Psychotherapy: Theory, Research, Practice, Training
2006, Vol. 43, No. 2, 173–185

0033-3204/06/$12.00 DOI: 10.1037/0033-3204.43.2.173

EFFECTS OF THERAPIST GENERAL SELF-DISCLOSURE AND COUNTERTRANSFERENCE DISCLOSURE ON RATINGS OF THE THERAPIST AND SESSION

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Therapist decisions about self-disclosure depend theoretically upon both content and context, such as the quality of the therapeutic relationship. In this analogue study, 224 undergraduates viewed 1 of 3 videos for which the working alliance was described as positive or negative and in which a therapist made general self-disclosures, countertransference disclosures, or no disclosures. Interaction effects indicated that participants rated sessions as deeper and the therapist as more expert when the therapist made general disclosures compared to no disclosures, but only when the alliance was positive. When the alliance was negative, participants perceived sessions as shallower and the therapist as less expert when the therapist made either general or countertransference disclosures compared to no disclosures.

Keywords: countertransference, self-disclosure, working alliance

Self-disclosure and countertransference are widely recognized to be important to the process of psychotherapy, although rarely are they considered together. Over the years, there has been considerable debate about the meaning and clinical utility of both of these constructs, with the general consensus being that judicious use of each can be of therapeutic value (Hayes & Gelso, 2001; Hill & Knox, 2002). However, although therapist disclosures of relatively superficial similarities between the therapist and the client seem to be helpful (Lundeen & Schuldt, 1989), little is known empirically about the effects of therapists' disclosures of countertransference material. In other words, what are the implications associated with therapists disclosing issues related to their own unresolved intrapsychic conflicts that parallel those of their clients? It may be that the ways in which both countertransference disclosures and general, anecdotal, empathic disclosures (hereafter referred to as "general" disclosures) affect psychotherapy depend upon contextual factors such as the quality of the relationship at the time a disclosure is made. The present study sought to examine the effects of therapists' general self-disclosures and disclosures of countertransference on perceptions of the therapist and the session under varying conditions of the working alliance. Additionally, an exploratory analysis was completed examining the effect that participants' previous therapy experience had on their perceptions of the therapist and session.

Before proceeding further, a word is in order about how countertransference is conceptualized for the purposes this study. Definitions range from Freud's (1910/1959) classical view of countertransference as the therapist's unconscious, defensive response to the client's transference to the totalistic notion that countertransference includes all of the therapist's reactions to the client (e.g., Little, 1951). Consistent with a more moderate perspective, we conceive of countertransference as therapists' internal and overt reactions to clients that are rooted in therapists' unresolved intrapsychic conflicts (Gelso & Carter, 1985; Gelso & Hayes, 1998). This definition retains Freud's focus on the therapist's unresolved issues as the source of countertransference while not limiting the phenomenon to unconscious reactions to transference. This synthesis of the classical and

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totalistic definitions has come to be known as the integrative view of countertransference, and it has been used as the basis for most countertransference research (Hayes & Gelso, 2001).

One extension of the definitional debate surrounding countertransference is the multiplicity of views about its clinical vices and virtues. For instance, in classic psychoanalysis, countertransference was to be recognized and overcome because it interfered with the therapist's neutrality and ambiguity (Freud, 1910/1959). However, proponents of the totalistic definition argue that countertransference is unavoidable and may be a source of valuable insights in therapy (Aron, 1991; Hoyt, 2001; Jacobs, 1999; Strean, 1999). In essence, what was once considered an obstacle to successful analysis is now recognized by therapists of varying theoretical persuasions to be an inherent part of the work, and a potentially beneficial one at that, if understood and successfully managed.

Understanding the role of countertransference in therapy is not unlike considering the utility of therapist self-disclosure. Consistent with previous research, we defined self-disclosure as statements that the therapist makes that reveal something personal about the therapist (Hill & Knox, 2002). Of course, from a broader vantage point, it could be argued that therapist self-disclosure is unavoidable. Aspects of the therapist may be revealed through decorations in one's office, the holidays one observes, and one's dress (Wilkinson & Gabbard, 1993). However, when disclosure is viewed more narrowly, it is evident that therapists face constant choices about whether and what to reveal to clients verbally (e.g., affective reactions to clients, observations about the course of therapy, reasons for needing to reschedule an appointment).

Therapists' decisions about self-disclosure ideally are grounded in an underlying rationale. For example, Anderson and Mandell (1989) and Mahalik, Van Ormer, and Simi (2000) proposed guidelines for therapists to consider before disclosing. First, disclosures should be made with the goal of enhancing or preserving the therapeutic relationship. Second, therapists should exercise caution to make sure that their personal needs do not take precedence over those of the client. Finally, disclosures should be tied to the client's issues to ensure that the primary focus remains on the client. Research suggests that common therapist intentions for self-disclosure include modeling, building rapport, validating the client's sense of reality, increasing client self-disclosure, demystifying the therapeutic process, and promoting a sense of solidarity with the client by sharing power (Counselman, 1997; Curtis, 1981; Mahalik et al., 2000; Simon, 1988).

