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DIFFERENTIAL EFFECTS OF MORE RESOLVED VERSUS LESS RESOLVED COUNTERTRANSFERENCE SELF-DISCLOSURES ON RATINGS OF THE PSYCHOTHERAPIST AND SESSION

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ABSTRACT

This study sought to examine the content of therapist self-disclosure by focusing on investigating the differential effects of therapist disclosure of resolved versus unresolved countertransference issues on perceptions of therapists and therapy process. Using an analogue methodology, participants (N = 116) were randomly assigned to watch 1 of 2 videos through a secured on-line website in which a therapist made self-disclosure of resolved or unresolved personal issues. Multivariate analysis of variance (MANOVA) was used to detect the differences between the two conditions. As hypothesized, therapist self-disclosure of relatively more resolved countertransference issues were rated significantly higher on the dimensions of the attractiveness of the therapist, the trustworthiness of the therapist, and the feelings of hope in the client than therapist self-disclosure of less resolved countertransference issues. No significant differences, however, were found between therapist self-disclosure of resolved versus unresolved personal issues on the expertness of the therapist, the depth of the session, the smoothness of the session, and how the client's likely feelings of universality was viewed. Limitations of this study and the implications of these results for research, and clinical application were discussed.

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Chapter 1: Introduction

Over the years, numerous theorists have emphasized the significance of the therapist's use of the self in the effectiveness of psychotherapy. For instance, Carl Jung (1963/1989) pointed out the importance of the therapist's use of the self by stating that "The patient's treatment begins with the doctor,... Only if the doctor knows how to cope with himself and his own problems will he be able to teach the patient to do the same" (p. 132). The person of the therapist has also been confirmed empirically to be an essential factor in the therapy process. According to a meta-analysis conducted by Ahn and Wampold (2001), therapist variables have been found to contribute to more variability in outcome than do treatment specific components. The present study will center on exploring the inner world of the psychotherapist by integrating two prominent and controversial elements related to the therapist's use of self: self-disclosure and countertransference. The specific focus of the study addresses differential effects of therapist self-disclosure of resolved versus unresolved personal issues on perceptions of the therapist and the session.

Therapist self-disclosure is a topic that has received much attention in the theoretical literature. Numerous theorists have suggested a variety of definitions of therapist self-disclosure (e.g. see Farber, 2006; Watkins, 1990). While some authors indicate that therapist self-disclosure can refer to any type of personal information that the therapist reveals about himself or herself, including pictures in the therapist's office, books on the therapist's desk, or the therapist's style of dress (e.g., Wilkinson & Gabbard, 1993), others argue that the definition of therapist self-disclosure should be more confined and specific. Along these lines, and for the purposes of the present study,

therapist self-disclosure is defined as "therapist statements that reveal something personal about therapists" (Hill & Knox, 2002, p. 256).

Views on the use of therapist self-disclosure tend to vary depending on the therapist's theoretical orientation. At one extreme, traditional psychoanalytic theorists tended to view therapist self-disclosure as harmful to treatment and contended that therapists should be neutral and non-self-disclosing in therapy. According to this perspective, therapist self-disclosure is perceived as a manifestation of the therapist's countertransferential reaction, and might shift the focus of therapy away from the client to the therapist, interfere with transference, and diminish treatment effectiveness (Aron, 1996; Freud, 1912/1958).

In contrast, theorists from humanistic approaches advocate for the use of therapist self-disclosure because disclosures can promote therapist authenticity and genuineness (Jourard, 1971; Truax & Carkhuff, 1967), and are believed to strengthen the therapeutic relationship and foster client change (Rogers, 1961). Feminist theorists also endorse the benefits of therapist self-disclosure and believe that therapist self-disclosure can help clients make informed choices about therapy and can empower clients (Mahalik, VanOrmer, & Simi, 2000). Likewise, cognitive-behavioral theorists support the use of therapist self-disclosure to normalize client struggles and model effective coping strategies (Goldfried, Burckell, & Eubanks-Carter, 2003).

A general theme emerging from this theoretical debate on the use of therapist self-disclosure lies in the recognition of the possible benefits of the judicious use of therapist self-disclosure (Goldfried et al., 2003; Knox & Hill, 2003). Empirical evidence has supported the positive impact of therapist self-disclosure on therapy process and

outcome (Barrett & Berman, 2001; Knox, Hess, Petersen, & Hill, 1997). Research, however, provided limited information on what types of therapist self-disclosure are helpful to clients (Hill & Knox, 2002; Watkins, 1990). One type of therapist self-disclosure that has been theorized to be helpful to clients is the disclosure of the therapist's countertransference.

Similar to the controversies on the definitions and the use of self-disclosure, countertransference has also been debated in regards to its conceptualization and usage. Since Freud (1910/1959) first developed the term countertransference to refer to the therapist's unconscious and neurotic reactions to the client's transference, a debate on the conceptualization of countertransference has existed. Several theorists considered the definitions of Freud to be too narrow and argued that the definition of countertransference should encompass all of the therapist's reactions toward the client (Little, 1951; Winnicott, 1949). This totalistic view of countertransference, however, has been criticized as being too general to be clinically useful for the conceptualization of countertransference (Kernberg, 1965). A moderate perspective of countertransference, thus, has emerged, integrating the two extreme conceptualizations of countertransference. According to this integrative perspective, and for the purpose of the present study, countertransference is defined as the therapist's internal and external reactions to the client that are based on the therapist's present or past emotional conflicts and vulnerabilities (Gelso & Hayes, 1998, 2007; Langs, 1974).

In spite of the lack of agreement on how to conceptualize countertransference, controversies also extend to the use of countertransference. In the traditional psychoanalytic community, countertransference was viewed as dangerous to therapy and

therapists were strongly advised to avoid it (Freud, 1912/1958). While recognizing that countertransference reactions can be harmful to the therapy process (Singer & Luborsky, 1977), contemporary psychodynamic theorists argue that the benefits of countertransference cannot be negated and should be emphasized. Countertransference is believed to contribute significantly to the therapist's ability to gain insight into the unconscious dynamics of clients and to achieve a deeper level of compassion in understanding clients' struggles (Epstein & Feiner, 1988; Hayes, 2002).

An important recognition arising from the discussions on how countertransference should be dealt with is that countertransference has a two-sided nature. Namely, countertransference can be harmful if not attended to and countertransference can be valuable if used appropriately (Brown, 2001; Ellis, 2001; Hoyt, 2001). Therapists' ability to make positive use of countertransference, indeed, resonates with the concept of wounded healer. That is to say, the ability of therapists to transform their weaknesses or countertransference into strengths to benefit clients is a manifestation of the healing power of the wounded healer. As Jung (1989) put it, "Only the wounded physician heals" (p. 134).

One of the active ways to enact the concept of wounded healer in psychotherapy is via the integration of countertransference and self-disclosure, that is, by means of the therapist's judicious disclosures of countertransference (Bollas, 1983; Brown, 2001; Hayes & Gelso, 2001; Little, 1951; Maroda, 1994). In an extensive review of literature, Gorkin (1987) explicated the benefits of countertransference disclosures include confirming a client's sense of reality, promoting an authentic therapy relationship, decreasing client's sense of isolation, and offsetting the power imbalance in therapy.

Research on countertransference disclosures, however, is scant at best. In reviewing the literature, only one published study investigated the effects of countertransference disclosures (Myers & Hayes, 2006). The results of the study, unfortunately, did not support the benefits of countertransference disclosures. In this study, countertransference disclosures were not viewed more favorably by participants than when no disclosures were made, under the condition of positive working alliance. The present research will extend the study of Myers and Hayes and focus on the content of therapist self-disclosure in investigating the differential effects of resolved and unresolved self-disclosure on perceptions of therapists and therapy process. Specifically, it is hypothesized that therapist disclosure of resolved countertransference will be perceived more favorably than therapist disclosure of unresolved countertransference on the dimensions of therapists' expertness, attractiveness and trustworthiness, and session depth and smoothness. In the condition of therapist disclosure of resolved countertransference, the client's likely feelings of hope will also be rated higher than therapist disclosure of unresolved countertransference. Additionally, we will be testing competing hypotheses with respect to how universality will be perceived. It is hypothesized that the universality will be perceived higher in the condition of therapist disclosure of unresolved personal issues than therapist disclosure of resolved personal issues. Another possibility is that universality will be rated equally in both conditions.

Chapter 2: Review of the Literature

Overview of Self-disclosure

Self-disclosure has long been regarded as an essential part of psychotherapy. As pointed out by Stiles (1995), "disclosure is at the heart of psychotherapy" (p. 71). In the process of psychotherapy, revealing personal information implicitly or explicitly is inevitable and fundamental regardless of treatment modality or theoretical orientation. Due to the significance of self-disclosure, numerous discussions and studies have been undertaken to investigate the definition, the appropriateness, the benefits and the dangers of disclosing personal information in psychotherapy (e.g., Farber, 2006).

The interest in self-disclosure in psychotherapy can be traced back to Sydney Jourard (1971), who pioneered studying the influence of self-disclosure in everyday life. Jourard proposed that self-disclosure plays a critical role in human beings' mental health and declared that "no man can come to know himself except as an outcome of disclosing himself to another person" (p. 6). Following his propositions, a line of research conducted by Jourard and his followers confirmed the importance of self-disclosure and further demonstrated that self-disclosure is beneficial to the well-being of human beings (Cozby, 1973). This empirical evidence on the contributions of self-disclosure to the welfare of human beings has very significant implications for the field of mental health and has paved the road for the literature on self-disclosure in psychotherapy.

In general, most of the literature on self-disclosure in psychotherapy can be divided into two major areas: self-disclosure from clients and self-disclosure from therapists, despite the fact that these two areas can be interactive and reciprocal in nature. Because the purpose of this study is to investigate the influence of therapist self-disclosure of

countertransference on therapy process, the focus of this literature review will be on therapists' self-disclosure.

Definition of Self-disclosure

Before delving into the theoretical and empirical literature on therapists' self-disclosure, having a clear definition of therapist self-disclosure is necessary and important. However, the operationalization of therapist self-disclosure is contentious and has ignited considerable debates. Two major controversies are involved in the operationalizations of therapist self-disclosure: how inclusive the definitions on therapist self-disclosure should be and the different categorizations of therapist self-disclosure.

Broadly speaking, therapist self-disclosure can refer to any types of personal information that the therapist reveals about himself or herself. This definition, however, has been criticized as too inclusive and vague to give a useful guide in conceptualizing therapist self-disclosure (Farber, 2006). For instance, pictures in the therapist's office, office decorations, books on the therapist's desk, or the therapist's style of dress offer private information to the client. This type of disclosure tends to be made in a passive way and can be referred to as "self-revelation" (Wilkinson & Gabbard, 1993). Indeed, self-revelation has been advocated by some authors to be distinguished from self-disclosure (Levenson, 1996; Meissner, 2002; Miletic, 1998). From this perspective, self-disclosure refers to what therapists choose to make known about themselves to clients in a deliberate and active way in order to benefit clients such as increasing clients' sense of universality, enhancing therapeutic relationships, and so on. By contrast, self-revelation refers to unintentional, passive and unavoidable revelations of therapists. In a similar vein, Farber (2006) differentiated intentional therapist disclosures from

unintentional disclosures. Likewise, Hill and Knox (2002) distinguish nonverbal disclosures from verbal disclosures and indicate that nonverbal disclosures are qualitatively different from verbal disclosures (i.e., verbal disclosures tend to be voiced at a specific moment while nonverbal disclosures are not).

Another controversy in operationalizing therapist disclosure lies in the discrepancy in categorizing self-disclosures. Some researchers (e.g., Anderson & Anderson, 1985; Hoffman-Graff, 1977) classify therapist self-disclosure into positive disclosures (sharing favorable information or feelings about one's experience) and negative disclosures (sharing unfavorable information or feelings about one's experiences). Other researchers (Nilsson et al., 1979) categorize disclosures differently by separating intrapersonal self-disclosures (therapist reveals information about his or her personal life outside of counseling) from interpersonal self-disclosures (therapist reveals feelings about the client's problem or the therapy relationship). In this regard, interpersonal self-disclosures have also been called "self-involving disclosures" or "immediacy" (Knox & Hill, 2003). Several authors argued that self-involving disclosures should be excluded from self-disclosing disclosures (McCarthy & Betz, 1978) while other researchers endorsed that both types of disclosures are self-disclosures (Hill et al., 1989).

Indeed, these two major controversies in operationalizing therapist disclosures bring out several problems in understanding therapist disclosures. Specifically, different perspectives in defining therapist self-disclosure make it difficult to make comparisons across studies and have in itself impeded the advancement in the knowledge about the literature on self-disclosure (Farber, 2006; Knox, Hess, Petersen, & Hill, 1997). Hence, in order to deepen and improve the comprehension of therapist self-disclosure, having a

consistent and clear definition of therapist self-disclosure is necessary and important. In this vein, Hill and Knox (2002) defined therapist self-disclosure as "therapist statements that reveal something personal about therapists" (p. 256). This definition of therapist self-disclosure is confined to verbal disclosure. For the purpose of this study, the definition offered by Hill and Knox will be utilized.

Theoretical Perspectives on Therapist Self-disclosure

Similar to the controversies on the definitions of therapist self-disclosure, there has long been a debate about the appropriateness of therapist self-disclosure in theoretical literature (Curtis, 1981; Lane & Hull, 1990; Weiner, 1983). In general, the theoretical perspectives on the use of therapist self-disclosure tend to parallel theoretical orientations and will be discussed below. Some theorists have argued that therapist self-disclosure is dangerous and may jeopardize treatment effectiveness while others have suggested that therapist self-disclosure is a potent factor in therapy effectiveness.

The danger of therapist self-disclosure has been addressed mostly by traditional psychoanalytic theorists since Freud. Despite having the reputation of making frequent self-disclosures himself in his practice, Freud (1912/1958) theorized blatantly that "the doctor should be opaque to his patients and like a mirror, should show them nothing but what is shown to him" (p. 117). Therapists of traditional psychoanalytic orientations, thus, were strongly advised to be neutral, anonymous and non-self-disclosing in therapy.

According to this abstinent approach, therapist self-disclosure impedes treatment because it might diminish client transference, or shift the focus of therapy away from the client to the therapist (Aron, 1996; Curtis, 1981; Freud, 1912/1958; Hanly, 1998). Specifically, the therapist should take on the role of a "blank screen" so that the client's

emotional reactions, fantasies, and associations are allowed to be elicited, analyzed and resolved in the context of therapy. By fostering transference and resolving the transference through interpretations, clients will move toward psychological change and symptom relief (Gabbard, 1990). Along this line, therapist self-disclosure is viewed as interfering with transference and detrimental to therapy effectiveness in traditional psychoanalysis (Goldstein, 1997).

Another objection to therapist self-disclosure from the perspective of psychoanalysis is that therapist self-disclosure has been viewed as shifting attention from client to therapist needs or feelings and may represent therapist countertransferential reactions (Aron, 1996; Goldstein, 1994). In other words, therapist disclosure may reverse the role of therapist and client and may reflect therapists' own needs related to their vulnerabilities or unresolved internal conflicts. In this vein, therapist self-disclosure may be motivated by therapists' need for approval from the client or the identification with or distance from the client (Goldstein, 1994; Hanly, 1998; Weiner, 1983). This abstinent and non-self-disclosing psychoanalytic approach, however, has raised concerns and criticisms in the psychoanalytic community. For instance, therapist neutrality and nondisclosure have been argued to be manifestations of the defensiveness of the therapist, may foster aloofness and distance between therapist and client, and may exacerbate a client's presenting problem due to the reenactment of the parent-child trauma (Ferenczi, 1933; Lane & Hull, 1990; Renik, 1995).

In the psychoanalytic community, the objections to this neutral classical Freudian approach parallel the theoretical shift to a relational/intersubjective model. In recent years, the psychoanalytic approach has undergone significant theoretical change from a strictly

neutral to an interpersonally oriented orientation which has endorsed judicious therapist self-disclosure (Aron, 1991; Bridges, 2001; Farber, 2006). As indicated by Gediman (2006), "the recent debate over whether analysts should or should not disclose aspects of their own psychic lives to their patients has moved, dialectically, from dichotomous, absolutistic, stereotyped positions to a place where analysts of varying persuasions appear to be entering a more harmonious realm of discourse" (p. 241). Specifically, in contemporary psychodynamic orientations, therapist non-self-disclosing has been discouraged and thoughtful use of self-disclosure has been viewed as a valuable tool in therapy (Billow, 2000; Gorkin, 1987; Lane & Hull, 1990). Several contemporary psychodynamic theorists have expressed that therapist judicious use of self-disclosure with clients can be valuable and the benefits of disclosures include promoting empathic attunement (Goldstein, 1994; Josephs, 1990), resolving treatment impasses (Gerson, 1996), adding authenticity to interpretation (Jacobs, 1997), and deepening therapeutic relationships (Bridges, 2001).

