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Exploring the Impact of Rural and Urban Settings on Therapist Self-Disclosure

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Exploring the Impact of Rural and Urban Settings on Therapist Self-Disclosure

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Abstract

There has been a significant amount of research that addresses the topic of therapist self-disclosure. Issues such as what to disclose, when to disclose, the ethics of therapist disclosure, and the benefits and harm of therapist self-disclosure have been debated over the years. How self-disclosure varies among therapists has also been a focus of research.

Unlike the area of self-disclosure, research on rural practice is a new and expanding field of research and there is great need for more research in this area. The hypothesis of this study proposes that therapist self-disclosure varies by setting; that rural therapists are more likely to disclose information about themselves than their urban counterparts. This hypothesis is based on anecdotal evidence from rural therapists who report that because of the close-knit nature of a rural community, they feel the need to self-disclose more in order to establish trust with their clients, but are at times unsure that this the right thing to do ethically.

A questionnaire was designed in collaboration with the author's supervisor to explore this hypothesis, which was sent out to both urban and rural therapists. The questionnaire addressed demographic variables, self-disclosure practices, and the therapists' perception of the impact of self-disclosures. Efforts were made to maintain the anonymity of the participants in acknowledgement of the controversial nature of the topic of self-disclosure.

The data from the questionnaires was analyzed using SPSS. There was one significant finding when the rural and urban groups (as defined by percentage of urbanization) were compared and this finding did not seem to support the hypothesis. This finding suggested that urban therapists perceive that their unintentional self-disclosures have a more positive impact than do rural therapists. One other significant finding indicated that therapists who identify as practicing in rural areas report experiencing more unintentional self-disclosure. This finding partially supports the hypothesis. Anecdotal responses to an open-ended item demonstrated the salience of such issues as dual roles and unintentional disclosure for those practicing in rural areas.

The reason for the paucity of significant results in unclear. There are several weaknesses associated with the survey research method and that may be associated with this study in particular. It is clear that more research is needed to determine the impact that dual roles and unintentional disclosure have on rural therapists and their clients.

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Chapter 1

Introduction

Self-Disclosure

Much research has been devoted to the study of therapist self-disclosure, which is generally defined as the intentional sharing of personal information – such as thoughts, feelings, or experiences – with a client (Goldstein, 1994). It is important in this review of the research to keep in mind that there are some concerns regarding research in self-disclosure, namely that many different definitions of therapist self-disclosure have been used (Barrett & Berman, 2001). For example, some definitions leave out intentionality or limit self-disclosure to verbal statements (leaving out non-verbal disclosures such as dress, office décor, etc.; e.g., Hill & Knox, 2002), other definitions distinguish between self-disclosure (revelations by the counselor of a personal nature) and self-involving statements (comments made by the counselor about the counseling process; Watkins, 1990 in Edwards & Murdock, 1994; Oakes, 2000). Some definitions are broad, for example, Jouard (1958 in Mathews, 1988) referred to self-disclosure as "the process of making the self known to other persons" (p. 521). Other authors offer more detailed definitions; Goldstein (1994) defines self-disclosure as "the therapist's conscious verbal or behavioral sharing of thoughts, feelings, attitudes, interests, tastes, experiences, or factual information about himself or herself or about significant relationships and

activities in the therapist's life" (p. 419). The multiplicity of definitions of self-disclosure in research makes it difficult and confusing to compare results across studies; such attempts at studying self-disclosure should thus be made with caution.

Studies have examined how and why therapists disclose information about themselves, and what kind of information is most often revealed in such self-disclosures. For example, Edwards and Murdock (1994) surveyed practicing doctoral-level psychologists about the frequency and reasons for self-disclosing in therapy. They found that therapists reported disclosing about professional qualifications and experience most often and indicated that they disclosed mainly to increase similarity between themselves and clients. The authors bring up the interesting contradiction here, that when therapists disclose their qualifications and experience, they ultimately emphasize the differences rather than the similarities between their clients and themselves. They speculate that the therapists disclose information regarding their professional qualifications as part of informed consent or at the request of the client and are referring to other disclosures when talking about increasing similarities between themselves and their clients. Mathews (1988) had similar findings. The 342 therapists, comprised of psychiatrists, social workers, and psychologists, in her study most frequently cited promoting feelings of universality and providing reality testing as their reasons for utilizing self-disclosure. They also listed the removal of the focus from the patient and interference with the transference as the most common reasons not to disclose to patients. Unfortunately, the author included no further statistical analysis of her data in the article, but rather gave examples of therapists' answers to the questions in the survey.

There remains much debate over the impact of therapist self-disclosure on the therapist-client relationship, though it seems that recent research has pointed toward the potential benefits of therapist self-disclosure (Barrett & Berman, 2001; Hill & Knox, 2002; Knox & Hill, 2003). This subject is frequently debated between practitioners of different theoretical orientations. As Yalom (1995) stated, "More than any other single characteristic, the nature and degree of therapist self-disclosure differentiates the various schools of ... therapy" (p. 202). In fact, psychoanalytic practitioners have historically taken the route of avoiding self-disclosure in an attempt to remain neutral and draw the client further into his or her own disclosures and transference fantasies (Goldstein, 1994). Freud (1912/2000, p. 18, quoted in Peterson, 2002) famously stated, "The physician should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him". In regards to psychodynamic therapist self-disclosure, Jackson (1990, quoted in Hill & Knox, 2002) stated, "The point of the therapist's revealing little...is so that the patient may reveal more" (p. 256). Hill and Knox go on to explain that many psychodynamic therapists have tempered their take on self-disclosure, which might explain the recent increase in support of its use. Goldstein (1994), for example, in a thoughtful analysis of self-disclosure from a self-psychology perspective, advocates for the careful use of self-disclosure in some situations.

