

ABSTRACT

Title of Document: The Real Relationship, Therapist Self-Disclosure, and Treatment Progress: A Study of Psychotherapy Dyads

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The present study examined therapists' and clients' perceptions of their real relationships, the amount and relevance of the therapists' self-disclosures, and treatment progress. Sixty-one therapist-client dyads in ongoing psychotherapy completed measures of these variables. Positive correlations were found between the strength of their real relationships and their treatment progress from both perspectives separately, and when perspectives were crossed. From the therapist's perspective, the amount of therapist self-disclosure positively correlated with both the strength of the real relationship and treatment progress. From the client's perspective, the amount of therapist self-disclosure positively correlated with the strength of the real relationship, and the relevance of therapist self-disclosure positively correlated with treatment progress. Overall the results imply that therapists should strive to strengthen their real relationships with their clients, and that appropriate use of therapist self-disclosure is one intervention that may help strengthen this relationship.

THE REAL RELATIONSHIP, THERAPIST SELF-DISCLOSURE, AND
TREATMENT PROGRESS: A STUDY OF PSYCHOTHERAPY DYADS

By

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Dissertation submitted to the Faculty of the Graduate School of the

University of Maryland, College Park in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy

2011

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Acknowledgements

I would first like to thank my advisor, Charlie Gelso, for supporting me, challenging me, and being able to know when I needed each over the past six years. I would not have taken on this project without his encouragement and belief in my ability to see it through. I feel very lucky to have had him as my advisor. I would also like to thank the other members of my committee, Clara Hill, Dennis Kivlighan, Barry Farber, and Cheri Marmarosh, who helped guide me from the start of this project. I would like to thank my research assistant, Courtnie Rodich, for her dedication to this project. Her hard work, meticulousness, and positive attitude were enormously helpful throughout this process. I am a better person just by knowing my parents, Esther and Michael Ain, and my brother, Andrew Ain. They have all been wonderful role models for me and I could not have asked for a better family. Finally, I would like to thank my fiancé, Dave Richter, for his seemingly endless patience, both in general and when it came to listening to me talk about this project. His support helped me make it to this point, and I am lucky to be with someone who has such a good heart.

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Chapter 1

Introduction and Review of the Literature

The psychotherapy relationship between client and therapist is important to study because it has been shown to play a significant role in the success of the therapy (i.e. Lambert, 2002). As with perhaps all relationships, the psychotherapy relationship is highly complex. Psychoanalyst Ralph Greenson (1967) helped clarify the psychotherapy relationship by conceptualizing it as consisting of three components: the working alliance, the patient transference, and the real relationship. Greenson's definition was later extended to all psychotherapy theoretical orientations (Gelso and Carter, 1985). Gelso and Samstag (2008) suggested that "In the reality of the psychotherapy hour, each of these components is present, not as a separate entity, but as intertwined and often not sharply distinguishable elements of the gestalt, the whole relationship" (p. 2).

The working alliance, the patient transference, and the real relationship each pertain to different aspects of the psychotherapy relationship. The working alliance between the client and therapist pertains to the therapeutic work. It is often defined by the amount to which the client and therapist agree on goals, agree on ways by which to obtain the goals, and experience an emotional bond with one another (Bordin, 1979). Transference occurs when the client unconsciously displaces conflicts from his or her past significant relationships onto the therapy, such as beliefs, feelings, and behaviors (Gelso and Hayes, 1998). Transference is always an error (Gelso and Hayes, 2001). It is unrealistic perceptions that that the client has of his or her therapist. The real relationship, on the other hand, involves realistic perceptions in the psychotherapy relationship. Gelso (2009) defined the real relationship as "The personal relationship

existing between two or more people as reflected in the degree to which each is genuine with the other, and perceives and experiences the other in ways that befit the other” (p. 7).

The real relationship in psychotherapy is the component of the psychotherapy relationship that has been studied the least. However, the research on the real relationship up to this point has demonstrated that it is an important construct because it relates to progress and outcome of psychotherapy (e.g. Ain and Gelso, 2008; Fuertes, Mislowack, Brown, Shovel, Wilkinson, & Gelso, 2007; LoCoco, Prestano, Gullo, & Gelso, in press; Marmarosh, Gelso, Markin, & Majors; Spiegel, et al., 2008). In the present study, I examined the real relationship component of the psychotherapy relationship. I also examined therapist self-disclosure, a psychotherapy intervention that has been shown to relate to the real relationship (Ain and Gelso, 2008). In order to investigate these constructs I surveyed psychotherapy dyads of clients and therapists in ongoing psychotherapy on their real relationships, the therapists’ self-disclosures, and the progress in therapy so far. Below I briefly describe each of these constructs. The review of the literature will elaborate on the real relationship and therapist self-disclosure.

The Real Relationship

Theoreticians have emphasized the importance of the real relationship between a client and therapist in psychotherapy for over a half-century (Eugster & Wampold, 1996; A. Freud, 1954; Fuertes et al., 2007; Gelso, 2002, 2004, 2009a, 2009b, 2011; Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998; Greenson, 1967; Menaker, 1942; etc.). However, there has not been much clinical investigation into the real relationship until the last few years. This is partly due to, until recently, a lack of a clear definition and, in

turn, a paucity of tools needed to measure the construct. Over the last 25 years, the concept of the real relationship has been refined (Gelso, 2002, 2004, Gelso, 2011; Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998), and measures of the construct have been developed (Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa, & Hancock, 2005; Kelley, Gelso, Fuertes, & Marmarosh, & Lanier, in press). A number of studies have used these measures to investigate the real relationship. Studies on both client and therapist perspectives have shown the strength of the real relationship to be related to treatment progress and outcomes (Ain and Gelso, 2008; Fuertes et al, 2007; Lococo et al., in press; Marmarosh et al., 2009; Spiegel et al, 2008). Therefore, the real relationship is an important topic in psychotherapy to continue investigating both in terms of treatment progress and outcome and in terms of constructs that may relate to the strength of the real relationship.

As stated above, the real relationship is the personal relationship between the client and therapist that is defined by two main components: genuineness and realistic perceptions (Gelso, 2011). Genuineness is the willingness and ability to be who one truly is in the relationship - in other words, to be authentic, honest, and open with the other person. Realistic perceptions between the client and therapist enable them to view each other accurately and realistically. They are perceptions of the client or therapist that are not distorted by transference or other defenses. The magnitude and valence of these components are also taken into account when defining the real relationship. Magnitude pertains to how much of the real relationship exists in terms of genuineness and realism. Valence pertains to the clients' and therapists' feelings toward one another within the

context of the real relationship. These feelings can range from very positive to very negative.

Therapist Self-Disclosure

Based on qualitative and quantitative studies, one intervention in psychotherapy that has been shown to relate to the real relationship from the client's perspective is therapist self-disclosure (Ain and Gelso, 2008; Knox, Hess, Petersen, & Hill, 1997). In a qualitative study, Knox et al. (1997) found that, from the client's perspective, therapist self-disclosures made them appear more real and human and allowed the client to be more open and honest in therapy. These findings relate to the genuineness component of the real relationship. In a quantitative study, Ain and Gelso (2008) found that when clients looked back on therapy that had ended up to three years previously, the clients whose therapists self-disclosed an appropriate amount had stronger real relationships and better outcomes than clients who felt that their therapists had not disclosed enough. These findings make sense when one considers the definitions of the real relationship and therapist self-disclosure. Hill and Knox (2002) define therapist self-disclosure as verbal statements that reveal something personal about the therapist. It seems likely that a client will view a therapist who reveals something about him or herself as more genuine than a therapist who does not disclose. This would relate to the genuineness component of the real relationship. In addition, self-disclosures will likely enable a client to gain a better sense of the therapist for whom he or she really is, and less likely to form distorted perceptions of him or her, than of a therapist who does not disclose. This would relate to the realism component of the real relationship.

The relationship between the real relationship and therapist self-disclosure is theoretically and empirically supported from the perspective of the client. However, not much is known about the relationship between these two constructs from the therapist's perspective. Therefore, one aim of the present study was to investigate the relationship between therapist self-disclosure and the real relationship from both client and therapist perspectives. A second aim of this study was to continue to examine how the real relationship relates to treatment progress from both client and therapist perspectives. Finally, a third aim of this study was to see if there was a relationship between therapist self-disclosure and treatment progress from both client and therapist perspectives. In order to do so I recruited psychotherapy dyads and had each member complete measures of the real relationship, therapist self-disclosure, and treatment progress.

Review of the Literature

The Real Relationship

The therapy relationship – the tripartite model. One area of psychotherapy research that has garnered much attention is the client-therapist relationship. Lambert's (2002) finding that the psychotherapy relationship was one of the strongest predictors of outcome is one example of why it is important to study its role in psychotherapy. In order to study the client-therapist relationship, one must first define it. Psychoanalyst Ralph Greenson (1967) contributed to the definition of the therapy relationship by conceptualizing it as being made up of three components: the working alliance, the patient transference, and the real relationship. Each component of the therapy relationship is theorized to be present in the therapy hour and the elements are not mutually exclusive from one another. At any given point, one component may be more

or less prominent than another. Gelso and Carter (1985, 1994) defined the psychotherapy relationship as “the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed.” Gelso and Carter (1985) extended Greenson’s definition of the psychotherapy relationship to all psychotherapy theoretical orientations and, more recently, Gelso and Samstag (2008) described it as a tripartite model. I discuss each component of the tripartite model below. I focus most on the real relationship because that is the component of the therapy relationship that was examined in the present study.

The working alliance. The working alliance is the component of the tripartite model of the therapy relationship that has to do with the therapeutic work. Gelso and Carter (1994a) define the working alliance as “the alignment or joining of the reasonable self or ego of the client and the therapist’s analyzing or ‘therapizing’ self or ego for the purpose of the work” (p. 297). The joining of these parts allows the therapeutic work to be observed, understood, and accomplished by the participants in the face of obstacles and resistances (Gelso and Hayes, 1998). Bordin (1979) suggested that the strength of the working alliance is affected by the degree to which the therapist and client (a) agree on the goals toward which they work, (b) agree on the tasks that they will use toward achieving these goals, and (c) experience an emotional bond with each other. The working alliance has been the most clearly defined component of the therapeutic relationship for the longest amount of time. It is arguably the most researched component for that reason. Meta-analyses of alliance-outcome studies have shown the working alliance to be one of the strongest predictors of overall therapy outcome (Horvath & Symonds, 1991; Marin, Garske, & Davis, 2000; Horvath, 2002).

The transference-countertransference configuration. The transference-countertransference configuration in psychotherapy is the component of the relationship that is based on unrealistic perceptions. Transference is “the client’s experience of the therapist that is shaped by his or her own psychological structure and past, and involves displacement on the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships” (Gelso and Hayes, 1998, p. 11). Gelso and Hayes (2007) define countertransference as “the therapist’s internal and external reactions that are shaped by the therapist are past and present emotional conflicts and vulnerabilities” (p. 25). Transference configurations can play positive, negative, or neutral roles in therapy, depending on the content and how it is incorporated into the therapy process. Countertransference is often seen as either a damaging force in therapy or as a potentially helpful tool, depending on its nature and how the therapist uses his or her countertransference.

The real relationship. Of the three components of the psychotherapy relationship, the real relationship is the least studied. This is due to, until recently, a lack of a clear definition of the construct and, therefore, a lack of the measures needed to research it (Gelso and Samstag, 2008). Most of the work on the real relationship has used Gelso’s (2002) definition of the real relationship. According to Gelso, the real relationship is the personal relationship between the client and therapist that is defined by two main components: genuineness and realistic perceptions. Genuineness is the willingness and ability to be authentic, honest, and open – in other words, to be who one truly is in the relationship. Realistic perceptions are defined by the perceptions of the client or therapist that are not distorted by transference or other defenses. Realistic

perceptions between the client and therapist enable them to view each other realistically. It is important to distinguish the real relationship from the other two components of the therapeutic relationship mentioned above. In the working alliance, the client and therapist may view each other realistically and may also be genuinely invested in their work. However, this is different from the real relationship because within the working alliance the clients' and therapists' genuineness and realistic perceptions are centered around their work together. On the other hand, within the real relationship, the genuineness and realistic perceptions are part of all interactions and not limited to the therapeutic work. In addition, within the transference-countertransference configuration, the therapist's and client's transference reactions may be genuine, but they are based on unrealistic perceptions. This is separate from the real relationship because the real relationship is based on realistic perceptions. Therefore, although the working alliance and the transference-countertransference configuration may each relate to aspects of the real relationship, the real relationship is a distinct component of the therapeutic relationship.

The history of the real relationship. The concept of the real relationship has been around for over a half-century. Freud, for instance, commented in 1937 that "Not every good relation between an analyst and his subject during and after analysis was to be regarded a transference; there were also friendly relations which were based on reality and which proved to be viable" (p.222). As early as 1942, psychoanalyst Esther Menaker wrote :

It seems to us, however, important to distinguish between that part of the analytic experience which is relived *as* 'real' . . .and that part which *is* real, that is, which

constitutes a direct human relationship between patient and analyst, which has an existence independent of the transference, and which is the medium in which the transference reactions take place In general, it is important that the real relationship between patient and analyst have some content and substance other than that created by the analytic situation itself (p. 172)

These quotes underscore that idea that there does exist a personal relationship between client and therapist that is based on reality. However, although the real relationship has long been recognized as a significant part of the psychotherapy relationship, it has been understudied until recently. This is partly due to, until recently, a lack of a clear definition of the concept and, in turn, a shortage of the instruments needed to measure the construct (Gelso & Samstag, 2008). Over the last two decades, work on the real relationship focused on these issues by refining the implications and definition of the concept (Gelso & Carter, 1985, 1994, Gelso and Hayes, 1998; Gelso 2002, 2004, 2009, 2011) and constructing the instruments needed to measure the construct (Gelso et al., 2005; Kelley et al., in press).

Gelso (2004) defined the real relationship in terms of both genuineness and realism as “the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that benefit the other” (Gelso, 2004, p.6). He defined genuineness as “the ability to be who one truly is, to be nonphoney, to be authentic in the here and now” (Gelso, 2002, p.37). Realism was defined as “the experiencing or perceiving the other in ways that benefit him or her, rather than as projections of wished for or feared others (i.e., transference)” (p.37). In addition, Gelso noted that magnitude and valence were necessary concepts to consider

when examining the real relationship. Magnitude refers to how much of a real relationship exists between the client and the therapist. It assumes that genuineness and realism (and therefore the real relationship) can fluctuate in terms of amount over the course of therapy, including within any given session. Valence pertains to the notion that clients' and therapists' feelings about one another within the context of the real relationship may range from very positive to very negative. Therefore, a client or therapist may genuinely like or dislike the other based on realistic perceptions.

Controversy over the real relationship. Although the real relationship has been recognized for over half a century and has more recently been the subject of significant research, there has been controversy surrounding the concept. Gelso (2002) addressed three arguments that have been posed against the concept of the real relationship.

The first argument is that the concept of a real relationship is redundant and unnecessary because everything in the therapeutic relationship is real. In response to this argument, Gelso (2002) suggested that despite the fact that everything is real in the therapeutic relationship, the concept of the real relationship (as it has been defined) is a significant addition to other relational constructs such as the working alliance and transference-countertransference configuration. Therefore, it is a valuable construct. A second argument against the concept of the real relationship is the question of who can know and decide what is real. This argument is directed toward the early psychoanalysts who wrote about the real relationship as though the therapists were the experts on what was real. The argument was against the idea that therapists were thought to be the authority on reality. Gelso's response to this argument is that neither the client nor the therapist is the total arbiter of what is real. Instead, the real relationship is perceptual,

and constructed by both members of the dyad. Finally, the concept of the real relationship has been criticized because even if there is a reality, it can never be fully known. Gelso (2002) responded that although this is true, it is also true regarding all theoretical constructs in human sciences. Therefore, this criticism against the concept of the real relationship cannot negate the utility of a construct because no construct can be fully known.

Measuring the real relationship. Eugster and Wampold (1996) conducted the first study that examined the role of the real relationship in psychotherapy, to the author's knowledge. In order to examine the real relationship in their study, they developed the first measures of the real relationship. However, these measures were only marginally reliable, and the patient form contained items that clearly tapped genuineness more than realism. Recently, more reliable and thorough therapist (Gelso et al., 2005) and client (Kelley et al., in press) forms have been developed to measure the real relationship. Both the therapist and client measures consist of 24 items, with 12 item subscales measuring genuineness and realism. Each scale also taps into the magnitude and valence of the real relationship. The rater is asked to rate the self, the other, and their relationship. The therapist form (Gelso et al., 2005) has been found to positively relate to the therapists' ratings of their working alliance with clients, clients' level of insight, and session outcome. The therapist form also negatively relates to negative transference. The client form (Kelley et al., in press) was found to relate to Eugster and Wampold's (1996) measures of the real relationship, clients' observing ego strength, and a measure of therapist congruence. The client form also negatively correlates with clients' tendency to

hide true feelings in order to meet others' expectations. The discriminant validity of both studies has also been supported (Gelso et al., 2005; Kelley et al., in press).