Indeed, the benefits of therapist self-disclosure are not only addressed by contemporary psychodynamic theorists but also are endorsed explicitly by theorists from the humanistic approach. From the perspective of humanistic theorists, self-disclosure by the therapist displays the genuineness (Truax & Carkhuff, 1967), congruence (Rogers, 1957), or transparency (Jourard, 1971) of the therapist. Therapist self-disclosure, thus, is theorized to be an essential component in facilitating the strong therapeutic relationship and fostering client change (Rogers, 1961). Specifically, therapist self-disclosure is believed to decrease client fears and anxieties, elicit client disclosures, encourage client self-exploration, and serve as a role model of personal growth for the client (Truax &

Carkhuff, 1965). Further, humanistic theorists believe that therapist self-disclosure can promote spontaneous human relating, make the therapist more humane, demystify therapeutic process, and normalize client struggles (Curtis, 1981).

Likewise, feminist therapy strongly advocates the value of therapist self-disclosure (Mahalik, VanOrmer, & Simi, 2000). Feminist therapy, which is founded on the premise of enhancing the empowerment of clients, believes that therapist self-disclosure can help clients make informed choices about whether or not they want to work with a therapist. According to feminist therapy, the content of therapist self-disclosure includes disclosures of lifestyle, background, religious ideals, political views, sexual orientation, and socioeconomic background. Moreover, therapist self-disclosure can be used as a tool to convey feminist values, equalize the power differential in the therapeutic relationship, and facilitate a sense of solidarity with clients. Therefore, through therapists' disclosing personal information about themselves, clients will feel less ashamed, move toward personal growth and improve the real relationship between therapist and client (Enns, 1997).

In a similar fashion, therapists with behavioral/cognitive/cognitive-behavioral orientations recommend that therapist self-disclosure can be an effective technique in facilitating the therapeutic relationship and promoting client change (Goldfried et al., 2003). They argue that therapist self disclosure can be helpful in providing clients with feedback on the interpersonal impact they make on others, increasing hope and motivations, normalizing client struggles, and modeling effective coping techniques.

Multicultural theories also promote the positive effects of therapist self-disclosure in working with culturally diverse clients (Burkard, Knox, Groen, Perez, Hess, 2006;

Constantine & Kwan, 2003). According to multicultural theorists, therapist self-disclosure can serve as an instrument to demonstrate therapist multicultural competency. Given that many culturally diverse clients have experienced prejudice and discrimination in society and may be distrustful of mental health professionals, therapist self-disclosure is believed to be crucial in conveying that the therapist is sensitive to cultural issues. In this regard, therapist disclosures can increase client trust, enhance clients' perceptions of therapist credibility and further strengthen the therapeutic relationship with culturally diverse clients (Sue & Sue, 2003). Further, therapist self-disclosure can serve as a tool to model therapeutic process because some minority clients may come from cultural backgrounds that are not familiar with psychotherapy process or stigmatize help-seeking behaviors for emotional distress (Constantine & Kwan, 2003).

Despite the diverse theoretical perspectives on the use of therapist self-disclosure, two themes emerge from a wide range of theoretical opinions. First, therapist self-disclosure should be used properly and cautiously. Indeed, even among theorists who endorse the use of therapist self-disclosure, there is an agreement that therapist self-disclosure should not be used indiscriminately or extensively (Constantine & Kwan, 2003; Goldfried, Burckell, & Eubanks-Carter, 2003; Mahalik, VanOrmer, & Simi, 2000). Improper use of therapist self-disclosure may change the focus of therapy away from the client and undermine the welfare of the client by abusing the power of therapists. The ultimate goal of therapist self-disclosure is to facilitate client change and increase therapy effectiveness. Along these lines, Knox and Hill (2003) provided guidelines for the use of self-disclosure regardless of theoretical orientations. 1) Therapists should consider using

self-disclosure because it is a helpful intervention though use it moderately and cautiously; 2) Therapists should disclose proper content; 3) Therapists should use appropriate levels of intimacy in disclosure; 4) Therapists should make the disclosure according to the needs and preferences of the particular client; 5) Therapists should disclose based on appropriate reasons; 6) Therapists should turn the focus back to the client after the disclosure; 7) Therapists should consider revealing in-the-moment or here-and-now reactions to what occurs in therapy; 8) Therapists should consider making self-disclosures to assist termination; 9) Therapists should ask clients about their reactions to therapist self-disclosure; 10) Therapists should disclose content that has been mostly resolved.

Second, the potential positive impact of therapist self-disclosure has been increasingly recognized regardless of theoretical orientations. The merits of therapist self-disclosure include enhancing the client's feelings of universality, establishing the therapist's genuineness, and strengthening the therapeutic relationship. As indicated by Knox and Hill (2003), the emerging common ground among diverse theoretical opinions lies in the noticeable recognition of the potential value of therapist self-disclosure. Goldfried et al. (2003) further pointed out that the consensus is that therapist self-disclosure has been viewed as "a natural part of intimate, human interaction of therapy" (p. 567). In other words, although the theoretical reasons and the ultimate goal for the use of therapist self-disclosure may be diverse, therapist self-disclosure is generally believed to increase clients' sense of universality and facilitate good therapeutic relationships. The focus of the present research will revolve around exploring the potential benefits of therapist self-disclosure.

Research Findings on Therapist Self-disclosure

The theoretical debate over therapist self-disclosure generates a great deal of research in this area. By and large, therapist self-disclosure tends to be used infrequently in therapy with clients. Research has demonstrated that therapist self-disclosure is a low-frequency intervention in psychotherapy from the perspective of therapists (Edwards & Murdock, 1994) and from the perceptions of clients (Ramsdell & Ramsdell, 1993). In a review of literature, Hill and Knox (2002) found that an average of 3.5% (range of 1%-13%) of all therapist interventions were self-disclosures when judges coded therapist in-session behaviors. Despite the low occurrence of therapist self-disclosure, the frequency of therapist use of self-disclosure does seem to be related to the theoretical orientations of therapists. Specifically, humanistic/experiential therapists reported using self-disclosures significantly more often than did psychoanalytic therapists in two survey studies (Anderson & Mandell, 1989; Edwards & Murdock, 1994) and in a qualitative study (Simon, 1988). Other factors have also been studied in regards to their influence on the frequency of therapist self-disclosure. No gender differences were found in the frequency of therapist disclosures (Edwards & Murdock, 1994; Robitschek & McCarthey, 1991) and nor were racial differences (Edwards & Murdock, 1994).

Even though therapist self-disclosure occurs infrequently within sessions, therapist self-disclosure is not uncommon across therapists (Simone, McCarthy & Skay, 1998). For instance, Pope, Tabachnick, and Keith-Speigel (1987) found that over 93% of therapists reported using self-disclosure in therapy with clients. In another study, Simi and Mahalik (1997) reported that 60% of clients indicated that their therapists had shared personal information during therapy. Apparently, therapist self-disclosure is not an uncommon

intervention in therapy from the perspectives of therapists and clients. Indeed, the prevalence of the use of therapist self-disclosure and the low-frequency of therapist self-disclosure highlights the two fundamental issues in the aspects of the attitude and the behavior of therapists' use of self-disclosure.

First, on an attitudinal level, therapists may have mixed feelings about disclosing personal information in therapy. For instance, in a series of intensive case studies, Hill et al. (1988) found that 5 out of 8 therapists rated self-disclosure as the least helpful intervention while the other three therapists viewed self-disclosure as the most helpful. The authors further theorized that therapists' mixed feelings about self-disclosures may result from their own insecurities related to unresolved personal issues or their discomfort with exposing vulnerabilities which may shift power dynamics in therapy. Another possibility that contributes to therapists' ambivalence toward self-disclosure may be the fact that therapists do not have enough information on whether what they disclose will be helpful and for which clients. In a study conducted by Anderson and Mandell (1989), more than half of the therapists reported having little or no training in the use of self-disclosure. Because of the limited knowledge on how to use self-disclosure appropriately, therapists may feel uncomfortable in relying on their own experiences when making self-disclosures. In this regard, having more empirical evidence on how to disclose personal information in therapy effectively is necessary in establishing guidelines for therapists in the use of self-disclosure and can be helpful in addressing therapists' ambivalent feelings in making self-disclosure. Of course, establishing guidelines on making self-disclosure is not an easy matter because therapist self-disclosure can be interdependent on the content of the self-disclosure, the quality of

the therapy relationship, the expectations of clients, timing of disclosures, and the ego-strength of clients (Wells, 1994). The present study will focus on examining which types of therapist self-disclosure will be most helpful to clients and provide guidelines in the appropriate use of self-disclosure.

Second, on a behavioral level, the prevalence and the low occurrence of therapist disclosure may reflect therapists' cautious use of self-disclosure in conducting therapy. As discussed earlier, the primary warnings against therapists' disclosing personal information are probably voiced most strongly by traditional psychoanalytic theorists who tend to view therapist self-disclosure as potentially reversing the role of therapist and client, shifting the focus away from the client to the therapist, and may serve the needs of the therapist in an attempt to gain client's approval (Farber, 2006; Lane & Hull, 1990; Weiner, 1983). Even though some of these warnings may provide a valid concern about therapist use of self-disclosure, the assertions against the use of self-disclosure cannot negate the benefit of therapist self-disclosure. In other words, while it is important to be aware of the danger of self-disclosure, the benefits of self-disclosure are equally important and should not be ignored. In this regard, the present study will focus on investigating the benefits of therapist self-disclosure while recognizing the significance of the warnings against self-disclosure.

Indeed, the power of therapist self-disclosure can be compared to the force of water. As described in a Chinese proverb: "Water can hold the ship, and water can also overthrow the ship." Namely, self-disclosure can be used as a powerful tool to either benefit clients or harm clients depending on how the therapist uses this tool. Results from several empirical studies support this two-sided nature of therapist self-disclosure in

recognizing that therapist self-disclosure can be both detrimental and beneficial to therapy (Audet & Everall, 2003; Wells, 1994).

Client perspectives on therapist self-disclosure. In discussing the influence of therapist self-disclosure, the perspectives from clients are of paramount importance and a lot of research works have been done in this field. The following will discuss relevant work based on quantitative and qualitative research. In general, analogue studies suggested that therapist self-disclosure tends to be viewed favorably by clients. In a comprehensive review by Hill and Knox (2002), they found that 14 out of 18 analogue studies of therapist self-disclosure reported that clients perceived therapist self-disclosure positively. For instance, in a study conducted by Lundeen and Schuldt (1989), they asked 160 observers to watch videotapes of simulated therapeutic interactions in which the therapist either remained quiet or briefly disclosed personal information related to what the client was sharing at three points in the encounter. Results indicated that the therapist was perceived as more attractive and trustworthy when he self-disclosed than when he did not. No significant effect was found on the ratings of therapist expertness.

In addition to these analogue studies that are focused on perceptions of therapist self-disclosure by volunteer clients, qualitative studies have sought to study how actual clients view therapist self-disclosure. Audet and Everall (2003) interviewed four clients who had positive or negative experiences with therapist self-disclosure. The content of disclosures were intimate details about the therapists' lives that were related to concerns addressed by the client in the course of treatment (e.g., therapists sharing their own struggles and strategies in dealing with social anxiety, their adopting a certain lifestyle that was dissimilar to the client, similarities in spiritual beliefs, and so on). Two of the

four clients described two types of unhelpful disclosures by therapists: dissimilar disclosures (i.e., disclosures of different values from clients) and overly frequent disclosures. The clients reported the following hindering effects of therapist disclosures: shifting the focus away from the client's issues, the need to "take care" of the therapist, inducing feelings of boredom, frustration, and resignation, reducing involvement in therapy, precluding the exploration of the client's issues, losing "reverence" for the therapist, feeling disappointed about the therapist, and questioning the competence of the therapist. The other two clients reported beneficial effects of therapist self-disclosure including strengthening the emotional bond, making the relationship "more equal", modeling coping strategies, perceiving resolution as more attainable, enabling the client to relate to the therapist on a deeper level, and enhancing the overall counseling experience.

Audet and Everall noted that findings from this study confirmed the negative and positive effects of therapist self-disclosures, and suggested that the effects of therapist self-disclosure do not function in isolation. They interact closely with many factors such as client factors, therapist factors and the timing of disclosures. Most importantly, when the therapist discloses personal information appropriately, clients reported that self-disclosure can be a therapeutic tool in strengthening the therapeutic relationship, equalizing the relationship, modeling, and fostering hope. The results of this study are consistent with the fundamental premise of the present study in recognizing that therapist self-disclosure can be a useful tool if used appropriately in therapy.

Similarly, Wells (1994) found that 5 out of 8 clients she interviewed reported mixed feelings about therapist self-disclosure in which they felt disappointed though they were

able to integrate the disclosure by the therapist into their overall therapy experience and maintain positive feelings based on a strong therapeutic relationship. The content of these disclosures were intimate details about the therapist's lives such as the therapist's struggles with diagnosis of cancer, substance use, difficulties in romantic relationships, and so on. Indeed, all eight participants in the study reported some degree of disillusionment or "surprise" at the therapist's use of self-disclosure and reported that self-disclosure by the therapist impeded their further explorations about disclosure. The clients used the following words or phrases to delineate their first reactions: "pissed off," "humiliated," "scared," "offended," "stunned," "ashamed," and "hurt." Half of the eight participants, however, regarded the self-disclosure as helpful as therapy progressed, and said that the disclosure helped to validate their experience, feel empowered and deepen the relationship with the therapist. This finding, again, supported the positive and negative effects of therapist self-disclosure and highlighted that therapist self-disclosure can be very beneficial if used appropriately.

Simply stated, despite the fact that both qualitative studies illustrated the positive and negative aspects of therapist self-disclosure, these two studies underscored the positive value of therapist self-disclosure if used appropriately. The benefit of therapist self-disclosure has been confirmed empirically. For instance, in a study that focused exclusively on exploring the benefits of therapist self-disclosure, the researchers interviewed actual psychotherapy clients who perceived therapist self-disclosure to be helpful (Knox et al., 1997). Results revealed that therapist disclosures were linked with improved therapy relationships, normalization of client concerns, and heightened client insight.

In summary, findings from the existing research indicated that clients liked and benefited from therapist self-disclosure. Further, therapist self-disclosure has been found to positively contribute to therapy process and outcome. Hill et al. (1988) found that therapist self-disclosure has been rated by clients as one of the most helpful response modes despite the low occurrence of therapist self-disclosure. In Hill et al.'s study, therapist self-disclosure was also found to contribute successfully to the process of therapy; that is, clients had the highest level of emotional experiencing (such as involvement with their feelings) in response to therapist self-disclosure. More recently, in a study that was conducted in an actual counseling setting, Barrett and Berman (2001) manipulated the amount of therapist self-disclosure in which the therapist increased the number of reciprocal disclosures with one client and avoided making self-disclosures with another client. They found that clients liked their therapists more when therapists made more self-disclosures. Most importantly, their results suggested that clients reported less symptom distress when therapists increased their self-disclosure.

Types of therapist self-disclosure that are viewed as helpful. Numerous studies have confirmed that the appropriate use of therapist self-disclosure is well-liked by clients and can be helpful to therapy process and outcome. Research, however, has provided limited information about which types of therapist self-disclosure are helpful to clients (Hill & Knox, 2002; Watkins, 1990). Instead, most previous research has focused on whether therapists should make self-disclosures or therapist self-disclosure is helpful or not. As pointed out by Hill and Knox (2002), research should focus on examining the effect of types of self-disclosures on therapy process and outcome. In examining the current literature, only a small body of research has explored which types of therapist

self-disclosure are helpful. For instance, Nilsson, Strassberg, and Bannon (1979) manipulated therapist self-disclosure and used three levels of self-disclosure: no disclosure, interpersonal disclosure (i.e., counselor shared feelings about the client's concerns), and intrapersonal disclosure (i.e., counselor shared personal experience outside of therapy that were similar to that of the client). Despite the findings that therapists who made interpersonal and intrapersonal disclosures received more favorable ratings than did the non-disclosing therapists, the results further indicated that the therapist making intrapersonal disclosures was rated more favorably than the therapist who made disclosures of an interpersonal nature (i.e., the therapist was better liked, perceived as more understanding and likeable). Hoffman-Graff (1977) examined two types of therapist disclosures: positive self-disclosures (i.e., disclosures about disclosures revealing personal strengths or positive experiences) and negative self-disclosures (i.e., disclosures about personal shortcomings or vulnerabilities). They found that therapists who made negative self-disclosures were perceived as more empathic, warm, and credible than therapists who made positive disclosures.

In summary, findings from these two studies indicated that the disclosures of more intimate or personal in nature were perceived more favorably. One type of therapist self-disclosure that is considered to be intimate is the disclosure of the therapist's countertransference. In reviewing the theoretical literature, Gorkin (1987) reported that disclosing countertransference to clients can increase clients' sense of universality, assist in establishing the therapist as genuine and honest, and even facilitate breaking through a treatment impasse. The present study will center on the content of therapist self-disclosure in investigating the effects of therapists' disclosures of

countertransference.