Humanistic theorists have more openly embraced the use of therapist self-disclosure; they believe that therapist self-disclosure facilitates openness and genuineness in the therapeutic relationship and demystifies the therapeutic process (Peterson, 2002). These theoretical differences are borne out in research – in one study, humanistic theorists reported disclosing more frequently than did psychoanalytic therapists (Hill &

Knox, 2002). Edwards and Murdock (1994) had similar findings, with psychoanalytic practitioners reporting using significantly less self-disclosure than did humanistic therapists. Other theories such as feminist and multicultural theories have also supported the use of self-disclosure, finding it particularly useful in creating trust with a client who is culturally different from the therapist (Hill & Knox, 2002).

Empirical studies of therapist self-disclosure seem to support its use – both therapists and clients have reported a positive impact on the therapeutic relationship. Oakes (2000) in her survey study of 81 practicing psychologists found that most therapists (75% of her sample) indicate that their self-disclosures have a favorable impact on the therapist-client relationship – only one therapist in this study indicated that self-disclosure had a negative impact. Barrett and Berman (2001) were interested in the client's feelings regarding therapist self-disclosure. They had two treatment conditions in their study – one in which the therapist was to increase the frequency of their self-disclosures in response to client disclosures, with the therapist attempting to meet the level of language sophistication and intimacy used by the client, and the other in which the therapists were told to restrict their disclosure of personal information in favor of maintaining the focus on the client. They found that clients in the increased disclosure condition reported higher levels of therapist disclosure than did those in the limited disclosure condition. Clients in the increased disclosure condition also reported lower levels of symptom distress and even liked their therapist more. Studies seem to show that clients report short-term benefits from therapist self-disclosure, but results regarding the long-term effects are mixed. Hill and Knox (2002) note that "the effects of therapist self-

disclosure were part of a complicated sequence of events combining both immediate and distal outcome" (260).

This is not to say that there haven't been studies reporting therapist self-disclosure having a negative impact on the client. Peterson (2002) cites one study by Wells (1994) in which 8 clients were interviewed about their experiences with therapist self-disclosure and reported fairly negative results, and another study by Knox et al. (1997) which had mixed results with regards to the impact of therapist self-disclosure on clients.

In addition to examining the impact of self-disclosure on the therapeutic relationship through quantitative studies, there has also been theoretical research that focused on what types of self-disclosure should be considered ethical. Some warn that therapist self-disclosure can be exploitative of the client, while others highlight the potential benefits of self-disclosure (Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001). Peterson (2002) states that the ethicality of any self-disclosure depends on the content of the disclosure, the therapist's rationale for the disclosure, the personality of the client, and the circumstances surrounding the self-disclosure. There are any number of articles listing suggestions for the use of therapist self-disclosure, most of which share common themes (Goldstein, 1994; Hill & Knox, 2002, Knox & Hill, 2003). Overall, however, it seems that most sources are in agreement that self-disclosure should be engaged in with caution, but can have benefits when handled correctly. There also appears to be agreement that therapists should self-disclose only for the benefit of the client (Simon & Williams, 1999; Stricker, 2003) and that they should abstain from self-disclosure when it leads to their own gratification at the expense of the client (Simon & Williams, 1999). "Disclosures given with the intention to aid the

client and enhance the therapy often have powerful positive effects" (Knox & Hill, 2003, p. 535).

Rural Practice

One can see from the above research that therapist self-disclosure can be an enigmatic and controversial topic into which many variables play. It seems that the setting of the therapy – urban or rural – could also impact the use of self-disclosure, however, there does not appear to be any research in this area. This may be because interest in the area of rural psychology has been low until recently and much research has yet to be done. Research in rural practice merits greater attention, as people living in rural areas have many unmet mental health needs (Campbell, Gordon, & Chandler, 2002).

The rural setting is unique and differs greatly from an urban setting. While there is great diversity among rural areas, Hargrove (1986) lists several of the general characteristics of rural areas. First, the greater distances between people in rural areas force them to live independently and in greater interdependence with family and neighbors. Mental heath treatment is scarce and many people living in rural areas have few options in this area (see Campbell, Gordon, & Chandler, 2002 for details regarding the need for mental health care in rural areas). Living and working in these small, tightly knit communities can increase the intensity of relationships and roles often overlap, sometimes confusing personal and professional relationships, to the distress of many rural mental health practitioners. It is the intensity of relationships in interaction with the overlap of personal and professional relationships (dual relationships) in rural areas that is of interest in this study.

Dual relationships are a concern for all mental health practitioners, but particularly for rural practitioners because of their inevitability (Catalano, 1997; Campbell & Gordon, 2003). Several authors have enumerated the difficulties for rural therapists, who wish to establish rapport with their rural clients who tend to be suspicious of "outsiders" and see non-disclosing therapists as cold and untrustworthy, but also wish to practice within the bounds of the ethical code, which cautions against dual relationships (Bersoff, 2003; Catalano, 1997; Cohen, 1987; Schank & Skovholt, 1997; Sobel, 1992; Stockman, 1990). The ethical code warns against dual relationships because they can confuse social roles, often leading to misunderstandings and even stress within the therapeutic relationship. Such role confusion in addition to the intensity of rural relationships could lead therapists to disclose more personal information than they would otherwise, which in turn, may again create a feeling in the therapist that they are practicing unethically or may, in fact, constitute unethical behavior.

This can be backed up by anecdotal evidence from rural therapists who have found that the rural culture is so tightly knit that clients often have difficulty trusting and confiding in them if they do not know a little about them. For example, in a preliminary questionnaire study conducted by the author and Dr. Clark Campbell, one rural therapist commented, "I think without a certain amount of disclosure, in a rural community the therapist comes off as being fake and unable to empathize."

