since all therapists self-disclose information to their clients through their dress and office decorations, gestures, and looks (Guetheil & Brodsky, 2008) or self-disclose information about their experience or professional training, the focus of this research is on deliberate verbal self-disclosures about issues related to their personal or social experiences consciously made by the therapist.
Early Research on Therapist Self-Disclosure

The literature on therapist self-disclosure documents the evolution of this topic in professional psychology. Originally, therapist-self-disclosure was treated negatively from a psychoanalytic tradition because in this view self-disclosure interfered with transference and shattered the perception the analyst is a blank slate for the client to project their feelings (Hanson, 2005; Mathews, 1988). Also, during this period therapists learned that therapist self-disclosure constituted a violation of boundaries (Zur, 2009). It was believed that if clients knew personal information about their analyst, it may constrain or foreclose certain areas of free association (Goldfried, Burckell, & Eubanks-Carter, 2003; Guetheil & Brodsky, 2008). However, within psychoanalysis, there was room for limited self-disclosure. For instance, Winnicott (1965) recognized children, adolescents, and adults with impaired capacity for analysis (such as individuals with schizophrenia or other severe disturbances) sometimes needed direct answers (Farber, 2006; Guetheil & Brodsky).

Carl Rogers’ (1961) client-centered therapy focused on empathetic attunement and he indicated therapists could make use of their personal experiences to reflect a client’s experience (Goldfried, Burckell, & Eubanks-Carter, 2003). Rogers’ work seemed to open the door to acceptable use of the therapist’s personal experience. As humanistic, cognitive-behavioral, feminist, existential, and multicultural psychology developed, these orientations accepted therapist self-disclosure, and they argued that when used appropriately, it offered therapeutic benefits (Simi & Mahalik, 1997). Self-disclosure literature identifies many therapeutic benefits such as: modeling/role-modeling, producing an egalitarian relationship, enhancing authentic connections,
increasing therapeutic alliance, normalizing client experience/feelings, helping the client improve their interpersonal behavior, demystifying therapy, providing information on credentials, exemplifying cognitive flexibility, offering an alternative perspective, promoting feelings of universality, providing reality testing, and helping the client choose a therapist who fits their needs (Constantine & Kwan, 2003; Farber, 2006; Goldfried, Burckell, & Eubanks-Carter, 2003; Hanson, 2005; Knox, Hess, Petersen, & Hill, 1997; Mathews, 1988; Simi & Mahalik, 1997; Zur, 2009). Zur (2009) posits that appropriate therapist self-disclosure may be included in conjunction with clinically effective therapeutic interventions in a client’s treatment plan. As psychotherapy is impacted by insurance companies with limited reimbursement plans, Health Maintenance Organizations (HMOs), and the development of evidence-based treatments, psychologists find they must do more work with less time. Self-disclosure may be a useful additional tool in the psychologist’s toolbox (Guetheil & Brodsky, 2008; Zur, 2009).

Current Scholarship

Current research indicates therapists from all orientations, even analysts, use self-disclosure in therapy sometimes (Bloomgarden & Mennuti, 2009; Farber, 2006; Knox & Hill, 2001). Interestingly, American culture seems to encourage self-disclosure because it has become accustomed to media portraying individuals “telling all” (Farber; Guetheil & Brodsky; Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001).

Newer literature examining therapist self-disclosure suggests that therapist self-disclosure may have therapeutic benefits. For instance, Hill and Williams (2000) contend that self-disclosure can make therapists seem more real and human, improve the
therapeutic relationship, make clients feel more normal or reassured, lead to symptom relief, and lead to greater liking of therapists. Zur (2009) writes clients often establish trusting and positive relationships with therapists who share common or parallel experiences such as war, addiction, parenting, religious or spiritual orientation, sexual orientation, or ethnic background; therefore, appropriate therapist self-disclosure facilitates relationship building. Zur (2009) argues that avoiding a potentially helpful self-disclosure because of risk management practices may negatively impact the quality of care.

**Questions and Concerns about Therapist Self-Disclosure**

Based on this information, there is a need for increased understanding of how therapist self-disclosures may be used therapeutically. Generally, therapist orientation and temperament guide self-disclosures (Wachtel, 1993). Much of the literature on self-disclosure is research reviews of other individuals’ work or perspective papers written based on an author’s experience and synthesis of therapist-self-disclosure literature. Other authors (Fisher; Hanson; Knox & Hill, 2003) provide general guidelines for therapists using self-disclosure. Unfortunately, this scholarship does not provide specific guidelines for situations in which a therapist may use self-disclosure effectively nor is it sufficiently grounded in rigorous empirical research. Zur (2009) advocates therapists show flexibility, but also cautions that self-disclosure beneficial to one client can be harmful to another. Clearly, therapist self-disclosure is not a “one size fits all” therapeutic intervention, but more research needs to be completed in order to help therapists have a better sense of how self-disclosure can be used therapeutically. The therapist self-disclosure literature indicates therapists should consider the consequences
of choosing self-disclosure, ensure the disclosure is for the client’s benefit, confirm that
the client is capable of handling self-disclosure, ensure the disclosure will not interfere
with therapy progress, limit the disclosure to therapeutic content, and avoid violating
ethical standards (Gutheil & Brodsky, 2008; Hanson, 2005; Hill & Knox, 2001; Knox &
Hill, 2003; Peterson, 2002; Psychopathology Committee of the Group for the
Advancement of Psychiatry, 2001; Simone, McCarthy, & Skay, 1998; Stricker, 2003;
Sweezy, 2005; Tsai, Plummer, Kanter, Newring, & Kohlenberg, 2010).

Clients sometimes request self-disclosure and once the therapist understands why
the client believes this request will benefit their treatment, the literature indicates it is
appropriate for the therapist to self-disclose (Constantine & Kwan, 2003; Gutheil &
and inflexible boundary applications may lead to poor rapport and negative therapeutic
alliance. Zur also points out that inflexible therapeutic boundaries: 1) decrease
therapeutic effectiveness, possibly causing the client to receive substandard care; 2) rigid,
cold, distant therapists or therapy styles are incompatible with healing; 3) rigid
boundaries minimize the most important factor in therapeutic effectiveness –
extratherapeutic factor, which reduces potential for self-healing (Zur, 2009). Zur goes on
to contend that inflexible proscriptions against self-disclosure are impossible to maintain,
unrealistic, and may ultimately harm therapeutic process. At the same time, therapists
should consider that the personal information they share with clients is not protected by
confidentiality standards. Clients may do with that information what they please
(Sweezy, 2005).
Therapist Self-Disclosure and Forensic Clients

Sometimes, psychologists find themselves working with clients who are court-referred for therapy or even find themselves working in a forensic setting which has its own unique rules. Knapp and VandeCreek (2006) define forensic psychology as psychological work applied to legal issues. Included are therapists appointed to treat individuals and report periodically back to the court. Even psychologists who have routine practices may find themselves unintentionally working in the forensic area (Knapp & VandeCreek). As Knapp and VandeCreek explain, some clients are court ordered into treatment and their progress in treatment may be linked to the disposition of their legal case. Therapists providing treatment may experience a therapeutic bind because the court expects the psychologists to outline the client’s progress; the therapist may find it difficult to develop a trusting therapeutic relationship with a client because of limited confidentiality (Welfel, 2010).

Very little literature and no empirical research studies addressing therapist self-disclosure exist for therapists working with forensic or court-mandated clients. What has been written primarily addresses ethical standards, forensic assessment, and guidelines for professionals providing courtroom testimony. For instance, Brodsky (2004) suggests psychologists conducting forensic assessments are generally adept at minimizing personal or professional self-disclosure. In contrast, psychologists providing testimony are expected to fully disclose information relevant to their professional training and experience in order to help establish they are credible experts (Brodsky). Brodsky (2004) provides self-disclosure guidelines for therapists providing testimony in the courtroom. Specifically, he explains attorneys, usually working for the opposing side, may ask
therapists extremely personal questions ultimately forcing or attempting to force therapist self-disclosure. Brodsky describes this technique as “forensic sharing of private self.” Oftentimes, attorneys use this technique if they have either accurate or distorted knowledge of something the therapist has or is alleged to have done (Brodsky, 2004). As mental health courts and other legal professionals become more aware of mental health, it is likely therapists may see an increase in court-mandated mental health clients (The Federal Judicial Center, 2003). Outside the courtroom, we currently do not have adequate understanding of how psychologists treating court-mandated clients use self-disclosure.

No research has yet examined whether psychologists who believe self-disclosure is helpful with voluntary clients change their view and behavior with forensic and court-mandated clients. Therefore, this particular topic presents many research avenues. Are self-disclosure guidelines outlined in current literature relevant when working with forensic or court-mandated clients? Does the client’s mental health diagnosis influence whether the psychologist uses self-disclosure during therapy? Are the therapist’s justifications for using self-disclosure the same with forensic or court-mandated clients compared with voluntary clients? How relevant is the therapist’s graduate training regarding self-disclosure when working with court-mandated clients? Are there disclosures therapists who work with both forensic and non-forensic clientele feel more comfortable making with one group as opposed to the other? Overall, it is unclear whether psychologist self-disclosure differs when working with court-mandated clients or self-referred clients.
Better understanding of therapist self-disclosure with court-mandated clients adds important information to counseling psychology literature because the practice appears to be commonly used but not rigorously studied. Second, psychologists providing therapy services may accept clients who may not have presented for treatment voluntarily, but instead are seeking treatment in order to fulfill a court mandate. Therefore, better understanding how psychologists may or may not use self-disclosure with court-mandated or forensic clients in treatment assists the psychologists in providing the client with the best services possible. Consequently, in addition to resolving ethical issues – such as identifying the client, confidentiality limits, relationship boundaries, and potential dual roles, to name a few – psychologists who may use self-disclosure therapy techniques in their practice, may appreciate guidelines on using self-disclosure with these particular clients.

**Research Questions**

It is imperative to understand whether psychologists providing therapy services to court-mandated clients use self-disclosure as part of the therapeutic process. If so, it is important to understand whether their self-disclosure rates increase, decrease, or remain the same as when they are providing psychotherapy with self-referred clients. In addition to understanding self-disclosure rates, it is also important to understand psychologists’ justifications for using self-disclosure with court-mandated clients. Knapp and VandeCreek (2006) explore some of the ethical considerations psychologists must consider when providing therapy services to court-mandated clients, but do not examine specific interventions, including self-disclosure. Hill (2001; 2000; 1992; 1988) and Knox and Hill (2003) indicate that self-disclosure is a poignant, but little used intervention that
may have positive therapeutic benefits; therefore, understanding self-disclosure rates as well as justifications for using self-disclosure with court-mandated clients adds knowledge to an unstudied area of self-disclosure research.

Previous studies (Mathews, 1988; Simone, 1994) have examined whether client diagnosis affects therapist self-disclosure and both studies indicate mental health professionals are more likely to self-disclose with clients diagnosed with adjustment disorders compared with personality disorders or other serious mental illnesses. It is not known if a psychologist working with a court-mandated client considers the client’s diagnosis before self-disclosing. None of the studies examined for this study explore whether psychologists have received specific training on self-disclosure and how psychologists utilize their graduate training in their professional lives. Therefore, this study will also attempt to address these literature gaps.

This research has five distinct goals: first, to identify psychologists’ frequency of self-disclosure with court-mandated clients; second, to determine if participants endorse similar justifications for using self-disclosure with court-mandated clients as documented in the literature; third, to understand whether years of experience influence self-disclosure with court-mandated clients; and fourth, to observe whether psychologists who had graduate training/experience with self-disclosure respond differently on the SDQ-R compared with psychologists who had little or no graduate training on self-disclosure. The research will also examine whether severity of client diagnosis is associated with the frequency of self-disclosure with court-mandated clients.
CHAPTER II  
LITERATURE REVIEW

The literature exploring therapist self-disclosure to clients has examined this phenomenon from various angles, including: whether therapist self-disclosure is therapeutic; whether orientation influences self-disclosure; whether the therapist self-disclosure is ethical; and if it can be ethical, whether guidelines for therapeutic self-disclosure can be identified. Therapist self-disclosure literature spans several decades and includes documents generated by several influential theorists, including past insights from Jourard (1971) to modern to perspectives provided by Hill (2003) and Farber (2006). Some articles are empirical whereas others are perspective papers or literature reviews.