Overview of Countertransference

Interestingly, both in definition and in usage, self-disclosure and countertransference share some very similar characteristics. The following will give a theoretical overview of countertransference by starting with the conceptualization of countertransference and introducing controversies about the definition of countertransference.

Like the controversies about the definition of self-disclosure, conceptions of countertransference are also diverse. In general, there are two traditional polarized ways to conceptualize countertransference. At one extreme, the "classical" definition of countertransference was developed by Freud (1910/1959) and was conceptualized as the therapist's unconscious and neurotic reactions to the client's transference. According to this classical perspective, countertransference originated from the unresolved conflicts of the therapist and was theorized as a hindrance to therapy because countertransference impedes therapists understanding of clients (Reich, 1951, 1960). At the other extreme, rejecting the classical view of countertransference, the "totalistic" definition of countertransference encompasses all of the therapist's reactions toward the client (Heimann, 1950, 1960; Little, 1951; Winnicott, 1949). In the totalistic conception, all of the feelings and attitudes the therapist has are viewed as countertransference and are believed to greatly benefit the therapy work in understanding the internal world of the client.

These two definitions of countertransference highlight the major controversies embedded in the operationalization of countertransference. As pointed out by Gelso and

Hayes (2007), the key distinct feature among various definitions of countertransference lies in the degree to which countertransference is seen as originating from therapist unresolved conflicts or as including those normal therapist reactions that are pulled from the client. In other words, disagreements about countertransference can be viewed as a continuum with one extreme viewing countertransference as restricted to therapist reactions originating from unresolved issues and the other extreme considering countertransference as encompassing all of the therapist reactions triggered by client behaviors. The disagreement, in fact, parallels the distinction between subjective countertransference and objective countertransference suggested by Kiesler (2001). Subjective countertransference refers to therapist reactions to the client that stem from therapists' own unresolved conflicts. Objective countertransference, developed by Winnicott (1949), refers to therapist reactions that are mostly triggered by clients' problematic behaviors and are extendable to other therapists. This differentiation of countertransference, indeed, illustrates the criticisms of countertransference. At one extreme, objective countertransference has been criticized as being so broad as to lose conceptual meaning (Kernberg 1965). If therapists' normal responses to clients' behaviors are considered as countertransference, then countertransference is not dissimilar from therapist reactions and defining the term countertransference is useless. At the other extreme, while subjective countertransference may closely resemble the conceptualization of countertransference, it may run the risk of being too narrow to specifically focus on therapists' vulnerabilities and may disregard the influence of clients.

In responding to the controversies among various conceptualizations, several theorists have proposed another "moderate" or "integrative" view of countertransference

(Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998; Langs, 1974). This "integrative" definition of countertransference refers to the therapist's internal and external reactions to the client that are based on the therapist's present or past emotional conflicts and vulnerabilities (Gelso & Hayes, 1998, 2007). This moderate perspective is not as narrow as Freud's classical definition because countertransference is not necessarily limited to unconscious reactions or to those in response to the client's transference. On the other hand, this integrative definition is not as broad as the totalistic definition in that countertransference reactions do not encompass some normal and expectable emotional reactions that therapists may experience. Two key features should be noted based on this integrative conceptualization of countertransference. First, this definition does not imply either positive or negative effects on therapy process and outcome. Second, countertransference can be based on past or current unresolved issues. Because of its clinical and empirical value, most of the research on countertransference has adopted this integrative definition of countertransference. Thus, consistent with current theoretical and empirical literature, this integrative definition of countertransference will be utilized in the present study.

Despite the different perspectives on the conceptualizations of countertransference, one crucial common ground on the conceptualization of countertransference lies in the gradual acknowledgement that countertransference always involves the interplay of therapist and client. According to Gabbard (2001), "theorists from diverse persuasions have converged on the idea that, to some extent, countertransference is always a joint creation involving contributions from both clinician and patient" (p. 989). This acknowledgement not only emphasizes the significance of taking into consideration the

interactive effects in conceptualizing countertransference but also highlights the importance for therapists of examining their own reactions in order to deepen their understanding of countertransference. According to Ogden (1982), it is important for therapists to distinguish reactions that originate in the patient from those rooted in the analyst so that therapists will reduce the risk of confusing their own reactions with clients' reactions. Distinguishing what comes from therapist and what comes from client, however, is not an easy matter, and creates the complexity in understanding countertransference. In this respect, a categorization suggested by Reich (1951) can shed light on the conceptualization of countertransference.

Reich (1951) differentiated countertransference into "acute countertransference" and "chronic countertransference." Acute countertransference refers to therapist reactions "under specific circumstances with specific patients" (Reich, 1951, p. 26). Acute countertransference is believed to be based on the identification with clients and can also reflect various needs of therapists. Chronic countertransference, on the other hand, reflects a general personality structure problem of the therapist. Even though client factors can trigger chronic countertransference, chronic countertransference tends to be triggered from the format of therapy such as termination of therapy, and can occur at any moment in the therapy context.

Given the complexity of countertransference, a clear guide in grasping myriad aspects of countertransference is necessary and beneficial. In this aspect, Hayes (1995) developed a structural theory of countertransference that is very useful in serving as a map in understanding the phenomenon of countertransference. Drawing on the clinical literature, Hayes identified five key elements of countertransference: origins, triggers,

manifestations, effects, and management. *Origins* refer to therapists' areas of unresolved internal conflicts. *Triggers* are therapy incidents/occurrences that touch on or induce therapists' unresolved issues. *Manifestations* refer to therapist reactions in responding to the elicitation of the therapist's unresolved issues. These reactions can be manifested internally, in countertransference thoughts and feelings, or displayed externally, in countertransference behaviors (Hayes & Gelso, 2001; Latts & Gelso, 1995). *Effects* are the ways in which countertransference manifestations influence therapy process and outcome. Finally, *management* refers to the ways therapists use to handle their countertransference reactions. The present study will utilize this five-factor model in guiding discussions on countertransference.

Therapeutic Implications of Countertransference

Since Freud (1910/1959) first introduced the term countertransference to the field of psychotherapy, countertransference has historically been viewed as negatively influencing therapy process. Because Freud narrowly defined countertransference as therapists' unconscious and unresolved reactions to client's transference, countertransference has been regarded as a "taboo" in therapy work and therapists need to make every effort to avoid and overcome countertransference. Specifically, countertransference was believed to impede therapists' ability to understand clients' issues or distort therapists' view of clients' transference and sense of self (Epstein & Feiner, 1979).

This one-sided perspective on countertransference, however, has been challenged by several theorists, mostly interpersonal theorists (e.g., in England, Heimann, Money-Kyle & Winnicott; in Argentina, Racker; and in the U.S., Fromm-Reichman,

Little & Sullivan). Not only did they broaden the definition of countertransference to refer to all therapist reactions as countertransference, but they stretched the therapeutic implications of countertransference and emphasized the positive aspect of countertransference. The therapeutic value of countertransference, as described in the literature, falls into two major areas: fostering deeper empathy and gaining insight into therapy work. On the one hand, countertransference can enhance therapist empathetic ability because therapists can draw from the experience of their own emotional conflicts and understand what client is experiencing (Hayes, 2002; Kiesler, 2001; Peaboy & Gelso, 1982). On the other hand, countertransference can help therapists gain insight into the client's contributions to therapy process, and gain more understanding of the client's unconscious dynamics and interpersonal patterns (Epstein & Feiner, 1988). Hence, despite the criticism that this approach operationalizes countertransference too broadly and ignores the negative implications of countertransference, an important trend emerging from this broadened perspective is the recognition of the potential highly positive contribution of therapist countertransference. As explicated by Gabbard (2001), "clinicians of all persuasions generally accept the idea that countertransference can be a useful source of information about the patient" (p. 984).

In spite of the ostensibly different perspectives on the operationalization of countertransference and the clinical implications of countertransference, another possibility that both perspectives are indicative of aspects of countertransference lies in the fact that each perspective may focus on different facets of countertransference and each perspective may therefore be valid. As pointed out by Peabody and Gelso (1982), the changing perspective on the definitions of countertransference and recognition of

positive value of countertransference may be related to the fact that the classical perspective focuses on therapist countertransference behaviors while the contemporary perspective focuses on therapist countertransference internal feelings or thoughts. In other words, the clinical implications of countertransference can be two-sided, depending on the facets of countertransference that one attends to. Countertransference, according to Hoyt (2001) and Racker (1957), can be both the greatest danger and the best tool in therapy. Specifically, countertransference behaviors can be detrimental if not attended to, and countertransference reactions can be instrumental if therapists are aware of their reactions and find ways to manage their countertransference reactions. A number of theorists from various orientations indicate that countertransference is an unavoidable process in therapy, and can have positive or negative influence depending on how therapists deal with it (Brown, 2001; Ellis, 2001; Gelso & Hayes, 2007).

Given the two-sided nature of countertransference, a significant question arises regarding how to manage countertransference. A model of countertransference management was developed by Van Wagoner, Gelso, Hayes, and Diemer (1991). This model consists of five interrelated factors: self-insight, self-integration, empathy, anxiety management and conceptualizing ability. Self-insight refers to therapist's awareness of countertransference feelings and understanding of countertransference origins. Self-integration refers to therapist's maintaining a healthy character structure. Anxiety management is the therapist's ability to acknowledge anxiety and cope with anxiety effectively. Empathy reflects the therapist's capacity to attend to client's needs while the therapist may be experiencing countertransference feelings. Lastly, conceptualizing ability refers to the therapist's ability to utilize theory in understanding client dynamics

and the therapeutic relationship.

Another issue related to managing countertransference is the disclosure or non-disclosure of countertransference in psychotherapy. Disclosure of countertransference has sparked numerous discussions. In a review by Tansey and Burke (1989), they classified theoretical perspectives on countertransference disclosures into three groups: conservative, moderate and radical. Conservative theorists such as Heimann (1950), Reich (1960) and Langs (1978) argued that therapists should refrain from making countertransference disclosures because this behavior is viewed as arising from the unresolved needs of therapists and runs the risk of burdening clients. Moderates such as Giovacchini (1972), Greenson (1974), and Winnicott (1949) believe that infrequent and judicious use of countertransference disclosures can be helpful to more seriously disturbed clients in the sense that such disclosure might serve as an impetus for resolving therapeutic impasses and might provide modeling for clients in regards to the journey of intrapsychic healing. Radicals such as Little (1951), Bollas (1983), Maroda (1994) and Searles (1979) advocated for disclosing countertransference with discretion and consider it to be an imperative element in psychotherapy because therapist disclosure of countertransference can decrease the power imbalance in therapy, deepen the therapeutic relationship, and increase the client's insight into his or her problem.

While there are different perspectives on disclosing countertransference, a trend arising from this discussion is the suggestion that countertransference disclosure can be a very powerful tool if therapists use it judiciously to benefit clients. As Kiesler (2001) put it, one of the emerging agreements on countertransference is that "the therapist's disclosure of his/her countertransference feelings to the client may be highly useful in

helping the client confront and change his/her basic problematic behaviors" (p. 1057). Several authors also promote the prudent use of countertransference disclosure because such disclosures may confirm a client's sense of reality, promote an authentic therapy relationship, decrease client's sense of isolation and offset the power imbalance in therapy (Brown, 2001; Gorkin, 1987; Hayes & Gelso, 2001).

The Notion of the Wounded Healer

The recent paradigm shift in recognizing the positive value of one's countertransference or vulnerabilities is akin to the notion of wounded healer in that woundedness in both perspectives is not seen as indications of weaknesses but as evidence of strength. According to Jackson (2001), the wounded healer refers to "the inner woundedness of a healer-the healer's own suffering and vulnerability, which have been said to contribute crucially to the capacity to heal (p. 2)". In other words, when the healer's woundedness is viewed as an asset, it can serve as a valuable tool in the healing practice.

Before delving into the discussions on the concept of the wounded healer, the term wounded healer and healer need to be differentiated and clarified. A healer can exist in various forms, and a wounded healer is considered to be one form of a healer. For instance, a fortune teller can be considered a healer because he or she can use his or her capacity of seeing the future to help a person. However, a fortune teller may not be a wounded healer, inasmuch as a wounded healer refers to a healer who has been wounded and who has worked through his or her wound sufficiently to benefit others.

The concept of the wounded healer has been in existence for thousands of years and can be traced back to the character of Chiron the Centaur in Greek mythology

(Holmes, 1991; Jackson 2001; Miller & Baldwin, 2000). Chiron, half human and half divine, was abandoned by his father and rejected by his mother at birth. Through being raised and instructed by Apollo, the god of music, prophecy and healing, Chiron became skilled in the healing arts including medicine, music and prophecy. However, accidentally afflicted with an incurable wound caused by the poisoned arrows of Hercules, Chiron's suffering was too painful to bear and he gave up his immortal status and passed it on to Prometheus. Ultimately, Chiron became a renowned healer and mentored many notable heroes in Greek mythology such as Achilles and Jason, as well as the founder of Greek medicine, Asclepius. Thus, through overcoming his own woundedness and utilizing his woundedness to help others by engaging in healing practices and mentoring others, Chiron demonstrated that one's own woundedness can become an asset to benefit others, thus vividly illustrating the concept of the wounded healer. More recently, the concept of the wounded healer has also been utilized extensively in various fields such as shamanism (e.g., Halifax, 1982), addiction counseling (e.g., White, 2000) and pastoral counseling (e.g., Nouwen, 1972).

As can be expected, the concept of wounded healer has been explored and underscored in the field of psychotherapy, especially in Jungian analysis. Jung (1989) advocated for the concept of the wounded healer and expressed this perspective in his well-known statement, "Only the wounded physician heals" (p. 134). He further explicated that "The doctor is effective only when he is affected. It is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician" (p. 134). Through his own experiences of going through psychological disturbances and utilizing this experience to develop his

psychological theory of healing practices, Jung (1989) illustrated and promoted the concept of the wounded healer in the field of psychotherapy.

Given the significance of the concept of the wounded healer, what are the key components that lead to the healing power of the wounded healer? Two essential elements that are considered to contribute to the healing power of wounded healer are the value of the wound and efforts to resolve the wound. The value of the wound, very similar to the therapeutic value of countertransference, enriches therapists' ability to achieve a deeper level of genuine empathy and understanding of human sufferings by using therapists' own experiences with internal conflicts or vulnerabilities. As indicated by Bennet (1979), the power of the wound "lies in its ability to foster empathy, understanding and acceptance in the healer (p.4)." Without the personal experience of being wounded, it is possible that therapists can only understand human suffering superficially or theoretically rather than profoundly or genuinely. Through the experience of being understood genuinely and being accepted deeply by therapists, clients can form a deeper level of connections with therapists and therapeutic relationship, which is considered to be the most effective therapeutic factor in therapy, can be enhanced.

Therapists' own woundedness, however, is absolutely not enough in becoming a wounded healer. Another significant factor that has been theorized to play a crucial role in becoming a wounded healer is therapists' efforts to treat the wound sufficiently. It should be noted that how the therapist resolves his or her personal issues should be viewed on a continuum rather than in a dichotomy. Resolving one's wound sufficiently is enough because no wound can be completely resolved. As Heimann (1960) put it, "no analyst is finally and perfectly analyzed and neurotic residuals remain" (p. 14). What counts is the

therapist's taking steps to resolve his or her own wound so that the therapist can not only avoid acting out his or her own emotional conflicts but also using his or her own personal experiences in dealing with the wound to benefit others. According to Hayes (2002), therapists' effort to work on personal issues "decreases the possibility of countertransference-based reactivity with clients and increases the pool of experiences that might be drawn upon in therapy" (p. 97).

As a matter of fact, the transmutation of one's wound or weaknesses into one's strength or assets to benefit others is the essence of the concept of the wounded healer and this also parallels the notion of using countertransference beneficially. As pointed out by Gelso and Hayes (2007), "this alchemical process-transforming the lead of the therapist's life into gold for patients-is at the heart of utilizing countertransference in therapy (p. 107)." One of the possible ways to function as a wounded healer is to share therapists' own experiences of working through personal painful wounds with clients. Through judiciously disclosing their more resolved personal issues to clients, therapists can offer hope to clients in helping clients keep faith of making improvement in their struggles and illustrate the possibility of transforming one's wound into one's assets. Instilling and maintaining clients' hope, indeed, has been recognized as one of the most powerful factors to the effectiveness of psychotherapy (Frank & Frank, 1991). Hence, the healing power of the wounded healer can lie in the form of therapists' disclosing more resolved countertransference to inspire clients' hope.