Research on the real relationship. A number of informative studies on the real relationship have been undertaken since the development of these new measures of the construct. Four studies that have used the new measures of the real relationship have examined client-therapist dyads (Fuertes et al., 2007; LoCoco et al., in press; Marmarosh et al., 2009; Spiegel et al., 2008). Fuertes et al. (2007) examined the real relationship from both the client and the therapist perspectives in a study that also examined therapist treatment progress, working alliance, therapist attachment, client attachment to therapist, and therapist empathy. The real relationship was found to positively relate to clients' ratings of the working alliance, clients' ratings of therapist empathy, and the security of the clients' attachments to their therapists. Clients' scores on the real relationship inventory were strongly and negatively related to an avoidant/fearful attachment to their therapists. From the therapists' perspective, the real relationship was positively related to therapists' ratings of the working alliance and negatively related to therapists' attachment avoidance.

Since the present study examined progress in the therapy relationship, it is especially important to highlight the following results from the Fuertes et al. (2007) regarding the real relationship and treatment progress. In that study, a marginally significant positive correlation was found between the therapist-rated real relationship and therapist ratings of the clients' treatment progress. In addition, the client-rated real relationship was positively correlated with client ratings of the progress in treatment. This

shows that the real relationship from both client and therapist perspectives may be important when it comes to predicting treatment progress from both perspectives.

A key finding from this study was that for clients, the strength of the real relationship related to progress in treatment above and beyond the variance in progress explained by their ratings of attachment to therapist, working alliance, and therapist empathy. Therefore, not only do the results of the study imply that client-rated real relationship predicts treatment progress, but that it predicts it beyond key relational variables such as therapist and client attachment patterns, empathy, and the working alliance.

In a different dyad study using the most recent measures of the real relationship, Marmarosh et al. (2009) examined the real relationship in relation to the working alliance, client attachment, the working alliance, therapist-rated client transference, and treatment outcome in a sample of 31 therapist-client dyads at a university counseling center.. They found therapists' ratings of the strength of their real relationship to be positively associated with treatment outcome, above and beyond the variance in outcome accounted for by the working alliance. However, they did not find a relationship between the strength of the real relationship and outcome from the clients' perspectives. The results of Fuertes et al.'s (2007) and Marmarosh et al.'s (2009) studies are significant because, although the working alliance and the real relationship have theoretically been viewed as similar constructs, these studies suggest that the strength of the real relationship relates to treatment progress and outcome independent of the working alliance.

In a study conducted at the counseling center at the University of Palermo in Sicily, Italy, LoCoco et al. (in press) examined therapist-patient dyads who had completed measures of the real relationship after the third and eighth sessions, and outcome measures after the first and last sessions. Although this study was similar to Marmarosh et al.'s (2009) study, their results were quite different. Marmarosh et al. found that therapist's ratings of the real relationship related to outcome, whereas patient's ratings did not. However, LoCoco et al. found that clients' ratings of the real relationship predicted therapy outcome, whereas therapists' ratings of the real relationship did not.

In a study of 28 therapist-client dyads at two university counseling centers in which clients and therapists rated the strength of the real relationship after each session of brief therapy, and completed measures of therapy outcome at the end of therapy, Spiegel et al. (2008) found results that were similar to those of LoCoco et al. (in press). They found that, although therapists' and clients' ratings of the strength of the real relationship early in treatment did not relate to therapy outcome, clients' overall ratings of the strength of the real relationship at the end of therapy did relate to therapy outcome. However, for therapists, although a medium effect size was obtained, it only approached statistical significance due to the small sample size. Although none of the above four dyad studies fully corroborated the findings of any other, they all pointed to a significant relationship between the real relationship and treatment outcome from therapists' and/or clients' perspectives.

In a study on client perceptions of the real relationship, Ain and Gelso (2008) examined clients' recollections of the strength of their real relationships with their therapists and how they related to their treatment outcomes and to their therapists' self-

disclosures in therapy that had ended up to three years prior. Ain and Gelso (2008) found that the overall strength of the real relationship, genuineness, and realism each positively predicted the treatment outcomes from the clients' perspectives. In addition, the authors found that clients who perceived their therapists as having self-disclosed an amount of information that was "just right" had stronger real relationships than clients who felt that their therapists disclosed "not enough." Interestingly, there were not enough clients who felt that their therapists disclosed "too much" to draw conclusions regarding their perceived real relationships with their therapists or their perceived therapy outcomes.

The results of Ain and Gelso's (2008) study also indicated that the strength of the real relationship was positively related to clients' perceptions of how much their therapists' self-disclosures related to themselves (the clients) and their problems. In addition, a simultaneous multiple regression revealed that the relationship between the overall relevance of therapist self-disclosure and the overall amount of therapist self-disclosure, on the one hand, and the strength of the real relationship, on the other, was significant. An interesting finding from this analysis was that the overall relevance of therapist self-disclosure was the only variable that uniquely related to the strength of the real relationship. Based on this, it appears that only the portion of the overall amount of therapists' self-disclosures that overlaps with the overall relevance of therapists' self-disclosures relates to the real relationship. This is important because it implies that the overall amount of therapist self-disclosure is not enough to predict the strength of the real relationship on its own. It is necessary to look not just at how much therapists self-disclose, but how relevant these disclosures are to their clients when it comes to predicting the strength of the real relationship.

Ain and Gelso's (2008) findings imply that one important aspect of the client-therapist relationship to examine in relation to the real relationship is therapist self-disclosure from the client's perspective. The present study examined the real relationship, therapist self-disclosure, and treatment progress from the client's perspective but also from the therapist's perspective, since Ain and Gelso's (2008) study did not take that perspective into account. The next section of this chapter will review the literature on therapist self-disclosure.

Therapist Self-Disclosure

Definition. Therapist self-disclosure is a broad term and can take on a number of different meanings. One can argue that all therapists self-disclose in one form or another. Even if therapists do not make any verbal disclosures, the way they decorate their office, the books on their bookshelves, and the way that they dress can all tell their clients something about who they are. For instance, if a therapist has the book *Gay Affirmative Therapy for the Straight Clinician: The Essential Guide* (Kort, 2008) displayed on his book shelf, he could be disclosing to his clients that he is both straight and gay affirming. Nonverbal therapist self-disclosures such as this can be either intentional or unintentional. For instance, a therapist with that book on his shelf could have deliberately placed it there to show that he is supportive of LGBT clients or, could have placed it on his shelf without having considered that his clients might see it and make inferences based on it. On the other hand, therapists can both intentionally and unintentionally make verbal self-disclosures. For example, a therapist can intentionally self-disclose how she overcame a challenge that is similar to what her client is facing in order to give her client insight into her own present issues. In this case, the therapist could be using self-disclosure

deliberately as a helping skill for her client (Hill, 2004). On the other hand, a therapist might, without thinking, blurt out a personal detail about herself to her client that is not relevant to the client's experience and could be seen as an unintentional self-disclosure.

In the present study, self-disclosures were defined according to using Hill and Knox's (2002) definition. They define therapist self-disclosure as verbal statements that reveal something personal about the therapist. Therefore, the present study examined verbal therapist self-disclosures that were both intentional and unintentional from both the client's and the therapist's perspectives.

Conceptualizations of therapist self-disclosure. Therapist self-disclosures have been conceptualized in many different ways (Farber, 2006), which is not surprising given the many ways in which it is possible to reveal something about oneself. Below are two examples of how types of therapist self-disclosures have been conceptualized. Hill & Knox's 2003 conceptualization includes several subtypes, and Farber (2006) conceptualizes self-disclosures as being either factual or self-involving.

Seven subtypes. Hill and Knox (2002) suggested that it is important to study the subtypes of therapist self-disclosure as opposed to maintaining a global view of the concept because many subtypes of therapist self-disclosures have important qualitative differences. Based on work by Hill and O'Brien (1999) and Kim et al. (2003), Hill and Knox (2003) suggest that there are at least seven subtypes of therapist self-disclosures: disclosures of facts, disclosures of feelings, disclosures of reassurance/support, disclosures of strategies, disclosures of challenges, disclosures of immediacy, and disclosures of insight. With disclosures of facts, the therapists tells his or her client factual information about his or her background (e.g., "I am a licensed social worker").

Disclosures of feelings occur when the therapist shares an emotional experience with his or her client. For example, Carl Rogers (1986) used a disclosure of feeling with one of his clients when he said “. . . I think I can understand pretty well – what it’s like to feel that you’re just no damn good to anybody, because there was a time when – I felt that way about myself. And I know it can be really rough” (Rogers, 1986). Disclosures of reassurance/support occur when the therapist shares with her client an experience that is similar to what the client is experiencing, such as “When I was a freshman in college I also struggled with adjusting to my new environment.” When a therapist makes a disclosure of strategy, he discusses an action that he has taken to deal with a problem that the client is experiencing (e.g. “When I start to feel anxious I relax myself by doing deep breathing exercises”). When a therapist makes a disclosure of challenge, she expresses a challenge that she has faced and overcome that relates to what her client is going through (e.g. “When I used to procrastinate, I learned that I needed to face both my fears of failure and my fears of success”). Disclosures of immediacy occur in the here and now of a session. They refer to a therapist expressing his or her reaction to a client in the moment (e.g. “I’m feeling stuck with what direction we should go in to work on this issue. I’m wondering if you are feeling the same”). Finally, with disclosures of insight the therapist shares something that he has learned about himself based on past experiences (e.g. “When I stopped and took look at my parenting style I noticed that, as a parent, I was more similar to my own parents than I had realized”).

To the author’s knowledge, there have only been a couple of studies that have included these particular subtypes of therapist self-disclosure and examined how they related to outcome. Kim, Hill, Gelso, Goates, Asay, & Harbin (2003) found that clients

perceived disclosure of strategies as being more helpful than disclosures of approval/reassurance, disclosures of facts, and disclosures of feelings. They also found that disclosures of strategies occurred more frequently in highly rated sessions than in session receiving low ratings. However, these results were based on a single session of counseling with Asian American clients and European American therapists. Therefore, the implications of this study are that a larger and more diverse sample is needed to be able to generalize the results. In addition, their study did not examine the helpfulness of therapist self-disclosures for therapy after multiple sessions.

Ain and Gelso (2008) examined clients' perceptions of their therapists' self-disclosures in therapy that had ended up to three years prior to their participation in the study. In this study Ain and Gelso (2008) also examined each of the aforementioned subtypes of therapist self-disclosure and how they related to clients' perceptions of their real relationships with their therapists and their therapy outcomes. The results were that clients who felt that their therapists self-disclosed an appropriated amount had stronger real relationships and better outcomes than clients who felt that their therapists did not disclosure enough. This was the case across all of the subtypes of therapist self-disclosure. The implication in this case is that, at least according to clients from therapy that has ended, is that it is important for therapists to disclose an appropriate amount of information regardless of the subtype of therapist self-disclosure that is used when it comes to the strength of the real relationship and therapy outcome. More information on this topic is needed in order to examine how therapist self-disclosure relates to the real relationship and to therapy progress prior to termination from both the client and therapist perspectives.

Factual versus self-involving. In his review of the literature on conceptualizations of therapist self-disclosures, Farber (2006) concluded that self-disclosures can be viewed as consisting of two main forms: factual self-disclosures and self-involving self disclosures. He defines factual self-disclosures as “facts or information about the therapist that can be further divided by the length of time spent discussing it, the personal nature of the information, and the amount of information shared” (p. 135). He defines self-involving disclosures as “the therapist’s articulation of his or her immediate or past feelings or experiences in response to a patient’s feelings or experiences” (p. 136). According to Farber (2006), self-involving disclosures have also been termed “immediacy,” or countertransference disclosures.

Myers and Hayes (2006) used a similar conceptualization in their analogue study on the effects of self-disclosure on ratings of therapist and session. They differentiated general self-disclosures, such as anecdotal or empathic disclosures, from countertransference disclosures, in which disclosures were of issues related to therapists’ unresolved intrapsychic conflicts that related to their clients’ issues. Their definition of countertransference disclosures in part pertains to Farber’s (2006) conceptualization of self-involving disclosures, although Farber’s definition does not specify that the disclosures must be about content that is unresolved. Myers and Hayes (2006) found that participants who had been in therapy before viewed sessions as deeper when the therapist made countertransference disclosures as opposed to general disclosures. However, participants who had not been in therapy before were in a better mood after sessions in which the therapist made general disclosures, as opposed to countertransference disclosures or no disclosures. In addition, they found that when the working alliance was perceived

to be positive, sessions were rated as deeper and the therapist was rated as more expert when he made general disclosures versus no disclosures. On the other hand, when the alliance was perceived as negative, sessions were rated as shallower and the therapist was rated as less expert than when he made either general or countertransference disclosures, as opposed to no disclosures. An implication from their results was that therapists should avoid discussing their own unresolved issues when their working alliance is poor and the client has not been in therapy before.

Therapist self-disclosure and theoretical orientation. Therapist self-disclosure is a controversial issue in psychotherapy. One reason for this is because therapist self-disclosures fall on the boundary between personal and professional behavior (Farber, 2006). According to Zur (2007), “Self-disclosure is considered a boundary issue as it crosses the interpersonal boundary between therapists and clients in the direction of the client rather than in the professionally expected direction of the therapist’ (p.151). Among various theoretical orientations there are different views as to if and how therapist self-disclosures should be used.

Traditional psychoanalysis. Traditional psychoanalysts typically strive to limit therapist self-disclosures for fear of diluting transference. From this perspective, the therapist should be a blank screen, as neutral as possible, to promote the client’s (or, using psychoanalytic terms, the patient’s) transference. Freud (1912), for example, stated that “The analyst should be impenetrable to the patient, and like a mirror, reflect nothing but what is shown to him” (p.18). The belief was that the more the patient learns about his or her therapist, the less he or she will experience transference with the therapist, and the transference that is experienced will be more muddled. From this perspective,

therapist self-disclosure was often thought to have a negative impact on therapy, because, according to traditional psychoanalytic theory, transference is the primary mechanism for therapeutic change. However, some classical psychoanalysts are more open to therapist self-disclosures. For instance, Greenson (1967), a prominent psychoanalyst, claims that it is important to accept that complete neutrality is impossible. He writes:

It is also important to keep in mind that while our patients have much less opportunity to know us than the other way around, nevertheless they are not without resources. Everything we do or say, or don't do or say, every bit of our surroundings from the office décor to our waiting room magazines, the way we open the door, greet our patients, make interpretations, keep silent, end the hour, all these and much more reveal something about our real self, going far beyond our professional self (p. 373).

Greenson believes that therapists should accept the fact that neutrality cannot exist, and should foster the real relationship. Other prominent psychoanalysts such as Esther Menaker (1942) and Anna Freud (1954) have also acknowledged the inevitability of the real relationship. Therefore, although many traditional psychoanalytic theorists may reject therapist self-disclosures and insist on neutrality, many others have become more accepting of therapist self-disclosures.

When it comes to examining therapist self-disclosure from a psychoanalytic perspective, it is also important to note the shift in psychoanalysis that has occurred over the past few decades. This shift has affected the definition of a successful psychoanalytic relationship and psychoanalytic views on therapist self-disclosure. Psychoanalysts have been moving away from classical drive and ego psychological theory toward object

relations theory, self psychology, and an integration of the two (Gelso and Hayes, 1998). This shift has relaxed the classical view that therapists should strive to be blank screens. As a result of this shift, one important change in the psychoanalytic perspective is that therapist self-disclosures are becoming more accepted by many psychoanalysts. Aron (1996) notes this transformation and its affect on the topic of therapist self-disclosure:

A study of the accumulating analytic literature on self-disclosure should lead us to marvel at the incredible transformation that has taken place in the world of psychoanalysis in just a few short years. It is, indeed, only recently that the analyst's self-disclosure has appeared on the psychoanalytic scene as a topic of panels and symposia in our meetings and as a subject worthy of investigation in our journals. In the near future, textbooks on psychoanalysis will undoubtedly contain chapters on self-disclosure, and institutes will have courses and clinical case seminars devoted to this subject (p. 221).

According to Aron, self-disclosure is becoming an important topic in the world of psychoanalysis and is no longer viewed as a mistake or something that psychoanalysts need to avoid. Gelso and Hayes (1998) sum up this shift as follows:

At this point, it is safe to say that self-disclosure is no longer a dirty word in psychoanalysis, and is beginning to be examined openly. Analytic therapists, on the whole, are surely less disclosing than their humanistic and feminist cousins, but are just as surely more open to the possible benefits of 'controlled disclosures' than they were in times past (pp. 181-182).