Empirical Research

Sixty-five empirical studies of therapist self-disclosure have been published in the professional literature. Henretty and Levitt (2010) observed of these, nine are surveys, three are analogue surveys, 32 are analogue experiments, 17 are analogue quasi-experiments, two are experiments, and two are naturalistic observations. Six of these studies examined whether clinical experience affects the amount of therapist self-disclosure and thirty of these studies addressed whether or not therapist self-disclosure (versus nondisclosure) has an effect on clients (Henretty & Levitt). These studies include
participants from various mental health professions including counseling, social work, psychologists, and students earning advanced degrees in one of these mental health professions. All of the studies focused on self-referred clients; none of these studies examine therapist self-disclosure with court-mandated clients.

**Clinical experience and amount of self-disclosure.**

Andersen and Anderson (1989) assessed the frequency with which counselors reported using self-disclosure and the demographic variables related to a therapist’s use or non-use of self-disclosure. The researchers surveyed 96 counselors with diverse education, experience, and theoretical orientation (Andersen & Anderson, 1989). Their results indicate that counselors used self-disclosure with their clients and their disclosures increased with therapy experience. Specifically, counselors with one year or less therapy experience disclosed less than therapists with 2-5 years experience or 10+ years experience (Heneretty & Levitt, 2010; Andersen & Anderson, 1989). Also, Andersen and Anderson found that counselors prefer using self-disclosures that reveal their emotional reactions to client’s behavior when the goal of the disclosure was to help the client understand how others perceive them. Counselors used positive affective responses the most frequently with clients but fantasies, images, and negative affective statements were also popular counselor self-disclosures (Andersen & Anderson, 1989). They also reported that counselor self-disclosures about past or present weaknesses were not frequently shared with clients and they theorize these disclosures were not shared frequently because they were personal and they damage the counselor’s “expert role” (Andersen & Anderson, 1989). Andersen and Anderson add to the knowledge by providing researchers with information regarding how experience and specific types of
disclosures are used in therapy. However, the researchers’ target group was “counselors.” The researchers did not operationally define their sample. It appears the respondents’ education ranged from bachelors through doctoral degree and included students. Most of the respondents worked in college counseling centers. It seems the researchers tried to generalize their findings, but it is unclear what professions (social work, counseling, psychology) the sample represents. Moreover, including students in the sample is problematic because students rely on their supervisors and what they do in therapy may be under the direction of the supervisor and may not reflect their own therapy style.

Simi and Mahalik (1997) developed the Feminist Self-Disclosure Inventory (FSDI) and appropriate psychometric properties for the instrument. The FSDI was designed to allow the researchers to test their hypothesis that feminist therapists would endorse principles of feminist self-disclosure more than psychoanalytic/dynamic and other (i.e. cognitive-behavioral, humanistic, and family systems) in their endorsement of self-disclosure items. The researchers recruited 150 female participants from the Association for Women in Psychology (AWP) and 150 female participants from APA Division 29 (Psychotherapy), of these 149 participants responded. Simi and Mahalik reported that FSDI factors: Therapist Background, Promotes Liberatory Feelings, and Promotes Egalitarianism appeared to have the best reliability and internal consistency, so future research with the FSDI should focus on these factors and the overall score. They also found the FSDI total score and five factors discriminated between feminist, psychoanalytic/dynamic, and other therapists, thus supporting their hypothesis that feminist therapists would endorse feminist principles of self-disclosure (Simi & Mahalik,
1997). The researchers also learned that although feminists were generally more open than psychoanalytic/dynamic and other therapists in the sample, feminist therapists did not believe all aspects of the therapist should be disclosed in therapy. Simi and Mahalik also reported feminist therapists used self-disclosure in therapy to (1) lessen power differentials between therapist and client, (2) promote egalitarian therapeutic relationships, and (3) allow clients to choose a therapist who can serve as a role model. Simi and Mahalik provided researchers with an assessment tool specifically designed to assess whether feminist principles influence feminist therapists’ use of self-disclosure with their clients. The score of this instrument is limited; however, it is not designed to assess how other theoretical orientations (i.e. humanistic, multicultural) use self-disclosure in therapy; therefore, the instrument is not generalizable to other orientations. Also, it is not clear from this research what disclosures feminist therapists would not make in therapy. Along the same lines, it is unclear whether feminist therapists would endorse disclosing personal statements about themselves, which reveal their own personal weaknesses, even if the disclosure serves to meet feminist principles.

Simone’s (1994) dissertation research goals were to understand the significance of client diagnosis and age (adult versus adolescent) with therapist’s self-disclosure behaviors. She hypothesized that therapists would report using self-disclosure more frequently with adolescents versus adults and with clients whose mental health diagnosis was relatively mild. Simone designed the Self-Disclosure Questionnaire and sent it to currently practicing male and female therapists residing in the Minneapolis – St. Paul and central Minnesota region, and holding either a Master’s or Doctoral Degree in counseling or a related field. 164 participants were recruited; 120 useable questionnaires were
returned from 41 male and 79 female therapists. She did not find support for her hypothesis that therapists self-disclose more frequently with adolescents compared with adult clients; however, her research was significant for client diagnosis and therapist’s reported self-disclosure. Specifically, therapists’ responses suggested high likelihood for self-disclosure with clients diagnosed with adjustment disorders whereas therapists were least likely to self-disclose with clients diagnosed with psychotic disorders, personality disorders, and conduct/impulse control disorders. Simone’s research also suggests the top five reasons therapists use self-disclosure with clients are: 1) promote feelings of universality; 2) give client encouragement/hopefulness; 3) build rapport/foster alliance; 4) model coping strategies; and 5) increase awareness of alternative viewpoints. Simone also lists the five reasons therapists are not likely to self-disclose: 1) avoid blurring boundaries; 2) stay focused on the client; 3) prevent client concern with therapist’s welfare; 4) prevent merging; and 5) prevent premature closure. Interestingly, Simone’s additional analysis appears to suggest gender, training in self-disclosure, respondent’s clinical experience, or respondent’s education were not significant factors for self-disclosure.

Simone’s dissertation research is valuable because a new self-disclosure instrument is now available for other researchers. It also uses short vignettes so each participant can respond to the same clinical situation. However, her research was not specifically focused on court-mandated clients; therefore, it is not known whether therapists’ responses may change when rating self-disclosures with this population.

Simone, Mc Carthy, and Skay (1998) explored client and counselor variables that influence the likelihood of counselor self-disclosure. Simone et al. (1998) created,
piloted, and ultimately utilized the Self-Disclosure Questionnaire (SDQ) and obtained responses from 120 therapists. The questionnaire uses sample vignettes therapists are likely to encounter in therapy and a five-point Likert scale to rate responses. The researchers discovered that contrary to findings from the prior literature that there was no difference between adolescent and adult disclosures, meaning disclosures were not more common with adolescent clients than adult clients. They also learned the client’s diagnosis influenced therapist self-disclosure: therapists self-disclosed more with clients who had less severe mental health diagnoses. In addition, this study found that there was no difference in respondent gender and self-disclosure, clinician experience and self-disclosure, and whether they had a therapist who used self-disclosure (Simone et al.). The researchers reported that the most commonly given reasons for therapist self-disclosure included: promoting feelings of universality, giving the client encouragement/hope, modeling coping strategies, building rapport, and increasing awareness of alternative viewpoints. The most commonly given reasons for not self-disclosing included: avoiding blurring boundaries, removing focus from the client, preventing client concern for therapist’s welfare, preventing merging, and preventing premature termination (Simone et al.). Simone et al. contributed a new assessment tool, the Self-Disclosure Questionnaire, which may be used in future research studies. The sample was diverse in education (most master-level), professional background (i.e. psychologist, social worker, nurse, psychiatrist), client population, which indicates the findings are generalizable across many professions, clients, and experience levels. This study also provided valuable information regarding how clinical diagnoses may affect therapist decisions regarding self-disclosure. Also, this study examined moderate self-disclosures using
vignettes. In addition, this study gives some therapist guidelines based on empirical research to consider (consider client diagnoses and use therapist self-disclosure with discretion) before using self-disclosure. Limitations of this research include the sample was nonrandom and from one Midwestern state. Also, the vignettes used medium level disclosures and none of the disclosures described in the article appear to disclose therapist vulnerabilities. Therefore, it is unclear whether intimate disclosures may be used positively.

**Therapist self-disclosure and likeability/attractiveness.**

Barrett and Berman (2001) focused on whether therapists who used self-disclosure were perceived as more personable than those who did not use self-disclosure. The researchers recruited 36 clients participating in outpatient therapy through a university counseling center and 18 therapists, all of whom were doctoral students. Of note, the researchers excluded clients exhibiting signs of psychotic behavior, disoriented thinking, or neurological impairment. In addition, they examined how clients rated the effectiveness of therapy between disclosing and non-disclosing therapists. After statistical analysis, Barrett and Berman learned that therapist self-disclosure could influence therapy outcome by reducing clients’ reported symptom distress compared to clients in treatment with non-disclosing therapists. Barrett and Berman also reported that therapists who used self-disclosure were better liked than therapists who did not self-disclose. They were unable to confirm that therapist self-disclosure exerts its impact by encouraging client self-disclosure. Also, the researchers found that their findings may be generalizable only to reciprocal self-disclosures between client and therapist. Barrett and Berman noted that therapist self-disclosure might have the most impact if the disclosure
is related to a client’s issue and that non-client focused disclosures may not be very beneficial. This study is valuable because it actually examines disclosures from both the client and therapist as they occur in treatment. However, the study only focused on the first four treatment sessions, so it is unknown how therapist disclosures may evolve as the client/therapist relationship develops. For example, might the therapist disclose more intimate information about himself or herself if the therapist decided it was therapeutically appropriate? Interestingly, the therapists and clients were generally young, so how might older therapists and clients use self-disclosure in therapy, and did Barrett and Berman detect therapy relationship changes resulting from a more self-disclosing modern culture?

Myers and Hayes (2005) designed an analogue experiment examining how perceptions of the therapist and the session are affected by general therapist self-disclosures and counter transference disclosures, especially in comparison to when therapists make no disclosures. The researchers hypothesized that strong working alliances would produce more favorable ratings of the therapist and session when no therapist disclosures were made. In addition, when the working alliance was weak, general disclosures would cause lower ratings of the therapist and session than when the therapist did not disclose (Myers & Hayes, 2005). Last, Myers and Hayes hypothesized that self-disclosures related to countertransference would produce more favorable ratings of the therapist and session than when the therapist made no disclosures, but only when the working alliance is strong.

Myers and Hayes recruited 236 undergraduates from a large mid-Atlantic university for this study and 224 participants provided usable data. Of these, 74 were men
and 150 were women. 200 participants identified themselves as White, eight identified themselves as African-American, five identified themselves as Hispanic, four identified themselves as Asian, three identified themselves as Other, four did not provide their racial information. The participants’ mean age was 20.4 years; age range was 18 to 46 years. Myers and Hayes created three, 10 minute taped simulated therapist – client interaction videos. In Scenario One the therapist made three general self-disclosures. In Scenario Two the therapist made three countertransference disclosures. In Scenario Three therapists made empathic statements, not self-disclosures. Written statements were given to the participants in order to introduce the therapy scenarios. The statements were identical but varied by one statement. One statement reported a positive working alliance with the client and therapist; the second a poor working alliance. Researchers also administered the Counselor Rating Form to assess participants’ perceptions of the therapist. They also gave the Session Evaluation Questionnaire.