Despite the two aforementioned elements contributing to the effectiveness of the wounded healers (i.e. the value of the wound and the efforts to resolve the wound), another aspect of the concept of wounded healer that is worth noting pertains to how the

healing power of the wounded healer can be related to other factors such as the similarities of the wounds between the therapist and the client. For instance, therapists who have been struggling with sexual abuse and have resolved their wounds appropriately can become wounded healers to clients with sexual abuse issues. However, whether therapists who have been battling with sexual abuse may be beneficial for clients with grief and loss issues is worth exploring. One possibility is that wounded healers can be most helpful to clients who share wounds that are alike and the similarities of the wound are the necessary component of the concept of the wounded healer. Another possibility is that the similarities of the wound may not be as important as the element of working through the wound. That is to say, while it can be most powerful for wounded healers to have similar wounds as clients, wounded healers' experiences of working through their own wounds can also be helpful to some degree to clients who present with dissimilar issues than therapists with unresolved countertransference because wounded healers can use their own process of healing to empathize with clients who are wounded. In other words, the concept of the wounded healer can be multidimensional and the healing power of the wounded healer can depend on many factors such as the value of the wound, the effort to resolve the wound and the similarities of the wound, etc.

Research Findings on Countertransference

Theoretical discussions on countertransference are supplemented by research which also seeks to examine the phenomenon of countertransference. Because the focus of the present study revolves around the potential positive value of countertransference, the following will discuss empirical evidence on how countertransference may play out in therapy, factors that contribute to the management of countertransference, and how

countertransference may influence therapy process and outcome.

One of the key advancements in theoretical and clinical literature of countertransference is the recognition that when therapists' unresolved internal conflicts are triggered in their work with clients, countertransference reactions can be multilayered (Hayes & Gelso, 2001). Empirical evidence also supports that therapist reactions can be manifested internally, in countertransference feelings and thoughts, or displayed externally, in countertransference behaviors. While keeping in mind that these reactions are interrelated, the following will discuss research findings in each area. In terms of countertransference feelings, research suggests that therapist anxiety is one of the most frequent emotional reactions that takes place when therapists' unresolved internal conflicts are stimulated in session (Fauth & Hayes, 2006; Hayes et al., 1998; Hayes & Gelso, 1991, 1993; Latts & Gelso, 1995). Other countertransference feelings that have been investigated empirically including anger, boredom, sadness, inadequacy, nurturing feelings, envy and guilt (Hayes et al., 1998). In addition to countertransference feelings, therapists' countertransference-based reactions may also be manifested in countertransference thoughts. A number of studies demonstrated that therapists' perceptions of clients can be distorted when clients discuss materials that touch upon therapists' unresolved issues while the form of cognitive distortions may play out in different ways (Cutler, 1958; Fiedler, 1951; Gelso et al., 1995). For instance, in a classic study conducted by Cutler (1958), he found that therapists tended to remember incorrectly the amount of time that clients actually spent discussing those topics that are related to therapists' unresolved issues. In another study, McClure and Hodge (1987) detected that therapists are very likely to misperceive clients as overly similar to or overly

dissimilar from themselves as a result of countertransference reactions. Empirical evidence also demonstrates that therapists' decision making about treatment planning can also be influenced when therapists' unresolved issues are evoked (Hayes et al., 1998).

When therapists cannot manage their countertransference thoughts or feelings in sessions with clients, they may display countertransference behaviors. In this respect, earlier empirical studies have demonstrated that therapists tend to display countertransference behaviors by becoming distant, withdrawn, or avoidant with clients (Bandura, Lipshur, & Miller, 1960; Hayes & Gelso, 1991; Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). In other words, therapist countertransference behaviors can take the form of under-involvement in sessions with clients such as ignoring what the client's said, changing topics and rejecting of clients. More recently, however, several studies found that therapist may display countertransference behaviors by becoming over-involved in session with clients such as oversupporting the client, trying to be friends with clients or engaging in too much self-disclosure with clients (Hayes et al., 1998; Rosenberger & Hayes, 2002; Williams, Judge, Hill, & Hoffman, 1997). Although more research is needed on countertransference behaviors, researchers speculated that therapist gender may influence how therapists act out countertransference behaviors; female therapists tend to become over-involved while male therapists tend to become withdrawn or under-involved with clients (Hayes & Gelso, 2001).

When therapists experience internal countertransference reactions or display external countertransference behaviors, what are the consequences of countertransference on therapy process and outcome? Before delving into discussing the empirical evidence

on the effects of countertransference, distinguishing the manifestations of countertransference is necessary, based on the aforementioned fundamental assumptions of the study in that countertransference thoughts or feelings can have positive influence on therapy if attended to and countertransference behaviors can have negative influence on therapy process and outcome. However, two major obstacles are encountered in this literature. First, there is limited research investigating the influence of countertransference effects. Second, the limited amount of research in this area has focused mostly on the effects of countertransference behaviors. Due to these two obstacles, the following will focus on discussing the influence of countertransference behaviors on treatment outcome based on direct and indirect empirical evidence.

Regarding direct empirical evidence on the countertransference behaviors and therapy outcome, only one study to date has examined the effects of countertransference behaviors on therapy outcome in a straightforward way (Hayes et al., 1997). In this study, researchers investigated 20 cases of brief therapy conducted by therapist-trainees, and found countertransference behaviors were not related to therapy outcome as reported by clients, therapists and therapists' supervisors. However, in cases with less successful treatment outcome, a strong negative relationship was detected between countertransference behaviors, as rated by therapist and supervisor, and treatment outcome, as rated by therapist, supervisor, and client.

In addition to the direct empirical evidence on countertransference behaviors and outcome, some indirect evidence that investigated the relationship between countertransference behaviors and working alliance sheds light on how countertransference may influence outcome. For instance, Ligiero and Gelso (2002)

found that therapist countertransference behaviors are associated with weaker therapist-client working alliance. Because the working alliance has been recognized empirically as a strong predictor of therapy outcome (Horvath & Greenberg, 1994; Martin, Garske, & Davis, 2000), results from this study suggests that it is possible that countertransference behaviors may interfere with outcome. The relationship between countertransference behaviors and therapy outcome, however, has been found to be influenced by other factors such as therapist abilities to manage countertransference. In an in-depth quantitative case study, Rosenberger and Hayes (2002) found indirect evidence for the relationship between countertransference and therapy outcome. They discovered that when the therapist displayed countertransference behaviors, the therapist's ability to manage countertransference is positively related to the working alliance as perceived by the client.

On the basis of the research, findings from direct and indirect evidence suggested that the relationship between countertransference behaviors and outcome is complex and may not be linear. Specifically, countertransference behaviors may interfere with therapy outcome, especially when the alliance between therapist and client is weak. On the other hand, the negative influence of countertransference behaviors may be mediated by other factors such as therapist ability to manage countertransference.

If countertransference behaviors may potentially interfere with therapy outcome, a significant question arises regarding how therapists can manage their countertransference. In a pioneering empirical work by Peabody and Gelso (1982), they found that therapist empathy is inversely related to countertransference behaviors and is positively associated with openness to countertransference feelings. In other words, their findings indicate that

therapist empathy can be facilitative of therapists' willingness to examine their own countertransference feelings, and that empathy can help therapists refrain from acting out countertransference behaviors and ultimately can contribute to countertransference management. Managing countertransference, of course, cannot only rely on therapist empathy. Following the line of work of Peabody and Gelso (1982), another important study conducted by Robbins and Jolkovski (1987) found that therapist conceptual skills, along with awareness of countertransference feelings, are beneficial to countertransference management.

Based on the findings from these two studies and other clinical literature, Van Wagoner et al. (1991) developed a five factor model of countertransference management. As mentioned earlier, this model theorized that there are five factors that can be crucial to the management of countertransference including empathy, anxiety management, self-integration, conceptualization, and self-insight. Empirical literature has generally supported the importance of this five-factor model. For instance, in a preliminary study conducted by Van Wagoner et al. (1991), results indicated that therapists who were identified as excellent were perceived more favorably on the five characteristics in this model of countertransference management than therapists in general. Additionally, Friedman and Gelso (2000) found that therapists' ability to manage countertransference (as rated by their clinical supervisors) on the five-factor model was inversely related to countertransference behaviors in therapists. Their results suggested that therapists who possess countertransference management ability can refrain from acting out their countertransference behaviors. If a therapist can reduce his or her countertransference behaviors through countertransference management ability, it is possible that

countertransference management ability may contribute to therapy effectiveness. Empirical evidence supported this perspective. In a case study conducted by Rosenberger and Hayes (2002), they found that the therapist's ratings of her ability to manage countertransference were positively related to the client's evaluations of working alliance and the depth of the session.

As is evident, most of the studies on countertransference focused on the negative aspects of countertransference including how countertransference may play out in therapy, how countertransference behaviors may affect therapy process and outcome, or how to best manage countertransference behaviors. Even though theoretical perspectives have evolved to acknowledge the positive aspects of countertransference (Gabbard, 2001), what has been missing in the empirical literature is the potentially beneficial aspects of countertransference. As Hayes (2002) succinctly put it, "Despite nominal acknowledgement of both the vices and virtues of countertransference, researchers have concentrated their efforts to date almost solely on the deleterious consequences of countertransference and how to avoid or manage them while disregarding the potential therapeutic value of countertransference" (p. 95). In an effort to advance the understanding of countertransference, the present study will attempt to investigate the positive aspects of countertransference.

Countertransference, Self-Disclosure and the Wounded Healer

Self-disclosure and countertransference, two seemingly different phenomena in psychotherapy, have two main commonalities. First, both self-disclosure and countertransference are related to the inner world of therapists. While countertransference can be viewed as therapist reactions to clients in psychotherapy that are coming from the

inner world of therapists, self-disclosure can be viewed as statements made by therapist in psychotherapy originating from the subjective experience of therapists. Self-disclosure and countertransference can both be seen as representations of the therapist's inner world in psychotherapy, though self-disclosure may also be seen as one of the various representations of countertransference in psychotherapy. The common ground of countertransference and self-disclosure may take the form of therapists' actively (or unconsciously) disclosing countertransference; that is, revealing a part of their inner world to clients.

Another link between countertransference and self-disclosure is reflected in the recent theoretical changes emphasizing the positive aspects in both concepts. As mentioned earlier, therapist self-disclosure has undergone a significant theoretical change in endorsing the potential value of the use of self-disclosure in psychotherapy. Similarly, theoretical perspectives on countertransference have transformed from being viewed as detrimental in psychotherapy to being perceived as potentially beneficial to therapy process. Endorsing the potential positive values appears to be the trend in theoretical perspectives about both self-disclosure and countertransference.

In fact, the integration of these two commonalities of self-disclosure and countertransference is related to the concept of wounded healer. Specifically, wounded healers are therapists who can transform their weaknesses into strengths and positively utilize their wound or their inner world in psychotherapy to benefit clients. And, one of the possible ways for therapists to utilize their wounds to benefit clients or to enact the concept of the wounded healer in psychotherapy lies in the wedding of self-disclosure and countertransference; that is, judiciously self-disclosing resolved personal issues in

psychotherapy.

One of the only published studies on the effects of countertransference disclosures provided partial support for the hypothesis that countertransference disclosures are more favorably perceived than no disclosures (Myers & Hayes, 2006). As mentioned earlier, Myers and Hayes theorized that the effects of therapist self-disclosure would depend on content and context. In this analogue study, the context of self-disclosure was a therapy relationship having either a positive or negative working alliance. In terms of content, three levels of therapist disclosures were manipulated: no disclosure, countertransference disclosures (i.e., therapist revelations about areas of unresolved conflict) and general disclosures (i.e., non-countertransference disclosures). In this between groups study, 224 undergraduate students viewed a videotape of a simulated therapeutic encounter in which a therapist made no disclosures, 3 countertransference disclosures or 3 general disclosures in the context of either a positive or negative working alliance (manipulated via a written description given to participants). The researchers hypothesized an interaction effect in which the ratings of therapist self-disclosure would depend on the quality of working alliance. They hypothesized that when the alliance was perceived as strong, countertransference disclosures would be rated more favorably than when the therapist made no disclosure. Their results provided partial support for the hypothesis. They found that participants rated sessions as deeper and the therapist as more expert when the therapist made general disclosures compared to no disclosures, under the condition of a positive working alliance. However, countertransference disclosures were not perceived as more favorable by participants than when no disclosures were made, under the condition of positive working alliance. Interestingly, the

findings were not the same when the researchers did an additional analysis in taking into consideration the impact of participants' prior therapy experience. The results from this analysis suggested that participants with prior therapy experience had more favorable ratings when the therapist made countertransference disclosures than when he made general disclosures on the dimensions of session depth.

A possible explanation for this null finding regarding countertransference disclosures may be related to the nature of the personal issues shared in the countertransference disclosures. Specifically, the countertransference disclosures contained materials about unresolved conflicts. The disclosure of resolved versus unresolved issues may have differential effects on the perceptions of clients. It is possible that therapists' sharing of countertransference disclosures that reflect more resolved personal issues will be perceived more favorably by clients and can further contribute positively to therapy process and outcome. This perspective is consistent with the recent paradigm shift in psychodynamic theory that focuses on the therapeutic value of countertransference as well as the concept of wounded healer. Additionally, this perspective also parallels the clinical suggestions from Hill and Knox (2003) who recommended "self-disclos[ure] about issues that you have mostly resolved rather than those with which you continue to struggle" (p. 537).

In conclusion, the aim of this research is to extend the study of Myers and Hayes (2006) not only by introducing a new independent variable (i.e., resolved countertransference) but also by examining other dependent variables which plausibly ought to be related to disclosures of resolved countertransference including hope and universality. Namely, this research will center on the content of therapist self-disclosure

in investigating the differential effects of resolved and unresolved self-disclosure on perceptions of the therapist and the session.

Focus of Present Study

The main purpose of this study will examine how therapist self-disclosure is perceived by observers. Specifically, there will be two distinct self-disclosure conditions: disclosures of resolved personal issues and disclosures of unresolved personal issues. In each therapeutic scenario, the observers will evaluate the therapist based on their perceptions of the therapist's expertness, attractiveness, and trustworthiness. They will rate how they viewed the session with regard to the amount of depth that was present, how smoothly they felt the session went, and the general affective tone of the session. The observers will also rate how they viewed the client with respect to the client's likely feelings of hope and universality.

The present study will be constructed as an experimental analogue. Although the generalizability of the findings to actual clinical practice will be lower than in field research, manipulating therapist self-disclosure and countertransference provides strict control over independent variables and has the benefit of overcoming serious ethical considerations pertinent to potential harmful effects on actual clients. Thus, an analogue design will be utilized.

Hypotheses

Compared to therapist disclosure of resolved personal issues, therapist self-disclosure related to unresolved personal issues will be viewed less favorably. Specifically, the therapist in the unresolved self-disclosure condition will receive less positive ratings in regard to expertness, attractiveness, and trustworthiness, and

the session will be rated as having less depth, being less smooth, and being less positive in tone. In addition, the client will be perceived as having less hope that problems will be resolved. In respect of the ratings on how universality will be perceived, it was expected that the client will be viewed as having more sense of being similar to the therapist when the therapist discloses unresolved personal issues because the client also has unresolved issues. Thus, it is possible that universality will be rated higher under the condition of therapist disclosure of unresolved personal issues than therapist disclosure of resolved personal issues.

Chapter 3: Method

Participants

A priori power analysis was conducted using power analysis software (Faul & Erdfelder, 1992) and it was determined that a total sample size of 128 (64 per cell) would be needed to reach a .80 level of power with an alpha level of .05. The actual participants for this study were 222 undergraduate students from the Pennsylvania State University. Of the total sample, 116 participants provided usable data.

Among the 116 students whose data were utilized in the analysis, 91 (78.4 %) were female and 25 (21.6 %) were male. With respect to ethnicity, 104 (89.7 %) identified themselves as Caucasian, 4 (3.4 %) identified as African American, 3 (2.6 %) as Asian American, 3 (2.6 %) as Hispanic, 1 (.9 %) as biracial, and 1 (.9 %) as other. The mean age of participants were 20.83, and ranged from 18 to 44 years old. The participants were from undergraduate education and human development classes, and received extra credit for participating in the study. Participations were voluntary, and alternative forms of extra credit were provided in accord with the guidelines outlined by Penn State University's Institutional Review Board (IRB).

Materials

The stimulus materials for this study were two video tapes, each twelve minutes in length. The tapes depicted simulated therapeutic interactions between a client and a therapist, who was played respectively by the friends of the primary investigator, both of whom had prior acting experience. The mock therapist was a 36-year-old white male and the mock client was a 24-year-old white female. The gender restriction of the actor and actress was done for simplicity of design. Both tapes followed a similar script of

interactions. The tapes consisted of a dialogue that contains equal numbers of minimal encouragers and questions on the part of the therapist (39 total therapist statements), with the only variation in the tapes being a self-disclosure dimension. The two conditions were resolved self-disclosure, and unresolved self-disclosure. The script of resolved self-disclosure was shown in Appendix A, and the script of unresolved self-disclosure was displayed in Appendix B.

In the unresolved self-disclosure condition, the therapist made a self-disclosing statement about unresolved personal issues at three points in the dialogue related to what the client is discussing. The video format is similar to the procedure that was used by previous researchers (Lundeen & Schuldt, 1989; Myers & Hayes, 2006), who also used videos that were ten minutes in length, incorporating three instances of therapist self-disclosure. The self-disclosure of resolved personal issues condition followed the same format as the previous tape, but the therapist self-disclosed resolved personal issues to the client at three points.