Cognitive, behavior, and cognitive behavior therapists. The controversy over therapist self-disclosure exists not only among psychoanalysts, but also among cognitive

therapists, behavior therapists, and cognitive behavior therapists. For instance, Wolpe (1984), a behavior therapist, stated that therapist self-disclosures are not a behavior therapy technique. On the other hand Lazarus (1985), a cognitive therapist, stated that self-disclosure can enhance the therapy relationship and can be useful when using techniques such as modeling and behavior rehearsal. Aaron Beck, arguably one of the most famous cognitive therapists, also felt that therapist self-disclosure can be helpful in psychotherapy. Beck, Freedman, & Associates stated that “Much of the [cognitive] therapist’s role consists of drawing on his or her own life experiences and wisdom to propose possible solutions to problems, as well as to educate the patient regarding the nature of intimate relationships” (1990, p. 66). Beck et al. (1990) felt that therapists should serve as role models, offering concrete examples of behaviors and patterns for their clients to emulate. Cognitive behavior therapists Godfried, Burckell, and Eubanks-Carter (2003) agree that therapist self-disclosure can be helpful. They found that therapist self-disclosure has the potential to strengthen the therapeutic bond, normalize the client’s reaction, reduce the client’s fears, and model an effective way of functioning.

Humanistic and existential therapists. Traditionally, humanistic and existential theorists on the whole are more in favor of using therapist self-disclosures than other theoretical orientations. They believe that therapist self-disclosure can be beneficial in psychotherapy because it equalizes power in the relationship (Jourard, 1971), demystifies the psychotherapy process (Kaslow, Cooper, & Linsenberg, 1979), and promotes clients’ openness, trust, insight, and change (Rogers, 1951; Truax & Carkhuff, 1967).

Feminist and multicultural therapists. Feminist theorists also tend to favor the use of therapist self-disclosures. They view it as an important intervention (Enns, 1997)

because it can help equalize power and foster a feeling of solidarity between therapist and client (Mahalik, VanOrmer, & Simi, 2000). These benefits of therapist self-disclosure are particularly important to feminist therapists because feminist therapy is based around enhancing the client's empowerment. Feminist therapists are known for being open with their clients about their values, opinions, and feelings about emotionally and politically controversial issues such as sexual orientation in order to allow their clients to determine whether or not their therapists are unbiased if these issues come up (Brown & Walker, 1990).

Multicultural theorists have suggested that therapist self-disclosure can be used to convey cultural and racial sensitivity to culturally diverse clients (Sue and Sue, 2003). Burkard, Knox, Groen, Perez, and Hess (2006) found that therapists self-disclosed in cross-cultural counseling with the intentions of enhancing the counseling relationship, acknowledging the role of racism/oppression in clients' lives, and acknowledging their own racist/oppressive attitudes. In this study, therapists felt that their self-disclosures typically had positive effects in therapy. They felt that their self-disclosures improved their relationships with their clients by helping their clients feel understood and by enabling their clients to advance to other pressing issues.

Research on therapist self-disclosure. The research on therapist self-disclosure suggests that there is a positive relationship between therapist self-disclosure and outcome. This was apparent from the client's perspective when Hill et al. (1988) found that clients gave the highest ratings of helpfulness to therapist self-disclosures over other verbal response modes and showed the highest levels of experiencing (involvement with their feelings) in response to therapist self-disclosures. However, therapists in the study

rated their self-disclosures as the least helpful response mode. Therapist self-disclosure was also the least frequently used response mode by therapists. Hill et al. (1988) hypothesized that they may have found their therapists' self-disclosures helpful because they enables the therapist to be seen as more human and may have shifted the power balance in such a way that allowed clients to feel less vulnerable. Hill et al. (1988) also hypothesized that the fact that therapist self-disclosures were used so rarely may have caused clients to value them more.

In a study by Ramsdell and Ramsdell (1993), clients also had positive reactions to therapist self-disclosures. The majority of the clients in this study rated therapist self-disclosure as one of only three social behaviors (out of 14 possible social behaviors) that was likely to be beneficial in therapy. However, only 15% of these clients indicated that their therapists self-disclosed more than two or three times over the course of therapy. Therefore, these findings indicate that clients find therapist self-disclosures helpful in small amounts. A qualitative study by Knox et al. (1997) shed some light on why clients find therapist self-disclosure helpful in therapy. They found the following positive consequences for clients that resulted from their therapists' self-disclosures: clients gained insight and perspective to make changes, the therapist was seen as more real, the relationship was seen as improved, clients felt more normalized and reassured, and the clients could use the therapist as a model for positive change.

More recently, two case studies have provided rich data on therapist immediacy, a type of therapist self-disclosure. Immediacy is defined by Hill (2004) as therapist disclosure of his or her feelings about the client, feelings about himself or herself in relation to the client, or feelings about the therapeutic

relationship. Both case studies found that the client had positive and negative reactions to therapist immediacy. Therapist immediacy in Kasper, Hill, and Kivlighan's (2008) seemed to help the client be more immediate, open up more, express her feelings, feel closer to her therapist, and be more satisfied with her session. On the other hand, therapist immediacy also seemed to cause the client to feel more pressure to respond, awkward, vulnerable, challenged, and hurt. In Hill, Sim, Spangler, Stahl, Sullivan, and Teyber's (2008) case study, therapist immediacy seemed to serve four functions. It helped the client negotiate the relationship, express her feelings about her therapist to him directly, help her heal by having a safe place to open up and explore personal topics deeply, and have a corrective emotional experience. However, therapist immediacy also seemed to have negative feelings on the client such as causing her to feel puzzled and pressured to respond.

Ain and Gelso's (2008) study on client's retrospective reports of therapy that had ended up to three years previously also showed how therapist self-disclosure related to the client-therapist relationship. Clients who reported that their therapists self-disclosed an amount that was "just right" had stronger real relationships and better therapy outcomes than clients who reported that their therapists disclosed "not enough." So few clients reported that their therapists disclosed "too much" that there was not enough power to statistically analyze those participants. All of these results taken together imply that clients find therapist self-disclosures helpful. However, there is not enough research on therapists' perspectives on how helpful they find their use of self-disclosures.

A number of questions remain when it comes to therapist self-disclosure. For example, although therapists are advised to be judicious in their use of self-disclosures, research is needed in order to determine what amount or frequency of therapist self-disclosure results in better or worse therapy outcomes. This is in large part due to the significant limitations of therapist self-disclosure research. Hill and Knox (2002) laid out the following limitations of therapist self-disclosure research: They state that the number of definitions for therapist self-disclosures make it difficult to make comparisons among studies, the reliance on analogue methodology to examine the effects of therapist self-disclosure result in low external validity, and, along those lines, a lack of practical strategies for obtaining more generalizable data on the effects of therapist self-disclosure on psychotherapy make it difficult to examine how therapist self-disclosure affects the psychotherapy outcome.

Suggestions for therapists on using self-disclosures. Based on the research, Hill and Knox (2003) made several suggestions for how therapists should disclose to their clients. They recommended that therapists use self-disclosures, but keep their use to a minimum because the focus should remain on the client. They also recommend that therapists make sure that they use appropriate content and levels of intimacy in their self-disclosures, and to fit their disclosures to the client's individual needs and preferences. Ain and Gelso's (2008) study lends support to Hill and Knox's (2003) recommendation to fit the disclosure to the client. They found that when relevance and amount of therapist self-disclosure were considered together, amount was only related to the real relationship when the relevance was taken into account. In addition, clients who related to their therapists' self-disclosures had better outcomes and stronger real relationships

than clients who did not relate to their therapists' disclosures. Hill and Knox's (2003) other recommendations for using self-disclosures are to have appropriate reasons for self-disclosing, return the focus to the client after self-disclosing, disclose resolved issues as opposed to current struggles, have their clients respond to the disclosure, consider using disclosures to facilitate termination, and to consider using disclosures of immediacy.

Therapist self-disclosure and the real relationship. When it comes to understanding the real relationship between the client and therapist, therapist self-disclosure is important to take into account. Gelso (2002) states "The real relationship unfolds whatever we do; it cannot *not* exist. At the same time, certain kinds of therapist sharing will bring it out and strengthen it" (p. 38). This seems likely because the concept of therapist self-disclosure seems to have connections to the genuineness and realism components of the real relationship. For example, a client might idealize his therapist and unrealistically perceive his therapist as being a perfect person. If his therapist were to tell him that he too has struggled with procrastination, the client might start to see his therapist as a person who, like everyone, has flaws that he has to deal with. In this case, the therapist's self-disclosure caused his client to see him more realistically, which related to the realism component of the real relationship. Another example of how therapist self-disclosure could influence the real relationship is if a therapist gives an honest reaction to her client as opposed to attempting to mask her reaction and be a blank screen. In this case, her client may be more likely to view the therapist as being non-phony and genuine. This relates to the genuineness component of the real relationship.

Knox et al.'s (1997) qualitative study in which 13 adult psychotherapy clients were interviewed about their experiences with therapist self-disclosure supports the idea

that therapist self-disclosure relates to the real relationship. Client participants in this study stated that therapists' self-disclosures resulted in perceptions of their therapists as more real and human and allowed the clients to be more open and honest in therapy. These results pertain to both the genuineness and realism components of the real relationship and imply that the therapists' self-disclosures strengthened their real relationships with their clients.

In addition, Ain and Gelso's (2008) study on the real relationship and therapist self-disclosure from the client's perspective (described in detail above) showed that clients whose therapists self-disclosed an amount that was "just right" had stronger real relationships than clients whose therapists disclosed "not enough." The results of this study also indicated that clients who related to their therapists' self-disclosures had better outcomes and stronger real relationships than clients who did not relate to their therapists' disclosures.

Therefore, since it appears that therapist self-disclosure relates to the real relationship from the client's perspective, it is important to continue to examine the relationship between these two constructs from the client's perspective. In addition, since, to the author's knowledge, there is no research linking therapist self-disclosure to the real relationship from the therapist's perspective, it would be helpful to learn more about how therapists view the relationship between their use of self-disclosures and the strength of their real relationships with their clients. The present study examined both client and therapist perspectives on the real relationship and therapist self-disclosure and how each relates to the progress of ongoing therapy.

Present Study

Research has shown that there is a link between the real relationship and therapist self-disclosure (e.g. Knox et al., 1997; Ain & Gelso, 2008). However, what we know about this link is mainly from the perspective of the client, not the therapist. The aim of the present study was to examine the real relationship and therapist self-disclosure individually as they relate to therapy progress and also to examine how they relate to each other from both client and the therapist perspectives. In order to get both perspectives, therapist-client dyads in ongoing psychotherapy were recruited to complete measures of the real relationship, therapist self-disclosure, and therapy progress.

Chapter 2

Statement of the Problem and Hypotheses

Statement of the Problem

Research over the past few years has suggested that the strength of the real relationship in psychotherapy relates to treatment progress and outcome (Ain & Gelso, 2008; Fuertes et al., 2007; LoCoco et al., in press; Marmarosh et al., 2009; Spiegel et al., 2008). Therefore, it is not only important to examine the real relationship to see if these findings are corroborated, but also to examine interventions that relate to the strength of the real relationship. One therapeutic intervention that seems to relate to the strength of the real relationship from the client's perspective is therapist self-disclosure (Ain & Gelso, 2008; Knox et al., 1997). In addition to its link to the real relationship, therapist self-disclosure appears to be linked to therapy outcome from the client's perspective (Ain & Gelso, 2008). However, since most of what we know is from the perspective of the client, more information is needed on therapist self-disclosure and its relation to the strength of the real relationship and treatment outcome from the therapist's perspective. In the present study the following relationships were examined: the real relationship and how it relates to therapy progress from both the client's and therapist's perspectives, therapist self-disclosure and how it relates to the real relationship from both perspectives, and therapist self-disclosure and its relationship to treatment progress from both perspectives. In order obtain more information on these relationships dyads in ongoing psychotherapy were surveyed on these constructs.

Hypotheses and Research Questions

Theoretical literature suggests that the real relationship is related to treatment progress and outcome. For example, Gelso and Hayes (1998) theorized that “The strength and valence of the real relationship, taken together, are significant factors in the effectiveness of psychotherapy.” In addition, empirical research on the real relationship has suggested that it positively relates to treatment progress and outcome in psychotherapy from both client and therapist perspectives (Ain & Gelso, 2008; Fuertes et al., 2007; LoCoco et al., in press; Marmarosh et al., 2009; Spiegel et al., 2008). Therefore, based on the theoretical and empirical literature, I predicted that the strength of the real relationship would positively relate to treatment progress from both the client’s and the therapist’s perspectives.

Hypothesis 1: There is a positive relationship between the strength of the real relationship and perceived progress in treatment. Thus, the stronger the real relationship, the better the treatment progress

Hypothesis 1a: The stronger the real relationship, the better the treatment progress from the therapist’s perspective.

Hypothesis 1b: The stronger the real relationship, the better the treatment progress from the client’s perspective. Ain and Gelso (2008) found that clients who perceived their therapists as disclosing an appropriate amount had stronger real relationships than clients who perceived their therapists as having not disclosed enough. Therefore, it was expected that these findings would be replicated in the present study. It was also predicted that clients who perceived their therapists as disclosing too much would have weaker real relationships than those who perceived their therapists as

disclosing an appropriate amount because disclosing too much can take the focus away from the client and can cause the therapist to seem as though he or she is too self-absorbed or not invested enough in what the client presents. This could affect the dimension of the real relationship that has to do with valence.

The appropriateness of the amount of therapist self-disclosure was examined as opposed to the amount of therapist self-disclosure because, for example, a therapist who discloses too much could weaken his real relationship with his client but a therapist who discloses too little could also weaken his real relationship with his client. Therefore, if the plan was to only examine the amount of therapist self-disclosure in relation to the real relationship, I would not have obtained as good of an idea of the nature of the relationship between the two constructs. A better way of gauging how therapist self-disclosures relate to the real relationship was by examining the appropriateness of the amount of disclosures. The appropriateness of the amount of therapist self-disclosures seemed likely to positively relate to the real relationship since it shows how satisfied the client is with his or her therapist's self-disclosures (for instance, it can show whether the client feels that the therapist disclosed not enough, too much, or about the right amount). This should be reflected in the aspect of the real relationship that has to do with valence, since valence pertains to clients' positive or negative feelings toward their therapists. In addition, Ain and Gelso's (2008) study examined therapist self-disclosure in terms of the appropriateness of the amount, and this hypothesis was based in part on their finding that clients who perceived their therapists as having disclosed an appropriate amount had stronger real relationships than those who perceived that their therapists did not disclose enough.

Hypothesis 2: Clients who perceive that their therapists disclosed an appropriate amount will view their real relationships with their therapists as stronger than clients who perceive that their therapists did not disclose enough or disclosed too much

It makes sense that clients who believe that their therapists disclosed too much or not enough will be less satisfied with their progress in treatment than clients who believe that their therapists have disclosed an appropriate amount. Hill and Knox (2003) state:

If therapists disclose either too infrequently or too frequently, the effect of the intervention may well be reduced. Therapists who never disclose may be experienced by clients as distant, aloof, and impenetrable, and as a result, the therapy relationship may be compromised. In contrast, therapists who disclose too frequently may be experienced as having tenuous therapy boundaries wherein the focus shifts away from the client and instead moves to the therapists. Thus, therapist self-disclosure may indeed be a helpful intervention, one whose frequency must be carefully monitored (p.533).

Ain and Gelso's (2008) study supported this rationale when it came to client's who felt that their therapist's did not disclose enough. They found that clients who perceived their therapists as not disclosing enough had poorer outcomes than clients who perceived that their therapists disclosed the right amount. Therefore, I predicted that, in ongoing therapy, clients who felt as though their therapists had disclosed an appropriate amount would perceive their treatment progress to be better than clients who felt as though their therapists had disclosed too much or not enough.

Hypothesis 3: Clients whose therapists disclose an appropriate amount will perceive their progress in therapy as better than clients whose therapists disclose too much or too little

Ain and Gelso (2008) found a positive correlation between the strength of the real relationship and the overall amount of therapist self-disclosure from the perspective of clients who had ended therapy up to three years previously. Therefore, in the present study I predicted that clients would also perceive a positive correlation between amount of therapist self-disclosure and the strength of the real relationship in therapy that was ongoing.

Hypothesis 4: The greater the amount of therapist self-disclosure, the stronger the real relationship from the client's perspective

One of Hill and Knox's (2003) suggestions for practitioners was to "Fit the disclosure to the particular client's needs and preferences" (p. 534). In addition, Bridges (2001) suggests that therapist self-disclosure is effective when therapists monitor their personal interest in disclosing and remain focused on the client. Ain and Gelso (2008) found a significant positive correlation between the strength of the real relationship and the relevance of therapists' self-disclosures from the clients' perspectives on previously terminated therapy. I predicted that the more relevant the therapists and clients perceived the therapists' self-disclosures, the stronger they would perceive their real relationships in therapy that was in progress.

Hypothesis 5: The more relevant the therapist self-disclosures are to the client the stronger the real relationship

Hypothesis 5a: The more relevant the therapist self-disclosures are to the client the stronger the real relationship from the therapist's perspective.