Beyond general guidelines and intentions, the functions and effects of self-disclosure are conceptualized differently in various approaches to therapy. For instance, in classic psychoanalysis, self-disclosure is viewed as a mistake typical of the novice therapist in an attempt to help clients overcome resistance (Freud, 1910/1959). Freud considered personal revelations to be inappropriate because they contradicted the principle that a therapist should act as an impenetrable mirror to clients, reflecting only what is revealed by the client. Jacobs (1997) noted that Freud's stance was likely influenced by the improper disclosures by some pioneering analysts who shared their erotic attraction and love for patients, occasionally resulting in sexually intimate relationships. Toward the other end of the continuum, Rogers (1961) believed that therapist self-disclosure was an essential part of the therapeutic relationship, which allowed for the therapist's expression of feelings to clients, without maintaining a façade. Other humanistic theorists advocate mutual self-disclosure in therapy as a means of facilitating spontaneous human relating (Curtis, 1981; Jourard, 1971). Similarly, feminist theory encourages therapists to use self-disclosure to help clients make informed decisions about choosing a therapist and to offset the power differential between client and therapist (Enns, 1997).

As might be expected, research has demonstrated a link between therapist self-disclosure and theoretical orientation, with psychoanalytic therapists exhibiting significantly less self-disclosure than humanistic therapists (Anderson & Mandell, 1989; Edwards & Murdock, 1994; Simon, 1988). Interestingly, Simon found that eclectic, behavioral, and humanistic therapists engaged in similar amounts of self-disclosure. Another point worth noting is that the studies cited above categorized therapists' theoretical orientations broadly and did not consider the variety of positions within these larger orientations. Specifically, within the psychoanalytic camp, there are varying perspectives on therapist self-disclosure. Contemporary analytic theory permits, and at times even encourages, relatively liberal sharing on the part of the therapist, creating a stark contrast to more traditional views espoused in early Freudian circles (Broucek &

Ricci, 1998; Jacobs, 1999; Wilkinson & Gabbard, 1993).

Self-disclosure may be considered akin to the use of touch in therapy: A double-edged sword that can be either of great benefit or damage depending upon its use. The foremost contraindication to self-disclosure by therapists is the possibility of role reversal, where the treatment focus shifts from the client to the therapist (Matthews, 1988; Widmer, 1995). Therapists also may self-disclose in an attempt to seek validation and approval from the client, which may undermine the therapy relationship (Wells, 1994). On the whole, however, research suggests that therapist disclosure tends to have favorable effects. For example, Lundeen and Schuldt (1989) showed students videotapes of simulated therapeutic encounters in which the therapist either made 3 self-disclosures or no disclosures. Participants rated the therapist as more attractive and more trustworthy in the disclosure condition than in the nondisclosure condition. Perceptions of therapist expertness were similar across the 2 conditions. These data are consistent with results of an experimental analogue conducted by Nilsson, Strassberg, and Bannon (1979) that examined the effects of 3 types of therapist disclosures: Interpersonal disclosure (i.e., reaction to client), intrapersonal disclosure (i.e., personal experience outside of therapy), and no disclosure. In both disclosure conditions, the therapist was better liked and was perceived as warmer, more sensitive, and more honest than in the nondisclosure condition. Ratings were especially favorable when the therapist made intrapersonal disclosures.

However, a qualitative study conducted by Wells (1994) revealed that 7 out of 8 clients had a negative first reaction to self-revealing statements made by their therapists. The disclosures tended to contain intimate details about the therapists' lives that related to concerns presented by their clients (e.g., therapists sharing their own struggles with substance abuse, romantic relationships, and familial conflict). Clients' initial reactions included feeling "stunned," "offended," "scared," and "pissed off." Reactions to subsequent therapist disclosures depended upon the quality of the therapeutic relationship; relationship quality was directly associated with how favorably disclosures were perceived. This finding parallels qualitative data from another study that found that perceptions of therapist disclosures were linked with quality of the therapy relationship, normalization of client concerns, and client insight (Knox, Hess, Petersen, & Hill, 1997). Further underscoring the potential value of therapist self-disclosure, Hill et al. (1988) found that clients rated therapist self-disclosure as the most helpful response mode used by therapists. Similarly, a field experiment by Barrett and Berman (2001) found that greater therapist self-disclosure was directly associated with clients' reports of liking their therapists and with symptom reduction.

In summary, then, clients seem to like and benefit from therapist disclosures, but perhaps not if the therapy relationship is insufficiently developed or otherwise weak. Findings from Nilsson et al. (1979) suggest that clients especially prefer disclosures that reveal something personal about the therapist, but it is unclear what type of personal information about the therapist might generate negative reactions in clients. For instance, what would be the effects of a therapist's disclosure of countertransference material? It is possible that the effects of such a disclosure are dependent on the quality of the therapy relationship. For example, it could be that if countertransference revelations are made when the alliance is weak, such disclosures will not be helpful, and may even be harmful, given the potential to divert undue attention to the therapist or raise questions in the client's mind about how such a disclosure fits with the goals of therapy. On the other hand, it is possible that therapist self-disclosure and discussion of countertransference could help repair a poor or ruptured alliance (Safran & Muran, 1996). By sharing countertransference reactions with a client, the therapist may be able to provide a sense of universality to the client and model vulnerability and authenticity in a therapeutically beneficial way.