The situation of rural therapists is further complicated by the greater presence (as compared to urban therapists) of what I will term unintentional disclosures – that is, in a rural community, it would not be unusual for therapists to experience unplanned, non-professional contact with clients, which may unintentionally reveal information about the

therapist. Such unintentional disclosures may also cause rural therapists discomfort, again, because therapist self-disclosure is generally discouraged and may be considered to be unethical. In such a close community, clients may obtain information about their therapist without even having contact with the therapist. Simon and Williams (1999) state appropriately, "In small rural communities the anonymity of mental health professionals is largely a fiction" (p. 1444). Horst (1989) found that psychologists practicing in rural areas reported significantly more unplanned, non-professional contact with clients than did therapists in larger communities. Regarding rural therapists, she states, "it is difficult, if not impossible, to isolate oneself completely from out-of-session contact with clients" (p. 16). Here again we see the plight of rural therapists who live in a setting in which they are seemingly unable to avoid dual relationships and self-disclosure, but may also feel that because they engage in these behaviors, they are practicing unethically or are potentially harming their clients. Horst (1989) states, "Under these circumstances, the distinction between beneficial outside contact and a dual relationship becomes increasingly difficult and increasingly important" (p. 17).

Hypothesis

Because of the unique circumstances of rural therapists described above, therapist self-disclosure occurs more frequently among rural therapists than among urban therapists. Because there has been no prior research on this topic, the proposed research is exploratory. It will examine the differences between urban and rural therapists regarding self-disclosure, looking specifically at what kind of information is disclosed and the perceived impact of intentional and unintentional disclosures. These findings will be foundational for further research into questions of both rural psychology and

therapist disclosure, and future research could contribute significantly to the understanding of the ethics and usefulness of therapist disclosure, particularly in rural areas. After this groundwork has been laid, future research could also examine the question brought up in the previous paragraph – why does therapist self-disclosure vary between urban and rural settings?

Chapter 2

Methods

Participants

Participants in this study were selected from lists of practicing licensed psychologists throughout the U.S. provided by the APA. The 300 participants were divided into two groups of 150 participants each, one practicing in urban areas, another in rural areas. For the purposes of this study, the dividing line between "urban" and "rural" was determined by percent urbanization – the rural group was taken from counties with less than 25% urbanization and the urban from counties with more than 50% urbanization. This was the dividing line recommended by the APA. A census block is considered urbanized if it contains at least 1000 people per square miles and surrounding census blocks have an overall density of at least 500 people per square mile. Participants were randomly selected within each group and were selected to be representative for age, gender, and race within each group.

Questionnaire

Both groups received a mailing with a cover letter (see Appendix A), a reminder postcard (see Appendix B), and a brief questionnaire (see Appendix C). The questionnaire had two parts, the first of which included questions regarding the frequency of different kinds of self-disclosure among the participants and questions examining the

perceived impact of these self-disclosures, both intentional and unintentional, on the therapeutic relationship. There was a space provided in the first part to allow the therapists to share any anecdotes that would demonstrate issues of self-disclosure that are specific to their practice setting (urban or rural). The second part contains questions regarding demographic information, including the therapist's degree, theoretical orientation, years in practice, age, race/ethnicity, and gender.

This questionnaire was designed specifically for this study by the author and her advisor. It was a self-report measure that was meant to examine the frequency with which therapists' self-disclose (both intentionally and unintentionally) about certain topics, and how therapists perceive the impact of these self-disclosures on the therapeutic relationship. The definitions of intentional and unintentional self-disclosure were included on the questionnaire to clarify their meanings for the participants. Intentional self-disclosure was described as, "Intentional sharing of personal information with a client through verbal expression (e.g., stating personal thoughts, feelings, experiences) and purposeful non-verbal expression (e.g. wearing a wedding ring with the knowledge that a client may notice it)." Unintentional self-disclosure was described as, "Unplanned situations with clients which may unintentionally reveal personal information about the therapist. This may occur in many forms, for example, unplanned, non-professional contact, through a mutual acquaintance revealing information, or through contact with a previous client." There are no existing questionnaires known to the author that explore these specific issues.

Procedure

Because therapist self-disclosure can be a controversial topic, it was important that participants in this study were assured of anonymity in responding. For this reason, the "reminder postcard strategy" recommended by Mangione (1995) was used. In this strategy, a reminder self-addressed stamped postcard is included in the first mailing and is sent to the researcher by the participant separately from the questionnaire. The postcard includes identification of the participant and allows the researcher to know which participants returned their questionnaires while maintaining their anonymity. Because the survey was anonymous, the questionnaires were printed on two different colors of paper – rural (less than 25% urbanization) on green and urban (more than 50% urbanization) on blue – so the researcher could track this important variable.

The first mailing included a cover letter (Appendix A), a reminder postcard (Appendix B), and a copy of the questionnaire (Appendix C). A second mailing with a different cover letter (see Appendix D) and another copy of the questionnaire was sent to those who had not yet returned their reminder postcard one month after the first mailing was sent. After all the completed questionnaires arrived, the data was analyzed using the Statistical Package for the Social Sciences (SPSS), looking for significant differences in the type and perceived impact of self-disclosure between the urban and rural populations.

Chapter 3

Results

Of the 300 questionnaires that were sent out, a total of 95 questionnaires were returned, 50 rural and 45 urban. This is a return rate of 31.6%. There were 62 (33 rural and 29 urban) questionnaires returned after the first mailing and 33 (17 rural and 16 urban) after the second.