A validation check was conducted to determine whether the counselor responses in the two scripts indeed were reflective of the above two conditions by three independent judges. These judges consisted of one man and two women. All of them were licensed psychologists with a mean of 20 years of post doctoral experience working as a therapist. Both of the scripts were evaluated to be plausible therapeutic scenarios. The three judges also completed the manipulation checks for self-disclosure that was developed for this study, and was able to appropriately identify the independent measures (e.g., the judges indicated that the therapist in the unresolved condition made disclosures based on some unresolved issues in his past).

Measures

Perceptions of the counselor. Perceptions of the counselor were measured with the *Counselor Rating Form* (CRF; Barak & LaCrosse, 1975). The CRF consists of 36 bipolar items, 12 items for each of three subscales that measure therapists' trustworthiness, expertness, and attractiveness, as perceived by the respondents. Items are rated in a 7-point semantic differential format, ranging from 1-7. Scores are summed and averaged for each 12-item subscale, and higher scores suggest greater trustworthiness, expertness, and attractiveness. Reliability coefficients using the Spearman-Brown formula were calculated for each of the scales, and are as follows: .87 for expertness, .85 for attractiveness, and .91 for trustworthiness (LaCrosse & Barak, 1976). Principal component analysis of the CRF supported the existence of three distinct factors, indicating the three theoretical constructs (Wilson & Yager, 1990). In another study, LaCrosse (1980) found that client ratings on the three dimensions of CRF were significantly related to treatment outcome (r = .37 to .56), thus providing evidence of the predictive validity of the CRF. In the current study, the reliability coefficients were calculated as follows: .93 for expertness, .87 for attractiveness, and .91 for trustworthiness. The alpha coefficient for the entire CRF was .96.

Session impact. Session impact was measured with the *Session Evaluation Questionnaire* (SEQ Form 3; Stiles & Snow, 1984). The SEQ consists of 24 bipolar adjective scales presented in a 7-point semantic differential format, and scores range from 1 to 7. The 24 items are divided into two sections: session evaluation, and post session mood. In the first section, the stem "This session was" preceded the first 12 adjective pairs (session evaluation) such as bad-good, safe-dangerous, shallow-deep, etc. Factor

analyses revealed two dominant indexes: Depth and Smoothness. In the second section, the stem "Right now I feel" preceded the next 12 adjective pairs (post session mood) such as happy-sad, angry-pleased, friendly-unfriendly, etc. Two dominant session indexes emerged through factor analysis: Positivity and Arousal. Scores are summed and averaged, with higher scores reflecting greater perceived session depth and smoothness and more positive postsession mood. Internal consistency estimates for the four dimensions are generally strong. Stiles, Reynolds, Hardy, Rees, Barkham, and Shapiro (1994) reported internal consistency measured by coefficient alphas for client ratings of .90 (Depth), .92 (Smoothness), .90 (Positivity), and .80 (Arousal). Stiles and Snow (1984) reported overall test-retest reliability estimates of .80 for this instrument over six weeks. In the current study, the following reliability coefficients were found: Depth scale = .77, Smoothness scale = .76, and Positivity scale = .54.

Hope. Hope was measured using the Instillation of Hope Subscale of the *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000). The TFI is a comprehensive and empirically based self-report measure developed to assess group members' perceptions of the degree to which the therapeutic factors described by Yalom (2005) are present. For the purposes of the present study, the nine items from the Instillation of Hope subscale were modified in order to allow for the application to individual therapy. For instance, the original item "Group helps me feel more positive about my future" was changed to "After counseling, the client will feel more positive about the future." Items are rated on a 7-point Likert scale that ranges from *strongly disagree (1) to strongly agree (7),* with higher scores reflecting greater hope. The Instillation of Hope subscale has adequate reliability. It has been used in a counseling

center population, with a test-retest reliability of .88 over one week, and the estimate of coefficient alpha was .93 (Lese & MacNair-Semands, 2000). Preliminary evidence suggests adequate construct validity as perceptions of therapeutic factors were related to participants' interpersonal problems (MacNair-Semands & Lese, 2000). The final copy of the modified TFI-H was shown in Appendix G.. In the current study, the alpha level for the overall scale was .88.

Universality. Universality was measured using the Universality Subscale of the *Therapeutic Factors Inventory* (TFI; Lese & MacNair-Semands, 2000). For the purposes of the present study, the nine items from the Universality subscale were modified in order to allow for the application to individual therapy. For instance, the original item "In group I have learned that I have more similarities with others than I would have guessed" was changed to "As a result of counseling, the client will learn that she has more similarities with others than she would have guessed." Items are rated on a 7-point Likert scale that ranges from *strongly disagree (1) to strongly agree (7),* with higher scores reflecting greater universality. The Universality subscale has adequate reliability. It has been used in a counseling center population, with a test-retest reliability of .85 over one week, and the coefficient alpha estimate was .86 (Lese & MacNair-Semands, 2000). Preliminary evidence suggests adequate construct validity as perceptions of therapeutic factors were related to participants' interpersonal problems (MacNair-Semands & Lese, 2000). The final copy of the modified TFI-U is shown in Appendix H. In the current study, the alpha level for the overall scale was .67.

A Self-disclosure Manipulation Check was developed for the purpose of the study. This questionnaire follows a yes/no format, which asked participants to answer a question

that stated: “Did the therapist make any statements revealing personal information during the session?” If they indicate that the answer is “yes”, then they continue to answer the following question to distinguish a self-disclosure of resolved personal issues from one based on a self-disclosure of unresolved personal issues: “Was the information that the therapist revealed based on personal difficulties with which he still struggles?”

Procedure

An on-line website was set up for this study. Passwords were used to ensure confidentiality. Participants were randomly assigned to one of two conditions (resolved and unresolved conditions). After signing implied informed consent forms (see Appendix I) by clicking on the “continue” button, participants were asked to fill out a brief demographic form. Following this, the participants were asked to download and watch a 12 minute video clip of a counseling session by clicking on the “play” button. Immediately following the end of the tape, each participant was asked to fill out a self-disclosure manipulation check questionnaire. After that, participants were instructed to complete copies of the CRF, SEQ, TFI-H, TFI-U in a counterbalanced order. Once participants completed the survey, they were directed to another website to provide their names and student id for extra credit. No personal identities were linked with participants’ survey responses.

Analysis

The research design is a one-way between-groups design, with two levels of self-disclosure (i.e., resolved vs. unresolved). All levels of the independent variable were considered nominal in nature. The dependent variables in this analysis were perceptions of the counselor (measured by CRF), session impact (measured by SEQ), hope (measured

by TFI-H), and universality (measured by TFI-U). The CRF, SEQ, TFI-H and TFI-U use seven point Likert-type scales. This data was treated as interval/ratio data, and was analyzed using a one-way multivariate analysis of variance (MANOVA). Differences were considered significant if they reach an alpha level of less than .05.

Chapter 4: Results

Preliminary Analysis

A one-way between groups multivariate analysis of variance was conducted on eight dependent variables: therapists' attractiveness, therapists' trustworthiness, therapists' expertness, session depth, session smoothness, session positivity, hope and universality. The independent variable was therapist disclosure, and it had two levels (resolved and unresolved). Before proceeding with the planned multivariate analysis of variance (MANOVA), a series of preliminary analyses were conducted. These analyses include calculation of descriptive statistics, and bivariate correlations, followed by a testing of assumptions required to proceed with the MANOVA analysis.

The original data file was examined for missing values and manipulation checks. A total of 222 participants began the study. Forty-seven participants terminated their participation after filling out the demographic questionnaire partly due to the fact that there were traffic jams of the website when they logged in. In looking at the data, there were only a few cases with missing data. Thus, a conservative approach was taken and cases with any missing data were not used. Two participants were excluded because of missing a few surveys and four participants were excluded due to missing a few items on one survey. The data set for the remaining 169 participants was examined for the validation check for the two conditions. For the resolved disclosure condition, one case was deleted because this participant answered questions all the same on all of the measures and one participant was deleted because of responses with extreme values on one of the measures detected by examining histograms. Data from 27 participants were excluded because their answers on the two manipulation check measures indicated that

they misperceived the disclosure condition. For the unresolved disclosure condition, three cases were deleted because they answered questions all the same on all of the measures and one participant was deleted because of responses with extreme scores on one of the measures detected by examining histograms. Data from 19 participants were excluded because their answers on the two manipulation check measures indicated that they misperceived the disclosure condition. Thus, data from a total of 116 participants was subsequently analyzed.

After examining the missing values and manipulation checks, the data was evaluated to determine if all assumptions for a MANOVA were met. According to Tabachnick and Fidell (2007), these assumptions include multivariate normality, linearity, outliers, homogeneity of variance-covariance matrices, and singularity and multicollinearity.

First, the assumption of normality was examined, and the means, standard deviations, skewness and kurtosis for each dependent variable are shown in Table 1. If the skewness value for a dependent variable was greater than 2 or less than –2, a transformation of the variable would be considered. None of the dependent variables met this criterion and thus none needed to be transformed. While there was moderate kurtosis with the Hope scale, the level of non-normality was not high enough to violate assumptions for MANOVA. As indicated by Tabachnick and Fidell (2007), the condition of multivariate normality is met if all variables are normally distributed. Based on the skewness and kurtosis conditions, the dependent variables have reasonably balanced distributions and the assumption of multivariate normality was considered to be met for the current study. When the assumption of multivariate normality is met, the assumption

for linearity is assumed because all the variables were normally distributed (Tabachnick & Fidell, 2007).

Next, the data was inspected for univariate and multivariate outliers. Univariate outliers refer to those cases with an extreme value on one variable and multivariate outliers are cases with an unusual combination of scores on two or more variables (Tabachnick & Fidell, 2007). Despite the two univariate outliers mentioned earlier, no significant univariate outliers were detected in this data set since the variables were mainly of a normal distribution. The Mahalanobis distances were utilized to check if there were any multivariate outliers (Tabachnick & Fidell, 2007, p. 74). For this study, there were eight dependent variables. According to Tabachnick and Fidell, any case with a Mahalanobis distance greater than $\chi^2(8)=26.13$, $p<.001$ is considered as a multivariate outlier. One multivariate outlier was identified, based on the Mahalanobis distance analysis. This outlier was thus removed from the MANOVA analysis.

After checking for normality, linearity and outliers, the assumption of homogeneity of variance-covariance was examined. Tabachnick and Fidell (2007) suggested that robust significance tests are expected if the data set is composed of equal sample sizes. Thus, the test of homogeneity of variance-covariance was assumed since sample sizes were not notably discrepant.

Finally, singularity and multicollinearity were evaluated for the data. Singularity happens when the variables are redundant or when one variable is a combination of two or more of the other variables (Tabachnick & Fidell, 2007). Since none of the dependent variables in this study were combinations of subscales and should be independent of each other, singularity was judged not to be a problem. Multicollinearity can be detected by

checking to see if any of the bivariate correlations between dependent variables is above .90 (Tabachnick & Fidell, 2007). The bivariate correlation matrix for all the dependent variables is presented in Table 2. Among dependent variables, correlations ranged from -.01 (CRF-E and SEQ-P) to .76 (CRF-T and CRF-E). None of the correlations were greater than .90 revealing that no variables need to be removed.

Correlations

As shown in Table 2, several scales in this study were significantly correlated. Significant correlations were found between the subscales of CRF and two SEQ subscales, as well as Hope and Universality. Specifically, CRF-Expertness correlated significantly at the .05 level with scores on SEQ-Depth (r = .54), SEQ-Smoothness (r = .35), Hope (r = .53), and Universality (r = .40). CRF-Attractiveness correlated significantly on the SEQ-Depth (r = .49), SEQ-Smoothness (r = .40), Hope (r = .39), and Universality (r = .30). Finally, there were significant correlations between CRF-Trustworthiness and SEQ-Depth (r = .54), SEQ-Smoothness (r = .31), Hope (r = .46), and Universality (r = .41). These correlations indicate that when participants perceived the therapist as more expert, attractive and trustworthy, they also viewed the therapist as conducting deeper and smoother sessions, instilling more hope for the client and providing greater universality for the client. Another significant correlation was found between Hope and Universality (r = .44). This correlation shows that the two therapeutic factors are related in which how hopeful that the client feels that her problem has been resolved has an influence on how universal that the client feels.

Primary Analyses

For the main research hypothesis of this study, it was expected that therapist self-disclosure of more resolved personal issues would be viewed more favorably than therapist self-disclosure of less resolved personal issues. To be specific, the therapist in the resolved self-disclosure condition was expected to receive more positive ratings in regard to expertness, attractiveness, and trustworthiness, and the session was expected to be evaluated as having more depth and being smoother. It also was predicted that the client would be viewed as having more hope that her problems would be resolved. Additionally, it was expected that the client would be seen as having less similarity to the therapist when the therapist made disclosures of more resolved personal issues than disclosures of unresolved personal issues.

To test these hypotheses, a one-way MANOVA was conducted on the dependent variables (i.e., CRF-Expertness, Attractiveness, Trustworthiness, Depth, Smoothness, Hope, and Universality) using the SPSS General Linear Model (GLM) analysis function. Independent variables were therapist disclosure conditions (resolved and unresolved disclosures).

With the use of Wilks' criterion and α = .05, the omnibus test of the main effect for disclosures on the dependent variables were statistically significant, Wilks' Λ = .84, F (7, 116) = 2.85, p = .009. Using guidelines suggested by Cohen (1988) (.01 = small effect, .06 = moderate effect, .14 = large effect), the results reflected a strong association between disclosure conditions and the combined dependent variables, partial $\eta^2 = 0.16$.

When looking at the between-groups effects, a Bonferroni adjustment was made for alpha by dividing the alpha value (α = .05) by the number of tests that were performed (Tabachnick & Fidell, 2007). This is equivalent to dividing alpha by the number of

dependent variables. In this study, the number of DVs is seven and the Bonferroni adjustment results in α = .007. The results revealed that three DVs reached statistical significance: CRF-Attractiveness F (1, 116) = 8.78, p < .007, partial $\eta^2 = 0.07$; CRF-Trustworthiness F (1, 116) = 8.02, p < .007, partial $\eta^2 = 0.07$; and Hope F (1, 116) = 12.89, p < .007, partial $\eta^2 = 0.10$. No significant differences were found between groups on CRF-Expertness, SEQ-Depth, SEQ-Smoothness, and Universality scores. Please refer to Table 3 for a detailed list of means and standard deviations for the respective dependent variables. Based on these results, the main effect expected for the disclosure conditions was supported for 3 of the 8 dependent variables.

Additional Analyses

Additional analyses were conducted to examine the effect of participants' previous therapy experience on their perceptions of the therapist and the session, as found in Myers and Hayes' (2006) study. Results of MANOVA indicated that there was not a significant difference between the perceptions of participants who had been in therapy before and those who had not, F (7, 116) = .90, p >.05, partial $\eta^2 = 0.06$. Similarly, multivariate analysis of variance revealed that there was not a significant interaction between therapy experience and disclosure condition, F (7, 116) = 1.12, p >.05, partial $\eta^2 = 0.07$.

Finally, while no specific hypotheses were offered with regard to the effect of participants' gender on their perceptions of the therapist and the session, in the interest of guiding future research, analyses were conducted. Overall, there were 25 men and 91 women in this sample. Tests of between groups indicated that there was a significant difference as a function of participant gender, F (7, 116) = 2.31, p < .05, partial $\eta^2 = 0.13$.

The multivariate tests revealed that male participants viewed the client as being more hopeful that her problem would be solved, F (1, 116) = 4.04, $p < .05$ (p = .04), partial $\eta^2 = 0.03$. Results of MANOVA showed that there was not a significant interaction between gender and disclosure condition, F (7, 116) = .89, $p > .05$, partial $\eta^2 = 0.05$.

Table 1. Descriptive Statistics for Dependent Variables

Descriptive Statistics					
	N	Mean	Std.	Skewness	Kurtosis
CRF_E	116	5.3161	0.81786	-0.818	0.679
CRF_A	116	4.8376	0.73981	-0.757	0.458
CRF_T	116	5.4404	0.79808	-0.297	0.051
SEQ_D	116	4.7207	0.78591	-0.446	0.601
SEQ_S	116	4.3276	0.88912	-0.244	0.232
SEQ_P	116	3.0603	0.69693	0.316	-0.164
TFI_H	116	4.9521	0.80647	-1.224	2.493
TFI_U	116	5.1312	0.59151	-0.211	0.123

Note: CRF_E = Counselor Rating Form-Expertness. CRF_A = Counselor Rating Form-Attractiveness. CRF_T = Counselor Rating Form-Trustworthiness. SEQ_D = Session Evaluation Questionnaire-Depth. SEQ_S = Session Evaluation Questionnaire-Smoothness. SEQ_P = Session Evaluation Questionnaire-Positivity. TFI_H = Hope. TFI_U = Universality.