However, even among those who believe that countertransference can be of therapeutic value, there is little consensus about whether therapists should share with their clients that such reactions have occurred (assuming, of course, that the therapist is aware that a reaction was countertransference based). Some writers advocate the judicious use of countertransference disclosures when such revelations might confirm a client's sense of reality, intentionally offset the power imbalance in therapy, foster an authentic therapy relationship, and decrease the client's sense of isolation (Brown, 2001; Gorkin, 1987; Hayes & Gelso, 2001). Echoing these points is a concerted movement in contemporary analytic thought that advocates for selective self-disclosure by thera-

pists to decrease asymmetry in the therapeutic relationship as a means to make the analytic process more collaborative (Broucek & Ricci, 1998). Renik (1995a) asserts that the traditional notion of analytic anonymity is neither possible nor constructive, and that at times, a therapist's choice to not disclose constrains a dialectical interchange between the client and therapist. Little (1951) takes the extreme perspective of suggesting that if the therapist has exhibited any countertransference behavior, the client should always be made aware of the origins of such behavior.

Interestingly, Ellis (2001) also has advocated discussing countertransference with clients. Ellis described countertransference as a manifestation of therapists' disturbed feelings that may overlap with client issues. He wrote, "It [countertransference] can hardly be completely avoided and may deflect from therapy's effectiveness if it is obsessively cultivated or neglectfully minimized" (p. 1001). Ellis suggested that both the client and therapist could benefit from talking about countertransference when it arises, providing an opportunity for rapport building and mutual learning of how to cope with common problems. In a similar, though not necessarily identical vein, Hoffman-Graff (1977) found that therapists who made self-disclosures about their personal shortcomings and vulnerabilities were described by clients as more empathic, warm, and credible than therapists who made personal disclosures about their skills and professional experiences.

Hypotheses

This study was designed to examine how perceptions of the therapist and the session are affected by general therapist self-disclosures and countertransference disclosures, especially in comparison to when therapists make no disclosures. Furthermore, the contextual role of the working alliance in affecting these perceptions was investigated. Finally, beyond our primary hypotheses in an exploratory analysis, we considered the potential effect of participants' previous therapy experience on their perceptions of the therapist and session.

More specifically, we expected to find an interaction effect such that when the working alliance was depicted as strong, general disclosures would produce more favorable ratings of the therapist and session than when no therapist disclosure was made (Barrett & Berman, 2001; Knox et al., 1997; Lundeen & Schuldt, 1989; Nilsson et al., 1979). However, when the alliance was depicted as weak, we predicted that general disclosures would cause lower ratings of the therapist and session than when the therapist did not disclose (Wells, 1994). In a similar manner, we hypothesized that self-disclosures related to countertransference would produce more favorable ratings of the therapist and session than when the therapist made no disclosure (Hoffman-Graff, 1977; Nilsson et al.1979), but only when the alliance was strong. When the alliance was portrayed as weak, we tested competing hypotheses regarding the effects of countertransference disclosures. One possibility is that countertransference disclosures will have positive effects because they may help repair a weak alliance. Thus, it is possible that countertransference disclosures will not interact with the working alliance and will be rated more favorably than the no disclosure condition when the alliance is both strong and weak. Alternatively, it is possible that countertransference disclosures will interact with the alliance similarly to our expectations for general disclosures, such that they will be rated more favorably than the no disclosure condition when the alliance is strong and less favorably than the no disclosure condition when the alliance is weak.

Method

Participants

An a priori power analysis was conducted, and it was determined that 216 participants (36 in each of 6 cells—3 disclosure conditions $\times$ 2 alliance conditions) were needed to detect small to moderate effects with a power of .80 and $\alpha = .05$ (Faul & Erdfelder, 1992). A total of 236 undergraduate students at a large, mid-Atlantic university participated in the study, 224 of whom provided usable data. Of these 224 participants, 74 (33%) were men and 150 (67%) were women. With respect to ethnicity, 200 participants (90%) identified themselves as European American, 8 (4%) as African American, 5 (2%) as Hispanic, 4 (2%) as Asian, 3 (1%) as belonging to another ethnic group, and 4 (2%) did not report their ethnicity. The mean age of participants was 20.4 years, with a range from 18 to 46. The participants were from undergraduate psychology and education classes, and they received extra course credit for participating in the study. None of the

participant demographic characteristics correlated with any of the dependent variables.