Demographics

Regarding gender, 40.7% of the participants were male and 59.3% were female. Participants were given six options to identify their race or ethnicity: Black/African American, Hispanic/Latino(a), White/Caucasian, Asian/Pacific Islander, Native American/Alaskan Native, and Other. The majority of the participants (94.5%) identified as White/Caucasian, 2.2% identified as Black/African American, 1.1% as Hispanic/Latino(a), and none identified as Asian/Pacific Islander. One participant identified as both White/Caucasian and Native American/Alaskan Native and one as both Hispanic/Latino(a) and White/Caucasian, for a total of 2.2%. Additionally, two of the participants who identified as White/Caucasian also wrote in the "Other" section that they were Jewish.

Regarding the highest degree held by the participants, 78% held a PhD, 15.4% held a PsyD, 4.4% held an EdD, and 2.2% held an MA or MS. The participants could

choose from six different theoretical orientations: 32.2% identified as Cognitive Behavioral, 23.0% as Psychodynamic, 32.2% as Eclectic, 4.6% as Humanistic, 5.7% as Family Systems, and 2.3% as Other.

While 47.4% of the participants were from urban areas and 52.6% were from rural areas as defined by percentage urbanization (this was determined by looking at the color of the questionnaire), 32.2% identified themselves as practicing in an urban setting, 33.3% as practicing in a suburban setting, and 34.5% as practicing in a rural setting on item 42.

Comparing the Rural and Urban Groups

In order to test the hypothesis that rural therapists disclose more about themselves than urban therapists, an independent *t* test was run to compare the means of the rural group and the urban group (as defined by percentage of urbanization) on questionnaire items 1-30 and 32-34. Results were significant on only one variable, item 32, which addresses the perceived impact of unintentional disclosures on the therapeutic relationship (t (80) = -2.208, $p < .05$). On this item, the mean for the urban group was significantly higher ($m = 3.68$, $SD = .62$) than the mean for the rural group ($m = 3.36$, $SD = .69$), indicating that urban therapists perceive that their unintentional self-disclosures have a more positive impact than do rural therapists. There were no other significant differences between urban and rural therapists (as defined by percentage of urbanization) in what topics they intentionally or unintentionally self-disclose about (e.g., age, feelings towards clients, political views), when during the course of therapy the intentional self-disclosures occur, or the perceived impact of the self-disclosures on either the therapeutic relationship or the therapist's family members.

Results for Other Variables

Setting. An ANOVA and a Tukey's HSD were run to compare the results for the different response options on item 42. On this item, participants could choose from three options for their primary practice setting: urban, suburban, and rural, thus showing the researcher which setting they believed they practiced in. The ANOVA showed the presence of a significant result when comparing items 42 and 30 (F (2,82) = 3.39, $p >$ .05), but the Tukey's HSD failed to identify which results were significant, so a less conservative test, the test of Least Significant Differences, was run to pick up the significant results. The results of the test of Least Significant Differences should be used with some caution as the test is prone to inflated Type I error. Item 30 had the participants "estimate the percentage of clients who know significant personal information about you before they come into therapy that you did not choose to reveal to them." The mean of the group that chose rural as their setting was significantly higher (m = 21.62, SD = 24.49) than the means of the both the group that chose urban (m = 10.41, SD = 15.70) and the group that chose suburban (m = 10.73, SD = 13.37) as their settings, indicating that those who chose rural as their setting report experiencing significantly more unintentional self-disclosure than did those who chose urban and suburban.

Age. A Pearson correlation coefficient was calculated for the relationship between the age of the participants and items 1-30 and 32-34. A strong positive correlation was found between age and items 1 (r (91) = .241, $p <$ .05), 6 (r (87) = .255, $p <$ .05), 10 (r (89) = .256, $p <$ .05), and 26 (r (78) = .245, $p <$ .05). This indicates that older subjects are more likely to intentionally disclose their age, sexual orientation, and political views and are more likely to believe that their clients discover their political

views without their intentional disclosure. A 3x2 ANOVA was calculated to determine if there was any interaction between age and perceived setting (as in item42) on item 26. To do this calculation, the age variable was divided at the median age (54) into two halves: younger (36-53) and older (54-72). There was a significant interaction of age and setting (F (2, 76) = 4.38, p = .02) such that older urban psychologists believe that clients know more about them (M = 2.25, SD = .87) than do any younger psychologists or older psychologists in suburban or rural settings (Means range from 1.33 to 1.90, Standard Deviations range from .49 to .86). This interaction is a large effect (eta squared = .11). There were no other significant findings with regards to age.

Gender. An independent t test was run to compare the mean scores of males and females on items 1-30 and 32-34. There was a significant result on one item, 13a (t (79) = 2.305, $p < .05$). This indicates that males reported intentionally disclosing significantly more frequently during the "Initial contact (before therapy begins)" phase of therapy (m = 10.58, SD = 14.77) than did females (m = 4.56, SD = 8.67). There were no other significant findings with regards to gender.

Ethnicity. There were only five participants who did not identify as White/Caucasian. The number of participants who identified as Black/African American, Hispanic/Latino/a, and Other was not great enough to hold up to statistical analysis, therefore no comparisons were made between the different ethnicities.

Theoretical orientation. A one-way ANOVA was computed to examine differences between those subscribing to different theoretical orientations on items 1-30 and 32-34. There was only one significant finding. There was a significant difference between participants with different theoretical orientations on item 4, which had the

participants rate the frequency with which they intentionally disclose their "personal psychological/therapy experiences" (F (5,81) = 4.199, $p < .01$). Tukey's HSD was used to determine the nature of the differences between the theoretical orientations. This analysis revealed that participants who subscribed to a Cognitive Behavioral orientation (m = 1.46, SD = .74) rated themselves as intentionally disclosing about their personal psychological/therapy experiences significantly less frequently than those with a Psychodynamic orientation (m = 2.3, SD = 1.03).

Highest degree. An ANOVA and a Tukey's HSD were run comparing the results of participants with different degrees (i.e., PhD, PsyD, EdD, and MA/MS). There were no significant findings, in part because the number of subjects with an EdD was four and those with an MA or MS totaled two. These numbers are too small to create reliable data for these tests.