Myers and Hayes found partial support for their hypothesis that the effects of general and countertransference disclosures on perceptions of the session and therapist would depend on the quality of the working alliance. If the alliance was strong, sessions were rated as deeper and the therapist was viewed as more expert when he made general disclosures rather than no disclosures (Myers and Hayes). However, if the alliance was rated weakly, then the therapist was better not making general or countertransference disclosures (Myers and Hayes). The researchers also found that disclosures also affected perceptions of expertness, but not attractiveness or trustworthiness. Myers and Hayes stated their study supported general self-disclosures are beneficial only when the therapeutic relationship is strong. Interestingly, they found that clients who have
previously participated in therapy valued countertransference self-disclosures, as long as the alliance is strong. Myers and Hayes research is valuable because it provides empirical research regarding self-disclosures of transference – something that has not been explored previously. It also found based on empirical research that therapists should consider their working alliance with the client before self-disclosing. One limitation of Myers and Hayes’ research is they used convenience sampling and may not be generalizable. Another limitation is viewers examined one therapy session; therefore, the research does not consider how disclosures might work if viewers had the opportunity to observe the same therapist/client throughout the treatment cycle. A third limitation is Myers and Hayes use vague, undefined terms to explain when self-disclosure may be detrimental. For example, they observe that if self-disclosures are “too personal” (p. 182), it may be detrimental to the treatment relationship. The term is not operationally defined; therefore, it is unclear what disclosures may fall into the category too personal.

**Relationship between orientation and therapist self-disclosure.**

Mathews (1988) conducted a survey of 282 therapists and interviewed 60 therapists (licensed psychiatrists, psychologists, and social workers) to discover how therapists use self-disclosure in practice. She explored the frequency of self-disclosure, factors that influence whether or not to disclose, if self-disclosure frequency changed with experience, client’s age and gender, and therapeutic and anti-therapeutic disclosures. Mathews found that the most commonly cited reasons for utilizing self-disclosure were to promote feelings of universality and provide reality testing. She also found the most frequently given reasons for not self-disclosing include it removes the focus from the patient and it interferes with transference. Mathews also found through the surveys and
interviews that therapist self-disclosure disagreements exist and may be a manifestation of theoretical orientation.

Mathews provides valuable insight into how social workers, psychologists, counselors, and psychiatrists manage therapist self-disclosure in their own practice. However, Mathews observes there is disagreement among professionals regarding therapist-self disclosure: what materials are appropriate or inappropriate for disclosure and what client diagnoses discourage self-disclosure. Exceptions to this disagreement are clients diagnosed with personality disorders. Her findings suggest participants were less likely to self-disclose with clients diagnosed with a personality disorder. Indeed, she theorizes self-disclosure with a client diagnosed with Narcissistic Personality Disorder is not of interest to the client and potentially destructive. In addition, clients diagnosed with Borderline Personality Disorder may find therapist self-disclosures overstimulating (Mathews, 1988). Less consensus exists amongst participants regarding using self-disclosure with clients diagnosed with a psychotic-spectrum mental illness. Also, this article surveyed individuals across the mental health profession, each with different orientation, training, and ethics. Although Mathews’ research is generalizable, including different mental health professions also makes understanding how each profession manages therapist self-disclosure in therapy unclear. Also, her work was completed 20 years ago. Since then our culture may have become more accepting of self-disclosure.

Edwards and Murdock (1994) surveyed 184 practicing doctoral-level psychologists to investigate their use of self-disclosure in therapy. The researchers discovered that their sample used a moderate amount of self-disclosure and generally reported self-disclosing most frequently regarding professional issues and the least when
examining controversial issues (i.e. sexual issues or personal feelings). They did not find any significant differences in self-disclosure when comparing therapists of different sexes or ethnic backgrounds. Edwards and Murdock also reported that theoretical orientation is related to self-disclosure; specifically, humanistic therapists disclosed more than psychoanalytic practitioners. The researchers also found therapists had specific intentions when using self-disclosure; the most common reason is modeling appropriate client behaviors or to increase similarity between the client and therapist. Their contribution is relevant to this research project because they specifically targeted practicing doctoral-level psychologists. Also, Edwards and Murdock found support that theoretical orientation is relevant to disclosure, something that had not been empirically studied in the previous literature. Third, the researchers provided general classifications of types of therapist self-disclosure and categorized them regarding frequency. The sample is not very racially diverse and Edwards and Murdock did not collect information on other unique characteristics, such as sexual orientation or disability. The researchers did not examine whether the client’s diagnostic impression/diagnosis affected therapist self-disclosures. Although the categories are helpful, it is not clear what specific questions made each category. In addition, ambiguity remains amongst therapists regarding how often disclosures should be made.

**Client’s perception of therapist self-disclosures helpfulness.**

Knox, Hess, Petersen, and Hill (1997) conducted a qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. Thirteen therapy clients participated in the study. Knox et al. reported the clients participated in an interview focusing on experiences in therapy, client’s estimation of
therapist self-disclosures, impact of therapist self-disclosures, helpfulness and unhelpfulness of disclosures. Clients later participated in a follow up interview that allowed researchers and clients to ask questions and clarify statements. The researchers reported all participants reported experiencing helpful therapist self-disclosures in therapy and some clients reported a mixture of positive and negative feelings regarding self-disclosure. Knox et al. also observed participants believed self-disclosures were important events in their therapies and of the clients who reported both positive and negative feelings, the positive feelings seem to override the negative and the clients remained in therapy. The researchers also noted clients reported they understood why their therapists used self-disclosure and reported they perceived their therapist’s self-disclosure as a way to reassure or normalize their experiences. Knox et al. stated clients reported that self-disclosures made the relationship seem real and equalized the power in the relationship. This article is beneficial because it helps researchers understand therapist self-disclosures from the clients’ perspective. Interestingly, Knox et al. observed two categories of client – one group that craved self-disclosure and others which expressed concern over the appropriateness of self-disclosure, but there was not enough information to understand these two types of clients. What is unknown is whether clients’ heard therapist self-disclosures that revealed the therapist’s vulnerabilities. Therefore, we do not know specifically how clients’ responded to these types of disclosures.

Hanson (2005) conducted a mixed quantitative and qualitative research project exploring how therapists’ disclosure and non-disclosure affects clients. Hanson interviewed 18 clients to understand their views of the how therapist self-disclosure and
nondisclosure affected them. Taped interviews lasted 35 to 90 minutes. Participants’ ages ranged from 24 to 57 years, with a mean age of 38. All the participants in this study were in therapy when data were collected. All the participants had at least one other therapist. Most of the participants were White females. She found that the participants in her study were two and a half times more likely to find disclosures helpful and twice as likely to experience non-disclosures as unhelpful (Hanson). She also found that disclosure and non-disclosure had the most impact on alliance followed by egalitarian values. Hanson concludes that therapists should use self-disclosure scrupulously and with deliberation and skill to help develop alliance. She justifies this by noting that unskilled disclosures and rigid policies of non-disclosure risk damaging therapist alliances with clients. This article adds to the literature because it applies empirical and qualitative research methods into studying therapist self-disclosure. This article also studied how clients perceived therapist self-disclosures both helpful and non-helpful interventions. Hanson’s article also suggested therapists can therapeutically use their own personal traumas (i.e. therapist self-disclosing she was an incest survivor to a client who disclosed she experienced incest). Hanson also provided self-disclosure researchers with two new categories which disclosures might be categorized: transitioning and moral solidarity. The limitations of Hanson’s research include the sample size was small and consisted primarily of White females. Therefore, Hanson’s results may not generalize to males or people of color.

**Therapist self-disclosure and client symptomology.**

Harper and Steadman (2003) completed a narrative qualitative research study addressing whether therapists’ boundaries shifted when working with clients who are
survivors of childhood sex abuse. Self-disclosure with this population is a particular challenge for therapists wishing to develop an equal client-therapist relationship, yet maintain healthy boundaries. The researchers used open-ended questionnaires completed by seven group therapists; a focus group to clarify issues raised in the questionnaire, and audio taped interviews with seven individual therapists. The participants, both male and female, included psychologists, social workers, child/youth workers, shelter workers, nurses, probation officers and crisis hotline workers (Harper & Steadman). Education, years of experience, and work settings varied.

Harper and Steadman reported that common incentives for shifting therapeutic boundaries included: anxiety about the survivor’s safety, feeling resentful toward the client, worry about the survivor’s feelings, and wanting to connect, give hope, or power in the relationship. Harper and Steadman concluded that therapists working with this population should remain insightful when shifting boundaries with survivors and receive adequate supervision. This research adds to the literature because it attempts to understand qualitatively how boundaries may shift appropriately when working with survivors of child sex abuse. The study is limited because of small sample size that makes it difficult to generalize to therapists working with child sex abuse survivors. Also, it is not known whether similar findings would be observed with other client groups. It also does not fully explore therapist decision-making when considering shifting boundaries therapeutically for a particular client (i.e. self-disclosure decision making).

Kelly and Rodriguez (2007) assessed whether therapists reported that they self-disclosed more to clients with greater levels of disturbance, which they defined as “client-
reported symptomology” (p. 471). The researchers predicted clients with greater initial symptomology and female clients would receive more therapist self-disclosure (Kelly & Rodriguez, 2007). The results indicated that therapists disclosed more with clients with lower initial levels of symptomology; however, the self-disclosures were not significantly related to the working alliance or symptom change (Kelly & Rodriguez). The researchers indicate possible reasons for this finding, including suggestions that therapists disclose more to clients who are like them, are uncomfortable or self-protective with clients experiencing more symptoms (Kelly & Rodriguez). Also, Kelly and Rodriguez hypothesized therapists may disclose less to clients experiencing more symptoms because they are trying help their clients and maintain professional boundaries. In addition, the researchers found evidence to support their hypothesis that therapists disclose more to female clients. They also suggest more therapist self-disclosure is not linked to better therapy outcome. Kelly and Rodriguez’s work is relevant because they attempt to empirically resolve an earlier question in the self-disclosure literature regarding patient symptomology and therapist self-disclosure. One area the study did not address is what kinds of topics therapists self-disclosed to their healthy clients.

Scholarship Reviews

**Therapist self-disclosure with specific client populations.**

Knight’s (1997) position paper postulates that therapist self-disclosure can be a beneficial tool in both group and individual therapy with adult survivors of child sex abuse. She explains that self-disclosure may reveal the therapist’s feelings about the client’s victimization that may affirm the client’s feelings and encourage exploration of emotional issues. Knight also contends that therapist self-disclosure validates the client’s
self-worth because the therapist’s disclosures may relate the therapist’s comfort with and trust in the client. Knight suggests that therapist disclosures about significant life experiences and his or her reactions to them assist survivors in developing a more accurate view of themselves. She indicates that even therapists who survived child sex abuse themselves can appropriately disclose this information as long as the therapist examines their motivations and anticipate how this information might impact the survivor. Knight concludes that there are risks including: countertransference, reversal of therapeutic roles, and increasing survivor’s sense of responsibility or feelings of inadequacy. Her work is valuable because she focuses on a specific group: adult survivors of child sex abuse. She also uses vignettes to illustrate specific types of disclosures. However, the vignettes do not convey the client’s response to the disclosure. Also, Knight does not specifically document her responses in some of the vignettes, so it is not clear how these looked in therapy. In addition, although Knight states a therapist’s own survivor status may be used therapeutically, she does not give specific information on how this personal information can be used therapeutically and how this might transpire in therapy. Last, her article is based on her experiences and what has been studied in previous literature.

