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Reflections on the Meaning of Clinician Self-Reference: Are We Speaking the Same Language?

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Self-reference refers to clinician revelations about themselves. Theory and research on self-reference are limited by a lack of uniform conceptualizations. This paper discusses two types of self-reference, self-disclosure, and self-involving responses. Included are definitions of each type of self-reference; description of definitional inconsistencies in the literature; discussion of prevalence, functions, and the multidimensional nature of self-reference; and practice implications and research recommendations. The ideas presented herein are intended to prompt researchers, practitioners, and educators to carefully consider the nature, scope, and functions of self-reference, and in doing so, bring greater conceptual and operational clarity to their work.

Keywords: clinician self-reference, self-disclosure, self-involving responses, psychotherapy, supervision

In this paper, I discuss my perspective on the conceptual distinctions concerning clinician self-reference. These distinctions are important because they have implications for researchers, practitioners, and educators interested in the effects of self-reference on psychotherapy and supervision processes and outcomes. Before describing my point of view, I would like to credit the sources of my long-standing interest in this topic. My initial introduction to practitioner self-reference came when, as an undergraduate, I enrolled in a paraprofessional helping skills course in the mid 1970s. The course instructor and senior author of the text, *Helping skills: A basic training program* (Danish, D'Augelli, & Hauer, 1980), was Dr. Steven Danish. Danish defined and distinguished between two types of self-reference—*self-disclosure* and *self-involving* responses. Then, when I was a graduate student, Dr. Danish suggested I conduct a study to empirically demonstrate the distinctions between self-disclosure and self-involving responses. His suggestion prompted me to conduct a series of analogue studies (McCarthy & Betz, 1978; McCarthy, 1979, 1982) investigating differential effects of self-disclosure and self-involving responses on client perceptions of the therapist and client verbal responses. For over 35 years, I have taught courses in basic counseling and supervision skills, including self-reference. Each of these experiences has enhanced my understanding of the subject.

In describing my conceptualization of clinician self-reference, I compare and contrast my ideas to those of the authors in this special section of this issue (Khurgin-Bott & Farber, this issue, pp. 330–335; Knox, Edwards, Hess, & Hill, this issue, pp. 336–341; Yeh & Hayes, this issue, pp. 322–329) and to other researchers who investigate this topic. Throughout I use the term "clinician" to refer to therapists and to supervisors. More research has been done on therapist self-reference than on supervisor self-reference, and I believe a majority is generalizable to supervision. However, further investigations, similar to the study by Knox et al. (this issue), are needed to establish unique effects of self-reference in supervision relationships.

The following sections of this paper include definitions of self-reference; definitional inconsistencies; prevalence and functions of self-reference; multidimensional aspects of self-reference; practice implications; and research recommendations. It is my hope the ideas presented herein will prompt researchers in particular, but also practitioners and educators to carefully consider the nature, scope, and functions of self-reference, and in doing so, bring greater conceptual and operational clarity to their work.

Definitions of Clinician Self-Reference: Self Disclosure and Self-Involving Responses

Research interest in clinician self-reference was fairly common in the 1980s, and that interest continues today. Yet, despite numerous studies of clinician self-reference, many questions remain about the nature, scope, and effects of clinician use of self in psychotherapy and in supervision. The three articles in this special section provide a sampling of the diverse issues that warrant investigation. They also illustrate the increasing sophistication researchers are bringing to their conceptualizations of self-reference and to their study designs. Nevertheless, a review of the authors' definitions of self-reference raises critical questions I and others have grappled with for years: What do we mean by self-reference? and Why is it that researchers appear to understand self-reference, but they understand it differently?

Everyone seems to agree that self-reference occurs when clinicians reveal something about themselves. Beyond that basic agreement, however, researchers diverge in their terms and their definitions of self-reference. I think this is due in part to their focus on different levels of abstraction/complexity regarding self-reference. I consider the basic unit of analysis to be the clinician's actual

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response (what many would refer to as a *microskill*) and believe this is the level researchers should draw upon to define self-reference. More uniformity in the definition and the name assigned to that basic unit would give researchers a common vocabulary to use when investigating more complex aspects of therapeutic and supervisory interactions (such as clinician reasons for their self-reference, clinician competency in use of the response, client, and supervisee perceptions of self-reference, etc.). I propose that researchers use the basic terms and definitions I first learned as an undergraduate, as they are precise and relatively easy to understand. Moreover, in a qualitative review of research on therapist "self-disclosure" Henretty and Levitt (2010) conclude that "For the studies that examined different types of self-disclosure (positive vs. negative, self-involving vs. self-disclosing, more intimate vs. less intimate), the only distinction that reliably seemed to affect clients was that of self-involving versus self-disclosing therapists' disclosures . . ." (p. 68).

In their book *Helping skills: A basic training program*, Danish et al. (1980) identify three major domains of therapist responses: Continuing responses, Leading responses, and Self-Referent responses. *Continuing responses* include content reflections and affect reflections that invite client elaboration of thoughts and feelings. *Leading responses* include open questions, closed questions, influencing responses, and advice that direct the client toward certain types of exploration, insight, and problem-solving. Both Continuing and Leading responses are client-focused. *Self-Referent responses*, broadly defined, include self-disclosure and self-involving responses that involve therapists' revelations about themselves. Self-Referent responses are therapist-focused.