Table 2. Bivariate Correlations among Dependent Variables

Variable	1	2	3	4	5	6	7	8
1. CRF_E	1							
2. CRF_A	0.70**	1						
3. CRF_T	0.76**	0.66**	1					
4. SEQ_D	0.54**	0.49**	0.54**	1				
5. SEQ_S	0.35**	0.40**	0.31**	0.17	1			
6. SEQ_P	-0.01	0.09	0.01	-0.04	0.14	1		
7. TFI_H	0.53**	0.39**	0.46**	0.47**	0.17	0.08	1	
8. TFI_U	0.40**	0.30**	0.41**	0.45**	0.13	-0.14	0.44**	1

Note: CRF_E = Counselor Rating Form-Expertness. CRF_A = Counselor Rating Form-Attractiveness. CRF_T = Counselor Rating Form-Trustworthiness. SEQ_D = Session Evaluation Questionnaire-Depth. SEQ_S = Session Evaluation Questionnaire-Smoothness. SEQ_P = Session Evaluation Questionnaire-Positivity. TFI_H = Hope. TFI_U = Universality.

**. Correlation is significant at the 0.01 level (2-tailed).

Table 3. Mean and Standard Deviations of Self-Disclosure on Ratings of the Therapist and the session

	Self-Disclosure					
	Resolved			Unresolved		
Dependent Variable	M	SD	n	M	SD	n
Expertness	5.51	.11	57	5.13	.10	59
Attractiveness	5.04	.10	57	4.64	.09	59
Trustworthiness	5.65	.10	57	5.24	.10	59
Depth	4.86	.10	57	4.58	.10	59
Smoothness	4.44	.12	57	4.22	.12	59
Hope	5.21	.10	57	4.70	.10	59
Universality	5.15	.08	57	5.11	.08	59

Chapter 5: Discussion

The primary purpose of this research was to examine the effects of countertransference disclosures. The disclosure conditions manipulated in this study were relatively more resolved and less resolved countertransference issues. The effects that were investigated were perceptions of the therapist and therapy process. This study was intended as an extension of the analogue study by Myers and Hayes (2006) by bringing in a new level of the independent variable (i.e., resolved countertransference disclosure) and by exploring other dependent variables including hope and universality.

Two aspects of the analysis are worth noting before proceeding further with the discussions. First, the standard deviations on all of the dependent measures were small, ranging from .59 to .89. The low standard deviations indicate that scores on all of the measures tended to be closely clustered which also occurred in Myers and Hayes' (2006) study. The restricted range of scores on dependent measures may attenuate the effects of therapist disclosure on dependent variables and may contribute to a lack of findings for some variables. Second, the internal consistency value of the SEQ-Positivity (alpha coefficient = .54) was quite low. To maximize statistical power, SEQ-Positivity scores were removed from subsequent analyses. It should be noted that the SEQ-Positivity subscale has mostly been found to have strong psychometric properties and this low reliability estimate seems idiosyncratic to the participants in this study.

Main Effects

The main hypotheses in the current study predicted that therapist self-disclosure related to resolved versus unresolved personal issues would lead to differences in the perceptions of the therapist, the session, and the client. As expected, the therapist who

made disclosures about relatively resolved countertransference issues was rated as significantly more attractive and significantly more trustworthy than was the therapist who made disclosures about more unresolved countertransference issues. In addition, when the therapist shared resolved countertransference disclosures, the client was viewed as feeling significantly more hopeful that her problems would be worked out than when the therapist shared unresolved countertransference disclosures.

The finding of this study partially confirmed expectations concerning the differential influence of therapists' sharing resolved versus unresolved countertransference issues, and indicated that therapist self-disclosure of more resolved personal issues can contribute positively to the perceptions of the therapist and therapy process. Such a finding resonates with the clinical guidelines suggested by Knox and Hill (2002), who advised therapists to self-disclose personal issues that are more resolved rather than less resolved. The recommendation to refrain from sharing unresolved personal issues appears to parallel the objections against therapist self-disclosure by several psychoanalytic theorists due to the fact that therapist disclosure of unresolved personal issues may originate from therapists' unresolved internal conflicts (Aron, 1996; Golstein, 1994; Heimann, 1950; Reich, 1960). While the design of the study did not investigate the negative effects of therapist disclosure of unresolved countertransference, results of the study suggest the potential harmful effects of therapist revelation of unresolved countertransference. Some possible negative effects of revealing unresolved personal struggles may include inducing clients to feel the need to take care of the therapist, running the danger of burdening clients and diminishing clients' trust in therapists' competence (Curtis, 1981; Simone et al., 1998). These adverse effects of

therapist self-disclosure have been supported in interviews with actual therapy clients in previous research (Audet & Everall, 2003).

Further, results of the study pointed out some possible therapeutic factors of therapist self-disclosure of resolved countertransference and these factors include promoting clients' positive perceptions of the therapist, and increasing the client's hope that problems will be resolved. These beneficial elements are consistent with previous research on the positive effects of therapist self-disclosure reported by actual therapy clients (Audet & Everall, 2003; Wells, 1994). In addition, the endorsement of these three therapeutic factors (i.e. attractiveness, trustworthiness and hope) suggests that therapist disclosure of resolved personal issues can enhance the therapeutic relationship pertaining to the positive bond between the therapist and the client such as the mutual trust, liking and hopefulness. The affective connections between the therapist and the client have been theorized to be one of the three main components in establishing the therapeutic working alliance (Bordin, 1976; Hovarth & Luborsky, 1993). Thus, therapist disclosure of resolved countertransference may strengthen the affective bond of the working alliance between the therapist and the client.

One explanation of this significant finding in support of the positive value of resolved countertransference disclosures is that therapist disclosure of more resolved personal issues illustrates that therapists have taken steps to work on their own struggles and have come to terms with their own internal conflicts. Therapists' ability to work through their intrapsychic struggles can contribute to therapists' capacity to be who one truly is in the here-and-now; that is, the genuineness of the therapist. By judiciously revealing to clients therapists' own journey of overcoming personal obstacles, therapists

not only demonstrate their empathy in understanding clients' problems but also provide modeling and hope for clients that there are resolutions to human suffering. Moreover, this disclosure can facilitate clients to experience the therapist in a "realistic" way. According to Gelso (2002), the genuineness and the realism have been theorized to be the two crucial elements of the real relationship between the therapist and the client. Following this line of thinking, therapist disclosure of resolved personal issues has the capacity to contribute to one of the crucial components of therapy relationship; that is, the real relationship. Results of this study, thus, provide initial support that the disclosure of resolved countertransference is the enactment of the concept of the wounded healer (Jackson, 2001; Miller & Baldwin, 2000).

Although the results of this study indicate that therapist self-disclosure of resolved versus unresolved personal issues brought about differential effects on the attractiveness and the trustworthiness of the therapist, and the feelings of hope in the client, the finding does not confirm the differential effects of resolved versus unresolved countertransference on the expertness of the therapist, the depth of the session, the smoothness of the session, and how the client's likely feelings of universality was perceived. The following paragraphs will discuss the findings relative to the effects of resolved versus unresolved self-disclosure on the perceptions of the counselor, session impact, hope and universality respectively.

Perceptions of the counselor

When the therapist disclosed resolved personal issues, he was found to be viewed as significantly more attractive and significantly more trustworthy than when he disclosed unresolved personal issues. No significant differences were found between disclosure

conditions with regard to the expertness of the therapist. The means that were found in the present study in the resolved disclosure condition (i.e., Expertness = 5.51; Trustworthiness = 5.65; Attractiveness = 5.04) are relatively similar to the means that were discovered in Laudeen and Schuldt (1989)'s analogue study pertaining to the condition of female raters' perceptions on therapist disclosure of physical barriers in (i.e. Expertness = 4.58; Trustworthiness = 5.28; Attractiveness = 5.32). As mentioned earlier, the significant findings regarding the beneficial effects of therapists' revealing resolved countertransference on the attractiveness and trustworthiness may have resulted from the fact that when the therapist self-discloses resolved personal issues, the therapist displays the capacity to understand clients and to heal from one's wounds. By sharing this experience with clients appropriately, the therapist can be viewed as more attractive since his or her ability to heal from personal wounds may contribute to the therapist's being perceived as more "appreciative," more "cheerful," more "compatible," and more "enthusiastic," as reflected in the items of Attractiveness subscale. Further, the therapist can also be seen as more trustworthy due to the fact that the therapist's sharing resolutions to personal struggles may make him or her appear to be more "open", more "sincere," more "respectful" and more "unbiased" than sharing unresolved struggles, as measured by the items of Trustworthiness subscale.

Therapist disclosure of resolved versus unresolved personal issues was not found to affect how expert the therapist was perceived. One possible explanation is that therapist disclosure of resolved versus unresolved personal issues may not affect the perceptions of the expertness of the therapist. This non-significant finding was conspicuously similar to the results in a previous study conducted by Lundeen and Schuldt (1989). The researchers

explored the effects of therapist self-disclosure versus non-self-disclosure on the three subscales of the CRF. The results indicated that when the therapist made a self-disclosure, the therapist was viewed as significantly more attractive and trustworthy, but not more expert. Likewise, in Myers and Hayes' (2006) study, the therapist was not viewed as more expert by participants when he made countertransference disclosures than when he either made no disclosure or when he made a general self-disclosure. These results suggest that the content of therapist disclosure (resolved versus unresolved) or whether the therapist discloses or not may not affect the perceived expertness of the therapist. Instead, therapist expertness has been established mostly through their credentials, confidence in presentations or reputations (Strong, 1968; Strong & Schmidt, 1970). For instance, in an extensive review of research, Corrigan, Dell, Lewis, and Schmidt (1980) suggested that the reputation as an expert as well as behavioral evidence such as the therapist's knowledgeable statements are the two most potent factors in contributing to the therapist's perceived expertness. In addition, it is possible that since therapist self-disclosure tends to be infrequent and minimal (Edwards & Murdock, 1994; Hill & Knox, 2002; Ramsdell & Ramsdell, 1993), sharing personal information with clients does not decrease therapist expertness.

Session Impact

Therapist self-disclosure of resolved versus unresolved personal issues was not found to differentially affect the depth and the smoothness of the session. These results may be accounted for in a number of ways. First, therapist disclosure of resolved versus unresolved countertransference may not influence the perceptions of the session depth and the session smoothness. The lack of significant differences on the SEQ-Depth and the

SEQ-Smoothness between the resolved and unresolved disclosure conditions is consistent with previous findings (Myers & Hayes, 2006). In Myers and Hayes' study, their results indicated that when the alliance was positive, and the therapist made any type of disclosure (i.e., general or countertransference), the session was not viewed as more deep or smooth than when no disclosure was made. Second, as mentioned earlier, the restricted range of ratings on how the session was perceived may have caused a lack of findings. Third, the artificiality of the analogue design may attenuate the effect of therapist self-disclosure on how the session was perceived. Specifically, asking participants rate a session after watching only a 12-minute interaction seems difficult because the 12-minute interaction may not represent the actual flow of therapy sessions and it may be difficult for the observers to generate well-formulated perceptions of the session. Since the SEQ measures are focused on the process of the session, it may be hard for participants to imagine themselves in the flow of therapy sessions.

Another possibility is related to the one-time evaluation of therapist disclosure because this evaluation may not be able to take into consideration the varied reactions that participants may have toward the disclosures. Indeed, in the current study, the ratings on the SEQ-D and SEQ-S were at an intermediate level. The results seem to indicate that participants' ratings on how the session was perceived with respect to the depth and smoothness seems to be neutral. However, participants' reactions toward each of the disclosures may have varied, with some being more positive and some being more negative. The aggregation of perceptions to the three disclosures in each vignette would not capture variations in perceptions to each of the disclosures. Fluctuations of clients' reactions toward therapist self-disclosure, indeed, have been found in a qualitative study

(Wells, 1994). In interviewing actual therapy clients about their reactions toward therapist self-disclosure, the results indicated that all clients expressed some degree of surprise, fear or disappointment about their first reactions toward therapist self-disclosure. Wells' findings also indicated that half of the clients changed their perspectives on therapist self-disclosure as the therapy progressed. Thus, the artificiality of the analogue design in the current study may not be able to capture the variations in reactions toward therapist self-disclosure and may lead to the non-significant findings on how the session was perceived.

Hope

Therapist self-disclosure of resolved personal issues was found to significantly enhance participants' perceptions that client would feel hopeful relative to therapist disclosure of unresolved personal issues. These findings support previous research in endorsing that one of the positive values of therapist self-disclosure lies in instilling hope for clients (Audet & Everall, 2003). Results from this study further indicated that compared to therapist disclosure of personal struggles that are unresolved, revelation of personal issues that are more resolved can contribute to the therapeutic factor in providing hope for clients that problems can be solved. One explanation for this significant finding is that when the therapist reveals how he has worked on the struggle quite successfully and appropriately, this revelation from the therapist not only provides modeling for clients in demonstrating that problems can be worked out but also increases clients' beliefs that ending human suffering is not an impossible task. In addition, this therapeutic factor (i.e., instillation of hope) may be more intensified because this revelation is made from a trustworthy and credible source, the therapist, rather than a

random person or a distant personal figure.

While instillation of hope has been theorized to be an effective therapeutic factor in group therapy (Yalom, 2005), this significant finding also points out that this therapeutic factor (i.e., instillation of hope) can occur in individual therapy through therapist disclosure of more resolved personal struggles. In other words, disclosure of resolved countertransference can become one of the effective interventions to instill clients' hope in individual therapy. The instillation of hope, indeed, parallels the expectancy effect or placebo effect that has been investigated extensively in empirical studies (Yalom, 2005). Based on an extensive review of the outcome research literature, Lambert and Barley (2002) estimated that expectancy effect can account for 15 % of client improvement. Thus, the findings that therapist disclosure of resolved countertransference can enhance clients' feelings of hope are very promising in providing indirect evidence that this type of disclosure may contribute to positive therapy outcome.

Universality

Therapist self-disclosure of resolved versus unresolved personal issues was not found to differentially affect client feelings of universality. Despite the aforementioned factors with respect to the low variability of scores on how universality was viewed, another explanation of this non-significant finding is that disclosures of resolved or unresolved personal issues are both similar to what the client is struggling with; in this study, that problems pertained to an alcoholic mother. Therefore, the client was viewed as being similar to the therapist in both conditions. This perspective can also be seen from participants' high ratings of universality in both disclosure conditions indicating that the client was perceived as being very similar to the therapist.

This non-significant finding reveals that therapist disclosure of resolved countertransference apparently did not decrease perceptions of the client's being similar to the therapist. In other words, the client's undue feelings of uniqueness in her struggles can be relieved through both the therapist's disclosing resolved and unresolved personal issues. This result can be illuminating given that there is the possibility that therapist disclosure of resolved personal issues has the potential of distancing the therapist from the client because the client may feel that the therapist is so perfect that he was able to resolve such difficult struggles. Thus the client may think that the therapist is vastly different from her and may increase the client's undue feelings of uniqueness. That is to say, this non-significant finding may indicate that therapist disclosure of resolved countertransference can be beneficial to clients' sense of universality. This result, indeed, is consistent with the significant relationship that was found between the two therapeutic factors (i.e., universality and instillation of hope) and again, supports the benefits of therapist disclosure of resolved countertransference.

Implications for Practice and Training

The results of this study have significant implications for the practice of psychotherapy. The findings indicate that therapist use of self-disclosure pertaining to resolved countertransference enhances attractiveness and trustworthiness, and increases clients' feelings of hope. These beneficial effects of resolved countertransference disclosures, indeed, highlight the two crucial elements to therapy effectiveness in the practice of psychotherapy: countertransference management and the notion of the wounded healer. The current results suggest that therapists can work on managing their countertransference so that they can benefit clients through judicious use of

countertransference disclosures (Gorkin, 1987). To accomplish this task, the earlier discussions on the five-factor model of countertransference management that was developed by Van Wagoner et al. (1991) can be a useful tool in serving as a conceptual map for therapists.

On the other hand, results of this study point out possible directions in underscoring the significance of the notion of the wounded healer in promoting therapists' ability to transform their woundedness into assets to help clients (Bollas, 1983; Little, 1951; Maroda, 1994). Therapist self-disclosure of resolved personal issues, however, is a complicated process and can be a painstaking task. That is to say, sharing resolved countertransference requires therapists to examine their wounds, to come to terms with their wounds, and to use discretion in sharing their intrapsychic process appropriately with different clients. The aforementioned clinical guidelines recommended by Knox and Hill (2002) on the use of therapist self-disclosure can be helpful when therapists consider revealing resolved personal issues with clients.

Further, results of this study also have significant implications for training. Despite the necessity of focusing on theories of psychotherapy and applications of therapeutic interventions, the training of therapists should also put emphasis on the use of self as a tool in therapy process and explicate the benefits of self-reflection and self-healing to therapy process (Boswell & Castonguay, 2007; Fauth, Gates, Vinca, Boles, & Hayes, 2007). Results of this study pointed out that when therapists are able to work on their wounds sufficiently and share this experience with clients appropriately, this type of disclosure can be a powerful tool in the mechanisms of change in therapy.