Hypothesis 5b: The more relevant the therapist self-disclosures are to the client the stronger the real relationship from the client's perspective. In Ain and Gelso's (2008) study on clients' views regarding therapy that had ended up to three years prior, a simultaneous multiple regression revealed that the overall relationship between the relevance of therapist self-disclosure and the amount of therapist self-disclosure, on the one hand, and the strength of the real relationship, on the other, was significant. However, the relevance of therapist self-disclosure was the only variable that uniquely related to the strength of the real relationship. This finding was interesting because it showed that the amount of therapist self-disclosure was not enough to predict the strength of the real relationship on its own. The finding implies that it is necessary to look not just at how much therapists self-disclose, but how relevant these disclosures are to their clients. This finding reinforced Hill and Knox's (2003) recommendation for therapists to only self-disclose material that is relevant to the client. Therefore, based on the empirical and theoretical literature, I predicted that when both client-rated relevance and amount of therapist self-disclosure were examined simultaneously, only the relevance would predict the client rated strength of the real relationship.

Hypothesis 6: When both the relevance and amount of therapist self-disclosures are examined simultaneously in relation to the real relationship, only the relevance will predict the strength of the real relationship from the client's perspective

I posed two research questions based on previous research that has implied that clients see a relationship between the appropriateness of the amount of their therapists'

self-disclosures and both their real relationships with their therapists and their therapy outcomes (Ain & Gelso, 2008). Since, to my knowledge, there was no research on the therapist's perspective of these variables, I planned to examine if therapists also saw relationships when it came to their self-disclosures and both the strength of their real relationships with their clients and the treatment progress.

Research question 1: Do therapists see a relationship between the appropriateness of the amount of their self-disclosures and their real relationships with their clients?

Research question 2: Do the therapists see a relationship between the appropriateness of the amount of their self-disclosures and the progress of therapy with their clients?

The third research question involved client and therapist agreement on the appropriateness of the therapist's self-disclosures. This research question was important because of its practical implications. If clients and therapists disagreed on the appropriateness of the amount of the therapists' self-disclosures, this discrepancy could have affected the therapeutic work. For instance, since research has implied that clients' perceptions of the appropriateness of the amount of their therapists' self-disclosures relates to both therapy outcome and the strength of their real relationships with their therapists, it is important for therapists to be aware of the appropriateness of the amount of their self-disclosures. But, if a discrepancy was found between how therapists perceived the appropriateness of the amount of their self-disclosures and how their clients perceived the appropriateness of the amount of their self-disclosures, this would imply that therapists need to gain a better understanding of how their self-disclosures are coming across to their clients. On the other hand, if the results showed that therapists and

clients appeared to be on the same page when it came to how they perceived the appropriateness of the amount of the self-disclosures, then it might have been concluded that therapists have a solid grasp on how their self-disclosures came across to their clients. Therapists could use that information to gauge for themselves whether or not they were disclosing too much, too little, or just the right amount.

Research question 3: To what extent do clients and therapists agree on the appropriateness of the amount of the therapists' self-disclosures?

Due to Ain and Gelso's (2008) finding that the more the therapist self-disclosed, the stronger the real relationship from the client's perspective of therapy that had ended up to three years prior, there was a question of whether this relationship would also exist from the therapist's perspective in ongoing psychotherapy. The fact that these results were found for clients in Ain and Gelso's study made it seem probable that therapists could have similar results. On the other hand, given that therapists are often cautioned against disclosing a great deal, it also seemed probable that a positive relationship would not be found between the amount of therapist self-disclosure and the strength of the real relationship from therapist's perspectives. Therefore this was posed as a research question in the present study.

Research Question 4: Is there a relationship between therapists' ratings of the amount of their self-disclosures and the strength of their real relationships with their clients?

In an analogue study on therapist self-disclosures and ratings of the therapist and session, Myers and Hayes (2006) found that, when the working alliance was positive, participants rated sessions as deeper and the therapist as more expert when the therapist

made general self-disclosures. However, they did not find this result when the alliance was negative. Their finding points to the possibility that the working alliance, a component of the psychotherapy relationship, may play a role in how self-disclosures relate to how the therapist and session depth are perceived. In the present study, it seemed probable that the real relationship would also play a role in how amount of therapist self-disclosure related to treatment progress, especially given the research that points to a link between the strength of the real relationship and therapist self-disclosure (Ain & Gelso, 2008; Knox et al., 1997).

From the client's perspective, the outcome of psychotherapy has been found to positively relate to both the strength of the real relationship and to the amount of therapist self-disclosure, and the amount of therapist self-disclosure has been found to relate to the strength of the real relationship (Ain & Gelso, 2008). Based on these relationships, the question arose of whether or not the real relationship would fully or partially mediate the relationship between the amount of therapist self-disclosure and treatment progress. In addition, given the mixed findings on the relationship between amount of therapist self-disclosure and outcome (Farber, 2006), it seemed that one way to better understand the nature of this relationship would be to see if it was mediated by the strength of the real relationship. This research question was posed from the therapist's perspective, the client's perspective, and their combined perspectives.

Research Question 5: Does the strength of the real relationship mediate the relationship between the amount of therapist self-disclosure and treatment progress?

Research question 5a: Does the strength of the real relationship mediate the relationship between the amount of therapist self-disclosure and treatment progress from the therapist's perspective?

Research question 5b: Does the strength of the real relationship mediate the relationship between the amount of therapist self-disclosure and treatment progress from the client's perspective?

Research question 5c: Does the strength of the real relationship mediate the relationship between the amount of therapist self-disclosure and treatment progress from the therapist's and client's combined perspectives?

Chapter 3

Method

Participants

Participants were nine therapists who were affiliated with a counseling psychology program at a large, mid-Atlantic University as faculty, adjunct, or affiliate, four therapists from a psychotherapy clinic affiliated with the same university, 20 therapists recruited from the editorial board of *Psychotherapy: Theory, Research, Practice, and Training*, and 83 therapists who were recruited from three divisions in the American Psychological Association. Twenty-four therapists were recruited from the division of Psychotherapy, 20 therapists from the Society of Counseling Psychology, and 39 therapists from the division of Psychologists in Independent Practice. One member of the division of Psychotherapy who was ineligible to participate referred a colleague who he believed would be willing to participate in the study. That colleague met the requirements of the study, agreed to participate, and was included in the study. In addition, a member of the editorial board referred his partner, who was also a practicing therapist who met all of the requirements for participation, and she was included as well.

Of those 118 therapists who agreed to participate, 28 did not respond to further emails after agreeing to participate, seven did not find a client to agree to participate, and one had a client who agreed to participate but then changed his or her mind. One of the therapists who agreed but then did not respond to further emails had a client who had also agreed, and who had completed the measures. Eighty-two therapist participants were left whose clients also agreed to participate. Seventy-nine of those therapist participants

completed measures. Of their 79 clients, 64 started the online measures and 61 completed them, leaving 61 dyads that were included in the study.

Participants each completed a demographic questionnaire, yielding the following: Therapist participants ranged in age from 31-76, with a mean age of 55.15 ($SD = 11.03$). A little over half the sample were male (52%, $N=32$), and the majority were Caucasian (87%, $n = 53$). Three therapists were African American (5%), one was Asian American, one was Hispanic, and three endorsed “other” as his or her racial identity. Fifty-seven therapists had Ph.D.s, three had MA or MS degrees, and one had an MD. Within the demographic questionnaire, therapists were given a list of theoretical orientations, including psychoanalytic, psychodynamic, cognitive, behavioral, and humanistic, and were asked to select the methods that best applied to their therapy with the client participant. They were given the option of endorsing all orientations that applied to their work because many therapists do not strictly adhere to any one theoretical orientation. The following numbers pertain to therapists who only endorsed one theoretical orientation: Seventeen therapists (27.9%) identified their theoretical as being psychodynamic, nine (14.75%) as being exclusively humanistic, eight (13.11%) as cognitive, and one (1.64%) as behavioral. Twenty-six therapists (42.62%) identified as being some combination of psychoanalytic, psychodynamic, cognitive, behavioral, and/or humanistic.

Client participants ranged in age from 19-74, with a mean age of 45 ($SD = 15.63$). The majority of the client participants were female (61%, $n = 37$), and the majority were Caucasian (93%, $n = 57$). One client was African American, one was Asian American,

one was Hispanic, and one endorsed “other” as his or her racial identity. The average number of sessions was 147.26 ($SD = 180.15$).

Measures

Real Relationship Inventory-Client Form (RRI-C; Kelley et al., in press; Appendix A). This scale was used to measure the strength of the real relationship from the client’s perspective. It contains 24 items, including two 12 item subscales to measure genuineness and realism. Genuineness is the willingness and ability to be authentic, honest, and open – in other words, to be who one truly is in the relationship. An example of an item from the RRI-C that measures genuineness is “I was able to be myself with my therapist.” Realistic perceptions are defined by the perceptions of the client or therapist that are not distorted by transference or other defenses. Realistic perceptions between the client and therapist enable them to view each other realistically (e.g., “I was able to separate out my realistic perceptions of my therapist from my unrealistic perceptions”). Within each subscale two additional dimensions, magnitude and valence, are examined, although scores are not provided for these. Magnitude pertains to how much of a real relationship exists between the client and the therapist. It assumes that the amount of genuineness and realism can fluctuate over the course of therapy. Valence pertains to the notion that clients’ and therapists’ feelings for one another within the context of the real relationship may range from very positive to very negative. Therefore, a client or therapist may genuinely like or dislike the other based on realistic perceptions. Items pertain to the client’s self, his or her therapist, and their relationship, and these items range on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores on the RRI-C reflect perceptions of the relationship as more real and genuine, with greater

perceived magnitude and positive valence. Overall, the higher the score on the RRI-C, the stronger the real relationship. The RRI-C was found to relate to Eugster and Wampold's (1996) measures of the real relationship, clients' observing ego strength, and a measure of therapist congruence. The RRI-C also negatively correlates with clients' tendency to hide true feelings in order to meet the expectations of others. The RRI-C did not correlate significantly with social desirability. Within the present sample, the internal consistency α was 0.84 for the Genuineness subscale, 0.87 for the Realism subscale, and 0.92 for the total measure.

The Real Relationship Inventory–Therapist Form (RRI-T; Gelso et al., 2005; Appendix B). The RRI-T was used to measure the strength of the real relationship from the therapist's perspective. Like the client version, the therapist version contains 24 items, including two 12 item subscales to measure genuineness and realism. An example of an item from the RRI-T that measures genuineness is "My client and I were honest in our relationship." An example of an item from the RRI-T that measures realism is "My client was able to see me as a real person separate from my role as a therapist." As with the client version, magnitude and valence are examined. Items pertain to the therapist's self, his or her client, and their relationship. These items range on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores on the RRI-T reflect perceptions of the relationship as more real and genuine, with greater perceived magnitude and positive valence. Gelso et al. (2005) found a coefficient alpha value of .89 for the total scale, .79 for the Realism subscale, and .83 for the Genuineness subscale. The RRI-T correlated in theoretically predicted ways with measures of the working alliance, session evaluation, client insight, and negative transference. It did not correlate significantly with social

desirability. In the present study, the internal consistency α was 0.80 for the Genuineness subscale, 0.76 for the Realism subscale, and 0.86 for the total measure.

Therapist Self-Disclosure Questionnaire-Client Form (TSDQ-C; Appendix C).

The main purpose of this measure is to assess the client-rated amount of therapist self-disclosures and the appropriateness of this amount. The instructions ask the client participant to rate items about his/her therapist with whom he or she is currently undergoing psychotherapy. The measure examines the seven subtypes of therapist self-disclosure suggested by Hill and Knox (2003): disclosures of facts, feeling, approval/reassurance, strategies, challenges, immediacy, and insight. Each subtype is rated by the clients on two scales, one for the amount of self-disclosure and one for the appropriateness of the amount of self-disclosure. The amount of therapist self-disclosure on each item is rated on a scale from 1 (*not at all*) to 2 (*some*) to 3 (*a lot*). The appropriateness of the amount of the therapist's self-disclosure for each item is rated on a scale from 1 (*not enough*) to 2 (*just right*) to 3 (*too much*). These scales originally ranged from 1 (*not enough*) to 3 (*just right*) to 5 (*too much*). Due to the ambiguity of what a "2" or a "4" would mean on the original scale, the new scale for this measure only ranges from 1 to 3. Two additional items appear at the end of the measure. In order to examine the participant's global view of his or her therapist's disclosures one item is "Overall, how much did your therapist disclose about him/herself." Participants rated this item on a scale from 1 (*not at all*) to 5 (*very much*). For the other item, participants rated how much their therapists' disclosures related to themselves (the clients) and their problems on a scale from 1 (*not at all*) to 5 (*very much*). Finally, for the present study, two new items were added to the measure. In order to get a more concrete estimate of

how much therapists self-disclosed, clients were asked: “How many self disclosures has your therapist made overall (please give your best estimate)?” Participants wrote in their answers and also wrote in the number of sessions that they had had so far with their therapists. Clients were also asked: “Overall how appropriate was the amount of your therapist’s self-disclosures?” Their options were 1 (*not enough*), 2 (*just right*), or 3 (*too much*). This item allowed me to look at a global scale of appropriateness of amount of therapist self-disclosure as opposed to being limited to looking at it only in terms of specific subtypes of therapist self-disclosures. This item was also added because in a previous study the subtypes of therapist self-disclosure did not yield differences for this item (Ain and Gelso, 2008).

Therapist Self-Disclosure Questionnaire-Therapist Form (TSDQ-T; Appendix D). The main purpose of this measure is to assess the therapist-rated amount of therapist self-disclosures and the appropriateness of this amount. The therapist version is very similar to the client version. It includes the same instructions and items except that they are framed for the therapist to answer from his or her perspective.

The Counseling Outcome Measure (COM; Gelso & Johnson 1983; Appendix E). This measure was used to assess client progress in therapy from both the client and therapist perspectives. Both clients and therapists completed this measure. The four-item measure asks the participant to evaluate the amount of the client’s improvement since the beginning of therapy. The item measures improvement in feelings, behavior, self-understanding, and overall functioning. The participant is asked to rate each item on a scale from 1 (*much worse*) to 4 (*no change*) to 7 (*much improved*). The scores on each item are added together to obtain one total score. The reliability of the COM has been

established via test-retest reliability and internal consistency. Gelso and Johnson (1983) found the 3-week test-retest reliability for individual items in the measure to range from .63 to .81. Tracey (1987) found the measure to have an alpha estimate of .89. Gelso, Kivlighan, Wine, Jones, and Friedman (1997) found the form to have an internal consistency of .89. The validity of the COM has been established via research that examined the interrelation in outcome estimates for structured interviews between clients, counselors, and independent judges. Gelso and Johnson (1983) found these correlations to be very high. Patton, Kivlighan, and Multon (1995) found significant correlations between client COM scores and the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). Patton et al. (1995) also reported significant correlations between client COM scores and the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). I used the COM as opposed to more established treatment progress measures because, in addition to being backed by sound data, it only consists of four items. This may have helped me recruit more participants for the study since it required less of a time commitment than other, more common progress measures. The internal consistency α within the current sample was 0.89 for clients and .86 for therapists.

The Global Assessment of Functioning Scale (GAF; The American Psychiatric Association, 1994; Appendix F). In order to obtain information regarding clients' levels of psychological functioning, therapists were asked to complete a modified version of the GAF. The GAF is a modified version of the Global Assessment Scale (GAS, Endicott, Spitzer, Fleiss, & Cohen, 1976) that assesses the client's overall psychological, social and occupational functioning. The GAF is a single score measure that can range from 1

(severe impairment) to 100 (superior functioning). The range of scores are divided into 10 equal intervals, with each interval describing a level of psychological, social, and occupational functioning. In the present study, the levels ranged from 1 to 10 rather than 1 to 100. Therapist participants also had the option of endorsing a 0 (“not enough information available to provide GAF”).

Procedure

Recruiting participants. A multi-pronged approach was used to recruit therapist participants. One approach was to recruit members from divisions of the American Psychological Association that related to psychotherapy and/or psychotherapy research. Three divisions were chosen from which to recruit participants: the division of Psychotherapy (division 29), the division Society of Counseling Psychology (division 17), and the division of Psychologists in Independent Practice (division 42). Membership lists with contact information were obtained from APA.org for each division that was used. In an effort to find members who were practicing psychotherapy, only full members who were state-licensed were included. Of these members, every fifth member from each division was contacted. If members did not have a valid email address, or if members had already been contacted due to being a member of a different division, they were skipped, and the next member on the list filled that slot. If members who were contacted responded that they were not eligible to participate in the study they were replaced by the next member on the list. Among all divisions, 1704 members were asked to participate.

In addition, due to their involvement and interest in psychotherapy research, 75 members of the editorial board of *Psychotherapy: Theory, Research, Practice, and*

Training were asked to participate in the hopes that the practicing members would be likely to agree. Six faculty, 12 adjuncts, and one affiliate of a counseling psychology program at a large, mid-Atlantic university who were practicing therapists were also asked for their participation. Finally, eight advanced graduate student therapists at a psychotherapy clinic and research lab at a large, mid-Atlantic university were asked for their participation.