Constantine and Kwan’s (2003) literature and case review focused on understanding cross-cultural considerations regarding therapist self-disclosure. They theorize that therapist self-disclosure may be particularly beneficial for working cross-culturally because it can demystify the therapeutic process and encourage client self-disclosure. In addition, appropriate therapist self-disclosure with clients of color necessitates therapists’ (a) awareness of their own and their clients’ cultural values, along
with their awareness of the interactive impact of these values in treatment; (b) knowledge about the cultural experiences of clients of color and the effects of these experiences on clients’ presenting issues and on the therapeutic relationship; and (c) skills in responding sensitively and competently to clients of color based on this information (Constantine & Kwan, 2003). Their work is especially valuable to self-disclosure literature because it specifically addresses cross-cultural considerations and application of therapist self-disclosure during therapy. It also provides a detailed case review of a White female therapist therapeutically using self-disclosure of her personal experience with sexism with an African-American female college student experiencing sexual and racial discrimination. The case review demonstrates how this intimate disclosure facilitated trust and moved therapy forward. However, the case review does not appear to have been empirically researched, therefore, it is unclear whether other therapists would agree with the researchers’ outcome. Also, it is not clear whether the same results would be produced if the client and therapist were of similar backgrounds.

**Therapist self-disclosure of personal issues.**

Goldstein (1997) explored the complex issues and dilemmas that arise when a therapist’s personal life experiences, such as illness or death, impact therapy. Goldstein writes that many therapists struggle alone with these dilemmas, especially the issue whether or not to self-disclose with their clients. This author analyzes psychoanalytic, humanistic, self-psychology, and intersubjective perspectives to learn how therapists should manage life circumstances with clients. Oftentimes, the client’s ego strength, therapist’s training, and the therapist’s unique characteristics should be taken into consideration before deciding whether or not to disclose personal issues to a client.
(Goldstein). Other considerations Goldstein identifies include: client’s ability to handle disappointment and possible rejection due to disruptions; a therapist’s personal life may be perceived as an unwanted intrusion for some clients, especially those who need the therapist as a mirror and are self-absorbed; whether the client has been placed in an inappropriate role in the past (child being a confidant for a parent); or clients who have a twinship transference, who need to see the therapist as a real person. Sometimes, therapists are confronted with the issue of how to make the self-disclosure therapeutic, especially when the client and therapist know people in common (Goldstein). Last, this author explores the therapist’s own countertransference, comfort level, and their right to privacy. Overall, this article illustrates some of the therapeutic and personal considerations therapists may need to address before disclosing personal information. However, Goldstein’s article is a position paper and she did not conduct her own research to arrive at her guidelines.

Bridges (2001) examined intentional self-disclosure by therapists, including sharing of affects, motives, intent, and personal opinions in the context of therapy. Bridges postulates that therapists can use self-disclosure to deepen therapy and bring unconscious client issues to the surface and concludes that therapists may find intentional self-disclosure useful in therapeutic relationships. In addition, according to this author, therapists who use self-disclosure should monitor the influence of self-interest, remain client-focused, rely on the client’s resources, model emotional honesty, and share their view of the clinical relational experience when using self-disclosure. Bridges asserts that therapist’s intentional self-disclosure is an essential tool that deeps therapeutic conversation and relationship and can lead to unexpected growth-fostering, clinical
experiences. Bridges’ article provides therapists with personal guidelines they should consider before self-disclosing to their clients. This research does not specifically address limits on intimate self-disclosures. Also, the article is a research review and does not provide new empirical information.

**Therapeutic application of therapist self-disclosure.**

Hill (1992) published a review article in which she examined various therapeutic techniques, including therapist self-disclosure, for its implications in practice. Hill’s purpose for her article is to discuss the implications of empirical research on therapist techniques for practitioners. She focused on (a) the overall effectiveness of the therapist techniques; (b) the effectiveness of two specific techniques – one of which is therapist self-disclosure; (c) factors moderating the effects of therapist techniques; and (d) the importance of therapist and client covert processes (Hill, 1992). Hill concluded that specific verbal therapeutic techniques used in therapy make a difference and also reported that self-disclosures are quite helpful, although more research is needed about type and timing. She also suggested therapists need to be aware of their intentions when using different therapeutic interventions and that clients who are externally oriented, low-conceptual level, reactant, at a low-experiencing level, closed, or defensive respond well to directive therapist techniques, such as direct guidance and paradox interventions. In contrast internally-oriented, high-conceptual level, and non-reactive clients respond well to less directive interventions, such as paraphrase and interpretation. Last, Hill related that therapists need to be aware that clients often hide negative reactions and sometimes there may be negative effects on therapy. Her review contributed clear definitions for therapist techniques, including therapist self-disclosure, which was lacking in previous
literature. This research review also provided therapists with an understanding of how various therapist techniques may be used in therapy and also specified types of therapist self-disclosures, including self-disclosing disclosures, which occurs when a therapist discloses information about their past. Hill also recognizes more research relevant to practitioners must be conducted. Hill’s work is very comprehensive and provides useful therapeutic strategies for therapists, but her review is a review, not actual research.

Ackerman and Hilsenroth (2001) published a review article in which they examined therapist personal attributes and in-session activities that negatively influence the therapeutic alliance. Ackerman and Hilsenroth’s purposes include: understanding how the therapist’s negative contribution to the alliance will refine and enhance understanding of the construct; guide future research toward more efficacious and clinically superior therapeutic techniques; and help therapists understand the factors that may impede developing a strong therapeutic relationship with their clients. Their review concluded that several therapist personal attributes that negatively influence the alliance: rigidity, aloofness, tension, uncertainty, and criticism. Misapplication of therapeutic techniques that also negatively impacted the relationship included: failure to develop a therapeutic frame, inappropriate use of self-disclosure, and unyielding use of transference interpretations (Ackerman & Hilsenroth, 2001). Therefore, the therapist’s personal qualities and use of techniques can significantly deteriorate a therapeutic relationship. This is a valuable review article because it provides specific ways therapists may inadvertently harm the therapeutic relationship. However, this article does not operationally define inappropriate self-disclosure and is a research review, not the authors’ own research.
Hill and Knox (2001) published a review article in which they conducted a meta-analysis review of therapist self-disclosure research. Based on their research review, the authors concluded that therapist self-disclosure occurs infrequently, is used more often by humanistic-experimental than psychoanalytic therapists, and often focuses on professional background rather than intimate information. They also found that therapists used self-disclosure for a wide variety of reasons, used self-disclosure cautiously, and found that self-disclosure is helpful in the immediate process of therapy. Hill and Knox note that long-term effects of therapist self-disclosure on the outcome of therapy are unclear and caution that therapist self-disclosure is not clearly defined through the literature. They go on to provide therapists with practice guidelines for self-disclosure that adds to the therapist self-disclosure knowledge base through increasing therapists’ understanding of how this technique may be used in therapy. They also highlight that the term therapist self-disclosure is still not consistently defined in the literature; therefore, agreed-upon definitions are needed. However, it appears Hill and Knox developed their guidelines through a literature review, not through empirical research. These guidelines do not clearly address whether it is or is not appropriate for a therapist to disclose personal information detailing a therapist’s vulnerabilities, even if the therapist follows all the other guidelines. Therefore, it is unclear if these types of therapist self-disclosures can be used therapeutically with clients.

The Psychopathology Committee of the Group for the Advancement of Psychiatry (2001) examined therapist self-disclosure in therapy. The group clearly defined self-disclosure and its goal of this article was to provide framework for the therapeutic use of deliberate self-disclosure in therapy. The group concluded that clinicians should
recognize both the benefits and dangers of therapist self-disclosure and it should be an active decision made by the clinician and the risks and benefits should be considered before self-disclosing. The authors also explain adequate supervision and skill are also useful in determining whether a therapist should or should not use self-disclosure. Lastly, the authors also noted although inappropriate self-disclosure is a component of many harmful violations, it is erroneous to conclude that self-disclosure leads to boundary violations. This research team provided several valuable contributions. First, they provided a framework for intentional therapist self-disclosure. Second, they recognized modern culture is more accepting of disclosures than they had been in the past. Third, this group recognized therapist self-disclosure of past experiences is part of the “ethic of sharing” (Psychopathology Committee of the Group for the Advancement of Psychiatry, p. 1492). In addition, this group also recognized the client’s unique characteristics (age, race, gender, personality, and socioeconomic background) should be considered before self-disclosing because different groups have different expectations. This article has limitations. First, it is a research review not the groups’ own empirical study. Second, although the article recognizes the value in a therapist sharing past experiences, it is not clear what types of past experiences may be beneficial to the client during therapy.

Goldfried, Burckell, and Eubanks-Carter (2003) examined how therapist self-disclosure is used in cognitive-behavioral therapy through clinical illustrations. The authors concluded with noting some of the issues therapists should be mindful of when making decisions to disclose information about themselves (Goldfried, Burckell, & Eubanks-Carter, 2003). They concluded from an empirical and conceptual perspective,
self-disclosure is an appropriate and useful therapeutic intervention in cognitive-behavioral therapy. From this orientation, therapist self-disclosure of positive and negative client impact on the therapist can help the client improve their interpersonal behavior; therapists can serve as role-models for changing behavior, thoughts, and emotions (Goldfried, Burckell, & Eubanks-Carter). The authors also note it may be partially useful in increasing client motivation and facilitating the effectiveness of other cognitive-behavioral techniques. Goldfried, Burckell, and Eubanks-Carter also caution against using self-disclosure for the therapist’s own enhancement or personal needs. This article is beneficial to research’s understanding of self-disclosure because it examines therapist self-disclosure from a Cognitive-Behavioral perspective and provides future researchers appropriate constructs for framing their research. It lacks empirical research and it is not understood empirically how therapist self-disclosure impacts clients participating in Cognitive-Behavioral therapy.

Knox and Hill’s (2003) literature review explains that therapist self-disclosure is the least frequently used, but most poignant form of therapeutic interventions. Their position is that self-disclosure can be used therapeutically with clients. They indicate that all theoretical orientations use self-disclosure to some extent, even psychoanalysts. Knox and Hill categorize therapist self-disclosures into seven groups and provide therapist guidelines for making appropriate self-disclosures. Knox and Hill conclude therapist self-disclosure is a helpful intervention, but should be used infrequently and judiciously. The authors caution that therapists should make sure the content is appropriate, use disclosures to facilitate intimacy, use appropriate levels of intimacy in self-disclosures, and fit the disclosure to the client’s needs. Knox and Hill assert therapists should return
the focus to the client after self-disclosure, ask the clients about their responses to self-disclosure, and only self-disclose issues that have been resolved. Knox and Hill provide a valuable, practical guide for therapists considering using self-disclosure therapeutically in the literature. The guidelines were developed based on reviewing past research and literature on self-disclosure. The limitation of this research is it is unclear whether more intimate disclosures may be used therapeutically. Also, terminology is unclear. For instance, the authors endorse using "moderately intimate content" disclosures (Knox & Hill, p. 538). It is not clear what therapist disclosures fall under the term "moderately intimate content." Consequently, it makes it difficult to quantify disclosures without clearly defined operational terms.

**Therapist self-disclosure and ethics.**

Corley and Schneider’s (2002) literature review described specific issues of disclosure that are relevant to therapists treating sex addicts and their partners. One area that therapists working with sex addicts may have to resolve is sharing personal experiences. For example, should a therapist reveal he is a recovering sex addict or also had an extramarital affair? Based on therapist self-disclosure literature, if the therapist discloses this information, it may help the client see the therapist as real or human, encourage client disclosure, provide the client with a role model, and instill hope. However, Corley and Schneider observe that in some circumstances therapist self-disclosure may interfere with the therapeutic relationship. The researchers give an example of a client seeking treatment for sex addiction and learning his therapist also is a sex addict. The client, who is a clergyman, summarizes his experience in therapy with the therapist:
“he talked too much… I think it is good for a counselor to share information about himself into the session, but this guy did it a bit too much. There were things I wanted to talk about, but I couldn’t get a word in edgewise” (p. 48).