Limitations

It should be noted that this study has several limitations. First, the main limitation of this study is the analogue design. While the nature of the experimental design of this study permits strong internal validity, the limited external validity of this study calls into questions how these results will generalize to actual therapists and clients. Second, related to the limitations of the analogue design, getting participants' responses after watching a 12-minute video clip may oversimplify the complexity of the therapeutic process and does not capture the essence of the process to a full extent.

Third, the imbalanced sample composition with respect to ethnicity and gender raises questions about external validity. In general, the sample for this study consisted primarily of White participants. Thus, generalizing the results to people of color is questionable. Moreover, the actor and actress who were portraying the therapist and the client in the video were both White Americans. How racial factors may play a role in participants' responses to therapist self-disclosure requires further research. Another factor that may influence the external validity of the results is gender. The imbalanced gender composition of the sample limits the capacity to generalize the results. Based on the results described in the *Additional Analysis* section earlier in this paper, it is possible that gender may be related to how hope was perceived since male participants tended to view the client as feeling more hopeful that problems can be solved. More research is needed in investigating how the role of gender may influence clients' perspectives on therapist disclosures of resolved versus unresolved issues.

Finally, the on-line nature of the design may take a toll in the internal validity of the research. Specifically, there were a number of participants who logged in several times due to the traffic jam of the website. While the researcher responded immediately

when participants sent emails asking about accessing the website, how the problems of fatigue or frustration may influence participants' responses or participation is worth paying attention to. Moreover, there were a number of participants who misperceived the disclosure condition. While it is possible that the disclosure conditions may not be salient enough, it is also plausible that some participants did not pay enough attention to watch the video clip or may have been distracted by other activities while watching the video.

Future Research

In general, findings from this study suggest that the benefit of therapist disclosure of resolved countertransference is a promising research area. The findings of significant differences in the effects of two types of therapist self-disclosure point out the importance of careful differentiation in further research on the use of self-disclosure. While replication of this study with a larger sample is one of the important directions in future research, future analogue research should consider using more salient disclosure conditions between resolved versus unresolved personal issues. As mentioned earlier, there were a number of participants who misperceived the disclosure conditions. It is possible that therapist disclosure of resolved or unresolved issues in the 12-minute video clip may not be apparent enough to let participants notice the nature of the experimental intervention (i.e., self-disclosure). Future research may consider making the disclosure more salient such as using stronger languages in the wordings of disclosure. Of course, doing so runs the risk of introducing greater artificiality into the experimental design. It should be noted that finding a balance of maximizing the salience of the disclosure conditions and minimizing the overuse of self-disclosure is an important task in conducting this type of analogue research.

To improve on the drawbacks of the analogue design, future research may consider using quasi-experimental design, as in Barrett and Berman's (2001) study or using case study research, as in Rosenberger and Hayes' (2002) study. In addition, incorporating qualitative research by interviewing participants about their immediate responses of the disclosures can also be beneficial in investigating this intervention (e.g. Hayes et al., 1998).

Future research can focus on investigating how other factors such as timing of disclosures and client readiness for disclosures may play a role in making resolved countertransference disclosures. As recommended by Watkins (1990), taking into consideration potential mediating variables such as timing and client expectation in conducting research on therapist self-disclosure is important. With respect to the timing of disclosures, revealing resolved personal issues in the early phase of treatment and at the termination may bring about differential effects. In terms of client readiness, some literature suggests that the client's ego-strength can be influential in the effectiveness of the use of therapist disclosure (Wells, 1994). Future research can take into account these factors and pay attention to the interactions among these factors when conducting research in this area.

Another crucial factor that can influence the effects of resolved countertransference disclosures falls in the content of disclosures. What the therapist in this study revealed was related to the experience with alcoholic mom and relationship problems. Future research can explore how therapist disclosure of resolved countertransference will influence therapy process if the content of disclosure is related to therapists' problems with mental illnesses, trauma, or one's sex life.

Finally, future research can consider investigating the guidelines for the "appropriateness" of therapist disclosure of resolved countertransference. For instance, how much information should the therapist share with the client that can be effective? How will this type of disclosure be most and least helpful for which types of clients?

Conclusions

All in all, the main hypotheses of this study were partially supported. This research points out the differential effects of resolved versus unresolved countertransference disclosures and endorsed that therapist disclosure of more resolved personal issues was perceived more favorably than disclosure of unresolved personal issues. It is especially intriguing that the small variations in the two conditions can lead to the significant differences on observers' perceptions of the two types of disclosures. Most important of all, this research could be one step in investigating the concept of the wounded healer and gives clinicians or human beings' hope that today's wounds can become tomorrow's gold.

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Appendix A

Script: Resolved Self-disclosure

Therapist: Hello Michelle, how are you today?

Client: Well, most things in my life are O.K., but my relationship with my boyfriend could be better. I don't even know what starts the fights at times, it's so confusing.

Therapist: Really, could you say more?

Client: It's like what we've been talking about before. When we disagree about the simplest little thing, I get afraid that he will think I am crazy or something. Like who's this psycho person that I'm involved with? I'm always thinking about how he's going to get tired of me eventually.

Therapist: It sounds like these arguments with your boyfriend really trigger some of your insecurities, making you wonder if something is wrong with yourself.

Client: Yeah, you know, I've been thinking about how my father could have put up with my mother for all of these years. I mean, how hard would it have been putting up with her constant drinking and arguing. I remember, even as a small child, watching my dad pour the booze down the drain. I also remember lying in bed listening to the two of them argue and fight. Sometimes my dad would talk to me about leaving my mom, even though he never obviously never did. My mom was just so crazy.

Therapist: There's that word "crazy" again. I'm wondering if there is a connection between your fear that Mike will think that you're crazy and your experiences with your mother.

Client: (The client is silent and becomes teary)

Therapist: What's going on for you right now?

Client: I'm just don't want to be like my mother. No matter what, I want to be as different as I can be from the way that she is. Everything that she is, I just don't want to be that.

Therapist: You know Michelle, I can relate to your wish to be dissimilar to your mother. My mother is very similar to how I've heard you describe your mother. I used to try not to be like her in any important ways. After working on this issue very hard, I have become more able to focus on being who I truly am and knowing what I really want. So, I can definitely understand your struggle.

Client: Yes. I recognize how my mother is, and try to think how she would handle things. I then try to act in exactly the opposite way that I think that she would.

Therapist: (nodding) So, you think of what your mother would do, and then do the opposite. Could you give me a concrete example?

Client: Sure, for instance, my mother has always had a problem saying no to a drink. I hardly ever drink. I go to parties on the weekend, but I can count on one hand the number of times that I have taken a drink. And, I never have gotten drunk. All of my friends are getting wasted, but I stay sober. It's not that bad, most of my friends like the fact I don't drink. After all, it doesn't hurt to have a designated driver around.

Therapist: That's probably true about the designated driver thing, but in terms of how it affects you, it seems like you do everything that you can to avoid the vice that has caused so much of your mother's problems, and by extension, so many of your problems as well.

Client: She's so weak, I can't imagine letting a substance control my life in that way: making me hurt those close to me.

Therapist: Like how she hurt you.

Client: Yeah, like how she hurt me. (client holds back tears) I can never, never do that to people who I love.

Therapist: So you watch what and how often you drink. That seems like a good idea, from what you've told me, there may be an alcoholism problem that runs in your family.

Client: All of this because my mother doesn't have any self control. You know my mother really didn't have control of much.

Therapist: So, it's all the more important that you maintain control.

Client: I'm not sure I follow you.

Therapist: Well, I was thinking how you try to control your feelings by holding your emotions to yourself and not expressing them.

Client: If I let my boyfriend see how I was feeling on the inside, he'd definitely think that I've lost my mind. He'd want to have nothing to do with me, I'm sure. No sane twenty year old person cries themselves to sleep because of something that happened to them as a child!

Therapist: Really?

Client: Look, none of my friends have these types of problems. They talk to me about relationship problems with boyfriends or girlfriends, professors that can't teach, or parents that are too involved in their lives, but nothing like what I've gone through. I've hardly ever seen them shed a tear. Awhile ago my boyfriend told me that he has not cried in two years. I'm lucky if I can go two days without crying my eyes out.

Therapist: So your boyfriend and your other friends do not experience the same emotional experiences that you do. I'd imagine that must leave you feeling pretty lonely.

Client: Exactly, I feel completely isolated, like no one else can possibly understand what I'm going through. The only other person that I imagined has felt this way is my mother, and we both know that having a heart to heart with her is out of the question. (sarcasm)

Therapist: I would imagine that it is.

Client: I just feel so alone. (cries for 10-15 seconds) I feel like I'm so messed up and crazy. After all, that's why I come in to see you every week, isn't it? I mean it's not like my other friends have to come to see a shrink to work through their problems.

Therapist: Remember a little while ago when I told you that our mothers were similar in many respects?

Client: Mmhm.

Therapist: Well, the similarities between you and I seem to go even deeper. I used to have difficulty in expressing my emotions to others for quite a long time

because I had an intense fear of being hurt. After being in therapy for some time myself looking at this issue, I am more able to freely express how I feel toward other people and build more intimate relationships with others.

Client: So are you trying to say that it's kind of normal to respond to have a reaction like mine**?**

Therapist: What I'm saying is that when people, like us, grow up in very difficult life situations, they can sometimes do things that protect themselves from emotional harm while in those situations, but that the very things that protect them can later hinder them in other situations. For example, it may have served you well to put up emotional walls when your mother was yelling and screaming at you, but now these same walls are getting in the way of your relationship with Mike. You've certainly experienced things that most children never see growing up**.**

Client: So this might be what's getting in between me and my boyfriend?

Therapist: How so?

Client: We've been arguing more than usual lately. And I find that when I'm feeling lonely, I get really irritable with him, and bite his head off over almost nothing. For instance, last night I was trying to study in my apartment, and I got that lonely feeling that we're talking about. I really wanted to be near him and have him comfort me, but instead, I noticed that he was watching the TV in the other room. Even though I could barely hear the TV, I got really annoyed with him and went out into the living room and told him how inconsiderate I thought he was. We argued, he left, and then I really was alone.

Therapist: So you really wanted his support, but instead pushed him away.

Client: Yeah, ironic, huh?

Therapist: Yeah. (pause) What made you stop yourself from reaching out for support?

Client: It goes back to thinking about how he would see me if I went out to him and told him that I felt alone.

Therapist: Alone is a pretty vulnerable feeling to have.

Client: No kidding.

Therapist: You're much less vulnerable, and perhaps more in control when you are angry at him.

Client: At least when I'm mad and arguing with him, I don't have to feel like I'm losing my mind. Strangely enough, I'm less concerned with him leaving me when I'm yelling at him and telling him to leave than when I'm crying in my room feeling horrible.

Therapist: You don't have to worry about when he's going to leave you because you are, in a sense, in control of when he leaves.

Client: (softly) I guess.

Therapist: Mmhm.

Client: This is so frustrating!

Therapist: Sure. (nodding)

Client: So let me put this into perspective, I want to grow closer to my boyfriend, and I really want him to be there for me. But, I'm actually pushing him away so I don't give him the chance to leave me first?

Therapist: Something like that.
(the two laugh a little)
Therapist: I'm wondering what it would be like for you if you didn't start and argument or pull away.
Client: You mean if I told him how I was really feeling. (pause) Told him that I was scared to death that he'd leave me, and that all I really want is to have him hold me and never let go. I don't know, I don't have much practice at that.
Therapist: It sounds like it is unfamiliar territory for you.
Client: Yeah, I don't even know where to start. Its one thing to realize that some of my reactions are normal; and I'm not completely convinced of that yet, but it's another to think about letting others into this part of me.
Therapist: Mmhm, sure.
Client: What if my boyfriend or other friends just can't handle that I've been affected by my mother in this way. What if they think I'm cracked? I mean this is such heavy stuff that I can't just be walking to class with someone and say, "and oh, by the way, my mother is this big drunk who screwed up my whole childhood. Heck, I still wake up at night in a cold sweat thinking about how she treated me. So, what do you think the lecture will be about today?"
Therapist: It seems like this has been a very painful part of your life that you have shut off to others as well as to yourself. But it seems like it may be important to reconnect with that part instead of boxing it up and hiding it.
Client: Hiding it certainly hasn't been working all that well. Having anxiety attacks in the middle of the night, picking fights with my boyfriend over little stuff, and not being able to concentrate on school work hasn't exactly been fun. It just sucks that part of what makes me who I am is so ugly.
Therapist: You certainly didn't do anything to deserve the things that you've experienced.
Client: Why couldn't I have had a happier life, you know one that I could share with anyone, not just with a therapist. I'm not looking for a Brady Bunch experience or anything like that, but it would have been nice to not have my mom keep me up most of the night drunk and screaming about something stupid.
Therapist: Yeah, I think you're right
Client: What's more, I can't even have a normal relationship because of this crap: I push away a totally great guy who most women would love to date, and keep all of my friends at arms length too, just so they don't know the soft side of me.
Therapist: The side that can get hurt.
Client: Uh ha, the soft side, the part that I would like to get rid of more than anything else.
Therapist: What's it like sharing that side of yourself with me in here.
Client: I can tell you, it's not fun. I mean, I know this is your job and everything, but I do wonder if you get sick of hearing the same old stuff week after week. Some times I expect you to tell me to leave and not come back next week.
Therapist: So you're concerned that I would get sick of you. Would you like to know what my take on all of this is.
Client: Sure.
Therapist: In hearing you talk about how difficult growing up was for you, I'm

reminded of my own experience, and how for a long time I shut myself and others off from that vulnerable part of me. I couldn't bring myself to risk being hurt like I was as a child. (pause) It was such a lonely place. Having worked on the pain for a long time, I now am more able to share my soft side with people. Even though the pain cannot be totally taken away, the awareness helps me to make some changes in myself and build more intimate relationships with other people.

Client: It is lonely, that's for sure.

Therapist: Mmhm, it is.

Client: All of this is so new; starting to understand the baggage that I'm carrying around from childhood, along with how that stuff is preventing me from having a happy relationship with my boyfriend----its just all so new.

Therapist: It can be very difficult and even unsettling to look at some of these issues for the first time, can't it?

Client: You can say that again.

Appendix B

Script-Unresolved Self-disclosure

Therapist: Hello Michelle, how are you today?

Client: Well, most things in my life are O.K., but my relationship with my boyfriend could be better. I don't even know what starts the fights at times, it's so confusing.

Therapist: Really, could you say more?

Client: It's like what we've been talking about before. When we disagree about the simplest little thing, I get afraid that he will think I am crazy or something. Like who's this psycho person that I'm involved with? I'm always thinking about how he's going to get tired of me eventually.

Therapist: It sounds like these arguments with your boyfriend really trigger some of your insecurities, making you wonder if something is wrong with yourself.

Client: Yeah, you know, I've been thinking about how my father could have put up with my mother for all of these years. I mean, how hard would it have been putting up with her constant drinking and arguing. I remember, even as a small child, watching my dad pour the booze down the drain. I also remember lying in bed listening to the two of them argue and fight. Sometimes my dad would talk to me about leaving my mom, even though he never obviously never did. My mom was just so crazy.

Therapist: There's that word "crazy" again. I'm wondering if there is a connection between your fear that Mike will think that you're crazy and your experiences with your mother.

Client: (The client is silent and becomes teary)

Therapist: What's going on for you right now?

Client: I'm just don't want to be like my mother. No matter what, I want to be as different as I can be from the way that she is. Everything that she is, I just don't want to be that.

Therapist: You know Michelle, I can relate to your wish to be dissimilar to your mother. Something that I haven't told you is that my mother is very similar to how I've heard you describe your mother. And, I can tell you that even today, I struggle with trying to make sure that I am not like her in any important ways. So you see I can understand your struggle.

Client: Yes. I recognize how my mother is, and try to think how she would handle things. I then try to act in exactly the opposite way that I think that she would.

Therapist: (nodding) So, you think of what your mother would do, and then do the opposite. Could you give me a concrete example?

Client: Sure, for instance, my mother has always had a problem saying no to a drink. I hardly ever drink. I go to parties on the weekend, but I can count on one hand the number of times that I have taken a drink. And, I never have gotten drunk. All of my friends are getting wasted, but I stay sober. It's not that bad, most of my friends like the fact I don't drink. After all, it doesn't hurt to have a designated driver around.

Therapist: That's probably true about the designated driver thing, but in terms of how it

affects you, it seems like you do everything that you can to avoid the vice that has caused so much of your mother's problems, and by extension, so many of your problems as well.

Client: She's so weak, I can't imagine letting a substance control my life in that way: making me hurt those close to me.

Therapist: Like how she hurt you.

Client: Yeah, like how she hurt me. (client holds back tears) I can never, never do that to people who I love.