Materials

Three videotapes, each approximately 10 minutes in length, were developed as stimulus materials for the present study. The tapes depicted simulated therapeutic interactions between a client and a therapist. The therapist was portrayed by a 33-year-old White male, and the client was portrayed by a 27-year-old White woman, both of whom had previous acting experience. The 3 tapes followed a similar script, containing 32 client-therapist speaking turns and equal numbers of minimal encouragers and questions on the part of the therapist. Tapes were also comparable to one another with respect to therapist/client nonverbal interactions. The only dimension along which the tapes varied was in terms of the therapist's self-disclosure. In the first tape, the therapist made 3 general self-disclosures, in the second tape the therapist made 3 countertransference disclosures, and in the third tape, the therapist made empathic statements instead of self-disclosures. The tapes thus were comparable to those in Lundeen and Schuldt's (1989) study in that they were 10 minutes in length and included 3 therapist self-disclosures.

To better illustrate, in 1 segment of the tape, the client describes how she wants to be different from her mother, particularly with regards to her mother's alcoholism. In the general self-disclosure condition, the therapist relates to the fact that the client rarely drinks alcohol. He says, "I remember my undergrad days, I wasn't much of a drinker either. I really didn't like the taste of the stuff. I found myself appointed designated driver by default on more than one occasion. My friends always seemed to appreciate the convenience of having a sober driver. But in terms of how it affects you, it seems like you make a very deliberate choice to avoid the vice that has caused so much of your mother's problems, and by extension, so many of your problems as well." In the countertransference disclosure condition, the therapist responds at the same point by saying: "You know, 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 many important ways. So you see I can understand your struggle." In the no disclosure condition, the therapist responds to the same material with a general empathic statement: "Mm hmm, you do the opposite of your mother, from the largest to the smallest details of living. I can certainly see how you would want to be different from your mother, especially given all that you went through growing up."

A brief written statement was used to introduce the therapeutic scenario to participants. In this statement, participants were asked to imagine themselves in the role of an objective observer, watching the seventh therapy session between a therapist and client. Two versions were created that were virtually identical in both length and general content. Both depicted a client whose presenting concern was relational difficulties with her boyfriend. The client also was described as having had a difficult childhood, primarily because of her mother's alcoholism and inconsistent parenting. The sole difference between the 2 statements was that 1 portrayed the client and therapist as having a positive working alliance and the other depicted a poor working alliance, in accordance with Bordin's (1979) conception of the working alliance. Specifically, the client and therapist were described in the introductory statement as agreeing or disagreeing on the goals and tasks of therapy, and having or lacking good rapport. This constituted the experimental manipulation of the working alliance. Thus, the design was a 3 (therapist disclosure) x 2 (working alliance) factorial design.

Three licensed psychologists (2 women, 1 man) with a mean of 20 years postdoctoral experience judged the videotapes to be highly plausible. In addition, the 3 judges were able to identify with 100% accuracy the self-disclosure condition (general, countertransference, none) to which each videotape belonged and the working alliance category (positive or negative) to which each written description corresponded.

Measures

A demographic form was created to measure participants' age, sex, ethnicity, major, year in college, and whether or not they had been in therapy previously. This last question utilized a dichotomous format.

The Counselor Rating Form (CRF; Barak & LaCross, 1975) was used to assess participants' perceptions of the therapist's trustworthiness, expertness, and attractiveness. The CRF is com-

posed of 36 semantic differential items, with each pair consisting of an adjective and its antonym (e.g., alert-unalert). Scores for each item range from 1–7 with higher scores reflecting greater trustworthiness, expertness, and attractiveness. Scores are summed and averaged for each 12-item subscale. In Barak and LaCross's study, 4 experts categorized items according to subscales with 100% agreement on 22 items and 75% agreement on 14 items. Component analysis of the CRF has supported the existence of 3 distinct factors consistent with the hypothesized factor structure (Wilson & Yager, 1990). Spearman-Brown reliability coefficients have been reported as .87 for expertness, .85 for attractiveness, and .91 for trustworthiness (Barak & LaCross, 1975). LaCross (1980) found that client ratings on the 3 dimensions were significantly correlated with treatment outcome (r = .37 to .56), lending support to the predictive validity of the CRF. In the present study, the following internal consistency coefficients were obtained: .93 for expertness, .89 for attractiveness, and .90 for trustworthiness.

The Session Evaluation Questionnaire (SEQ; Stiles, 1980) was used to measure participants' perceptions of session depth, smoothness, and their postsession mood. The SEQ contains 24 bipolar adjective scales, with scores for each item ranging from 1 to 7. Scores are summed and averaged, with higher scores reflecting greater perceived depth and smoothness and more positive postsession mood. Factor analyses have revealed support for the subscales, and internal consistency estimates tend to exceed .80 (Stiles & Snow, 1984; Stiles, Reynolds, Hardy, Barkham, & Shapiro, 1994). In the present study, internal consistency estimates were .77 for positivity and smoothness and .85 for depth.

Manipulation Checks

Manipulation checks were developed for the 2 independent variables (i.e., working alliance and self-disclosure). First, a 3-item Working Alliance Manipulation Check was constructed for the present study. This instrument employed a yes/no format and asked participants if the therapist and the client agreed on the specific tasks of therapy, agreed about the overall goals of therapy, and had a good rapport. This manipulation check was created to evaluate participants' perception of the working alliance and is distinct from the previously described evaluation of the vignettes' plausibility completed by the 3 licensed psychologists.