Corley and Schneider caution sex addict therapists against sharing information about their affairs or sexual acting out history. If the therapist discloses information about his affair, he is violating his partner’s confidentiality. Also, the therapist places himself at risk if he discloses to a client who later seeks revenge by publicly disclosing the therapist’s private information (Corley & Schneider, 2002). Similarly, the authors observe therapists may experience unintended boundary violations and client misinterpretations through sharing personal information. For example, a client with dependent personality disorder may believe he/she is the therapist’s best friend after learning personal information about his therapist, which is not the therapist’s intention for disclosure (Corley & Schneider). In summary, Corley and Schneider state intimate personal information should be shared only when it is relevant to the treatment goals. Also, Corley and Schneider recommend that therapists either share less intimate stories that teach skills or demonstrate techniques for resolving problems and use case examples or metaphors for the therapist’s personal story. The authors’ work is valuable because it provides therapist disclosure guidelines regarding whether self-disclosure of sexual or marital information is appropriate. However, there are limitations. Corley and Schneider contradict themselves within their article because they recognize therapist self-disclosure of sex addiction may be beneficial and damaging, so it is not clear how a therapist should proceed when disclosing highly sensitive material. Also, their recommendations are based on research reviews and their own clinical experience. Similarly, it is not clear
whether these guidelines are applicable if a therapist is considering self-disclosing other personal material (i.e. survivor of sexual trauma); therefore, it is unclear how generalizable these findings are to therapists working with other populations.

Peterson’s (2002) literature review examines scholar’s ethical perspectives of self-disclosure. These views are varied – some regard self-disclosure as exploitative, others see it as beneficial. Peterson explains therapists considering self-disclosure should analyze: their rationale for disclosing, personality traits of client, and the circumstances surrounding disclosure. The author concludes because scholars in ethics view the benefits of self-disclosure as mixed, therapists should carefully consider ethical principles before using self-disclosure. Peterson’s contribution is valuable because it adds profession ethics into the discussion of the merits and risks of therapist self-disclosure. The article’s limitations are it is based on a literature/research review. It also does not address how therapists may ethically manage self-disclosures, which expose their personal vulnerabilities.

Fisher (2004) published a review article in which he reviewed three empirical investigations, case studies, and APA ethical code to make specific conclusions regarding therapists’ use of self-disclosure of sexual feelings. Fisher concludes therapist self-disclosure of sexual feelings toward their clients violates APA ethical principles regarding client harm, sexual harassment, multiple relationships, and informed consent. Fisher generated several key guidelines therapists should consider before disclosing sexual feelings for their clients. First, he explained that therapists must refrain from self-disclosure involving explicit communication of sexual feelings for clients, since sexual disclosures may harm clients and may be considered unethical professional behavior.
Second, therapeutic middle ground, such as disclosures or acknowledgment of caring and warmth in a therapeutic relationship exists; however, he writes that it is desirable for therapists to use other interventions because the therapist cannot be sure how the client might interpret the disclosure. Third, the author explains that therapists need to be aware of risk management, especially when they develop sexual feelings for a client and are considering disclosing these feelings. Fourth, therapists must use supervision, consultation, personal therapy, and didactics through their careers. Fifth, when therapists develop sexual feelings for their clients, he emphasizes that it is on the therapist to make sure they take appropriate steps to manage their feelings professionally and ethically. Fisher’s work is valuable because he examines a very controversial and little-studied topic in therapy literature. He also clearly establishes therapist self-disclosure of sexual attraction is not appropriate and unethical. This article appears to clearly state that there is no therapeutically beneficial reason for self-disclosing therapist sexual attraction to their client. Since this article focused on sexual attraction, it brings the question whether there are other clearly inappropriate therapist self-disclosures.

**Conclusion**

Overall, the literature reviewed demonstrates how researchers have studied therapist self-disclosure over the past twenty years. Researchers and experts interested in therapist self-disclosure have worked to make precise definitions for therapist self-disclosure (Hill, 1992; Knight, 1997). Also, researchers have developed categories of therapist self-disclosures that make classifying and researching therapist self-disclosure efficient (Hanson, 2005; Knox & Hill, 2003). Therapist self-disclosure research and literature also produced several guidelines therapists should consider before self-
disclosing to their clients (Goldstein, 1997). If a therapist is considering self-disclosing, the therapist should consider whether the therapist-client working alliance is strong (Hanson, 2005; Myers & Hayes, 2005), the client’s symptomology (Kelly & Rodriguez, 2007; Simone, McCarthy, & Skay, 1998), and the therapist’s therapeutic goals of using self-disclosure (Edwards & Murdock, 1994; Wachtel, 1993). The therapist should also consider whether the disclosure is for the client’s benefit or for the therapist’s personal reasons (Bridges, 2001).

Research on client perceptions of therapist self-disclosure is mixed. Some research indicates clients generally view therapist self-disclosure positively, helpful, and may encourage more self-disclosure from the client (Constantine & Kwan, 2003; Hill, 1992; Knox, Hess, Petersen, & Hill, 1997; Knox & Hill, 2003; Peterson, 2002; Watkins, 1990). Clients sometimes view therapists who use self-disclosure as more favorable or attractive (Barrett & Berman, 2001; Watkins). Therapist self-disclosure research indicates clients generally perceive therapist self-disclosure positively as long as the client clearly understands the therapist’s purpose for disclosure (Knox, Hess, Petersen, & Hill, 1997) and maintains healthy boundaries (Harper & Steadman, 2003). Therapist self-disclosure can demonstrate warmth, trust, and safety (Hanson, 2005); show the client he/she is cared for and understood (Hanson; Knox, Hess, Petersen, & Hill, 1997; Mathews, 1988) and provide reality testing (Mathews). Interestingly, therapist self-disclosure may also demonstrate to clients the therapists will take responsibility for mistakes (Hanson). Therapist self-disclosure has been demonstrated as effective even when working with clients presenting with significant problems, such as surviving child
sex abuse (Harper & Steadman; Knight, 1997) and sex addicts (Corley & Schneider, 2002).

Although several researchers indicate therapist self-disclosure has potential benefits, there are limits for therapist self-disclosure. Inappropriate therapist self-disclosure has been documented as a catalyst for ethical violations (Guetheil & Brodsky, 2008; Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001), including inappropriate boundary violations, role reversal, and sexual misconduct (Fisher, 2004; Guetheil & Brodsky) as well as violation of privacy and client misinterpretations (Corley & Schneider, 2002). Indeed, if the client has extratherapeutic knowledge about their therapist, review boards have treated this as evidence of wrongdoing (Guetheil & Brodsky). Therapists also avoid using self-disclosure if they feel the disclosure makes them appear weak or ineffective with their client (Andersen & Anderson, 1989) or if the self-disclosure is controversial, such as feelings of sexual attraction toward the client or personal feelings (Edwards & Murdock, 1994). Therefore, therapists who use self-disclosure must understand their personal reasons for disclosure and ensure the disclosure is in the client’s best interest before self-disclosing (Goldstein, 1997). The literature also explicitly cautions against certain self-disclosures for professional and ethical reasons, including self-disclosing feelings of sexual attraction (Fisher, 2004). Other risks of using therapist self-disclosure in therapy include removing attention/focus from the client (Mathews, 1988; Peterson, 2002) and self-disclosure interferes with transference (Mathews). Nonetheless, it is ethical for therapists to use self-disclosure as long as it is in the client’s best interest and the therapist does not violate
American Psychological Association ethical guidelines against exploitation, malfeasance, and beneficence (American Psychological Association, 2002; Peterson).

Most importantly, all of the studies, research reviews, and author perspective papers discussed above do not mention using self-disclosure as a therapeutic intervention with court-mandated clients. The papers reviewed were all written from the perspective that the client is a voluntary, willing participant in the therapeutic process. Court-mandated clients are the opposite of voluntary clients in the simple fact they are not presenting themselves at the therapist’s office voluntarily. A judge, probation or parole officer, or other court professional expects their compliance with therapy perhaps as an alternative to jail, loss of custody, or divorce proceedings. Oftentimes, therapists working with court-mandated clients experience many challenges. Building a working, therapeutic relationship with a client who may have little or no insight into their problems is particularly difficult. Also, the therapist may have boundary and ethical concerns because the therapist may also have to be accountable to the court. The research review seems to suggest therapist self-disclosure is one tool with which a therapist can use with positive therapeutic outcomes. However, therapist self-disclosure with court-mandated clients, whether the technique is successful or not with this population, has not yet been written about in scholarly literature.
CHAPTER III

METHOD

This chapter is divided into five sections. The first section details research hypotheses. The second section describes research participants. The third section details chronological data collection methods. The fourth section provides descriptions of the research instrument, including validity indicators, and modifications to the instrument. The fifth section overviews data analysis.

Hypotheses

1. Psychologists will report using self-disclosure at a significantly higher frequency with self-referred clients than with clients who are court-mandated.

2. Psychologists will report using self-disclosure at a significantly higher frequency with clients diagnosed with acute non-chronic mental health diagnoses than with clients diagnosed with a psychotic disorder or personality disorder.

3. Psychologists with court-mandated clients will endorse at least three of the five justifications that are most highly rated by therapists with non court-mandated clients.
4. Years of experience among psychologists will be positively correlated with self-disclosure rates at a significant level with both self-referred and court-mandated clients.

5. Psychologists who received graduate training/education on self-disclosure will report following self-disclosure philosophies that match with their graduate training/experience.

Participants

Three hundred surveys were mailed, three were returned undeliverable, and 83 surveys were returned. Twenty-four of the 83 returned surveys were not completed properly and eliminated. Therefore, the sample consisted of 59 participants.

Fifty-eight licensed psychologists and one unlicensed participant (16 female, 42 male, one did not provide gender information) from the United States participated in the study. The mean age was 58.78 years, \( (SD = 11.59) \), with a range from 30 through 86 years. Fifty-two participants identified their race as Caucasian-American, three identified as African-American, one identified as Hispanic-American, one identified as Asian-American, one identified as Biracial-American, and one identified as Other. Forty-nine participants reported their highest degree as a Ph.D. and nine identified their highest degree as a Psy.D.; one participant did not provide this information. Of the 58 individuals who provided this information, the mean years providing psychotherapy was 28.57 \( (SD = 12.19) \), ranging from one year to 59 years of experience. Participants mean years of working as a licensed psychologist was 26.17 years \( (SD = 11.01) \) with a range varying from one to 49 years.
Procedures

Following approval from the Cleveland State University Institutional Review Board (IRB) for Human Subjects in Research, 300 survey packets containing the Self-Disclosure Questionnaire – Revised (SDQ-R), a letter explaining the purpose of this study, demographic questions, and a self-addressed, stamped envelope were mailed to licensed psychologists residing in the continental United States. Mailing information was collected from a public website, find a psychologist: the first step to improving your mental health (n.d.) that allowed users to collect members’ contact information for research purposes. Since mailing addresses instead of email addresses were readily available on this website, surveys were mailed to selected participants. In addition, one of the goals of this study was to survey experienced psychologists and mailing addresses, instead of email, were readily available. Participants were selected using the search criteria “forensic evaluation and individual therapy” increasing the likelihood that names generated with these key terms were experienced in providing treatment with court-mandated clients.

Thirty days after the surveys were mailed, 300 reminder postcards were mailed thanking individuals for their participation and reminding others if they wished to participate they should complete and mail the survey by July 11, 2011. Completed survey results were entered into an SPSS spreadsheet for analysis. The SDQ-R had participants rank their likelihood of using self-disclosure with both voluntary treatment clients and court-mandated treatment clients in addition to client mental health diagnosis. A six-point Likert scale was used with 1 meaning “never or almost never” and 6 meaning “have never worked with this population.” Any participant who circled a 6, indicating
they have never worked with a particular population had their responses recoded into scale one. Therefore, a total of 324 responses were recoded from scale 6 to scale 1.