Data collection. The 1808 potential participants were emailed a letter that briefly described the nature of the study and asked them to respond if they were interested, or to respond that they were ineligible or did not wish to participate (Appendix G). If, after 10 days, no response was received, a reminder letter was sent ($n = 1366$). If no response was received after an additional 10 days, a final reminder was sent ($n = 1087$). For therapists who responded that they were interested in participating, a letter was emailed describing the study in more detail and requesting that they ask their next client on their current caseload with whom they had had at least five sessions, who was at least 18 years old, and who they believed would agree to participate, to participate (Appendix H). The letter instructed them to tell their client that it was a study on the therapy relationship, therapist self-disclosure, and treatment progress, that it would be completed online and would take approximately 20 minutes, and that the researchers ensured that their responses would be handled in a confidential manner. Although selection issues were created by allowing therapists to select which clients they would ask to participate, the intent of this approach was to increase the likelihood of both therapist and client participation. The idea was that therapists would be more likely to agree to participate if it meant that they could decide which client to ask, and they might choose to ask clients who would be more likely to

participate. Fuertes et al. (2007) was able to obtain approximately a 20 percent return rate using this procedure. Therapists were asked to request participation from one client at a time until they found one client who agreed to participate in the study. The letter instructed the therapists to ask the client participants for their email addresses, so that I could email them the measures.

If no response was received after 10 days, therapists were sent a reminder email ($n = 85$), and received a final reminder if they were not heard from after another 10 days ($n = 65$). Upon receipt of the client email addresses, links for the surveys were sent to both clients and therapists. Clients and therapists were also assigned corresponding numbers for the purpose of anonymity. Participants were instructed to complete the surveys with the other person in mind. They were instructed that the measures would take approximately one half-hour to complete. If, after 10 days, the surveys were not completed, reminder emails were sent to participants ($n = 28$), and another, final reminder would follow if there was no response for 10 days ($n = 18$). In addition, if surveys were only partially completed, an email was sent to notify the participant of the incomplete survey in case it was in error ($n = 8$). The email stressed that it was his or her choice if he or she wanted to complete the measures or not.

Of the 1808 potential participants contacted by email, 420 (23.2%) were either ineligible, or their email addresses did not work. A variety of reasons for being ineligible were given, including that the potential participants did not practice, or were no longer practicing psychotherapy, they worked only with minors, they worked in an environment in which research was not permitted, and they did not have clients who met the criteria, among others. Of the remaining 1388 potential participants, 118 (8.5%) agreed to

participate, 219 (15.78%) declined participation, and 1051 (75.72%) did not respond. As mentioned above, 79 therapists completed all measures, resulting in a return rate of 5.69% for therapists. This return rate was low, and will be discussed in the limitations section in Chapter 5. Although it was not possible to know precisely the number of clients who were asked to participate due to therapists who did not respond to reminder emails, the information that was obtained from therapists was that 90 clients were asked for their participation. Of these clients, seven declined, and one agreed but later declined, leaving 82 clients who agreed to participate. Sixty-two of these clients completed the measures, resulting in a return rate of 68.89 percent. One of these clients was not included in the analyses because his or her therapist did not complete the measures. Client response rates are likely high due to the selection bias of therapists asking clients whom they thought would agree to participate.

In this study, online data was collected through the use of an online survey on [surveymonkey.com](https://www.surveymonkey.com). The choice of internet data collection was made given the many advantages of internet research, such as lower costs, ease of administration, design options, and the fact that results tend to be equivalent to paper-and-pencil survey methods, including the factor structure and psychometric properties of instruments in measure development research (e.g., Gosling, Vazire, Srivastave, & John, 2004).

Chapter 4

Results

This chapter consists of the descriptive findings, analysis of hypotheses and research questions, and additional analyses for the present study. In the present study, alpha was set at .05.

Descriptive Findings

Descriptive data regarding the participants including age, number of sessions, number of therapist self-disclosures, and therapists' Global Assessment of Functioning (GAF) for their clients is present in Table 1. The number of sessions was calculated by averaging therapist and client reports of number of sessions. The average difference between therapist and client reported number of sessions was 76 sessions ($SD = 159.56$), suggesting that the reported number of sessions was not a reliable indicator of actual number of sessions. On other hand, it could be reliably concluded that there was a high number of sessions as compared to other similar studies. For example, the average number of sessions in Marmarosh et al.'s, (2009) study was 15, and the average number in Spiegel et al.'s (2008) study was eight. In the present study, therapists and their clients consistently reported high numbers of sessions as compared to these other studies. For example, in 20 of the dyads (32.79%), both members reported that the number of sessions were over 100. However, due to the inconsistent reports of numbers of sessions, all results from analyses examining number of sessions should be interpreted with caution.

The distribution for number of sessions was highly skewed. The number of sessions, in addition to all measures, were examined for outliers using the definition that

any scores with absolute z values greater than 3.29 ($p < .001$, two-tailed) can be considered outliers (Tabachnick & Fidell, 2001). According to this definition, eight dyads had an average reported number of sessions that exceeded the limit. However, in four of those dyads, only one member's report exceeded the limit. Careful consideration was given to whether or not to exclude the outliers from the analysis, as it would eliminate valuable information regarding dyads in long-term therapy. It was concluded that excluding the dyads would go against the aim of the present study, which was to examine real cases of psychotherapy as they naturally occur. It was therefore decided that those dyads in which outliers were found for number of sessions would be included in analyses.

Table 1

Means and Standard Deviations of Descriptive Data

Variable of interest	N	Min	Max	Mean	Median	Mode	SD
Therapist Age	61	31	76	55.15	57	60	5.33
Client Age	61	19	74	45.00	48	55	15.63
Number of Therapy Sessions	61	7	679	147.26	75	36.5	180.15
GAF	61	4	7	6.61	7	7	1.13

Means and standard deviations of the therapist perceptions of the real relationship, therapy progress, overall amount of therapist self-disclosure, and overall relevance of therapist self-disclosure are reported in Table 2. The means of the therapist ratings of the real relationship is higher than means from previous studies on therapist perceptions of the real relationship (Gelso et al., 2005; Marmarosh et al., 2009).

Table 2

Means and Standard Deviations of Variables of Interest from the Therapist's Perspective

Variable of interest	N	Item Range	Mean Item Score	SD
Real relationship	61	1-5	4.03	.39
Treatment Progress	61	1-7	6.08	.67
Amount of therapist self-disclosure	61	1-5	2.80	.87
Relevance of therapist self-disclosure to client	61	1-5	4.38	.84

Means and standard deviations of the client perceptions of the real relationship, therapy progress, amount of therapist self-disclosure, and relevance of therapist self-disclosure are reported in Table 3. The means of the client ratings of the real relationship fall between client ratings from prior studies..

Table 3

Means and Standard Deviations of Variables of Interest from the Client's Perspective

Variable of interest	N	Item Range	Mean Item Score	SD
Real relationship	61	1-5	4.04	0.38
Treatment Progress	61	1-7	6.34	0.69
Amount of therapist self-disclosure	61	1-5	2.87	0.99
Relevance of therapist self-disclosure to client	61	1-5	3.84	1.07

Correlations of variables of interest and demographic variables including age, number of therapy sessions, and client global assessment of functioning (GAF) are presented in Table 4 (see Appendix I). Due to the high correlation between number of sessions and number of months in therapy ($r = .71, p < .01$), only sessions were included as a measure of therapy duration. The number of sessions was calculated by averaging the client-reported number of sessions and the therapist-reported number of sessions. The following correlations were all significant and will be discussed in Chapter 5: From the clients' perspectives, a significant positive correlation was found between the strength of the real relationship, on the one hand, and client age and therapist age, on the other.

From both therapist and client perspectives, a positive correlation was found between the number of sessions, on the one hand, and treatment progress and the strength of the real relationship, on the other. In addition, a positive correlation was found between therapist age and amount of therapist self-disclosure from both perspectives. Finally, a significant positive correlation was found between the therapist-rated GAF for their clients and treatment progress.

Means and standard deviations for amount of therapist self-disclosure from both therapist and client perspectives for each subtype of therapist self-disclosure are presented in table 5 (Appendix J). From both perspectives, the average amount of therapist self-disclosure for most of the seven subtypes fell between 1 (not at all) and 2 (some).

Analysis of Hypotheses and Research Questions

The following results are organized according to each hypothesis and research question from the present study. Correlations for hypotheses 1, 2, and 3 and research question 3 are presented in Table 6.

Of the 61 clients who participated in this study, only two clients reported that their therapists did not disclose enough. No clients reported that their therapists disclosed too much, leaving 59 clients who reported that the amount that their therapists disclosed was “about the right amount.” In addition, of those clients’ 61 therapists who participated in this study, only one therapist reported that he or she did not disclose enough, and one therapist reported that he or she disclosed too much, leaving 59 therapists who reported that the amount that they self-disclosed was “about the right amount.” Therefore, there was not enough data from clients and therapists who thought that there was “too much” or “not enough” self-disclosure to analyze two of the hypotheses and three of the research questions. In addition, hypothesis 6 could not be analyzed because the relevance of therapist self-disclosure did not significantly predict the strength of the real relationship from either the therapist’s or the client’s perspective. Since this relationship was not statistically significant from either perspective, a regression analyses could not be completed using the relevance of therapist self-disclosure as an independent variable and the strength of the real relationship as the dependent variable. As a result, the above hypotheses and research questions were dropped. The rest of the hypotheses and research questions from chapter 3 were renumbered and appear below.

Table 6

Intercorrelation Matrix for Hypotheses and Research Questions

Variable	1	2	3	4	5	6	7	8
1. Real Relationship - C	1.0							
2. Treatment Progress - C	.64**	1.0						
3. Amount of Self-Disclosure - C	.40**	.24	1.0					
4. Relevance of Self-Disclosure - C	.20	.46**	.36**	1.0				
5. Real Relationship - T	.48**	.27*	.17	.10	1.0			
6. Treatment Progress - T	.42**	.67**	.22	.41**	.41**	1.0		
7. Amount of Self-Disclosure - T	.33**	.27*	.39**	.32*	.35**	.42**	1.0	
8. Relevance of Self Disclosure - T	-.11	-.05	.02	.09	.06	-.19	.03	1.0

Note. C = Client's perspective, T = Therapist's perspective

* $p < .05$. ** $p < .01$

Hypothesis 1: There is a positive relationship between the strength of the real relationship and perceived progress in treatment. Thus, the stronger the real relationship, the better the treatment progress.

This hypothesis was separated into two subhypotheses in order to examine it from the therapist and client perspective.

Hypothesis 1a: The stronger the real relationship, the better the treatment progress from the therapist's perspective.

This hypothesis was supported by the data. The Pearson's correlation between the strength of the real relationship and treatment progress from the therapist's perspective was 0.41 ($p < .01$).

Hypothesis 1b: The stronger the real relationship, the better the treatment progress from the client's perspective.

This hypothesis was supported by the data. The Pearson's correlation between the strength of the real relationship and treatment progress from the client's perspective was 0.64 ($p < .01$).

Hypothesis 2: The greater the amount of therapist self-disclose, the stronger the real relationship from the client's perspectives.

This hypothesis was supported by the data. The Pearson's correlation between the amount of therapist self-disclosure and the strength of the real relationship from the client's perspective was 0.40 ($p < .01$). These variables are examined from the therapist's perspective in research question 1, and the results are presented below.

Hypothesis 3: The more relevant the therapist self-disclosures are to the client, the stronger the real relationship.

This hypothesis was broken up into two subhypotheses in order to examine both therapist and client perspectives.

Hypothesis 3a: The more relevant the therapist self-disclosures are to the therapist, the stronger the real relationship from the therapist's perspective.

This hypothesis was not supported by the data. The Pearson's correlation between the relevance of therapist self-disclosure and the strength of the real relationship from the therapist's perspective was 0.03 ($p = .82$).

Hypothesis 3b: The more relevant the therapist self-disclosures are to the client, the stronger the real relationship from the client's perspective.

This hypothesis was not supported by the data. The Pearson's correlation between the relevance of therapist self-disclosure and the strength of the real relationship from the client's perspective was 0.20 ($p = .12$).

Research Question 1: Is there a relationship between the therapists' ratings of the amount of their self-disclosures and the strength of their real relationships with their clients?

A positive correlation was found between the overall amount of therapist self-disclosure and the strength of the real relationship from the therapist's perspective. The Pearson's correlation between the amount of therapist self-disclosure and the strength of the real relationship from the therapist's perspective was 0.34 ($p < .01$).

Research Question 2: Does the strength of the real relationship mediate the relationship between the amount of therapist self-disclosure and the progress of treatment?

Since no significant relationship was found between the strength of the real relationship from the client's perspective and treatment progress, this research question could only be examined from the therapist's perspective. A mediation analysis using logistic regression was conducted to determine whether the strength of the real relationship mediated the relationship between the amount of therapist self-disclosure and treatment progress from the therapist's perspective. Due to the skewed distribution of the strength of the real relationship from the therapist's perspective, the data was recoded into a dichotomous variable reflecting weaker real relationships (scores of 97 or less; 42.62%), and stronger real relationships (scores greater than 97; 57.38%). The predictor variable, the amount of therapist self-disclosure, was also recoded into a dichotomous

variable due to the skewed distribution of scores. Scores of 2 or less (40.98%) were reflective of lower amounts of therapist self-disclosure, and scores greater than 2 (59.02%), were reflective of higher amounts of therapist self-disclosure. The dependent variable, treatment progress, was also recoded into dichotomous variables due to the distribution of scores. Low progress reflected scores of 24 or less (52.56%), and high progress reflected scores greater than 24 (47.54%).

Demographic variables for therapists were then examined to determine whether or not they were significant predictors of treatment progress by conducting a series of logistic regression analyses. Therapist age was the only variable to reveal significant effects. The results indicated that compared to younger therapists (ages 30-44 years old), older therapists (ages ≥ 60) had greater odds of a higher progress score ($p < .05$). Therefore, therapist age was included in the final models.

Baron and Kenny's (1986) procedure for analysis of mediation effects was used. Their procedure consists of four steps:

1. There must be a significant relationship between the predictor variable (amount of therapist self-disclosure) and the criterion variable (treatment progress).
2. There must be a significant relationship between the predictor variable (amount of therapist self-disclosure) and the potential mediator (strength of the real relationship).
3. There must be a significant relationship between the potential mediating variable and the criterion variable, while controlling for the effects of the predictor variable

4. In order to establish that the potential mediator completely mediates the relationship between the predictor and the criterion, the effect of the predictor on the criterion, controlling for the mediator, should equal zero.

All four steps must be met in order to for there to be evidence that the potential mediator completely mediates the relationship between the predictor variable and the criterion variable, and the first three steps much be met in order to obtain evidence that the potential mediator partially mediates the relationship. Below are the results for the steps of the mediation analysis in the present study:

1. The results indicated that the amount of therapist self-disclosure predicted greater odds of better treatment progress (OR = 4.90, $p < .01$). Therapist age was not significant. The requirements for the first step were met.
2. The strength of the real relationship was regressed on the amount of therapist self-disclosure, controlling for therapist age. Therapist age was not significant. The results revealed that the amount of therapist self-disclosure did not predict greater odds of a stronger real relationship ($p = .16$). The requirements for step two were not met. Thus, mediation could not be tested.

The results suggest that the strength of the real relationship does not significantly help to better predict the treatment progress.

Additional Analyses

All correlations are presented in table 4, and significant correlations will be discussed in the next chapter. Pearson's correlations were used to examine the relationship between the relevance of therapist self-disclosure from the client's perspective and variables of interest. Significant positive correlations were found

between the relevance of therapist self-disclosure and treatment progress ($r = .46, p < .01$) and relevance of therapist self-disclosure and amount of therapist self-disclosure ($r = .36, p < .01$).

Pearson's correlations were also used to examine the relationship between the amount of self-disclosure from the therapist's perspective and variables of interest. Significant positive correlations were found between the amount of self-disclosure from the therapist's perspective, on the one hand, and the strength of the real relationship ($r = 0.34, p < .01$), genuineness ($r = .30, p < .05$), realism ($r = .33, p < .05$), and treatment progress ($r = .38, p < .01$), on the other.

In addition, Pearson's correlations were used to examine the cross-correlations between the therapists' perspectives and the clients' perspectives on variables of interest. A number of significant correlations were found related to the strength of the real relationship and therapist self-disclosure. When analyzing cross-correlations for the real relationship, client perceptions of the strength of the real relationship, on the one hand, were significantly and positively correlated with therapist perceptions of the strength of the real relationship ($r = .48, p < .01$), therapist perceptions of treatment progress ($r = .42, p < .01$), and therapist perceptions of the amount of therapist self-disclosure ($r = .33, p < .01$), on the other. Therapist perceptions of the real relationship were significantly and positively related to treatment progress from the client's perspective ($r = .27, p < .05$). Therapist perceptions of treatment progress were also significantly and positively correlated with client perceptions of treatment progress ($r = .67, p < .01$).