In addition, to provide additional evidence that the experimental manipulation of the working alliance had the intended effects, the shortened observer-rated version of the Working Alliance Inventory (WAI-O-S; Tichenor & Hill, 1989) was administered to participants. Specifically, the WAI-O-S was used to determine whether participants' perceptions of the alliance were higher in the positive alliance condition than in the poor alliance condition. The WAI-O-S measures the quality of the alliance between therapists and their clients in relation to the 3 areas that Bordin (1976) proposed to be quintessential elements of the therapeutic alliance (i.e., presence of a therapeutic bond, agreement on therapeutic tasks, and agreement on the goals of therapy). The WAI-O-S was adapted from Horvath and Greenberg's (1989) original WAI by Tichenor and Hill (1989). The WAI-O-S is a 12-item questionnaire that asks respondents to rate statements that pertain to the quality of the client/therapist relationship on a 7-point Likert scale (1 = *never* and 7 = *always*). Median interrater reliability has been estimated at .42 (Andrusyna, Tang, DeRubeis, & Luborsky, 2001). For the present study, intraclass correlation coefficients in each of the 6 cells ranged from .74 to .81, and α for all of the participants was .88.

A Self-disclosure Manipulation Check also was constructed for the purposes of this study. This questionnaire used a yes/no format and asked participants to answer a question that asked: "Did the therapist make any statements revealing personal information during the session?" If the participants answered "yes," then they were asked to distinguish between a general and a countertransference self-disclosure by answering the following question: "Was the information that the therapist revealed based on personal difficulties with which he still struggles?"

Procedure

Participants were randomly assigned to 1 of 3 disclosure conditions and 1 of 2 working alliance conditions. After signing an informed consent form and completing the demographic form, participants read the introductory statements that contained the experimentally manipulated descriptions of the working alliance between the client and therapist. Participants then watched the videotape and immediately afterward completed the CRF, SEQ, WAI-O-S, 3-item working alliance manipulation check, and self-disclosure ma-

nipulation check in random order, and were given a debriefing statement informing them of the purpose of the research.

Results

Preliminary Analysis

Missing data points were estimated by averaging other items from the same subscale and substituting the mean of those items for the missing item. No participant left more than 2 items blank on any instrument. Data fell within acceptable limits for linearity and normality. Pearson correlation coefficients among the dependent measures ranged from .13 to .69. Data from 11 of the 236 participants was excluded from analysis because scores on the 2 manipulation check measures revealed that they misperceived the disclosure condition, working alliance condition, or both. Additionally, 1 participant failed to fill out 3 pages of instruments, and thus these data were excluded. An analysis of WAI-O-S scores (with a possible range of 1–7) revealed that the alliance was perceived as stronger in the positive alliance condition ($M = 5.05$, $SD = .66$) than in the negative alliance condition ($M = 3.81$, $SD = .68$), $F(1, 223) = 191.27$, $p \leq .01$. Further evidence that the working alliance manipulation was effective was reflected in the fact that scores on all of the dependent measures except Positivity were higher in the positive alliance condition than in the negative alliance condition (see means in Tables 1 and 2).

In general, participants rated the therapist as more attractive than unattractive, with an average attractiveness score of 5.06. The therapist also was rated across conditions as fairly expert ($M = 5.33$) and trustworthy ($M = 5.50$). Scores on the SEQ fell closer to the midpoint on each scale, with the following mean scores: Depth = 4.62, smoothness = 4.16, and positivity = 4.80. On the whole, sessions were rated as slightly more deep than shallow, more smooth than rough, and left participants feeling more positive than negative.

Primary Analyses

To test for possible interaction effects between type of therapist disclosure and quality of the working alliance, 2-way factorial analyses of variance were conducted for each of the dependent measures. Results indicated that there was a statistically significant interaction between working alliance and self-disclosure on measures of therapist expertness, $F(2, 224) = 4.42$, $p < .01$, $d = .04$, and session depth, $F(2, 224) = 5.56$, $p < .00$, $d = .05$. There were no other significant interaction effects between type of disclosure and working alliance. Tables 1 and 2 contain means and standard deviations for the CRF and SEQ, respectively, within each experimental condition.

Independent *t* tests and inspection of the means revealed that when the alliance was positive, Expertness and Depth scores were both significantly higher when the therapist made a general self-disclosure than when he made no disclosure, $t(75) = 2.81$, $p < .01$ and $t(75) = 2.29$, $p < .05$, respectively. However, when the alliance was

TABLE 1. Effects of Working Alliance and Self-Disclosure on Ratings of Therapist Expertness, Attractiveness, and Trustworthiness

	Countertransference			General disclosure			No disclosure		
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*
				Expertness					
Working alliance									
Positive	5.52	.85	36	5.86_a	.59	39	5.41_b	.80	38
Negative	4.90_c	1.05	39	4.98_c	.95	36	5.34_b	.80	36
				Attractiveness					
Working alliance									
Positive	5.36	.69	36	5.45	.76	39	5.09	.71	38
Negative	4.97	.82	39	4.83	.84	36	4.65	.71	36
				Trustworthiness					
Working alliance									
Positive	5.55	.75	36	6.02	.60	39	5.64	.65	38
Negative	5.12	.90	39	5.27	.92	36	5.37	.66	36

Note. Subscripts a–c are used to designate significant differences amoung means. Means with different subscripts differ at $p < .05$.