**Instrument**

**The Self-Disclosure Questionnaire (SDQ).**

The Self-Disclosure Questionnaire (SDQ) is a nine-page assessment tool developed by Simone (1994). Simone, McCarthy, and Skay (1998) later used the measure in a second study.

Simone (1994) developed the SDQ based on self-disclosure research literature, clinical experience, and consultation with other licensed psychologists experienced with research. The SDQ consists of three parts: Demographics, Self-Disclosure Scenarios, and Self-Disclosure Criteria (Simone, 1994; Simone, McCarthy, & Skay, 1998). The first section contains 21 questions regarding the respondent’s age, gender, ethnicity, credentials, clinical experience, work setting, theoretical orientation, experience working with the nine client diagnostic categories in the Self-Disclosure Scenarios section, and whether the respondent had ever been in therapy with a self-disclosing therapist, and the frequency and helpfulness of disclosure (Simone, 1994; Simone et al., 1998). The instrument uses a 5-point Likert scale. The Self-Disclosure Scenarios section contains four vignettes in which respondents are to imagine they are the therapist and to rate their likelihood of disclosure for nine diagnostic criteria and two client age groups (adolescents and adults over age 18); therefore, each vignette is rated 18 times (Simone, 1994; Simone et al., 1998). Simone describes the vignettes’ content as moderate emotional potency. Each scenario was standardized for length, disclosure of resolved past issues verses ongoing therapist issues, and for disclosures similar to the client rather than discrepant
from the client’s experience (Simone, 1994). Simone states scenarios were evaluated for face, content, and criterion validity by a researcher with expertise on therapist self-disclosure.

Scenario One describes a situation in which a therapist experienced a medical procedure similar to one for which the client is scheduled and he or she is fearful (Simone, 1994, p.37). In Scenario Two, the client is feeling guilty about unresolved anger toward a dead parent – an issue the therapist worked through in the past (Simone). Scenario Three describes a client who feels shameful about an urge to slap his/her 2 year-old child; the therapist experienced similar feelings when his/her children were young (Simone). In Scenario Four, the therapist, while in school, experienced writer’s block that stopped process on a writing project and the therapist’s client is now presenting with the same issue (Simone).

The diagnoses selected for the Self-Disclosure Questionnaire are: Psychotic Disorders, Narcissistic Personality Disorder, Conduct and Impulse Control Disorder, Posttraumatic Stress Disorder, General Anxiety and Phobic Disorders, Borderline Personality Disorder, Mixed Personality Disorders, Adjustment Disorders, and Mood Disorders (Simone, Simone et al.). The Diagnostic and Statistical Manual of Mental Disorders, Third Edition, was current when the SDQ was created. The final section contains two checklists: reasons to disclose to clients (n=17) and reasons not to disclose to clients (n=15) (Simone, Simone et al.). Simone (1994) explains justifications for and against self-disclosure were reasons reported in clinical research literature.
The Self-Disclosure Questionnaire - Revised (SDQ-R).

Since the SDQ (1994) itself does not have questions specifically evaluating participants’ experience providing therapy services with court-mandated clients, adding these questions was necessary in order to ensure the sample group has experience providing therapy services to court-mandated clients. Extraneous demographic questions were eliminated from the SDQ-R, reducing the number of demographic questions from 21 to 17, which may decrease SDQ-R completion time and encourage increased participation.

The scenarios remained intact, with the exception substituting the phrase “is taking some adult education classes” in place of “a student,” which better encapsulates adult learners. Also, the original SDQ compared therapists’ responses to adolescent and adult clients. Since the focus of this study is on adults, both voluntary therapy clients and court-mandated clients, the SDQ-R reflects these two groups. Also, mental health diagnoses were updated to reflect current standards in the Diagnostic and Statistical Manual – Fourth Edition, Text Revision (DSM-IV-TR). The minimum possible score obtained from the SDQ – R was 96 and the maximum possible score obtained from the SDQ – R was 480. The justifications for and against self-disclosure remained identical to those created by Simone. The instrument took less than 30 minutes to complete.

Data Analysis

A series of paired sample t-tests were performed to investigate Hypotheses 1 and 2. Frequency analyses were utilized to test Hypothesis 3. A bivariate correlation was used to test Hypothesis 4 and a Chi-Square test was performed to analyze Hypothesis 5.
Paired sample t-tests are used to compare the means of two variables and this statistical measure was the most appropriate to test Hypotheses 1 and 2 since the same participants ranked how diagnosis influences whether or not they would self-disclose with both court-mandated and self-referred clients. Using frequency analyses to examine Hypothesis 3 were the most statistically appropriate methods because the goal was to determine the number of times participants endorse particular justifications for and against using self-disclosure with both groups. In order to explore the relationship between participants’ years of experience and self-disclosure rates with both self-referred and court-mandated clients, a bivariate correlation was utilized to test Hypothesis 4. In order to understand whether positive, negative, or neutral training on self-disclosure and participant’s reported self-disclosure rates, a Chi-Square analysis was used to examine observed versus expected data results for Hypothesis 5.
CHAPTER IV
RESULTS

This chapter describes and summarizes the statistical analyses used to evaluate the hypotheses outlined in Chapter 3.

Research Hypothesis 1

*Psychologists will report using self-disclosure at a significantly higher frequency with self-referred clients than with clients who are court mandated.*

A two-tailed paired-sample t-test revealed that participants were less likely to use self-disclosure with court-mandated clients \((M = 73.46, SD = 34.59, t(57) = 5.69, p < .05)\) than clients who voluntarily sought therapy \((M = 81.99, SD = 33.40)\).

Research Hypothesis 2

*Psychologists will report using self-disclosure at a significantly higher frequency with clients diagnosed with acute non-chronic mental health diagnoses than with clients diagnosed with a psychotic disorder or personality disorder.*

To test Hypothesis 2, the variable representing acute, non-chronic mental health diagnoses (ANC) was compiled using General Anxiety and Phobic Disorders, Depressive Disorders, and Adjustment Disorder. The variable representing personality disorders (PERDO) was compiled using Antisocial Personality Disorder, Narcissistic Personality Disorder, Borderline Personality Disorder, and Other Personality Disorders. Results
indicated that participants were more likely to use self-disclosure with court-mandated clients diagnosed with acute, non-chronic mental health diagnoses ($M = 29.23, SD = 14.26, t(58) = 3.45, p<.05$) than court-mandated clients diagnosed with personality disorders ($M = 25.45, SD = 12.42$). Furthermore, participants were more likely to use self-disclosure with court-mandated clients diagnosed with acute, non-chronic mental health diagnoses ($M = 29.23, SD = 14.26, t(58) = 14.83, p<.05$) than court-mandated clients diagnosed with psychotic disorders ($M = 6.50, SD = 3.63$).

**Research Hypothesis 3**

*Psychologists with court-mandated clients will endorse at least three of the five justifications that are most highly rated by therapists with non court-mandated clients.*

To test Hypothesis 3, frequency analyses were used to identify the most significant reasons participants used and did not use self-disclosure with self-referred and court-mandated clients. All 59 participants provided justifications for and against using self-disclosure with court-mandated clients. Results indicated the five most significant reasons participants reported for using self-disclosure with self-referred clients included: 1) to give the client encouragement and a sense of hopefulness (64.4%), 2) model coping strategies for clients (54.2%), 3) promote feelings of universality/help the client not to feel so alone (52.5%), and two variables tied with 45.8% of participants reporting using self-disclosure to increase the client’s awareness of alternative viewpoints as well as to build rapport/foster therapeutic alliance with the client. The top four reasons participants reported for not using self-disclosure with self-referred clients include: 1) avoid blurring boundaries (84.7%), 2) stay focused on the client and the material they present in session.
(74.65%), 3) prevent merging (the process of identifying too closely with the therapist) (45.8%), and 4) prevent the client from being concerned about the therapist’s welfare (44.1%).

Only 45 participants gave justifications for and against using self-disclosure with court-mandated clients. As Table 1 depicts, participants’ justifications for using self-disclosure with court-mandated clients indicated the top two most significant reasons self-disclosure is used with this population were: increasing the client’s awareness of alternative viewpoints as well as promote feelings of universality/help the client not to feel so alone (42.%). The next most frequent justification reported by participants for using self-disclosure with court-mandated clients is to model coping strategies for the client (40.7%) followed by to build rapport/foster therapeutic alliance with the client (39%). The fifth most significant justification reported by participants in this study for using self-disclosure with court-mandated clients is to give the client encouragement and a sense of hopefulness (35.6%).

Table 2 depicts the justifications the 45 participants gave for not using self-disclosure with court-mandated clients. The most significant justification is to avoid blurring boundaries (69.5%) followed closely by to stay focused on the client and the material they present (64.4%). The next most important justification participants identified for not using self-disclosure with court-mandated clients was to avoid giving the client information that could be used to manipulate the therapist (45.8%) and finally 40.7% reported preventing merging as a reason for not self-disclosing.

Justifications for using self-disclosure overlap both groups. Participants who report using self-disclosure with court-mandated clients often use the same rationale as
with self-referred clients: model coping strategies for the client, promote feelings of universality/help the client not to feel so alone, increase the client’s awareness of alternative viewpoints, and to build rapport/foster therapeutic alliance with the client.
Table 1

*Justifications for using Self-Disclosure with Court-Mandated Clients.*

<table>
<thead>
<tr>
<th>Justification</th>
<th>Frequency</th>
<th>Percent Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase client’s awareness of alternate viewpoints.</td>
<td>25</td>
<td>42.4</td>
</tr>
<tr>
<td>Promote feelings of universality/help the client not to feel so alone.</td>
<td>25</td>
<td>42.4</td>
</tr>
<tr>
<td>Model coping strategies for clients.</td>
<td>24</td>
<td>40.7</td>
</tr>
<tr>
<td>Build rapport with client/foster therapeutic alliance.</td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td>Give the client encouragement and a sense of hopefulness.</td>
<td>21</td>
<td>35.6</td>
</tr>
<tr>
<td>Provide reality testing.</td>
<td>16</td>
<td>27.1</td>
</tr>
<tr>
<td>Decrease client resistance.</td>
<td>16</td>
<td>27.1</td>
</tr>
<tr>
<td>Decrease client’s anxiety.</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>Increase therapist authenticity.</td>
<td>12</td>
<td>20.3</td>
</tr>
<tr>
<td>Increase client self-disclosure through modeling and/or reinforcement.</td>
<td>12</td>
<td>20.3</td>
</tr>
<tr>
<td>Challenge the client.</td>
<td>8</td>
<td>13.6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>6.9</td>
</tr>
<tr>
<td>Prevent the client from idealizing the therapist and devaluing her or himself.</td>
<td>3</td>
<td>5.1</td>
</tr>
<tr>
<td>Prevent transference from occurring with clients who have poor reality testing.</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>Dilute the transference near the end of therapy.</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>Decrease transference reactions in general.</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>Decrease therapist’s anxiety.</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>Provide therapist satisfaction.</td>
<td>1</td>
<td>1.7</td>
</tr>
</tbody>
</table>
### Table 2

*Justifications for Not using Self-Disclosure with Court-Mandated Clients*

<table>
<thead>
<tr>
<th>Justification</th>
<th>Frequency</th>
<th>Percent Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid blurring boundaries.</td>
<td>41</td>
<td>69.5</td>
</tr>
<tr>
<td>Stay focused on the client and the material she/he presents.</td>
<td>38</td>
<td>64.4</td>
</tr>
<tr>
<td>Avoid giving the client information that she/he may use to manipulate the therapist.</td>
<td>27</td>
<td>45.8</td>
</tr>
<tr>
<td>Prevent merging.</td>
<td>24</td>
<td>40.7</td>
</tr>
<tr>
<td>Prevent the client from communicating confidential information about the therapist to others.</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>Prevent premature closure.</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>Avoid information overload that may confuse the client.</td>
<td>12</td>
<td>20.3</td>
</tr>
<tr>
<td>Prevent the client from being concerned about the therapist’s welfare.</td>
<td>10</td>
<td>16.9</td>
</tr>
<tr>
<td>Prevent the client from questioning the ability of the therapist to help her/him.</td>
<td>9</td>
<td>15.3</td>
</tr>
<tr>
<td>Prevent the client from feeling resentful about being burdened by the therapist’s problems.</td>
<td>9</td>
<td>15.3</td>
</tr>
<tr>
<td>Avoid interfering with the transference process.</td>
<td>8</td>
<td>13.6</td>
</tr>
<tr>
<td>Avoid personal discomfort on the part of the therapist.</td>
<td>8</td>
<td>13.6</td>
</tr>
<tr>
<td>Avoid raising questions about the therapist’s mental health.</td>
<td>8</td>
<td>13.6</td>
</tr>
<tr>
<td>Prevent the client from feeling demoralized by the therapist’s success or failure.</td>
<td>7</td>
<td>11.9</td>
</tr>
<tr>
<td>Avoid losing credibility as an expert or “healer.”</td>
<td>3</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.4</td>
</tr>
</tbody>
</table>
Research Hypothesis 4

Years of experience among psychologists will be positively correlated with self-disclosure rates at a significant level with both self-referred and court-mandated clients.