In terms of therapist self disclosure, therapist perceptions of the amount of therapist self-disclosure, on the one hand, were positively and significantly related to

client perceptions of the amount of therapist self-disclosure ($r = .39, p < .01$) and client perceptions of treatment progress ($r = .27, p < .05$), on the other. Client perceptions of the relevance of therapist self-disclosure were significantly and positively related to therapist perceptions of treatment progress ($r = .41, p < .01$).

Finally, therapist-client agreement was examined in relation to variables of interest. In order to examine these correlations, a variable was created to reflect therapist-client agreement by taking the absolute value of the difference between therapist scores and the RRI and client scores on the RRI. Values were then inverted in order to reflect extent of agreement, as opposed to extent of disagreement. A significant, positive correlation was found between therapist-client agreement on the strength of the real relationship and therapist perceptions of the strength of the real relationship ($r = .26, p < .05$). A significant negative correlation was found between therapist-client agreement and client age ($r = -.27, p < .05$).

Chapter Five

Discussion

This chapter will include an overview and discussion of the major findings from the present study. First, descriptive findings will be discussed. Next, the main findings will be discussed followed by a discussion of additional analyses. Finally, implications for research and practice and limitations of the present study will be addressed. All findings were examined from the perspectives of clients and therapists who had completed at least seven sessions of ongoing psychotherapy. Based on the relatively high means for GAF scores and treatment progress scores, results should be viewed within the context of clients who were generally well functioning and who had progressed extremely well in their treatment.

Descriptive Findings

Number of therapy sessions. The finding that the average number of sessions was 147.26 was remarkable given how other similar studies had averages under 20 (eg., Marmarosh et al., 2009; Spiegel et al., 2008). On the other hand, it was also remarkable that the average difference between therapist reports and client reports was 75 sessions. One likely explanation for the unreliable reports of the numbers of sessions was that therapists and clients had had so many sessions that it was difficult to accurately recall a precise number to report. For example, if a therapist and client had been meeting once a week for two years, three months, and three weeks, they might have different ways of estimating their numbers of sessions. In this case, the therapist may have estimated that they met for about two and half years, and then multiplied that by the number of weeks in a year in order to come up with 130 sessions. The client, on the other hand, may have

estimated that they met for two years and remembered that there had been about 10 weeks in which they were unable to meet to arrive at an estimate of 94 sessions. When taking into consideration the high number of sessions, and that fact that participants were asked to estimate, off the top of their heads, the number of sessions that they had had, the fact that they differed so much in their reports makes more sense. However, due to the unreliability of the reports of number of sessions, all analyses in which number of sessions is included should be interpreted with caution.

The finding that there was a significant positive correlation between the number of therapy sessions and the strength of the real relationship from the both therapist and client perspectives is inconsistent with research on the working alliance, another theorized component of the therapeutic relationship. A meta-analysis of 24 studies on the working alliance did not reveal a relationship between the number of sessions and the strength of the working alliance (Horvath & Symonds, 1991). However, the working alliance is the component of the relationship that is centered around the therapeutic work, whereas the real relationship is the more personal component of the therapeutic relationship that is defined in terms of genuineness and realistic perceptions. It is possible that, when it comes to the real relationship in psychotherapy, the more time that clients and their therapists spend together, the more likely it will be that they see the other in a realistic light, and are able to be more genuine with the other. Additional research on how the real relationship relates to number of sessions in long--term therapy is needed in order to see if these results are replicated, especially given the unreliability of the reports of number of sessions in the present study.

A positive correlation was found between the number of therapy sessions and treatment progress from both therapist and client perspectives. For the participants in the present study, it appears that the more time they had together, the more work they were able to accomplish. Research on the relationship between duration of treatment and outcome have been mixed (Shapiro et al., 2003). Based on their findings, Kopta, Howard, Lowry, and Beutler (1994) estimated that a little over a year of weekly therapy produced recovery in 75% of patients. However, they also found that 50% of patients significantly improved by the end of 11 sessions. One implication of these findings is that, while long term therapy may be helpful for some clients to fully recover, briefer therapy may be sufficient. In a review of dose-effect research, Shapiro et al. (2003) concluded that the number of sessions that clients need varies depending on the client characteristics, such as diagnosis. Since information on client diagnoses and symptoms was not obtained in the present study, it is difficult to know the context in which this relationship between number of sessions and treatment progress was found. It is also impossible to know whether less therapy for these clients would have been sufficient. In addition, the unreliable data on number of sessions in the present study makes it difficult to draw conclusions regarding its relationship to other variables. Therefore, although the number of sessions positively related to therapy progress, it does not necessarily imply that the more sessions the better the treatment progress.

Therapist age. From the therapist's perspective, a significant positive correlation was found between therapist age, on one hand, and the strength of the real relationship from the client's perspective and amount of therapist self-disclosure from both perspectives, on the other. The finding that the older the therapist, the stronger the real

relationship from the client's perspective supports Anderson, Ogles, Patterson, Lambert, and Vermeersch's conclusion that "age serves as an indicator of the accumulation of clinical experiences needed to master the interpersonal qualities inherent in facilitative interpersonal skills" (p.10, 2009). Aspects of facilitative interpersonal skills include warmth, empathy, and alliance-bond capacity, all of which connect to the strength of the real relationship (Gelso, 2011). Therefore, the therapists' ages may be a reflection of their collections of interpersonal experiences and skills that aid in their ability to foster strong real relationships with their clients, which would explain the finding that there is a relationship between therapist age and the strength of the real relationship from the client's perspective.

The positive relationship between amount of therapist self-disclosure and therapist age from both therapist and client perspectives is surprising because a review of previous research on therapist self-disclosure found no such relationship (Henretty & Levitt, 2010). It is possible that the older the therapist, the more experiences he or she has to draw from to form self-disclosures. Future research can help shed light on whether these findings extend to other samples.

Client age. For the participants in the present study, client age was significantly and positively correlated with the strength of the real relationship from the client's perspective. The relationship between client age and strength of the real relationship from the client's perspective supports Ain and Gelso's (2008) finding of a positive relationship between client age and the strength of the real relationship for therapy that had ended up to three years prior. For the present sample, the mean client age was 45, and the mean therapist age was 55. It is possible that the older the clients were, the closer

in age they were to their therapists. Clients may have found themselves forming stronger real relationships with therapists who were closer to their age group for the same reasons that many people gravitate toward forming relationships with other people who are close in age. However, more research is needed before any firm conclusions can be drawn regarding this finding.

GAF. Not surprisingly, there was a significant, positive relationship between the therapist-rated Global Assessment of Functioning (GAF) of their clients and the treatment progress from both therapist and client perspectives. The higher the therapists rated their clients' overall functioning, the better the treatment progress. The GAF has been used as a measure of progress and outcome (e.g., Driscoll, Cukrowicz, Reitzel, Hernandez, Patty, & Joiner, 2003), so it seems logical that it would positively correlate with the progress measure in the present study. It also makes sense that the more progress clients have made in therapy, the better they would function, because, in the present study, progress was defined by improvement in feelings, behavior, self-understanding, and overall functioning (Gelso & Johnson, 1983).

The Real Relationship and Treatment Progress

As predicted, the strength of the real relationship positively correlated with the treatment progress from both therapist and client perspectives. In addition, cross-correlational analyses revealed that client perceptions of the strength of their real relationships with their therapists positively correlated with therapist perceptions of treatment progress, and therapist perceptions of their real relationships with their clients positively correlated with client perceptions of treatment progress. These findings support the empirical literature on the relationship between the real relationship and

therapy progress and outcome from the client's perspective (Fuertes et al., 2007; Spiegel et al., 2008; Ain & Gelso 2008; LoCoco et al., in press) and from the therapist's perspective (Fuertes et al., 2007; Marmarosh et al., 2009). The findings bolster the evidence in support of what theoreticians have been saying for over half a century (Menaker, 1942): that the real relationship between the client and the therapist is an important part of the therapeutic relationship. The findings from the present study suggest that this theory holds true for both therapists and clients. This is also the first study to examine this relationship in long term therapy.

The Real Relationship and Therapist Self-Disclosure

Amount of therapist self-disclosure. As predicted, from the client's perspective, the amount of therapist self-disclosure correlated positively with the strength of the real relationship. This hypothesis was based on Ain and Gelso's (2008) finding that clients who had ended therapy up to three years prior felt that the more their therapists self-disclosed the stronger their real relationships with their therapists. The present study replicates these findings from the perspective of clients in ongoing psychotherapy. In addition, from the therapist's perspective, the amount of therapist self-disclosure was positively correlated with the strength of the real relationship from both the therapist's and the client's perspective.

These results would appear to conflict with Hill and Knox's (2003) suggestions for practitioners to use self-disclosures sparingly because they can steer the focus of therapy away from the client. However, it is important to keep in mind that the mean score for amount of therapist self-disclosure was 2.87 from the client's perspective, and 2.80 from the therapist's perspective, on a scale from 1 (not at all) to 5 (very much).

Therefore, although there was a positive relationship between the amount of therapist self-disclosures and the strength of the real relationship, it does not necessarily mean that clients therapists who perceived a great deal of therapist self-disclosure had better real relationships than clients and therapists who felt that there was little therapist self-disclosure. It is possible that a positive relationship between the amount of therapist self-disclosures and the strength of the real relationship would not be found, or at least would not be linear, if more clients and therapists perceived that there had been a great deal of therapist self-disclosure.

Relevance of therapist self-disclosure. In addition to the amount of therapist self-disclosure, the relevance of therapist self-disclosure was examined in terms of its relationship to the strength of the real relationship. The hypothesis that the relevance of therapist self-disclosure would be positively related to the strength of the real relationship was not supported by either therapist or client perspective. This finding was surprising because in Ain and Gelso's (2008) study of clients' perspectives on therapy that had ended up to three years prior, only the relevance of therapist self-disclosures uniquely related to the strength of the real relationship. In addition, therapists are advised to only disclose material that is relevant to the client (Hill & Knox, 2003). It appears that, in the present study, only the amount of therapist self-disclosures related to the strength of the real relationship from both client's and therapist's perspectives. One reason for this could be that the therapists in the study viewed self-disclosures as relationship-building, not as interventions in which it was necessary for the disclosures to relate to their clients.

The Therapist Self Disclosure, Treatment Progress, and Real Relationship

Due to the link between the strength of the real relationship, amount of therapist self-disclosure, and treatment progress from the therapist's perspective, a mediation analysis was completed in order to determine whether the strength of the real relationship fully or partially mediated the relationship between the amount of therapist self-disclosure and progress from the therapist's perspective. The real relationship did not mediate the relationship between the amount of therapist self-disclosure and treatment progress. It appears as though, at least for the therapists from this sample, the amount of therapist self-disclosure was related to treatment progress regardless of the strength of the real relationship. One implication from this finding is that the amount of therapist self-disclosure is an intervention in itself, independent of the strength of the real relationship. When keeping in mind that therapists from this study were perceived to have disclosed a moderate and appropriate amount from both therapist and client perspectives, this finding supports the empirical and theoretical literature that judicious use of therapist self-disclosure can be seen as a potentially successful therapeutic intervention in its own right (Hill & Knox, 2003; Farber, 2006).

Therapist Self-Disclosure and Treatment Progress

The relevance of therapist self-disclosures was found to positively correlate with therapy progress from the client's perspective. This finding fits with Hill and Knox's (2003) suggestion that therapist's should tailor their self-disclosures to the individual needs of their clients. The finding also supports Ain and Gelso's (2008) study, in which clients' retrospective reports indicated a relationship between the relevance of their

therapist's self-disclosures and their therapy outcomes. The relationship between relevance of self-disclosure and treatment progress makes sense because the more relevant a self-disclosure is to a client the more likely it would be a successful therapeutic intervention, and thus facilitate or be part of treatment progress.

On the other hand, the amount of therapist self-disclosure did not correlate with the treatment progress from the client's perspective. When examining the above results together, it appears that there is a positive relationship between the treatment progress and the relevance of therapist self-disclosure, but no significant relationship between the treatment progress and the amount of therapist self-disclosure, and there is no significant relationship between the strength of the real relationship and the relevance of therapist self-disclosure, but there is a positive relationship between the strength of the real relationship and the amount of therapist self-disclosure. Based on these findings, the following explanation may be drawn: It is possible that, at least from the client's perspective, relevance has more to do with progress than with the strength of the real relationship because when a disclosure is more relevant to the client, it might be more likely to be viewed as a successful intervention geared toward helping the client. A very relevant self-disclosure may come across as more of an intentional intervention, and may not feel as genuine and real as a more spontaneous self-disclosure that pertains more to the therapist than to the client. On the other hand, the finding that the amount of self-disclosure positively relates to the real relationship from the client's perspective may be because therapist sharing of personal information ties into the more personal, or real, relationship between client and therapist. Therefore, when it comes to therapist self-

disclosure, relevance may pertain more to progress and amount may pertain more to the real relationship, at least from the client's perspective.

Although no significant relationship was found between the amount of therapist self-disclosure and treatment progress from the client's perspective, a positive relationship was found between the amount of therapist self-disclosure and treatment progress from the therapist's perspective. This finding is similar to the finding that the amount of therapist self-disclosure positively relates to the strength of the real relationship from the therapist's perspective, and is surprising for the same reasons mentioned above - therapists are often advised to keep their disclosures to minimum in order to avoid taking the focus off of the client. However, as mentioned above, when interpreting this result it is important to consider the fact that all therapists thought that their self-disclosures had some relevance for their clients (none endorsed that their disclosures were "not at all" relevant) and that 84 percent of the therapists rated how much they self-disclosed to be a 3 or below on a scale from 1 (not at all) to 5 (very much). Only 5% of therapists endorsed a 5 (very much) for amount of self-disclosure. Therefore, it cannot be inferred that therapists who disclosed a great deal had better treatment progress than therapists who only disclosed a little.

A cross-correlational analysis on the amount of therapist self-disclosure revealed that therapist perceptions of the amount of self-disclosure positively related to client perceptions of treatment progress. This finding does not seem to fit with the finding that client perceptions of the amount of therapist self-disclosure did not relate to treatment progress from the client's perspective. One way to interpret this discrepancy is that, although there does appear to be a link between amount of therapist self-disclosure and

treatment progress, this relationship differs depending upon whose subjective view of the amount of self-disclosure is being examined. This result emphasizes the importance of future research using a more objective measure of the amount of therapist self-disclosure.

Finally, another cross-correlational analysis revealed a positive relationship between client perceptions of the relevance of therapist self-disclosure and therapist perceptions of treatment progress. This finding further supports the above finding of a relationship between both of these variables from the client's perspective, and also supports Ain and Gelso's (2008) finding of a positive relationship between relevance of therapist self-disclosure and treatment outcome from client's recollections of therapy. These results imply that, when therapists use self-disclosure in a way that relates to the client, it may be viewed as a successful intervention geared toward improving the treatment progress and outcome. This finding bolsters the literature on therapist self-disclosure that encourages therapists to tailor their self-disclosures to fit the needs of their clients (Hill & Knox, 2003; Farber, 2006).

Additional Analyses

A cross-correlational analysis revealed a significant, positive association between the strength of the real relationship from the therapist's perspective and the strength of the real relationship from the client's perspective. This finding of a moderate relationship between therapist and client perceptions is similar to Horvath and Greenberg's (1989) finding of a moderate relationship between therapist and client ratings of the Bond scale of the Working Alliance Inventory. It appears as though clients and therapists were on the same page when it came to their perceptions of their real relationships with one another. It is also possible that feelings about the real relationship are somewhat contagious. For

example, if a therapist responds to a client in ways which convey that she has positive feelings toward her client and, presents herself genuinely and realistically, her client may, in turn, reciprocate those positive feelings and be more likely to present herself more genuinely and realistically. Gelso (2011) proposed a similar idea when it comes to using immediacy to strengthen the real relationship: "...the therapist's immediacy begets patient immediacy: The more the therapist works with and through the real relationship, the more the patient is likely to respond to the person of the therapist and express him-or-herself genuinely" (p.79).

In addition to significant correlations that were found across therapists and clients regarding their real relationships, significant positive correlations were also found regarding therapist self-disclosure across perspectives. One relationship that was found was that the amount of therapist self-disclosure from the client's perspective was positively related to the amount of therapist self-disclosure from the therapist's perspective. This correlation seems logical because both clients and therapists in the same session should have similar views on how much of an intervention was used. However, the fact that there was only a moderate correlation of .39 shows that, although clients and therapists appear to agree to an extent on the amount of self-disclosure, the recollections of amount of self-disclosure are subjective. This points to a limitation in the present study of subjective reports of amount of self-disclosure. Future studies should aim to obtain more objective information on amount of therapist self-disclosure. This limitation is further discussed in the limitations section below.