Anecdotes. Item 35 of the questionnaire asked participants to, "Please share any anecdotes that would demonstrate issues of self-disclosure that are specific to your practice setting (e.g., rural or urban)." Forty-nine (51.58%) of the participants chose to respond to this item – 29 were rural (as defined by percentage of urbanization - 58% of the total rural participants) and 20 were urban (44.44% of the total urban participants).

To analyze this item, this researcher read through all the responses and attempted to categorize them. There were a just a few overall categories. The first involves those who did not seem to completely understand what the item was asking for – this category actually accounts for a substantial number of the responses to this item. These people would share anecdotes about self-disclosure that did not appear to be specific to their setting. For example, some stated that they would share their struggles with giving up

cigarettes with their clients, or that they would share their positive feelings towards their clients as a form of validation. Others discussed their self-disclosure practices as they related to their theoretical orientation (e.g., the therapist subscribes to Interpersonal theory and discloses feelings the client evokes in her, but nothing else), or as they related to a specific population they work with (e.g., the therapist works with adoptive parents and their adopted child and shares that he is an adoptive father).

The second category had to do with unintentional self-disclosures. Those with this type of response were primarily from the rural group, though there were a few from the urban group as well. These responses would involve anecdotes or comments about clients and others knowing many things about the therapist. One rural therapist stated, "My life is quite transparent in a small community," another stated, "Most clients know much about me...prior to ever making contact," and another stated, "Everywhere I go, I see clients, and they see me." One urban therapist shared that he is well-known in his community.

The third category involved reports of dual roles and running into clients in the community. Again, the majority of those who responded in this way seemed to be from the rural group, though a few from the urban group also reported these experiences. One rural therapist shared that he treated the adult daughter of a local restaurant manager who continues to give him updates on her daughter even though therapy is over; another stated that her clients work at the grocery, gas station, post office, etc.; and another shared that a cop client once stopped her for speeding. One urban therapist shared that she once ran into a teen client while getting a manicure.

The final category included only a few responses, but all of them were from urban participants. In this category, the participants commented that self-disclosure was rare or unnecessary. For example, "It's very rare that I make personal disclosures," or "S.D. [self-disclosure] very unnecessary for purpose of psychotherapy," or "Unintentional [self-disclosure] is rarely or never an issue."

Chapter 4

Discussion

Hypothesis

The hypothesis above stated that therapist self-disclosure occurs more frequently among rural therapists than among urban therapists. The research discussed in the last chapter may support this hypothesis, at least in part. However, this finding had to do with differences between those who chose rural as their primary practice setting and those who chose urban and suburban as their primary practice setting, *not* with differences between the rural and urban groups as defined by percentage of urbanization. In this finding, those who chose rural as their primary practice setting on item 42 estimated (on item 30) that a significantly higher percentage of their clients know information about them before they enter therapy than did those who chose urban or suburban. Again, this result should be interpreted with caution as the test that was used (Least Significant Differences) is prone to Type I error; in other words, it is prone to finding a significant difference where one doesn't actually exist.

This result is puzzling as there were no significant differences between the different practice settings on items 17-28, which required participants to rate the frequency of specific unintentional self-disclosures (e.g., marital status, religious beliefs, etc.). Perhaps it was difficult for the participants to gather information about specific

unintentional disclosures, but it was easier for them to give an overall impression of the occurrence of unintentional disclosures. It is also interesting that the results that compared the means of the urban and rural groups (as defined by percentage of urbanization) on item 30 were not significant. It seems that only those participants who *believed* they practiced in a rural setting reported experiencing increased rates of unintentional self-disclosure. This supports the hypothesis only in part because it appears that it is only those who *perceive* themselves as rural practitioners who show increased rates of self-disclosure, and it is only increased rates of *unintentional* self-disclosure – there were no significant differences found in intentional self-disclosure. This finding is consistent with that of Horst (1989), who found that psychologists practicing in rural areas reported significantly more unplanned, non-professional contact with clients than did therapists in larger communities.

There was one other significant finding related to the hypothesis that had to do with differences between the urban and rural groups as defined by percentage of urbanization. This finding involves item 32 on the questionnaire which reads, "Rate the impact that unintentional disclosures usually have on the therapeutic relationship with your clients." The participants were to circle a number on a five-point Likert scale, with 1 being "Negative impact," 3 being "Neutral impact," and 5 being "Positive impact." They were also given a "Don't Know" option; those who selected "Don't Know" were not included in the data analysis for this item. The mean for the urban group was found to be significantly higher than the mean for the rural group, indicating that the urban group rated the impact of their unintentional disclosures as more positive than the rural

group. When the "Don't Know" group was included in the analysis, there was no difference in the findings.

This result is difficult to explain. If rural therapists have more experience with unintentional self-disclosures (as in the finding discussed above), one might think that a self-serving bias ("the tendency to perceive oneself favorably," Meyers, 1999, p. 55) may be a factor, which would keep them from admitting to themselves the potential negative consequences of these unintentional self-disclosures, and would encourage them to see their disclosures in a positive light. On the other hand, perhaps if the rural participants did, in fact, have more experience with unintentional self-disclosure, they may have been more aware of the potential negative consequences of such disclosures, whereas urban therapists may have been nearly unaware of the consequences of unintentional self-disclosures if they had very little exposure to them, and thus may have rated them in a more positive light. Finally, it is possible that due to their exposure to unintentional disclosures, rural therapists likely had more negative experiences related to unintentional self-disclosure (e.g., caught in an embarrassing situation, or feel uncomfortable because of the ethical dilemma). These negative experiences may have colored their impression or the impact of unintentional disclosures, causing rural therapists to see them in a more negative light.