TABLE 2. Effects of Working Alliance and Self-Disclosure on Ratings of Session Smoothness and Depth and Positivity

	Countertransference			General disclosure			No disclosure		
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*
					Smoothness				
Working alliance									
Positive	4.27	1.06	36	4.56	1.03	39	4.44	.95	38
Negative	3.91	.81	39	4.17	.91	36	3.60	.88	36
					Depth				
Working alliance									
Positive	4.76	1.09	36	5.08_a	.68	39	4.61_b	1.09	38
Negative	4.19_c	1.21	39	4.27_c	1.02	36	4.84_b	.85	36
					Positivity				
Working alliance									
Positive	4.86	.89	36	5.04	.96	39	4.80	.96	38
Negative	4.88	.86	39	4.83	.97	36	4.39	.80	36

Note. Means with different subscripts differ at $p < .05$.

weak, Expertness scores were higher when the therapist made no disclosure than when he made either a general self-disclosure, $t(70) = -2.61$, $p < .01$, or a countertransference disclosure, $t(73) = -2.68$, $p < .01$. Similarly, when the alliance was weak, Depth scores were higher when the therapist made no disclosure than when he made a general self-disclosure, $t(70) = -2.68$, $p < .01$, or a countertransference disclosure $t(73) = -2.01$, $p < .05$. Figures 1 and 2 depict these interaction effects.

Additional Analyses

In the interest of determining how results might generalize to actual clients, we examined the impact that participants' prior therapy experience may have had on their perceptions of the therapist and the session. Because participants' prior therapy experience was not considered in assigning participants to experimental conditions, there was considerable variation in the number of participants with prior therapy experience in each condition. Consequently, when prior therapy experience was examined in multivariate analysis, observed power for this variable was low, ranging from .28 to .66. Overall, 34% of the sample identified themselves as having been in some form of therapy at some point in their lives. Of these 76 individuals, 29 were assigned to the countertransference disclosure condition, 15 to the general disclosure condition, and 32 to the no disclosure condition. Of the 148 participants with no previous experience in therapy, 46 were assigned to the countertransference disclosure condition, 60 to the general disclosure condition, and 42 to the no disclosure condition.

Multivariate analysis indicated that there was a significant difference in scores on dependent measures for participants with and without prior therapy experience, $F(6, 224) = 2.63$, $p < .05$, $d = .07$. Follow-up univariate tests indicated that, in general, participants with prior therapy experience viewed the therapist as being more expert, $F(1, 224) = 5.76$, $p < .05$, $d = .03$, and rated the session as deeper, $F(1, 224) = 6.75$, $p < .01$, $d = .03$, than participants without prior therapy experience. There was not a significant interaction between prior therapy experience and quality of the working alliance, but there was a significant interaction between participants' therapy experience and disclosure condition, $F(12, 224) = 2.87$,

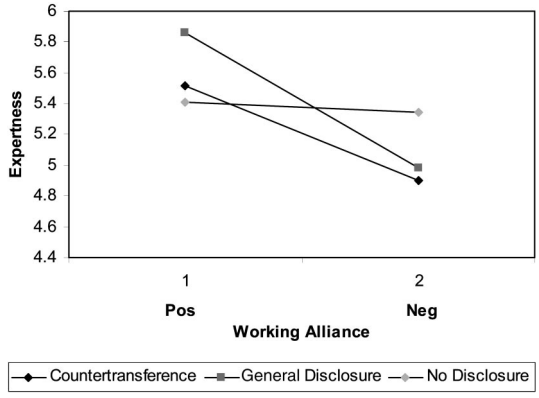

FIGURE 1. Interaction effect between quality of alliance and type of therapist disclosure on ratings of therapist expertness.

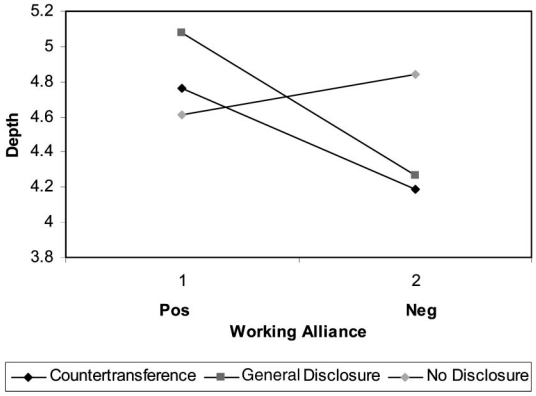

FIGURE 2. Interaction effect between quality of alliance and type of therapist disclosure on ratings of session depth.