Bivariate correlations using Pearson’s correlations were used to analyze the relationship between years participants worked as licensed psychologists and their self-disclosure rates with both self-referred and court-mandated clients. Based on Table 3, a negative correlation was observed for years of experience, self-referred verses court-mandated client, and responses to all four scenarios; however, significance was observed for Scenarios One and Four in the Self-Referred group and significance was observed in Scenarios One, Two, and Four for the Court-Mandated group.

Table 3

Bivariate correlation of psychologists’ years of experience and self-disclosure with self-referred and court-mandated clients

<table>
<thead>
<tr>
<th>Groups</th>
<th>Scenarios</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One</td>
<td>Two</td>
<td>Three</td>
<td>Four</td>
</tr>
<tr>
<td>Self-Referred</td>
<td>-.26*</td>
<td>-.24</td>
<td>-.22</td>
<td>-.32*</td>
</tr>
<tr>
<td>Court-Mandated</td>
<td>-.28*</td>
<td>-.27*</td>
<td>-.23</td>
<td>-.30*</td>
</tr>
</tbody>
</table>

*p. < .05
Research Hypothesis 5

*Psychologists who received graduate training/education on self-disclosure will report following self-disclosure philosophies that match with their graduate training/experience.*

Chi-square goodness of fit tests were performed to examine observed frequencies versus expected frequencies of occurrence for each category (i.e., graduate training on self-disclosure and self-disclosure philosophies). Results indicated that receiving graduate training on self-disclosure was not significant $\chi^2(1) = .153, p \geq .05$. However, significance was observed on whether the participants were encouraged, discouraged, or received neutral instruction regarding self-disclosure $\chi^2(2) = 13.86, p \leq .05$. A Cramer’s V post-test was completed to determine strengths of association to determine the significance of the previous finding. The Cramer’s V effect size, .41 indicated a moderate association between graduate training on self-disclosure and whether participants reported their training encouraged, discouraged, or neither encouraged or discouraged self-disclosure. Based on Table 4, we can see that substantially fewer psychologists were encouraged to self-disclose, despite the fact that over half of the sample received graduate training on self-disclosure.

Table 4

*Chi square levels for differences in psychologists’ use of self-disclosure as a function of self-disclosure training in graduate school.*

<table>
<thead>
<tr>
<th>Graduate training</th>
<th>Encouraged</th>
<th>Discouraged</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>19</td>
<td>9</td>
</tr>
</tbody>
</table>
Summary

According to this study, Hypothesis 1 was significant, indicating that participants in this study self-disclose less frequently with court mandated clients compared with self-referred clients. Hypothesis 2 was also significant indicating that client diagnosis affects therapist self-disclosure. Hypothesis 3 was significant since participants’ justifications for and against using self-disclosure with self-referred and court-mandated clients overlapped. Hypothesis 4 did not show a positive correlation as initially predicted but instead showed a negative correlation indicating the longer psychologists practice, self-disclosure decreases. Hypothesis 5 had partial support since participants did not typically self-disclose, despite the fact that over half of them had graduate training in self-disclosure. The implications will be discussed in Chapter 5.
CHAPTER V

DISCUSSION, LIMITATIONS, AND CONCLUSION

The purpose of this chapter is to summarize the current findings and integrate them with previous research. Implications for practice, educating and training psychologists working with court-mandated clients and future research are offered.

Discussion

This study found that psychologists who use self-disclosure do so more often with clients who are self-referred into treatment compared with clients who are court-mandated into treatment. It also demonstrates that as with previous studies (Mathews, 1988; Simone, 1994; Simone, Mc Carthy, & Skay, 1998) psychologists are more likely to use self-disclosure with clients diagnosed with acute, non-chronic mental health diagnoses than with court-mandated clients diagnosed with personality disorders or psychotic disorders. This study also found that the five most common justifications psychologists endorsed for using self-disclosure with court-mandated clients include: increase the client’s awareness of alternative viewpoints, promote feelings of universality/help the client not feel so alone, model coping strategies for the client, build rapport/foster therapeutic alliance with the client, and give the client encouragement and a sense of hopefulness. All of these justifications have been popular in previous studies (Mathews; Simone; Simone et. al.). This study also showed the most common
justifications for not using self-disclosure with court-mandated clients included: avoid blurring boundaries, stay focused on the client and the material they present, avoid giving the client information that could be use to manipulate the therapist and preventing merging – some of these justifications have been popular in previous studies (Mathews; Simone; Simone et. al.). This study also provides support for work written by Corley and Schneider (2002), Fisher (2004), as well as Guetheil and Brodsky (2008) who examine the role inappropriate therapist self-disclosure has on boundary violations, role reversal, sexual misconduct, as well as violation of privacy and client misinterpretations. Because providing therapy services to court-mandated clients has risks, such as the possibility of having a court-mandated client use a therapist’s self-disclosure against the therapist, participants in this study may have been cognizant of ethical guidelines and actively avoided self-disclosure in order to safeguard against unintended violations, manipulation, or false accusations.

Hypothesis 4 stated that years of experience among psychologists will be positively correlated with self-disclosure rates at a significant level with both self-referred and court-mandated clients. However, this study did not find support for this hypothesis nor are its findings consistent with those obtained from Andersen and Anderson’s (1989) study which suggested that self-disclosure rates increase as the therapist’s years of experience increase. Instead, this study found a negative correlation, indicating self-disclosure rates decreased as the participants’ years of experience increased. Hypothesis 4 may not have been supported since the sample was made primarily of older males, many of whom identify as having a psychodynamic theoretical orientation. It is also possible Hypothesis 4 was not supported because having a client...
who is court-mandated into therapy may override other considerations regarding the use of self-disclosure.

**Limitations**

One significant limitation of this study was with the Self-Disclosure Questionnaire – Revised (SDQ-R). The Likert scale responses are subjective and open to participant interpretation. If a participant circled “1,” they were reporting that they “never or almost never” use self-disclosure with clients diagnosed with a particular mental health issue. If the participant circled “2,” they were reporting they “rarely” self-disclose with clients diagnosed with a particular mental health issue. If the participant circled “3,” they are reporting they “sometimes” self-disclose, “4” they are “fairly likely” to self-disclose, and “5” they are “very likely” to self-disclose with a particular population. Response 1 was most problematic since it included the word “never,” clearly stating the person never self-discloses as well as “almost never.” To make the data collected with the SDQ-R, the statement “almost never” should be eliminated from response 1. Also, the other terms such as “rarely,” “sometimes,” “fairly likely,” and “very likely” are subjective and adding either definitions or percentages to these terms would make the instrument more objective. In addition, the “N/A” response should also be eliminated from the instrument since if this is circled; the individual is reporting they have never worked with clients from this particular population. In this study, any reported responses from this category were recoded into the “never/almost never” category. Recoding the “N/A” responses into the “never/almost never” category may have diluted the results and self-disclosure may have been underreported.
A second limitation was the small sample size due to low response rate. Three hundred surveys were mailed and only 59 usable surveys were returned for a response rate of 19.6 percent. Of these, only 45 participants completed justifications for and against using self-disclosure with court-mandated clients. Had the response rate been higher, the sample size would have been larger and study outcomes may have been different.

A third limitation to this study was the fact participants were not diverse and consisted primarily of older males. Current APA membership indicates that 56 percent are females; however, only twenty-eight percent of the participants in this study identified themselves as female. Therefore, the results may not generalize well to individuals who are not male. Another limitation of this study was the collection of limited information about the participants’ forensic experience. Forensic work takes place in a multitude of settings such as court clinics that provide evaluations, prisons, jails, hospital settings, or private practice. In addition, it is not clear what forensic issues participants are addressing with their clients through counseling or therapy. For instance, some participants may be providing mental health as well as parenting skills to clients mandated into counseling through children’s services, or providing treatment for clients mandated into sex offender treatment.

Many participants reported they did not, as a rule, self-disclose with court-mandated clients and 45.8 percent of the participants specifically reported that they did not use self-disclosure with court mandated clients because they did not want to give clients information that could be used to manipulate them. A few participants did report using self-disclosure with court-mandated clients; however, no data exist about the
circumstances that led these psychologists to use self-disclosure. The survey was not
designed to provide detailed information on the specific legal circumstances of the client,
the context in which the psychologist used self-disclosure with their client, or decision-
making process the psychologist utilized before providing self-disclosure to court-
mandated clients.

Implications

Implications for practice.

This study has shown that some psychologists use self-disclosure with court-
mandated clients; therefore, this is an intervention that may also have therapeutic
benefits. Since forensic mental health treatment has many risks unique to the specialty,
psychologists involved in this profession have to be even more cognizant of their
justifications for self-disclosing with their court-mandated clients compared with clients
self-referred into treatment.

Psychologists providing therapy services to clients court-mandated into treatment
should also consider the client’s diagnosis before using self-disclosure since this study
showed that participants were more likely to use self-disclosure with clients diagnosed
with acute, non-chronic mental health diagnoses. Therefore, psychologists providing
therapy services to court-mandated clients should take extra precautions to make sure of
their client’s diagnosis in order to rule out the possibility of a personality disorder or
other severe mental illness before using self-disclosure with their client.

Implications for education.

The results from this study may have relevance for graduate instructors as well as
clinical supervisors who are responsible for training graduate students about various
therapeutic interventions, including self-disclosure. Graduate training on the benefits and risks of therapist self-disclosure may be beneficial, especially to inexperienced students who may not have fully decided what client population or work setting they may ultimately find themselves in after their training is complete. Since Knapp and VandeCreek (2006) stated in their work that many mental health professionals become involved with the court system, graduate instructors and clinical supervisors should also provide instruction on the risks and benefits of self-disclosing with clients court-mandated into treatment, even if the training program is not forensic.

**Future Research**

Future studies should focus on whether the legal severity of the client’s charge as well as the psychologist’s work setting might alter the psychologist’s use of self-disclosure in court-mandated situations. For instance, a client who is court-mandated into individual counseling in a psychologist’s private practice order to regain custody of their children may be perceived differently than an inmate who is receiving individual sex offender treatment from a psychologist who works in a prison. Therefore, participants in future studies should be asked to include details regarding their client’s legal status, types of services provided (anger management, parenting, sex offender, etc.), and details regarding the setting in which the participants provide services. Future studies might focus on understanding the circumstances a psychologist considered before deciding that self-disclosure would be the most therapeutic intervention for a court-mandated client as opposed to trying to obtain results through other interventions and examining the outcome of that decision. Another interesting consideration for future study is how the
psychologist’s work setting (private practice, prison, etc.) shapes the therapeutic interventions they use with court-mandated therapy clients.