Other Significant Findings

Age. The finding that older subjects are more likely to intentionally disclose their age, sexual orientation, and political views was not particularly surprising. This may be explained by personality changes that occur as people age. Research shows that most people become more self-confident, show a greater openness to self, and show an

increase in overall maturity as they get older (Bee, 1996). Thus, it is possible that the anxieties that surround disclosing such difficult topics as age, sexual orientation, and political views may have lessened for older therapists. Because they feel more comfortable with and confident in themselves, they may have less difficulty disclosing about these topics.

It is difficult to say why older urban participants in this study are more likely to believe that their clients discover their political views without their intentional disclosure. It is possible that older therapists would are generally more open about their political views than younger therapists because of the personality changes mentioned above, and that they may therefore think their clients would find out about their political views. Research also shows that older people are less interested in compartmentalizing the different parts of their lives (e.g., work, political view, religion, etc.). In older therapists, there may be subtle ways in which their political views become obvious to their clients due to this decompartmentalization over time. However, this would not explain why it is only older *urban* therapists who have this belief. In a way, this finding is counterintuitive; one might think that because of the increased incidence of unintentional self-disclosure in rural therapists, they would be more likely to believe that clients discover such information about them. More research should be done to determine how increasing age impacts therapist self-disclosure.

Gender. There was one significant finding with regards to gender: on item 13a, males reported intentionally disclosing significantly more frequently during the "Initial contact (before therapy begins)" phase of therapy than did females. This finding is difficult to interpret, and other studies have either not mentioned or not found effects

between self-disclosure and gender. For example, Edwards and Murdock (1994) found no significant differences in self-disclosure when comparing therapists of different sexes. There are many established gender differences that could cause the difference found in this study; further research would have to be done to determine the reason for this difference.

Theoretical orientation. In this study, participants who subscribed to a Cognitive Behavioral orientation rated themselves as intentionally disclosing about their personal psychological/therapy experiences significantly less frequently than those with a Psychodynamic orientation. As stated in the first chapter, Hill and Knox (2002) found that psychodynamic therapists, at least in theory, would generally be against any kind of self-disclosure, and they also reported that they thought it likely that those with a cognitive-behavioral orientation would view self-disclosure more positively. The finding of this study is nearly opposite of what Hill and Knox (2002) discussed. Perhaps this is because Hill and Knox (2002) were addressing theory in their article; perhaps the practice of the therapists in the current study differs from the theory their orientation is based on. This discrepancy may also be caused by the recent tempering of the psychodynamic view in favor of self-disclosure that was reported by Hill and Knox (2002) and Goldstein (1994). One other possible explanation for the discrepancy lies in the difference between the various subgroups that fall under the broad category of psychodynamic; perhaps those who hold to a strict psychoanalytic viewpoint refrain from self-disclosure, while those who subscribe to object relations or self psychology are more open to practicing self-disclosure. The questionnaire did not differentiate between these subgroups, but it is

possible that more of the participants who endorsed psychodynamic as their theoretical orientation were from a subgroup that supports self-disclosure.

Anecdotes. While the anecdotal evidence gathered through item 35 cannot be used to support the hypothesis, it does seem to emphasize some important points. It reinforces that dual roles and unintentional self-disclosures are very salient issues for rural therapists, and that urban therapists are sometimes unaware of these issues or only rarely have to deal with them. The anecdotal evidence also showed that urban therapists may have the luxury to state that self-disclosure is "very unnecessary" for the purposes of psychotherapy, while rural therapists note that self-disclosure, particularly unintentional self-disclosure, is not only a way of life, but it may be useful or necessary to practice in rural areas. One rural therapist noted that "a positive evaluation (or affiliation) by members of the community allows for a sense of trust prior to contact." Another rural therapist demonstrated the importance of unintentional self-disclosure for client referrals and client trust by stating, "I have had clients call and say things like 'Since you've been married many years and have children, we thought perhaps you could help us with our family problems.'"

Two of the respondents to item 35 were of particular note because they had worked in both rural and urban areas and they shared the differences they had noticed between the two settings. One stated, "There was much more visibility in a small town and I worried about the unintentional self-disclosure…I had the sense that people knew things about me…I feel less concern about unintentional self disclosure now in a large city." The other related that, "Having practiced in both settings, I have found there is a qualitative difference in the experience of unintentional disclosure. I cannot go anywhere

in my small community without encountering a client who then is exposed to my spouse, my children, my grandchildren, my friends, the places I shop or eat, the books I purchase, the community events I attend, etc." It seems clear that unintentional self-disclosure is a difficult and important issue for therapists practicing in rural areas.

Possible self-serving bias. One might think that, given the self-serving bias, all the therapists who participated in this study might rate their self-disclosures in a positive light and might be unwilling to think of their disclosures, even disclosures made unintentionally, as having a negative impact. Certainly, Oakes (2000) found that most therapists feel that their self-disclosures have a positive impact on the therapeutic relationship. The findings of this study were consistent with Oakes' (2000) study. On item 32, only three of the participants (3.2 %) rated the impact of their unintentional self-disclosures as 2 (between neutral and negative) and none rated it as 1 (negative). The overall mean for this item was 3.51, indicating that on average participants perceived the impact of their self-disclosures on the positive side of neutral. A similar pattern held for similar items such as 15, 16, 33, and 34, in fact, none of the participants ever rated the impact of their self-disclosures as 1 (negative) on any of these items. It seems that the possible negative ethical implications of therapist self-disclosure discussed in Chapter 1 could increase these effects; participants may have been less likely to admit to negative consequences of self-disclosure if such an admission might imply an ethical violation.