$p < .01$, $d = .08$. Participants with prior experience in therapy perceived the session as deeper in the countertransference condition ($M = 4.93$, $SD = 1.06$) than in the general self-disclosure condition ($M = 4.59$, $SD = .99$), and participants who had not been in therapy rated the session as deeper in the general self-disclosure condition ($M = 4.71$, $SD = .94$) than in the countertransference condition ($M = 4.17$, $SD = 1.17$), $F(2, 224) = 4.15$, $p < .05$, $d = .04$. A significant interaction also was present between prior therapy experience and disclosure condition with respect to positivity, $F(2, 224) = 4.64$, $p < .01$, $d = .04$. Participants who had been in therapy viewed the session as more positive in the countertransference condition ($M = 5.00$, $SD = .88$) than they did in either the general self-disclosure condition ($M = 4.47$, $SD = 1.05$) or the no disclosure condition ($M = 4.43$, $SD = .94$). Participants who had not been in therapy rated the session as more positive in the general self-disclosure condition ($M = 5.06$, $SD = .91$) than they did in either the countertransference condition ($M = 4.78$, $SD = .86$) or the no disclosure condition ($M = 4.73$, $SD = .86$).

Discussion

Data reflected partial support for the hypothesis that the effects of general and countertransference disclosures on perceptions of the session and the therapist would depend upon the quality of the working alliance. When the alliance was perceived to be positive, sessions were rated as deeper and the therapist was viewed as more expert when he made general disclosures rather than no disclosures. However, when the alliance was perceived as negative, it was better for the therapist not to make general or countertransference disclosures. He was rated as less expert and sessions were seen as shallower when the therapist made either a general or countertransference disclosure rather than no disclosure.

These findings extend, and in some ways contradict, previous research efforts on the effects of therapist self-disclosure. For example, Lundeen and Schuldt (1989) and Nilsson et al. (1979) found that therapists were judged to be more attractive and trustworthy when they disclosed as opposed to when they did not disclose, but disclosures did not affect perceptions of therapist expertness. We found that disclosures affected perceptions of expertness but not attractiveness or trustworthiness. Furthermore, Nilsson et al. and Hoffman-Graff (1977) found that perceptions of the therapist tended to be more favorable when disclosures were more personal in nature. In the present study, participants did not tend to view the therapist or the session more favorably when personal disclosures of a countertransference nature were made. In fact, countertransference disclosures caused the session to be viewed as shallower and the therapist to be perceived as less expert when they were made in the context of a working alliance that was perceived to be weak. The same was true of general therapist disclosures. Thus, therapist self-revelation may be problematic, at least when the therapy relationship is poor. The analogue nature of the study should be kept in mind, however. On the one hand, effects might be even more pronounced in actual therapy where therapist and client behaviors differ when the alliance is strong as opposed to when it is weak; here the only variations in behavior were a function of therapist disclosure. On the other hand, it may be that in the context of actual therapy, more in-depth discussion and processing with the client of a therapist's emotional reactions can serve to foster the alliance (Safran & Muran, 1996).

Our data indicate that when the relationship is perceived as strong, general self-disclosures can be beneficial. The finding that general revelations about the therapist caused him to be seen as more expert than when he did not share any details about himself supports the notion that being more genuine and human enhances the therapeutic process (Gelso & Hayes, 1998; Jourard, 1971; Rogers, 1961). It may be that self-disclosure is helpful to the extent that it helps the client realize that

the therapist is a real person, but it may become detrimental when the disclosure is too personal or reveals the therapist's unresolved issues. A fertile area for future research would be to examine the effects of therapists' disclosures of personal issues that were more resolved than unresolved. Studies along these lines would help shed light on the mechanisms by which the concept of the wounded healer can be effectively applied to psychotherapy (Hayes, 2002).

In fact, participants who had been clients in therapy showed a preference for countertransference disclosures. Whereas on the whole, sessions were viewed as equally deep whether the therapist made a general or countertransference disclosure, participants with prior therapy experience perceived sessions as deeper when the therapist made countertransference disclosures than when he made general disclosures. The opposite was true for participants without previous experience in therapy, however. In addition, participants with prior therapy experience were in a better mood after sessions in which the therapist made countertransference disclosures than when he made general or no disclosures. However, participants without prior therapy experience were in a better mood after sessions in which the therapist made general disclosures as opposed to making countertransference or no disclosures. It could be that individuals who are unfamiliar with therapy do not expect, and therefore have a negative reaction to, countertransference disclosures. Prior experience in therapy, on the other hand, may be accompanied by exposure to therapist disclosures of countertransference, and perhaps beneficial consequences.

It would then seem that when a client has not been in therapy before, and when the working alliance is perceived as poor, therapists would do well to avoid discussing their own unresolved issues. This implication is consistent with existing guidelines that caution against using self-disclosure to overshadow the client's needs (Mahalik et al., 2000), which is especially likely to occur when such disclosures precede the development of rapport between the therapist and the client (Anderson & Mandall, 1989; Wells, 1994). At the same time, therapy sessions may be deepened when therapists make a generally self-revealing statement in the context of a working alliance that is perceived as strong, especially with clients who are new to the process of therapy. Furthermore, when clients have been in therapy before and a solid alliance has been established, data from the present study suggest that countertransference disclosures can lend depth to sessions and may cause clients to feel more positively.