Utilizing the SDQ – R with mental health professionals who provide substance abuse treatment with court-mandated clients could provide insight into whether clinicians working with this population may respond differently than participants in this study. It is possible clinicians specializing in treating clients diagnosed with substance abuse or dependence may feel more comfortable self-disclosing, despite a client’s involvement with the legal system. Therefore, future studies may provide clarification in this area.

As forensic psychology graduate programs evolve, replicating this study with graduate students from forensic psychology, clinical psychology, and counseling psychology may provide additional understanding of how each of these specialties educate their students about self-disclosure. Understanding how these specialties educate and prepare their graduate students about self-disclosure and how to address it with court-mandated clients may offer additional information on effective methods for preparing students to manage self-disclosure in their professional careers.

Since very few participants in this sample reported using self-disclosure with court-mandated clients, future studies examining therapist self-disclosure with court-mandated clients may benefit from utilizing qualitative research methods. Qualitative research methods would make it possible to elicit detailed information from participants, such as detailed descriptions of situations in which a psychologist decided to use self-disclosure with a court-mandated therapy client and the psychologist’s decision-making processes in depth that quantitative research methods cannot achieve.
Although accessing potential participants’ mailing addresses was more feasible for this study than obtaining email lists, future studies may benefit from utilizing electronic data collection methods, such as email surveys or on-line survey websites where participants contribute electronically. This may increase the participant response size, reduce the number of incomplete surveys, and collect responses from younger psychologists. If this survey were used to study graduate students’ attitudes about self-disclosure with court-mandated clients, electronic data collection methods would encourage participants to contribute to the study. The SDQ – R should also be modified to include detailed questions about the respondent’s work setting, the client’s legal status and forensic issues involved with treatment, as well as treatments provided to court-mandated clients.

Another area for future exploration is whether reversing the order in which participants complete the SDQ – R may improve response rates and survey usability. Having the participants complete the scenarios, justifications for and against self-disclosure for both groups, then ending the survey completing the demographic questionnaire may encourage participants to complete the instrument more carefully and improve both return rate as well as the number of useable surveys for analysis. Also, future studies using the SDQ – R should make sure the rating scale terminology is clearly defined to reduce ambiguity and improve respondent accuracy.

**Conclusion**

This study is the first to examine psychologists’ use of self-disclosure with court-mandated clients. It has answered a few of the many questions that exist surrounding this particular topic, including the most significant that psychologists do use self-disclosure
with court-mandated clients. Knox and Hill found that self-disclosure is the least frequently used therapeutic interventions utilized by therapists; this study suggests that it is even rarer among court-mandated therapy clients.

Psychologists working with court-mandated clients are likely to exercise even more caution before self-disclosing with their court-mandated clients. They are likely to use the same justifications for using self-disclosure; however, they may need to ensure they are taking extra precautions to ensure the disclosure is therapeutically beneficial to the client. Since court-mandated clients may have secondary gains and attempt to manipulate the psychologist, psychologists working with this population may look for other methods to provide the same therapeutic benefits of self-disclosure.
REFERENCES


APPENDIX
APPENDIX A

Letter to Dawn Simone, Ph.D., L.P.

Barbara Doremus
2510 River Rd.
Willoughby Hills, OH 44094
440-975-0313
bdoremus@adelphia.net
March 3, 2010

Dawn Simone, Ph.D., L.P.
St. Mary's University of Minnesota
2500 Park Avenue
Minneapolis, MN 55404

Dear Dr. Simone:

Thank you again for speaking with me February 26, 2010 regarding the Self-Disclosure Questionnaire. I also appreciate you giving me permission to use the SDQ for my dissertation research. I will appropriately cite and give recognition for allowing me to use your instrument in my dissertation research.

As you suggested I purchased your dissertation and am looking forward to examining the SDQ in detail. As I mentioned, my particular dissertation interest is Psychologist self-disclosure with court-mandated and non court-mandated clients. Therefore, I might add a sentence or phrase to some of the scenarios to the effect of "a court-mandated client referred for treatment."

Once again, thank you for your assistance and your permission. If you'd like, I'd be happy to keep you updated with my progress.

Sincerely,

Barbara A. Doremus, M.A.
Ph.D. Candidate – Counseling Psychology
Cleveland State University
APPENDIX B

Reply from Dawn Simone, Ph.D., L.P.

Barbara Doremsus  
2510 River Rd.  
Willoughby Hills, OH 44094  
440-975-0313  
b.doremsus@adolphia.net  
March 3, 2010

Dawn Simone, Ph.D., L.P.  
St. Mary's University of Minnesota  
2500 Park Avenue  
Minneapolis, MN 55404

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Once again, thank you for your assistance and your permission. If you’d like, I’d be happy to keep you updated with my progress.

Sincerely,

Barbara A. Doremsus, M.A.

Doremsus A. Doremsus, M.A.  
Ph.D. Candidate – Counseling Psychology  
Cleveland State University

I give permission to use the SDQ for her research – 3-5-10

(Dawn Simone)
**APPENDIX C**

**Thesis and Dissertation Proposal Approval Form**

Prior to a student registering for Master’s Thesis or Doctoral Dissertation, a Committee must be formed. Once a student has a proposed thesis or dissertation project approved by the supervising committee, the student should complete this form and secure the required signatures. The completed form, intact, should be sent by the Committee Chairperson to the Department Chairperson, for signature, then to the Academic College Dean and finally to the Graduate College Dean. Upon final approval, the student is then permitted to register for thesis/dissertation credits. A copy of the form is sent to the student and the Department after all signatures are secured. See the section below on Committee member requirements.

<table>
<thead>
<tr>
<th>Name</th>
<th>Barbara Doremus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>2510 River Rd., Willoughby Hills, OH 44094</td>
</tr>
<tr>
<td>CSU ID#</td>
<td>2233284</td>
</tr>
</tbody>
</table>

Proposal: [ ] Master’s Thesis [ ] Doctoral Dissertation

Department of: [ ] UECP: Counseling Psychology

Proposed Title: Psychologist Self-Disclosure with Court-Mandated and Self-Referral Therapy Clients

Provide a brief description of the project:

See Attached Abstract

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**Committee Membership** (please print names)

- **Chairperson**: Elizabeth Welzel
- **Member**: Justin Perry (Methodological)
- **Member**: Dilani Perera-Diltz
- **Member**: Sarah Toman
- **Member**: Gilho Cho (MetroHealth Hospital)

**Notification**

- **Department Chairperson**: G. Stead
  - **Date**: 2/18/2011
- **Academic College Dean**: C. B. Crow
  - **Date**: 3/23/2011
- **Graduate College Dean**: D. J. Jeffers
  - **Date**: 3/8/11

**Approval**

- **Distribution**
  - White - Graduate College
  - Yellow - College Dean
  - Pink - Department
  - Gold - Student
  - 09/03

---

*Thesis and dissertation Committees must be composed of at least three members of Graduate Faculty. Additional Graduate Faculty may also serve as voting members of the committee. Persons not holding Graduate Faculty status may serve as non-voting members of the committee. The chairperson of the committee must be a member of the Graduate Faculty. Doctoral dissertation committees must include at least one member of the Graduate Faculty who holds an appointment outside of the student’s degree program. To determine if a faculty member holds Graduate Faculty status, please consult the College of Graduate Studies' website at: www.cshio.edu/gradecollege/. Or, contact the Graduate College Office at ext. 9370, Keith Bldg., 1621 Euclid Avenue, Suite 1150.*
APPENDIX D

Approval from the Cleveland State University Institutional Review Board for
Human Subjects in Research

---

Date: Thursday, April 28, 2011 2:34 PM
From: John J Jeziorski <jjeziorski@cshio.edu>
To: bdoremus@adelphia.net, Elizabeth R Wiefel <e.wiefel@cshio.edu>
Cc: Barbara A Bryant <b.bryant@cshio.edu>, Richard Piiparinen <r.piiparinen@cshio.edu>
Subject: Re: IRB Submission #29323-WEL-LS - revised

Dear Investigators Doremus and Wiefel:

I am in receipt of your email dated 04/27/2011 09:57pm (including attachments) in response to my correspondence of 04/20/2011 following the preliminary review of your IRB Submission #29323-WEL-LS. You have addressed all of the items of interest generated from that initial review and are hereby approved (Category: Exempt.....from further review - b2) to commence with your study as of this day/date (Thursday, April 28, 2011). You will be receiving written confirmation of this approval from the CSU IRB office in the very near future. Both myself and the secondary reviewer want to take this opportunity to wish you the very best of luck in your investigative endeavors. It has indeed been both a privilege and a pleasure to be of assistance to you throughout this review process!

Respectfully expressed,
John Jeziorski, Primary Reviewer
IRB Submission #29323-WEL-LS

-----<bdoremus@adelphia.net> wrote: -----

To: John J Jeziorski <jjeziorski@cshio.edu>
From: <bdoremus@adelphia.net>
Date: 04/27/2011 09:57PM
Cc: Elizabeth R Wiefel <e.wiefel@cshio.edu>, Barbara A Bryant <b.bryant@cshio.edu>, Richard Piiparinen <r.piiparinen@cshio.edu>
Subject: IRB Submission #29323-WEL-LS - revised

Hello,

I appreciate the feedback I received on my IRB submission. I have made the necessary changes and have attached my revised IRB and proposal for your review. Please let me know at your earliest convenience if my dissertation chair and I need to update our signature page. I also wanted to inform the board that no data has been collected and none will be collected until the project is approved by the board. Also, please feel free to contact me if you have any questions or concerns.

Thank you for your time.

- Barbara Doremus

[attachment "IRB Doremus Barbara revised 4-27-2011.doc" removed by John J Jeziorski/jjeziorski/CSUOHIO]
[attachment "Doremus Barbara Consent letter revised 4-27-11.doc" removed by John J Jeziorski/jjeziorski/CSUOHIO]
Dear Participant:

I am a doctoral student in counseling psychology (APA accredited) at Cleveland State University and I am asking you to participate in my dissertation research, by completing a survey being given to licensed psychologists from across the United States. The purpose of this survey is to gain insight into how psychologists use self-disclosure with clients court-mandated into individual therapy. The survey will ask questions about your education, clinical experience, work setting, self-disclosure training, and length of time working as a licensed psychologist. In addition, you will read four therapy scenarios and rate your likelihood of using self-disclosure in that situation with both court-mandated and self-referred clients diagnosed with particular disorders. Afterward, you will be asked to rate your top five reasons for and against using self-disclosure with court-mandated and self-referred clients. It is our hope that information from this survey will contribute to a better understanding of how psychologists working with court-mandated individual therapy clients may use self-disclosure with this particular therapy population. The survey should take no more than 20 minutes to complete.

Your responses to the survey will be anonymous. Your name will not be collected or appear anywhere on the survey and complete privacy will be guaranteed.

Participation is completely voluntary and you may withdraw at any time. There is no reward for participating or consequence for not participating. There are no known risks to you if you choose to participate in the study.

For further information regarding this research please contact my dissertation chair Dr. Elizabeth Welfel at (216) 687-4605, email: E.WELFEL@csuohio.edu, or you may contact me, Barbara Doremus, at (440) 975-0313, email bdoremus@adelphia.net.

If you have any questions about your rights as a research participant you may contact the Cleveland State University Institutional Review Board at (216)687-3630.

I am 18 years or older and have read and understood this consent form. By my return of the completed measures I am indicating that I have read this consent form and have agreed to participate in this research.

Thank you in advance for your cooperation and support.

____________________________  ______________________________
Elizabeth Reynolds Welfel, Ph.D.  Barbara A. Doremus, M.A.
Dissertation Chair    Counseling Psychology
APPENDIX F

Self-Disclosure Questionnaire-Revised (SDQ-R)

Self-Disclosure Questionnaire

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