Possible Weaknesses

That there were few significant results when comparing urban and rural groups on self-disclosure indicates that either the hypothesis is incorrect – that in actuality there are few or no significant differences in self-disclosure between urban and rural practitioners

– or the research design of the study was somehow faulty. Such fault could come through numerous variables: the questionnaire may not have been a valid measure of therapist self-disclosure or was otherwise poorly designed, or the population sampled may not have been a good representation of the general urban and rural therapist populations. For example, the definition of rural as less than 25% urbanization and urban as more than 50% urbanization may not have been the best way to define urban and rural. The finding that those who described themselves as practicing in a rural setting reported more unintentional self-disclosure may indicate that it is not the *actual* practice setting, but the *perceived* practice setting of the therapist that impacts their self-disclosures.

Two potential problems associated with survey studies could have influenced the findings. The low return rate (only 31.6%) may have had an impact on the findings; with such a low return rate the author was unable to run several of the desired statistics. A low return rate may otherwise skew the results, leading to a small sample that is somehow not representative of the general group that was sampled. Because of the low return rate, the findings of this study should be interpreted with caution. The exact reason for the low return rate is unclear. It is possible that participants did not want to have to examine their feelings and practices regarding self-disclosure, because it is such a difficult and controversial topic. It is also possible that urban therapists did not understand the meaning or import of the study since they are not faced with issues of unintentional self-disclosure as frequently as rural therapists; in fact, several urban therapists made notes on their questionnaires indicating that they didn't understand unintentional self-disclosure. Finally, perhaps the research design could have been partially to blame for the low

response rate; for example, it is possible that if an incentive had been included in the mailings, more of the sample would have responded.

Non-response bias may also have had an impact on the findings of this study. While the mailing list used in this study was randomly selected from a large group of practicing psychologists, only those who chose to respond to and send back the questionnaire could be included in the results of the study; there may therefore have been some bias if those who chose to send in their questionnaires differed in some way from those who did not. It is also possible that, despite attempts at maintaining the anonymity of the participants, they felt unsafe openly discussing their attitudes towards and practices of self-disclosure (possibly because of the ethical debates surrounding this topic), thus their answers to the questionnaire may not represent their actual attitudes and practices of self-disclosure.

Summary and Conclusion

Anecdotal evidence highlights the salience of the issues of dual roles and unintentional disclosure for rural therapists, and the research indicates that participants who believed they practiced in rural settings report experiencing more unintentional self-disclosure. This research partially supports the hypothesis that rural therapists disclose more than urban therapists.

More research into the impact of dual roles and unintentional disclosure on rural therapists and their clients is necessary. Future research could continue with the hypothesis that rural therapists disclose more than urban therapists, but could utilize different research methods (in case those used in this study were flawed). Future research could also examine other potential impacts of dual roles and unintentional

disclosures on rural therapists; for example, how do rural therapists cope with the fear that these dual roles are unethical? Is there a self-serving bias effect? What are the psychological implications for rural therapists who feel their lives are "transparent?" Finally, future research could further explore the finding that the therapists' *perception* of their setting seems to have a greater influence on their experience of unintentional self-disclosure than does their *actual* setting, as defined by percentage of urbanization. Perhaps it was the increased experience of unintentional self-disclosure that led these therapists to feel they worked in a rural area, rather than the other way around. Such research could further the cause of rural practitioners, potentially giving them insight into their situation and how best to serve their clientele.

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Appendix A

Cover Letter for First Mailing

September 9, 2005

Dear Practicing Psychologist:

I am a doctoral student in clinical psychology at George Fox University and I am interested in studying the impact that setting (urban and rural) may have on therapist self-disclosure. I am therefore conducting a survey of psychologists who practice in both rural and urban areas, with the hope of shedding more light on their self-disclosure practices.

This brief survey will take about **10 minutes** of your time. I recognize that self-disclosure can be a difficult and controversial topic. For this reason, I want to assure you that all information will be kept anonymous. You were selected randomly from a list of licensed psychologists. I do not ask you to identify yourself or any clinic affiliation and there is no name or identification number on the questionnaire. After you return your questionnaire to me, send separately the enclosed postcard. That will tell me that you don't need any reminders, while at the same time maintaining your anonymity. Each questionnaire is important in my data collection, and I ask that you return your completed questionnaire in the self-addressed, stamped envelope as soon as possible. If you return your postcard and questionnaire within the next week, you should not receive any reminders.

The Human Subjects Research Committee of George Fox University has approved this research project. If you would like a copy of the aggregate findings, I would be happy to send them to you if you send me a note with your address requesting such information. By completing and returning this survey, you are giving your consent to participate in this study.

Thank you for your time and consideration in responding to this survey. If you have any questions about this research, please contact me (Katie Pierson Fruhauff, M.A., 847-433-6944) or my dissertation chair (Clark Campbell, Ph.D., 503-554-2753).

Sincerely,

Katie Pierson Fruhauff, M.A.
Research Associate, Graduate School of Clinical Psychology
George Fox University

Appendix B

Reminder Postcard

Back

This is to let you know that Subject ____
has returned his or her questionnaire
and will not require a reminder.

Front

Katherine Fruhauff
George Fox University
Box 5979
Newberg, OR 97132-2697

Appendix C

Self-Disclosure Questionnaire

SELF-DISCLOSURE QUESTIONNAIRE

Intentional Self-Disclosure: Intentional sharing of personal information with a client through verbal expression (e.g., stating personal thoughts, feelings, experiences) and purposeful non-verbal expression (e.g. wearing a wedding ring with the knowledge that a client may notice it).

Practices

Please rate the frequency with which you intentionally disclose the following information to clients during the course of therapy using the following scale. Please circle the number that best represents your response.