From the client's perspective, the relevance of therapist self-disclosure positively correlated with the amount of therapist self-disclosure. Ain and Gelso (2008) had the

same finding from the perspective of clients whose therapy ended up to three years prior. One explanation for this result is that it is possible that therapists who make relevant self-disclosures are more likely to incorporate self-disclosures into therapy. However, this explanation seems less likely since a relationship between relevance and amount of self-disclosures was not found from the therapist's perspective. Another explanation is that clients may be more likely to remember therapist self-disclosures that resonated with them as opposed to therapist self-disclosures that were irrelevant to them. Therefore, even if, for example, all therapists disclosed the same amount, clients whose therapists made more relevant disclosures may have perceived their therapists as having disclosed more than clients whose therapists made less relevant disclosures. Future research is needed to continue to examine whether this relationship exists in other samples and other ways in which this relationship can be explained.

When therapist-client agreement on the strength of the real relationship was correlated with variables of interest, a significant positive correlation was found between the therapist-client agreement on the strength of the real relationship and therapist perceptions of the strength of the real relationship. It appears that the more the therapists and clients agreed on the strength of their real relationships, the stronger their real relationships from the therapists' perspectives. This result could mean that agreeing on the strength of the real relationship may allow the therapist and client to bond in such a way that it increases the strength of the real relationship. In that case, even if, for example, the therapist and client agree that the relationship is mediocre, the fact that they are on the same page may help improve the relationship, at least from the therapist's perspective. This may tie into Gelso's (2011) proposal that immediacy can have a

healthy effect on the real relationship. For instance, if therapist and client are able to process their feelings about their real relationship in the here-and-now and work toward being on the same page when it comes to their feelings about their relationship, even if those feelings are that the relationship is not at its best, it may result in strengthening their real relationship. Very little research exists on the therapist-client agreement on the strength of the real relationship, so more research is needed in order to better understand how it relates to the strength of the real relationship.

The correlation between therapist and client perceptions of treatment progress is high compared to therapist-client agreement on treatment outcome in prior studies. In a review of the literature, Lampropoulos (2010) found a range of therapist-client agreement on outcome, from no relationship between the two perceptions (Bryan, Dersch, Shumway, & Arrendodo, 2004), to low and moderate relationships between therapist and client perceptions of outcome (e.g., Weiss, Rabinowitz, & Spiro, 1996). The higher agreement on progress in the present study may be a result of selection bias. For instance, therapists may have been more likely to ask clients with whom they felt connected when it came to their views on their work together to participate, as opposed to clients with whom they did not feel such a connection. Selection bias will be discussed further in the limitations section below.

Implications for Research and Practice

The real relationship. The results from the present study lend support to the theoretical (Gelso & Carter, 1985, 1994; Gelso, 2009a; Gelso 2011) and empirical (Ain & Gelso 2008; Curtis, Field, Knaan-Kostman, Mannix, 2004; Eugster & Wampold, 1996; Fuertes et al., 2007; Gelso et. al., 2005; LoCoco et al., in press; Marmarosh et al., 2009;

Spiegel et al., 2008) literature on the real relationship and the important role that it plays in psychotherapy. The findings from the present study suggest that from both client and therapist perspectives individually, and from client perspectives crossed with therapist perspectives, the strength of the real relationship positively relates to treatment progress in ongoing psychotherapy. In addition, given that the mean number of sessions for participants in the present study was 147.26, this study is the first study to examine the real relationship within the context of therapy that is not brief, and shows that this relationship between the strength of the real relationship extends to long-term therapy. It will be important for future studies to examine how the real relationship unfolds in longer-term therapy and how its relationship to treatment progress and outcome evolves (Gelso, 2011). Given its relationship to psychotherapy progress and outcome, it will be important for researchers to continue to examine the real relationship and how it can be strengthened. Additional future directions for research on the real relationship and treatment progress and outcome are to examine the salience versus the strength of the real relationship, convergence in client and therapist perceptions of the real relationship, and dyads which include culturally similar and dissimilar clients and therapists (see Gelso, 2011, for an more extensive discussion of future directions for research on the real relationship).

The present study also lends support to recent literature that suggests that therapist self-disclosure is one therapeutic intervention that relates to the strength of the real relationship (Ain and Gelso, 2008; Gelso, 2011). Based on the results from the present study it appears that, from both therapist and client perspectives, the amount of therapist self-disclosure positively relates to the strength of the real relationship. However, the

majority of the therapists in this study did not disclose a great deal, and the majority of both clients and therapists felt that the disclosures were relevant to the clients. In future studies, it will be important to examine if these results hold true even if therapists disclose a substantial amount or disclose information that is not as relevant to the clients. Given the important role that the real relationship appears to play in psychotherapy, it will be wise to continue to examine interventions, such as therapist self-disclosure, that relate to the real relationship.

In addition to the implications that the present study has for future research, the results of the present study are also relevant to practitioners. The most important implication for practitioners is to strive to strengthen their real relationships with their clients, as this may relate to treatment progress. Gelso (2011) provides a number of ways in which therapists can attempt to cultivate and nurture strong real relationships with their clients. Gelso (2011) encourages therapists to be themselves with clients, and to avoid being phony or presenting a stiff, overly professional demeanor, in order to strengthen the genuineness component of the real relationship. Gelso (2011) also strongly encourages therapists to be empathically attuned to who the client is, and to strive to grasp the client's inner world. This is facilitated by the therapist's countertransference management, and aids in allowing the therapist to perceive the client more realistically. Immediacy, or processing the client-therapist relationship in the here-and-now (Kasper, Hill, and Kivlighan, 2008), is another way in which the therapist can promote genuineness in the therapy relationship (Gelso, 2011). Immediacy can be seen as one type of therapist self-disclosure (Hill, 2004), which connects to the implication from the present study that appropriate use of self-disclosures may strengthen the real relationship.

More specific implications from the present study regarding therapist self-disclosure are discussed below, but it is important to keep in mind that, although the amount of therapist self-disclosures has been found to relate to the strength of the real relationship in the present and past studies (Ain & Gelso, 2008), the implication is not for therapists to be continuously or even highly revealing in order to strengthen the real relationship. Therapists should be judicious in their use of self-disclosures, and to disclose appropriate information that is relevant to their clients (Hill & Knox, 2003). While therapist self-disclosures can be used as a tool toward strengthening the real relationship by, for example, allowing therapists to be seen as real and human (Knox et al., 1997), this is not to say that real relationships will be weaker without such disclosures. In sum, according to Gelso (2011):

...what strengthens the real relationship most from the therapist's side is the therapist *being* a genuine human being, actually caring and having other positive feelings toward the patient and empathically grasping the reality of the patient. Interactions in the here and now help considerably, but self-disclosures are generally more a matter of theoretical preference than a key to strengthening the real relationship" (p.81).

Therapist self-disclosure. In addition to the research implications that stem from the major finding that the amount of therapist self-disclosure positively related to the strength of the real relationship from both therapist and client perspectives, it is also important to consider the implications that stem from the findings regarding the relevance of therapist self-disclosures. The relevance of therapist self-disclosures did not relate to the strength of the real relationship from either perspective. One explanation for why amount of self-disclosure related to the strength of the real relationship and relevance of self-disclosure did not is that it is possible that self-disclosures are experienced by clients and therapists as a relationship building intervention as opposed to an intervention that

relates directly to the content of the therapeutic work. Therefore, when it comes to strengthening the real relationship, the relevance of the content of the disclosure might not be as important as the fact that information about the therapist is being shared.

The relevance of therapist self-disclosure did positively relate to treatment progress when examined solely from the client's perspective, and client-rated relevance positively related to therapist-rated treatment progress. Therefore, it appears as though the amount of therapist self-disclosure relates to the strength of the real relationship, whereas the relevance of therapist self-disclosure is more likely to relate to treatment progress. Taken together, amount of therapist self-disclosure can be viewed as a way to foster the real relationship, whereas relevance of therapist self-disclosure can be viewed as an intervention for advancing treatment progress. Future research should continue to examine these and other aspects of therapist self-disclosure in order to better understand how they can be used and for what purpose.

More research is also needed on clients and therapists who perceive the therapist self-disclosure as being not enough or too much, since information of this type could not be analyzed in the present study due to a lack of participants who perceived the amount of therapist self-disclosure to be not enough or too much. Information is needed not only on how the appropriateness of the amount of self-disclosure relates to the strength of the real relationship and treatment progress, but information is also needed on what amount of therapist self-disclosure makes it not enough or too much. In other words, an important question for future research is what constitutes an appropriate amount of therapist self-disclosure, and what constitutes an inappropriate amount of therapist self-

disclosure. Research of this type could help clinicians avoid erring on being either too disclosing or too withholding when it comes to their use of self-disclosure.

Based on the present study and past literature (Hill & Knox, 2003; Farber, 2006), the implications for practitioners regarding self-disclosures are that therapists may want to consider incorporating appropriate self-disclosures, as this was found to relate to the strength of the real relationship and treatment progress from both client and therapist perspectives. In addition, therapists should aim to use self-disclosures that are relevant to their clients, as this was related to treatment progress from the therapists' and clients' and perspectives. Gelso (2011) presented the following guidelines for using self-disclosures to strengthen the real relationship based on the research findings on self-disclosure and immediacy (e.g., Farber 2006; Hill et al., 2008):

...self-disclosures . . . have a healthy effect on the real relationship if they are highly relevant to the patient's needs, well timed, infrequent, and given in small doses. . . The best message for a practicing therapist is to think deeply and empathically about the patient and his or her needs, and to monitor your own needs and conflicts closely, when deciding what and how to share with the patient (p. 158).

Although the present study and prior studies have presented encouraging findings in support of therapists use of self-disclosures as an intervention in psychotherapy (e.g., Knox et al., 1997; Hill & Knox, 2003; Farber, 2006; Ain & Gelso, 2008), this does not mean that therapists who do not disclose at all are necessarily doing their clients a disservice. In the present study, clients and therapists ranged from reporting that the therapist disclosing "not at all" was an appropriate amount to disclose, to reporting that the therapist disclosing "very much" was an appropriate amount to disclose. This lends further support to the suggestion that therapists' use of self-disclosures should fit with their personal approaches to their work with clients (Gelso, 2011), and should be tailored

to their clients' needs (Hill & Knox, 2003; Farber, 2006), since, so far, there does not appear to be a magic number of self-disclosures that therapists should attempt to include in their work with their clients. Gelso (2011) presents the following four factors to enhance perceptions of genuineness for therapists who disclose little. He encourages therapists to attend to their nonverbal behaviors and work toward exuding genuineness through facial expressions and body language, he encourages therapists to match the content of what they say to the way in which they express it, he advises therapists to be consistent in their work with clients in order to foster a sense of trustworthiness and authenticity, and, finally, he advises that therapists clarify their reasons for not disclosing in order for clients to understand that their reasons come from a place of genuineness and are based on good intentions. Future research can examine these tactics and how they relate to the strengths of the real relationship, especially regarding psychotherapy in which the therapist discloses little.

Limitations

The sample for the present study consisted of therapists from a clinic at a mid-Atlantic university, therapists on the editorial board for *Psychotherapy: Theory, Research, Practice, and Training*, and therapists who were members of divisions of the American Psychological Association that related to psychotherapy practice and research, and their clients. As a result, the vast majority of the therapist participants in this study were psychologists. Therefore, the results of this study may not readily generalize to social workers, psychiatrists, and other providers of psychotherapy who come from different training models. In addition, not only were therapists self-selected, but therapists were told to ask their clients to participate whom they thought would be most

likely to participate in the study. This also may limit the generalizability of the study, especially since therapists were aware that the purpose of the study was to examine the therapeutic relationship, therapist self-disclosure, and treatment progress before they consented to participate. Therapists may have chosen to participate due to an interest in the topic of self-disclosure, or may have chosen to ask clients to participate because they felt that they had good relationships with those clients. It seems unlikely that therapists would want to ask clients with whom they felt they had poor relationships to participate in any study. Clients were also self-selected in that they had a choice in whether or not to participate once they were asked by their therapists. Therefore, there are a number of self-selection factors that may have resulted in biased responses from the sample and thus limited external validity.

A further limitation of the present study was the low return rate for therapist participants. This may also limit the generalizability of the study. Although the response rate for therapists was low, it should be interpreted with caution, given the large number of non-responders. Unfortunately, there is no way of knowing how many of the potential participants who were contacted were even therapists, let alone eligible to participate in the study. For example, even though only people listed as state licensed were contacted from divisions of the American Psychological Association, emails were still sent back from members stating that they did not practice or were not licensed. In addition, there is no way of knowing whether the intended recipients of the emails actually received them, as they could have been sent directly to a spam folder or to a wrong or inactive email account. This is clearly a limitation of the exclusive use of email as a means to contact potential participants in the present study. Although efforts were made to connect to

potential participants by addressing each one by name in the letter and by attempting to make the tone of the letter collegial and amiable, the less personal nature of email as compared to phone calls or mailed items may have also made it less likely for people to feel inclined to respond. Communication via email was chosen due to the choice to collect data online, for its efficiency when it came to reaching a large amount of people in a shorter amount of time than regular mail or by phone, for its low cost, and because it is less wasteful than using paper to contact the large number of potential participants.

Another limitation of the present study is that all of the measures used were self-report measures. As a result of using self-report measures, the findings of the present study are based on the subjective experiences of the participants in the study. One important issue that resulted from this limitation is that there is no objective way of knowing how much therapists in the study actually self-disclosed. Future studies should examine more objective ways of measuring therapist self-disclosure, such as the use of recordings and transcripts of therapy sessions. In addition, the self-report bias could be minimized in future studies by examining how supervisors or outside observers perceive the real relationship, therapist self-disclosure, and treatment progress in psychotherapy.

The fact that the real relationship inventories are relatively new and not yet extensively validated is another limitation of the present study. Although research using these measures up to this point looks promising (Gelso, 2011), it will be important for future research to continue to refine and validate the measures. In addition, the therapist self-disclosure questionnaires are new, and only the client version has been used in a prior study (Ain & Gelso, 2008). Therefore, more information is needed on the validity and reliability of these measures. For example, one item that may be ambiguous from the

therapist's perspective is "Overall, how much did your disclosures relate to your client and his/her problems," which was used to measure relevance of therapist self-disclosures. It is possible that this item was interpreted differently from therapist to therapist, and may not have been a reliable or valid measure of relevance of therapist self-disclosure. This could explain why hypotheses regarding the relevance of therapist self-disclosure were not supported. Future research should work toward improving upon this measure of therapist self-disclosure from both therapist and client perspectives.

An additional significant limitation of the present study was that there was very little data on therapists and clients who felt that there was too much or not enough therapist self-disclosure to analyze two of the hypotheses and three of the research questions. This limitation is particularly surprising given the traditional psychoanalytic notion that any amount of therapist self-disclosure is too much since self-disclosure may dilute transference. The lack of data on clients who felt that their therapists did not disclose enough is also surprising because the Ain and Gelso (2008) sample included a significant percentage of clients who felt that their therapists did not disclose enough. Future studies are needed in which data can be obtained from clients who feel that their therapists either do not disclose enough or disclose too much and therapists who feel that they do not disclose enough or disclose too much.

In addition, a limitation of the present study is that the majority of the participants were White, and most of the dyads consisted of clients and therapist of the same race. Future research should take into account Gelso's (2011) recommendation to examine the relationship between the real relationship and treatment progress for dyads of the same

and different races and dyads with additional similar and different aspects of their cultural identities.

Another limitation of the present study is the potential for inflated type I error due to the number of variables and analyses in the present study. Alpha was set at .05 as opposed to .01 because of the directional nature of the hypotheses. In addition, a higher alpha was tolerated rather than risking type II errors. However, due to the risk of inflated type I error, results should be interpreted with caution.

Finally, the correlational nature of the present study is another limitation. Although inferences can be made about the relationships among the variables based on the results, conclusions about causality cannot be drawn. For example, based on the results it can be concluded that there is a positive relationship between the strength of the real relationship and treatment progress, and that the more the therapist self-discloses, the stronger the real relationship. However, it cannot be concluded that treatment progress improves as a direct result of stronger real relationships, or that more therapist self-disclosures result in stronger real relationships. Although some of the discussion above may imply that relationships among variables work in one direction, there is also the possibility that they work in the opposite direction. For example, although results from the present study suggest that stronger real relationships cause better treatment progress, the results could just as easily imply that better treatment progress leads to stronger real relationships. Therefore, in addition to the implications discussed above, it is also important to consider additional ways in which the variables may relate to one another.

Despite the above limitations, the present study presents important information about the real relationship, therapist self-disclosure, and treatment progress from both

therapist and client perspectives. Although the results may not generalize to all populations, it is still important to learn from what these clients and therapists experienced in their work together. This study provides new information about the real relationship, therapist self-disclosure, and treatment progress that can inform both practitioners and researchers. In addition, it expands previous research by being the first study to examine these variables within the context of therapy that is not brief. Future research will hopefully provide information on whether or not these results extend to additional populations.