Therapist: So you watch what and how often you drink. That seems like a good idea, from what you've told me, there may be an alcoholism problem that runs in your family.

Client: All of this because my mother doesn't have any self control. You know my mother really didn't have control of much.

Therapist: So, it's all the more important that you maintain control.

Client: I'm not sure I follow you.

Therapist: Well, I was thinking how you try to control your feelings by holding your emotions to yourself and not expressing them.

Client: If I let my boyfriend see how I was feeling on the inside, he'd definitely think that I've lost my mind. He'd want to have nothing to do with me, I'm sure. No sane twenty year old person cries themselves to sleep because of something that happened to them as a child!

Therapist: Really?

Client: Look, none of my friends have these types of problems. They talk to me about relationship problems with boyfriends or girlfriends, professors that can't teach, or parents that are too involved in their lives, but nothing like what I've gone through. I've hardly ever seen them shed a tear. Awhile ago my boyfriend told me that he has not cried in two years. I'm lucky if I can go two days without crying my eyes out.

Therapist: So your boyfriend and your other friends do not experience the same emotional experiences that you do. I'd imagine that must leave you feeling pretty lonely.

Client: Exactly, I feel completely isolated, like no one else can possibly understand what I'm going through. The only other person that I imagined has felt this way is my mother, and we both know that having a heart to heart with her is out of the question. (sarcasm)

Therapist: I would imagine that it is.

Client: I just feel so alone. (cries for 10-15 seconds) I feel like I'm so messed up and crazy. After all, that's why I come in to see you every week, isn't it? I mean it's not like my other friends have to come to see a shrink to work through their problems.

Therapist: Remember a little while ago when I told you that our mothers were similar in many respects?

Client: Mmhm.

Therapist: Well, the similarities between you and I seem to go even deeper: Even today, I have difficulty in expressing my emotions to others because I have an intense fear of being hurt. I've been in therapy for some time

myself working on this, but my work is far from over.

Client: So are you trying to say that it's kind of normal to respond to have a reaction like mine?

Therapist: What I'm saying is that when people, like us, grow up in very difficult life situations, they can sometimes do things that protect themselves from emotional harm while in those situations, but that the very things that protect them can later hinder them in other situations. For example, it may have served you well to put up emotional walls when your mother was yelling and screaming at you, but now these same walls are getting in the way of your relationship with Mike. You've certainly experienced things that most children never see growing up.

Client: So this might be what's getting in between me and my boyfriend?

Therapist: How so?

Client: We've been arguing more than usual lately. And I find that when I'm feeling lonely, I get really irritable with him, and bite his head off over almost nothing. For instance, last night I was trying to study in my apartment, and I got that lonely feeling that we're talking about. I really wanted to be near him and have him comfort me, but instead, I noticed that he was watching the TV in the other room. Even though I could barely hear the TV, I got really annoyed with him and went out into the living room and told him how inconsiderate I thought he was. We argued, he left, and then I really was alone.

Therapist: So you really wanted his support, but instead pushed him away.

Client: Yeah, ironic, huh?

Therapist: Yeah. (pause) What made you stop yourself from reaching out for support?

Client: It goes back to thinking about how he would see me if I went out to him and told him that I felt alone.

Therapist: Alone is a pretty vulnerable feeling to have.

Client: No kidding.

Therapist: You're much less vulnerable, and perhaps more in control when you are angry at him.

Client: At least when I'm mad and arguing with him, I don't have to feel like I'm losing my mind. Strangely enough, I'm less concerned with him leaving me when I'm yelling at him and telling him to leave than when I'm crying in my room feeling horrible.

Therapist: You don't have to worry about when he's going to leave you because you are, in a sense, in control of when he leaves.

Client: (softly) I guess.

Therapist: Mmhm.

Client: This is so frustrating!

Therapist: Sure. (nodding)

Client: So let me put this into perspective, I want to grow closer to my boyfriend, and I really want him to be there for me. But, I'm actually pushing him away so I don't give him the chance to leave me first?

Therapist: Something like that.

(the two laugh a little)

Therapist: I'm wondering what it would be like for you if you didn't start and argument

or pull away.

Client: You mean if I told him how I was really feeling. (pause) Told him that I was scared to death that he'd leave me, and that all I really want is to have him hold me and never let go. I don't know, I don't have much practice at that.

Therapist: It sounds like it is unfamiliar territory for you.

Client: Yeah, I don't even know where to start. Its one thing to realize that some of my reactions are normal; and I'm not completely convinced of that yet, but it's another to think about letting others into this part of me.

Therapist: Mmhm, sure.

Client: What if my boyfriend or other friends just can't handle that I've been affected by my mother in this way. What if they think I'm cracked? I mean this is such heavy stuff that I can't just be walking to class with someone and say, "and oh, by the way, my mother is this big drunk who screwed up my whole childhood. Heck, I still wake up at night in a cold sweat thinking about how she treated me. So, what do you think the lecture will be about today?"

Therapist: It seems like this has been a very painful part of your life that you have shut off to others as well as to yourself. But it seems like it may be important to reconnect with that part instead of boxing it up and hiding it.

Client: Hiding it certainly hasn't been working all that well. Having anxiety attacks in the middle of the night, picking fights with my boyfriend over little stuff, and not being able to concentrate on school work hasn't exactly been fun. It just sucks that part of what makes me who I am is so ugly.

Therapist: You certainly didn't do anything to deserve the things that you've experienced.

Client: Why couldn't I have had a happier life, you know one that I could share with anyone, not just with a therapist. I'm not looking for a Brady Bunch experience or anything like that, but it would have been nice to not have my mom keep me up most of the night drunk and screaming about something stupid.

Therapist: Yeah, I think you're right

Client: What's more, I can't even have a normal relationship because of this crap: I push away a totally great guy who most women would love to date, and keep all of my friends at arms length too, just so they don't know the soft side of me.

Therapist: The side that can get hurt.

Client: Uh ha, the soft side, the part that I would like to get rid of more than anything else.

Therapist: What's it like sharing that side of yourself with me in here.

Client: I can tell you, it's not fun. I mean, I know this is your job and everything, but I do wonder if you get sick of hearing the same old stuff week after week. Some times I expect you to tell me to leave and not come back next week.

Therapist: So you're concerned that I would get sick of you. Would you like to know what my take on all of this is.

Client: Sure.

Therapist: In hearing you talk about how difficult growing up was for you, I'm reminded of my own experience, and how for a long time I shut myself and others off from that vulnerable part of me. I couldn't bring myself to risk being hurt like I was as a child. (pause) To be honest, I still struggle

with this, and don't let many people close enough to me to really know me. It is a lonely place at times.

Client: It is lonely, that's for sure.

Therapist: Mmhm, it is.

Client: All of this is so new; starting to understand the baggage that I'm carrying around from childhood, along with how that stuff is preventing me from having a happy relationship with my boyfriend----its just all so new.

Therapist: It can be very difficult and even unsettling to look at some of these issues for the first time, can't it?

Client: You can say that again.

Appendix C

Self-disclosure Manipulation Check

1. Did the therapist make any statements revealing personal information about himself during the session?

   Yes (Please go on to question #2)

   No (Do not answer question #2)

2. Was the information that the therapist revealed based on personal difficulties with which he still struggles?

   Yes

   No

Appendix D

Demographic Form

Age:

Sex:

Ethnicity:

Major:

Year in College:

Appendix E
CRF

Please circle the appropriate number to show how you viewed the therapist who you viewed and read about.

unalert	1	2	3	4	5	6	7	alert
diffuse	1	2	3	4	5	6	7	analytic
vague	1	2	3	4	5	6	7	clear
unsure	1	2	3	4	5	6	7	confident
inexperienced	1	2	3	4	5	6	7	experienced
inexpert	1	2	3	4	5	6	7	expert
ignorant	1	2	3	4	5	6	7	informed
insightless	1	2	3	4	5	6	7	insightful
stupid	1	2	3	4	5	6	7	intelligent
illogical	1	2	3	4	5	6	7	logical
unprepared	1	2	3	4	5	6	7	prepared
unskillful	1	2	3	4	5	6	7	skillful
disagreeable	1	2	3	4	5	6	7	agreeable
unappreciative	1	2	3	4	5	6	7	appreciative
unattractive	1	2	3	4	5	6	7	attractive
formal	1	2	3	4	5	6	7	casual
depressed	1	2	3	4	5	6	7	cheerful
distant	1	2	3	4	5	6	7	close
incompatible	1	2	3	4	5	6	7	compatible
indifferent	1	2	3	4	5	6	7	enthusiastic
unfriendly	1	2	3	4	5	6	7	friendly
unlikable	1	2	3	4	5	6	7	likeable
unsociable	1	2	3	4	5	6	7	sociable
cold	1	2	3	4	5	6	7	warm
revealing	1	2	3	4	5	6	7	confidential
undependable	1	2	3	4	5	6	7	dependable
dishonest	1	2	3	4	5	6	7	honest

closed	1	2	3	4	5	6	7	open
unreliable	1	2	3	4	5	6	7	reliable
disrespectful	1	2	3	4	5	6	7	respectful
irresponsible	1	2	3	4	5	6	7	responsible
selfish	1	2	3	4	5	6	7	selfless
insincere	1	2	3	4	5	6	7	sincere
deceitful	1	2	3	4	5	6	7	straightforward
untrustworthy	1	2	3	4	5	6	7	trustworthy
biased	1	2	3	4	5	6	7	unbiased

Appendix F
SEQ

Please circle the appropriate number to show how you feel about the session that you viewed.

This session was:								
bad	1	2	3	4	5	6	7	good
safe	1	2	3	4	5	6	7	dangerous
difficult	1	2	3	4	5	6	7	easy
valuable	1	2	3	4	5	6	7	worthless
shallow	1	2	3	4	5	6	7	deep
relaxed	1	2	3	4	5	6	7	tense
unpleasant	1	2	3	4	5	6	7	pleasant
full	1	2	3	4	5	6	7	empty
weak	1	2	3	4	5	6	7	powerful
special	1	2	3	4	5	6	7	ordinary
rough	1	2	3	4	5	6	7	smooth
comfortable	1	2	3	4	5	6	7	uncomfortable
Right now I feel:								
happy	1	2	3	4	5	6	7	sad
angry	1	2	3	4	5	6	7	pleased
moving	1	2	3	4	5	6	7	still
uncertain	1	2	3	4	5	6	7	definite
calm	1	2	3	4	5	6	7	excited
confident	1	2	3	4	5	6	7	afraid
wakeful	1	2	3	4	5	6	7	sleepy
friendly	1	2	3	4	5	6	7	unfriendly
slow	1	2	3	4	5	6	7	fast
energetic	1	2	3	4	5	6	7	peaceful
involved	1	2	3	4	5	6	7	detached
quiet	1	2	3	4	5	6	7	aroused
Today I feel the therapist was:								
skillful	1	2	3	4	5	6	7	unskillful
cold	1	2	3	4	5	6	7	warm

trustworthy	1	2	3	4	5	6	7	untrustworthy

Appendix G

The Therapeutic Factors Inventory

Instillation of Hope

1. After counseling, the client will feel more positive about the future. 1 2 3 4 5 6 7
2. After counseling, the client will feel less despair about the future. 1 2 3 4 5 6 7
3. As a result of counseling, the client will feel less anxious about her future. 1 2 3 4 5 6 7
4. After counseling, the client will be inspired about the future. 1 2 3 4 5 6 7
5. Hearing about change in the therapist will give the client hope for herself. 1 2 3 4 5 6 7
6. As a result of counseling, the client will believe she can make changes in her life, just as the therapist has. 1 2 3 4 5 6 7
7. As a result of counseling, the client will feel much better about being able to solve her problems. 1 2 3 4 5 6 7
8. As a result of counseling, things will seem more hopeful for the client. 1 2 3 4 5 6 7
9. After counseling, the client will not think therapy helps her feel any better about the future. 1 2 3 4 5 6 7

Appendix H

The Therapeutic Factors Inventory

Universality

1. As a result of counseling, the client will learn that she has more similarities with others than she would have guessed. 1 2 3 4 5 6 7
2. After counseling, the client will recognize how much she has in common with other people. 1 2 3 4 5 6 7
3. As a result of counseling, the client will see that others have problems like hers. 1 2 3 4 5 6 7
4. The therapist and the client have little in common. 1 2 3 4 5 6 7
5. As a result of therapy, the client will have a sense that she shares similar feelings with others. 1 2 3 4 5 6 7
6. After counseling, the client will feel really different in her reactions and feelings than the therapist. 1 2 3 4 5 6 7
7. The client has nothing whatsoever in common with the therapist. 1 2 3 4 5 6 7
8. Because the client has got a lot in common with the therapist, the client will start to think that she may have something in common with people outside therapy too. 1 2 3 4 5 6 7
9. In therapy, the therapist and the client are more alike than different from each other. 1 2 3 4 5 6 7

Appendix I

Implied Informed Consent Form for Social Science Research

The Pennsylvania State University

Title of Project: Perceptions of Psychotherapy

Principal Investigator: Yun-Jy Yeh, Doctoral Student
520 Toftrees Ave. Apt. 234
University Park, PA 16803
(804) 300-0396; yuy114@psu.edu

Advisor: Dr. Jeffrey Hayes
307 Cedar Building,
University Park, PA 16802
(814) 863-3799; jxh34@psu.edu

1. **Purpose of the Study:** The main purpose of this study is to explore the perceptions of counseling.

2. **Procedures to be followed:** You will be asked to view a 12-minutes on-line video clip and will be asked to answer an on-line survey. The on-line survey includes questions about some demographics and your thoughts and attitudes about the video clip.

3. **Duration/Time:** It will take about 20-25 minutes to complete the survey.

4. **Statement of Confidentiality:** You will be asked to provide your name and student ID for extra credit. However, no personal identities will be linked with your survey responses. The data will be kept in the principal investigator's personal computer at home. Your confidentiality will be kept to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet by any third parties.

5. **Right to Ask Questions:** Please contact Yun-Jy Yeh at (804) 300-0396 or yuy114@psu.edu with questions or concerns about this study. Her advisor is Dr. Jeffrey Hayes and can be reached at (814) 863-3799 or jxh34@psu.edu

6. **Payment for participation:** You will receive _____ extra credit points. Once you have completed the survey, you will be directed to another website to provide your name and student ID. However, there is not linkage between your name/student ID and your responses to this study. Your name and student ID will be provided to your instructor indicating that you have participated in this study for extra course credit. There is another option to participating to receive the extra credit. This option may involve _____ that takes no more than 30 minutes.

7. **Voluntary Participation:** Your participation is strictly voluntary. You can withdraw from the study at any time. If you decide to withdraw, do not submit your answers.

You must be 18 years of age or older to participate in this research study.

Completion and return of the survey implies that you have read and understand the above statements the information in this form and consent to take part in the research. Please keep this form for your records or future reference.

If you have read and understand the above statements, please click on the “Continue” button below to indicate your consent to participate in this study.

CONTINUE

Vita: Yun-Jy Yeh

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EDUCATION

The Pennsylvania State University, University Park, PA Dec 2009
Ph.D. Candidate in Counseling Psychology
Minor: Educational Psychology (Focus Area: Measurement/Statistics)
The University of Texas at Austin, TX Dec 2002
M.Ed. in Educational Psychology with a focus on Counselor Education
National Sun Yat-sen University, Taiwan Jun 1999
B.A. in Foreign Languages and Literature

COUNSELING EMPLOYMENT

Staff Psychologist August 2009-present
Counseling Services, The State University of New York at Buffalo
Associate Clinical Staff October 2008-May 2009
Counseling and Psychological Services, Pennsylvania State University
Pre-doctoral Psychology Intern Aug 2007-Aug 2008
University Counseling Services, Virginia Commonwealth University

TEACHING EXPERIENCE

Teaching Assistant, Foundations of Guidance and Counseling Processes
The Pennsylvania State University Jan 2006–May 2006
Teaching Assistant, Individual Counseling Procedures
The Pennsylvania State University Sep 2005–Dec 2005

PUBLICATIONS/PRESENTATIONS

- Hayes, J. A., **Yeh, Y.**, & Zentz, A. (2007). Good grief and not-so-good grief: countertransference in bereavement therapy, Journal of Clinical Psychology, 63, 345-355.
- **Yeh, Y.**, & Hayes, J. A. (2007, August). Operationalizing Countertransference as Deviation from Baseline: A Case Study. Poster presented at the American Psychological Association Annual Convention: San Francisco, CA.
- **Yeh, Y.**, Hayes, J. A., & Zentz, A. (2004, November). Good Grief: An Empirical Investigation of the Wounded Healer Concept among Bereavement Counselors. Poster presented at the North American Chapter Society for Psychotherapy Research Conference, Springdale, Utah.

RESEARCH AWARDS

- **APA Student Travel Award** – American Psychological Association 2007
- **Enrico E. Jones Memorial Award** –North American Chapter Society for Psychotherapy Research Conference 2006.