1	2	3	4	5	DK
Never	Rarely	Sometimes	Often	Always	Don't Know

1.	Your age	1	2	3	4	5	DK
2.	Your marital status	1	2	3	4	5	DK
3.	Your family status (e.g., number of children)	1	2	3	4	5	DK
4.	Your personal psychological/therapy experiences	1	2	3	4	5	DK
5.	Feelings you are experiencing toward the client	1	2	3	4	5	DK
6.	Your sexual orientation	1	2	3	4	5	DK
7.	Your current weaknesses or struggles	1	2	3	4	5	DK
8.	Your past weaknesses or struggles	1	2	3	4	5	DK
9.	Your religious beliefs	1	2	3	4	5	DK
10.	Your political views	1	2	3	4	5	DK
11.	Your ethnicity	1	2	3	4	5	DK
12.	Other:_____	1	2	3	4	5	DK

13. Given questions 1-12, please estimate the percentage of intentional self-disclosure that occurs in general during each of the following phases of treatment: (should total 100%)
    a. Initial contact (before therapy begins) _____%
    b. Informed consent (when therapy begins)_____%
    c. In session (during the course of therapy)_____%
    d. Questions asked to your secretary _____%
    e. Contact outside therapeutic setting _____%
14. Please estimate the percentage of your clients who request personal information about you (without you offering it to them). _____%

Attitudes

15. Rate the impact that these intentional disclosures usually have on the therapeutic relationship with your clients. (circle one)

Negative impact		Neutral impact		Positive impact	
1	2	3	4	5	DK

16. Rate the impact that these intentional disclosures may have on your family members as a result of clients knowing more about you. (circle one)

Negative impact		Neutral impact		Positive impact	
1	2	3	4	5	N/A

Unintentional Self-Disclosure: Unplanned situations with clients which may unintentionally reveal personal information about the therapist. This may occur in many forms, for example, unplanned, non-professional contact, through a mutual acquaintance revealing information, or through contact with a previous client.

Practices

Please estimate how frequently clients discover the following information about you during the course of therapy without your intentional disclosure of such information using the following scale. Please circle the number that best represents your response.

1	2	3	4	5	DK
Never	Rarely	Sometimes	Often	Always	Don't Know

17.	Your age	1	2	3	4	5	DK
18.	Your marital status	1	2	3	4	5	DK
19.	Your family status (eg., number of children)	1	2	3	4	5	DK
20.	Your personal psychological/therapy experiences	1	2	3	4	5	DK
21.	Feelings you are experiencing toward the client	1	2	3	4	5	DK
22.	Your sexual orientation	1	2	3	4	5	DK
23.	Your current weaknesses or struggles	1	2	3	4	5	DK
24.	Your past weaknesses or struggles	1	2	3	4	5	DK
25.	Your religious beliefs	1	2	3	4	5	DK
26.	Your political views	1	2	3	4	5	DK
27.	Your ethnicity	1	2	3	4	5	DK
28.	Community activities	1	2	3	4	5	DK
29.	Other:_____	1	2	3	4	5	DK

30. Please estimate the percentage of clients who know significant personal information about you before they come into therapy that you did not choose to reveal to them.

_____%

31. How do your clients obtain such personal information about you? (E.g., former clients, community members, referring professionals, your secretary, etc.)

32. Rate the impact that unintentional disclosures usually have on the therapeutic relationship with your clients. (circle one)

Negative impact		Neutral impact		Positive impact	
1	2	3	4	5	DK

33. Rate the impact that unintentional disclosures may have on your family members as a result of clients knowing more about you. (circle one)

Negative impact		Neutral impact		Positive impact	
1	2	3	4	5	N/A

34. In general, what kind of impact do you believe your self-disclosures (both intentional and unintentional) have on your therapy with clients? (circle one)

Negative impact		Neutral impact		Positive impact	
1	2	3	4	5	DK

35. Please share any anecdotes that would demonstrate issues of self-disclosure that are specific to your practice setting (e.g., rural or urban).

About You

36. Age (in years): _____

37. Gender (circle one): Male Female

38. Race/Ethnicity (circle all that apply): Black/African American Hispanic/Latino(a)
White/Caucasian Asian/Pacific Islander
Native American/Alaskan Native
Other: _____

39. Highest Degree (circle one): PhD PsyD EdD MA/MS Other: _____

40. Theoretical Orientation (circle one): Cognitive Behavioral Psychodynamic Eclectic
Humanistic Family Systems
Other: _____

41. Years practicing in the mental health field: _____

42. Your primary practice setting (circle one): Urban Suburban Rural

43. Years practicing in the practice setting indicated in # 42: _____

Appendix D

Cover Letter for Second Mailing

October 24, 2005

Dear Practicing Psychologist:

This is just a reminder in case you haven't yet sent in your questionnaire. It is important to me that I understand your point of view on this interesting topic. As you may recall, I am a doctoral student in clinical psychology at George Fox University and I am interested in studying the impact that setting (urban and rural) may have on therapist self-disclosure. I am therefore conducting a survey of psychologists who practice in both rural and urban areas, with the hope of shedding more light on their self-disclosure practices.

I have included another copy of the brief questionnaire in case you have misplaced the first one I sent. I recognize that self-disclosure can be a difficult and controversial topic. For this reason, I want to reassure you that all information will be kept anonymous. Each questionnaire is important in my data collection, and I ask that you return your completed questionnaire in the self-addressed, stamped envelope within the next week.

The Human Subjects Research Committee of George Fox University has approved this research project. If you would like a copy of the aggregate findings, I would be happy to send them to you if you send me a note with your address requesting such information. By completing and returning this survey, you are giving your consent to participate in this study.

Thank you for your time and consideration in responding to this survey. If you have any questions about this research, please contact me (Katie Pierson Fruhauff, M.A., 847-433-6944) or my dissertation chair (Clark Campbell, Ph.D., 503-554-2753).

Sincerely,

Katie Pierson Fruhauff, M.A.
Research Associate, Graduate School of Clinical Psychology
George Fox University