Appendix A

RRI-C

Instructions: Please use the following scale to evaluate your perceptions of yourself, your therapist, and your relationship with your therapist, placing your rating in the space next to the item.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

- ___ 1. I am able to be myself with my therapist.
- ___ 2. My therapist and I have a realistic perception of our relationship.
- ___ 3. I hold back significant parts of myself.
- ___ 4. I appreciate being able to express my feelings in therapy.
- ___ 5. My therapist likes the real me.
- ___ 6. It is difficult to accept who my therapist really is.
- ___ 7. I am open and honest with my therapist.
- ___ 8. My therapist's perceptions of me seem colored by his or her own issues.
- ___ 9. The relationship between my therapist and me is strengthened by our understanding of one another.
- ___ 10. My therapist seems genuinely connected to me.
- ___ 11. I am able to communicate my moment-to-moment inner experience to my therapist.
- ___ 12. My therapist holds back his/her genuine self.
- ___ 13. I appreciate my therapist's limitations and strengths.
- ___ 14. We do not really know each other realistically.
- ___ 15. My therapist and I are able to be authentic in our relationship.
- ___ 16. I am able to see myself realistically in therapy.
- ___ 17. My therapist and I have an honest relationship.
- ___ 18. I am able to separate out my realistic perceptions of my therapist from my unrealistic perceptions.
- ___ 19. My therapist and I have expressed a deep and genuine caring for one another.
- ___ 20. I have a realistic understanding of my therapist as a person.
- ___ 21. My therapist does not see me as I really am.
- ___ 22. I feel there is a significant holding back in our relationship.
- ___ 23. My therapist's perceptions of me are accurate.
- ___ 24. It is difficult for me to express what I truly felt about my therapist.

Appendix B

RRI-T

Instructions: Please complete the items below in terms of your relationship with your client or patient. Use the following scale in rating each item, placing your rating in the space adjacent to the item.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

- ___ 1. My client is able to see me as a real person separate from my role as a therapist.
- ___ 2. My client and I are able to be genuine in our relationship.
- ___ 3. My client feels liking for the “real me.”
- ___ 4. My client genuinely expresses his/her positive feelings toward me.
- ___ 5. I am able to realistically respond to my client.
- ___ 6. I hold back significant parts of myself.
- ___ 7. I feel there is a “real” relationship between us aside from the professional relationship.
- ___ 8. My client and I are honest in our relationship.
- ___ 9. My client has little caring for who I “truly am.”
- ___ 10. We feel a deep and genuine caring for one another.
- ___ 11. My client holds back significant parts on him/herself.
- ___ 12. My client has respect for me as a person.
- ___ 13. There is no genuinely positive connection between us.
- ___ 14. My client’s feelings toward me seem to fit who I am as a person.
- ___ 15. I do not like my client as a person.
- ___ 16. I value the honesty of our relationship.
- ___ 17. The relationship between my client and me is strengthened by our understanding of one another.
- ___ 18. It is difficult for me to express what I truly felt about my client.
- ___ 19. My client has unrealistic perceptions of me.
- ___ 20. My client and I have difficulty accepting each other as we really are.
- ___ 21. My client distorts the therapy relationship.
- ___ 22. I have difficulty being honest with my client.
- ___ 23. My client shares with me the most vulnerable parts of him/herself.
- ___ 24. My client has genuinely expressed a connection to me.

Appendix C

TSDQ-C

Instructions: Clients may find their therapists' self-disclosures either helpful or unhelpful. The following pages list types of disclosures that therapists sometimes discuss with their clients. Each type is defined, and an example is given to illustrate what a therapist might say if he or she were using that type of disclosure. These examples are only one way that a therapist might make that type of disclosure. Please think carefully about ways that your therapist may have disclosed to you on each topic. Please rate how much your most recent therapist (whom you no longer see) has used each type of disclosure and how you felt about the amount of disclosure. Also, please provide an example of each type of disclosure that your therapist gave.

<p>1. <u>Disclosures of Facts:</u></p> <p>With disclosures of facts, the therapist shares factual information about his or her background (e.g., "I have a Ph.D. in counseling psychology").</p>	<p>Amount of therapist self-disclosure :</p>	<p>How did you feel about the amount of disclosure?</p>												
	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center; width: 33%;">1</td> <td style="text-align: center; width: 33%;">2</td> <td style="text-align: center; width: 33%;">3</td> </tr> <tr> <td style="text-align: center;">Not At All</td> <td style="text-align: center;">Some</td> <td style="text-align: center;">A Lot</td> </tr> </table>	1	2	3	Not At All	Some	A Lot	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center; width: 33%;">1</td> <td style="text-align: center; width: 33%;">2</td> <td style="text-align: center; width: 33%;">3</td> </tr> <tr> <td style="text-align: center;">Not Enough</td> <td style="text-align: center;">Just Right</td> <td style="text-align: center;">Too Much</td> </tr> </table>	1	2	3	Not Enough	Just Right	Too Much
1	2	3												
Not At All	Some	A Lot												
1	2	3												
Not Enough	Just Right	Too Much												

Please provide an example of a disclosure of this type that your therapist gave:

2. Disclosures of Feelings:

Disclosures of feelings occur when the therapist uses specific words to describe an emotional experience. (e.g., “I also felt angry when my parents divorced”)

Amount of therapist self-disclosure :

1	2	3
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that your therapist gave:

3. Disclosures of Reassurance/Support:

Disclosures of reassurance/support

occur when therapists disclose an experience similar to what the client is experiencing (e.g., “I too experienced the loss of a loved one, and I know how hard it can be”).

Amount of therapist self-disclosure :

<u>1</u>	<u>2</u>	<u>3</u>
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

<u>1</u>	<u>2</u>	<u>3</u>
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that your therapist gave:

4. *Disclosures of Strategies*

In disclosures of strategies, the therapist discusses an action that he or she has taken to deal with a problem the client is experiencing (e.g., “when I feel overwhelmed with work, I prioritize my tasks”).

Amount of therapist self-disclosure :

<u>1</u>	<u>2</u>	<u>3</u>
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

<u>1</u>	<u>2</u>	<u>3</u>
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that your therapist gave:

5. Disclosures of Challenges:

Disclosures of challenges are when therapists express a challenge they faced that relates to what the client is going through (e.g., “I have also experienced conflicts with my partner, and needed to look carefully at my contributions to our issues”).

Amount of therapist self-disclosure :

1	2	3
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that your therapist gave:

6. Disclosures of Immediacy:

Disclosures of immediacy occur in the here and now of a session. They refer to a therapist expressing his or her reactions the client/therapist relationship in the moment (e.g., "I feel some tension between us"). Another way that a therapist might make a disclosure of immediacy is to express his or her reactions to the client in the moment ("What you're telling me makes me happy").

Amount of therapist self-disclosure :

1	2	3
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that your therapist gave:

7. *Disclosures of Insight:*

Disclosures of insight occur when the therapist shares something that he or she has learned about him or herself based on past experiences (e.g., “When I looked hard at my tendency to procrastinate, I realized that it was due to a fear of succeeding, and how success would affect my life”).

Amount of therapist self-disclosure :

1	2	3
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that your therapist gave:

8. Overall, how much did your therapist disclose about him/herself? (not at all) 1 2 3 4 5 (very much)

9. Overall, how much did your therapist's disclosures relate to you and your problems? (not at all) 1 2 3 4 5 (very much)

10. Overall, how appropriate was the amount of your therapist's self-disclosures? 1 2 3
Not Just Too
Enough Right Much

11. How many disclosures has your therapist made overall (please give your best estimate) ? _____

Appendix D

TSDQ-T

Instructions: Clients may find their therapists’ self-disclosures either helpful or unhelpful. The following pages list types of disclosures that therapists sometimes discuss with their clients. Each type is defined, and an example is given to illustrate what a therapist might say if he or she were using that type of disclosure. These examples are only one way that a therapist might make that type of disclosure. Please think carefully about ways you have disclosed to your client on each topic. Please rate how much you have used each type of disclosure and how you felt about the amount of disclosure. Also, please provide an example of each type of disclosure that you used. **Complete this measure regarding your disclosures to your client who is participating in this study.**

1. Disclosures of Facts:

With disclosures of facts, the therapist shares factual information about his or her background (e.g., “I have a Ph.D. in counseling psychology”).

Amount of therapist self-disclosure :

How did you feel about the amount of disclosure?

<u>1</u>	<u>2</u>	<u>3</u>
Not At All	Some	A Lot

<u>1</u>	<u>2</u>	<u>3</u>
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

2. Disclosures of Feelings:

Disclosures of feelings occur when the therapist uses specific words to describe an emotional experience. (e.g., “I also felt angry when my parents divorced”)

Amount of therapist self-disclosure :

1	2	3
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

3. Disclosures of Reassurance/Support:

Disclosures of reassurance/support occur when therapists disclose an experience similar to what the client is experiencing (e.g., “I too experienced the loss of a loved one, and I know how hard it can be”).

Amount of therapist self-disclosure :

<u>1</u>	<u>2</u>	<u>3</u>
Not At All	Some	A Lot

How did you feel about the amount of disclosure?

<u>1</u>	<u>2</u>	<u>3</u>
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

4. Disclosures of Strategies

In disclosures of strategies, the therapist discusses an action that he or she has taken to deal with a problem the client is experiencing (e.g., “when I feel overwhelmed with work, I prioritize my tasks”).

Amount of therapist self-disclosure :

How did you feel about the amount of disclosure?

1	2	3
Not At All	Some	A Lot

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

5. *Disclosures of Challenges:*

Disclosures of challenges are when therapists express a challenge they faced that relates to what the client is going through (e.g., “I have also experienced conflicts with my partner, and needed to look carefully at my contributions to our issues”).

Amount of therapist self-disclosure :

How did you feel about the amount of disclosure?

1	2	3
Not At All	Some	A Lot

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

6. Disclosures of Immediacy:

Disclosures of immediacy occur in the here and now of a session. They refer to a therapist expressing his or her reactions the client/therapist relationship in the moment (e.g., "I feel some tension between us"). Another way that a therapist might make a disclosure of immediacy is to express his or her reactions to the client in the moment ("What you're telling me makes me happy").

Amount of therapist self-disclosure :

How did you feel about the amount of disclosure?

1	2	3
Not At All	Some	A Lot

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

7. Disclosures of Insight:

Disclosures of insight occur when the therapist shares something that he or she has learned about him or herself based on past experiences (e.g., “When I looked hard at my tendency to procrastinate, I realized that it was due to a fear of succeeding, and how success would affect my life”).

Amount of therapist self-disclosure :

How did you feel about the amount of disclosure?

1	2	3
Not At All	Some	A Lot

1	2	3
Not Enough	Just Right	Too Much

Please provide an example of a disclosure of this type that you gave:

8. Overall, how much did you disclose about yourself? (not at all) 1 2 3 4 5 (very much)

9. Overall, how much did your disclosures relate to your client and his/her problems? (not at all) 1 2 3 4 5 (very much)

10. Overall, how appropriate was the amount of your self-disclosures? 1 2 3
 Not Enough Just Right Too Much

11. How many disclosures have you made overall to this client (please give your best estimate) ? _____

Appendix E

The COM

Instructions: Please complete the four questions below by circling the number that best fits your view.

COMPARED TO WHEN YOU BEGAN COUNSELING:

1. How do you feel?

much worse	moderately worse	slightly worse	about the same	slightly better	moderately better	much better
1	2	3	4	5	6	7

2. To what extent has your behavior changed?

much less effective	moderately less effective	slightly less effective	no change	slightly more effective	moderately more effective	much more effective
1	2	3	4	5	6	7

3. To what extent do you understand yourself?

much worse	moderately worse	slightly worse	about the same	slightly better	moderately better	much better
1	2	3	4	5	6	7

4. Rate your overall change in counseling:

much worse	moderately worse	slightly worse	about the same	slightly better	moderately better	much better
1	2	3	4	5	6	7

Appendix F

Global Assessment of Functioning (GAF)

Instructions: Please rate your client's Global Assessment of Functioning (GAF) based on the scale below.

- 10 - Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
- 9 - Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
- 8 - If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.
- 7 - Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
- 6 - Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
- 5 - Serious symptoms OR any serious impairment in social, occupational, or school functioning.
- 4 - Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
- 3 - Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
- 2 - Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
- 1 - Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.
- 0 - Not enough information available to provide GAF.

Appendix G
Initial Letter to Therapists

Dear _____

I am writing to you because of your involvement in psychotherapy. If you are not currently seeing clients or patients, please respond to this email and I will not contact you further. If you do currently see clients or patients for individual psychotherapy, please read on.

I hope that you will consider participating in a study that I am conducting for my dissertation under the supervision of my advisor, Dr. Charles Gelso. We are studying the therapeutic relationship between client and therapist. We hope to gain valuable insight into this important piece of psychotherapy; however, in order to do so we really need your help. This research would involve approximately 20 minutes of your time and 20 minutes from one your clients to complete some measures. We are aware that your time is extremely important, but believe that the nature of this research will make your participation worthwhile. All participants will receive a summary of our findings and be notified of any publications that result from this study.

If you are agreeable to participating in the study please do contact me by phone or email to let me know. At that point, I would be happy to discuss the study further and answer any questions you might have. Again, your participation is greatly needed and would be incredibly helpful and appreciated.

This study has received IRB approval from The University of Maryland. If you are willing to participate and/or have any questions regarding this study, please contact Stacie Ain at gelsoain@psyc.umd.edu or (202) 422-7676. Thank you.

Sincerely,

Stacie Ain, M.S.

Doctoral Candidate

Phone: 202-422-7676

Email: gelsoain@psyc.umd.edu

Charles Gelso, PhD

Professor of Psychology

Appendix H

Follow-Up Letter to Therapists

Dear _____

Thank you so much for your interest in our study. Your participation will be extremely helpful. Here is how the study will work:

We are asking that you ask your next client or patient, who you believe will be willing to fill out three measures and a demographic questionnaire to participate in a study on the therapy relationship, therapist self-disclosure, and treatment progress. Please choose a client with whom you have had at least 5 sessions, and who is at least 18 years old. You can tell your client that he or she would complete the study online and it will take about 20 minutes. Assure your client that the study is completely confidential. You will not be able to see your client's responses, and no one will be able to link your client's responses to your client.

If your client agrees to participate, please ask for your client's email address and let your client know that he or she will be emailed with a link to the online study. If your client chooses not to participate, please ask the next client who you think would participate, and so on.

Once one of your clients agrees to participate, please email me your client's email address. I will then email your client with a link to the survey. I will also email you a link to the survey and ask that you complete the survey with that client in mind. Your survey will be similar to the client's in that it will consist of three measures and a demographic questionnaire, and take about 20 minutes of your time.

Thanks again for your time and participation. If you have any additional questions, feel free to respond to this email or to call me at the number below.

Sincerely,

Stacie Ain, MS
Doctoral Candidate
(202) 422-7676

Charles Gelso, PhD
Professor of Psychology

Appendix I

Table 4

Intercorrelation Matrix for Variables of Interest

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Age-T	1.0																
2. Real Relationship - T	.03	1.0															
3. Genuineness - T	-.02	.92**	1.0														
4. Realism - T	.08	.91**	.67**	1.0													
5. Progress - T	.39**	.42**	.38**	.39**	1.0												
6. Amount of SD - T	.39**	.34**	.30*	.33*	.38**	1.0											
7. Relevance of SD - T	.08	.03	-.02	.08	.13	.03	1.0										
8. GAF	.01	.16	.15	.15	.34**	.04	.12	1.0									
9. Number of Sessions	.36**	.31*	.29*	.28*	.48**	.51**	-.04	.08	1.0								
10. Age - C	.22	.23	.19	.24	.18	.12	-.26*	.06	.33*	1.0							
11. Real Relationship - C	.26*	.48**	.44**	.43**	.42**	.33**	.11	.10	.33**	.28*	1.0						
12. Genuineness - C	.25	.47**	.47**	.38**	.42**	.33**	.05	.18	.30*	.25	.92**	1.0					
13. Realism - C	.22	.42**	.35**	.43**	.36**	.28*	.15	.01	.32*	.28*	.93**	.71**	1.0				
14. Progress - C	.32*	.27*	.23	.27*	.67**	.27*	.05	.36**	.32*	.21	.64**	.62**	.56**	1.0			
15. Amount of SD - C	.35**	.17	.26*	.04	.22	.39**	.02	.04	.10	.19	.40**	.38**	.35**	.24	1.0		
16. Relevance of SD - C	.32*	.10	.06	.13	.41**	.32	.19	.10	.12	.20	.20	.14	.23	.46**	.36**	1.0	
17. Real Relationship C-T Agreement	.02	.26*	.18	.30*	.11	.01	.03	.13	.08	-.26*	.01	-.12	.11	.07	.11	.15	1.0

Note. T = therapist perspective, C = client perspective, SD = therapist self-disclosure

* $p < .05$. ** $p < .01$

Appendix J

Table 5

Averages for Amount of Therapist Self-Disclosure for Seven Subtypes

Subtypes of Therapist Self-Disclosure	Average Amount (Therapist Perspective)	Average Amount (Client Perspective)
Facts	2.25	2.16
Feelings	1.75	1.77
Approval/Reassurance	1.87	1.79
Strategies	1.72	1.80
Challenges	1.64	1.64
Immediacy	2.11	1.95
Insight	1.56	1.69

Note. Scale for amount of therapist self-disclosure: 1 = not at all, 2 = some, 3 = a lot

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