Given that therapists report experiencing countertransference reactions in as many as 80% of sessions (Hayes et al., 1998), the Freudian ideal of being an impenetrable mirror may be a bit of a lofty aspiration, if not altogether contra-indicated (Renik, 1995a). Countertransference is an inevitable part of therapy, and it can be both a challenging occupational hazard of sorts and an invaluable source of information. Given the results of the present study, Little's (1951) suggestion to discuss with clients all instances of countertransference, as well as their origins, seems ill advised. Admittedly, however, it is beyond the scope of the current data to offer sweeping proscriptions against collaboratively exploring subjective, and in some cases even countertransference, reactions with clients (Renik, 1995b). Therapist decisions about countertransference disclosures should include consideration of the strength of the working alliance and clients' prior experience in therapy. Even when the working alliance is perceived to be strong and clients have previous experience in therapy, our own clinical experience would indicate that there is probably an upper limit to the maximal number of times countertransference can and should be shared with a client. Furthermore, whereas we would agree with Jourard (1971) that therapists should be willing to answer any questions that they pose to a client, the more critical question is whether it is in the client's best interest that they actually do so. Again, results of the present study suggest that therapists should be mindful of whether and what to disclose in the context of the perceived strength of the therapeutic relationship.

Beyond the scope of the present findings, but nevertheless worth considering before disclosing are hosts other contextual factors, including but not limited to client diagnosis, presenting concerns, phase of therapy, skill level of the therapist, and others. For instance, a therapist may choose to be more reserved in disclosing his or her own unresolved issues to a client whose difficulties are more characterlogical in nature. We would also be remiss if we did not acknowledge the role that clinical intuition plays in therapists' decision to disclose or not. Frequently the therapeutic process is guided by factors that are not easily reflected in the empirical data. After all, countertransference is among the most personal information that a therapist has, thus it is a very

personal decision in deciding to share such information.

This study possessed several limitations that need to be kept in mind in interpreting its findings. First, by virtue of its laboratory analogue design, questions of external validity arise. Simply stated, does collecting data from undergraduates under experimental laboratory conditions yield results that are meaningful to the practice of psychotherapy? Whereas this is a question for the reader to answer, one advantage to such a design is that it allowed for perceptions of the working alliance to be manipulated, which would be unethical in a field study since the alliance is directly related to outcome (Horvath & Symonds, 1991). Furthermore, although generalizability of the findings also is limited by the convenience sample that was employed, participants can be thought of as potential consumers of psychotherapy; in fact 76 of the 224 participants had been in therapy previously, and findings suggested that prior therapy experience was related to perceptions of the therapist and the session. Another limitation of this study was the fact that data were collected following a single observation of a brief segment of therapy. Given the complex and fluid nature of the therapeutic process, a sole observation does not capture the essence of the process. For example, if the working alliance is formed through a rupture and repair cycle, as Safran and Muran (1996) propose, then a 1-time observation would be an insufficient reflection of this process. Similarly, Ellis (2001) encourages an active dialogue when countertransference arises, with the opportunity for the therapist as well as the client to share their reactions in the moment. In the interest of consistency across experimental conditions, no such ancillary discussion was included in any script. Whereas this enhanced internal validity, it likely detracted from the more fluid response pattern that might have emerged in actual therapy. In addition, it is worth noting that the effect sizes that were detected tended to be small according to standards outlined by Cohen (1988). On the one hand, this may be a reflection of clinical reality. On the other hand, statistical power may need to have been even greater to detect effects that were deemed statistically nonsignificant. Still further, given the number of analyses that were conducted, it is possible that spurious findings were deemed significant due to Type I error.

In addition, it should be kept in mind that participants' perceptions of the alliance were manipulated experimentally, and that we did not study the effects of the therapist's potentially differing view of the alliance. This is an important topic for future research. Finally, external validity was limited by the fact that both the therapist and the client depicted in the videotapes were White, as were most participants, and therapist and client gender effects could not be tested since only 1 gender was used to portray each. Future research could profitably expand on existing studies by focusing on the cultural context in which disclosures are made and how they are perceived (e.g., Ridley, 1984). For example, are disclosures more potent when the therapist's culture creates a greater power differential between the therapist and client? For instance, self-disclosures made by an Italian American, heterosexual male may help a Latina lesbian client trust the therapist more than they would affect the trust of an Italian American, heterosexual male client.

Limitations notwithstanding, this study underscores the importance of therapists' assessing and, if necessary, attending to the working alliance before making self-disclosures. General self-disclosure in the context of an alliance that is perceived to be strong can positively affect perceptions of session depth and therapist expertness. However, in the absence of a solid alliance, it may be better for therapists to be more conservative in their disclosures, since the present study indicates that general disclosures and countertransference disclosures can negatively affect perceptions of the therapist and the session. Perhaps when the alliance is viewed as weak, disclosures on the part of the therapist should be more focused on relational issues between the client and therapist. Client factors, such as previous experience in therapy, also seem to be important for therapists to consider in making decisions about whether and what to disclose.

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