Self-Disclosure Responses

Self-disclosure occurs when a therapist communicates information about her or himself to a client (Danish et al., 1980). Self-disclosure is "A conscious, intentional technique in which clinicians share information about their lives outside the counseling relationship" (Simone, McCarthy & Skay, 1998, p. 174). Self-disclosure encompasses a range of information including demographic information, attitudes, values, beliefs, perceptions, and personal experiences (McCarthy Veach, LeRoy, & Bartels, 2003; Robitschek & McCarthy, 1991). An example of a self-disclosure response is: ". . . Something that I haven't told you is my mother is very similar to how I've heard you describe your mother . . ." (Yeh & Hayes, this issue, p. 328).

Self-Involving Responses

Self-involving responses are therapist expressions of feelings about and reactions to the client in the present interaction (Danish et al., 1980). Self-involving responses encompass a broad range of therapist emotions and reactions (Robitschek & McCarthy, 1991). A key distinction is their here-and-now focus. An example of a self-involving response is: "As I listen to the story you just told me I also feel a deep sense of hopelessness and despair" (Kuutmann & Hilsenroth, 2011).

Definitional Inconsistencies

Early research often lacked precise definitions of therapist self-reference, and the definitions were quite varied. Some researchers claimed to investigate self-disclosure, but actually studied both self-disclosure and self-involving responses. Others seemed to study only self-disclosure, although specific definitions sometimes were lacking in their reports. Definitional inconsistencies persist today. Indeed, definitions provided in recent studies indicate that researchers are using similar terms to describe different phenomena. Some researchers continue to classify both self-disclosure and self-involving behaviors as self-disclosure. For instance, Hanson (2005) adopted Knox and colleagues' (Knox, Hess, Petersen, & Hill, 1997) definition of therapist self-disclosure: "an interaction in which the therapist reveals personal information about him/herself and/or reveals reactions and responses to the client as they arise in the session" (p. 275). Knox and Hill (2003) defined self-disclosure as ". . . verbal statements that reveal something personal about the therapist . . . seven subtypes of disclosures include: disclosures of facts, feelings, insight, strategies, reassurance/support, challenge, and immediacy" (p. 530). Knox et al. (this issue) defined supervisor self-disclosure as ". . . a supervisor reveals personal information or reveals reactions and responses to the supervisee as they arise in supervision. (p. 337)"

I believe these "all inclusive" definitions of clinician self-disclosure are too broad to be useful for research. Moreover, prior analog and survey research (e.g., McCarthy & Betz, 1978; McCarthy, 1979, 1982; Robitschek & McCarthy, 1991) has differentiated responses such as "I've struggled in the past with a similar issue" (self-disclosure), and "I'm sorry that you had to go through such a difficult experience" (self-involving responses). Those studies indicate self-disclosure and self-involving responses are distinctly different responses—self-disclosure responses are primarily "I-focused," whereas self-involving responses are "We-focused." Furthermore, self-disclosure and self-involving responses have different effects on therapeutic processes and outcomes.

Another definitional inconsistency concerns the term *immediacy*. Earlier literature used this term to refer to clinician self-involving responses; immediacy actually became the more popular term to refer to this microskill. Over time researchers have moved from defining immediacy solely as therapist self-involving responses and now use the term to refer to a more complex phenomenon. For example, Hill and Knox (2004) define immediacy as ". . . such therapist actions as inquiring about reactions to the therapy relationship, drawing parallels between other relationships and the therapy relationship, processing ruptures or boundary crossings, and disclosing feelings of closeness to or lack of closeness from others" (p. 14).

Two recent case studies examined the effects of therapist immediacy on counseling process and outcomes (Hill et al., 2008; Kasper, Hill, & Kivlighan Jr., 2008). Both defined immediacy essentially as "disclosures within therapy sessions of how the therapist is feeling about the client, him or herself in relation to the client, or about the therapy relationship . . . [and] discussing and processing what occurs in the here-and-now client-therapist relationship" (Kasper et al., 2008, p. 281). Examples of dialogue these researchers regarded as immediacy do contain therapist self-involving responses, but they also contain other types of therapist responses. Some even contain client responses. Immediacy, as these authors defined it, encompasses therapist behaviors such as feedback (Kasper et al., 2008), a response which I regard as a type of positive confrontation (when done effectively); questions to gather more information about the client's here-and-now reactions;

and primary and advanced empathy (interpretation) to reflect what the client appears to be experiencing in the moment. Some examples are much more client-focused, than therapist-focused, for instance, "There's a lot of sadness in some ways when you talk about that. It's like you touch on that sadness and then you go away from it with words . . ." (Kasper et al., 2008, p. 289).

In my opinion, immediacy, as conceptualized by these authors, is a *process goal,* whereas self-involvement comprises *one type of therapist response* that may be used to achieve that goal. I therefore, agree with Kuutmann and Hilsenroth's (2011) view that immediacy is a larger phenomenon which may or may not include therapists referring to their feelings about and reactions to clients (i.e., self-involving responses).

Greater definitional precision and consistency are necessary in order to explain equivocal findings in studies of clinician self-reference and to offer more useful guidance for researchers, educators, and practitioners. As Henretty and Levitt (2010) assert, "Multiple definitions of therapist self-disclosure render meaningful analysis of findings across studies difficult, if not impossible" (p. 69). The knowledge base can only deepen when researchers are clear about the phenomenon they are studying—a microskill, an interaction, a process goal, and so forth, and when they use a uniform vocabulary to refer to those phenomena.

Prevalence, Frequency, and Functions of Clinician Self-Reference

Prevalence and Frequency

A defining characteristic of the therapeutic relationship is that most self-disclosures and affective expressions are by the client. Thus, one would expect therapist self-referent behaviors to be far less frequent than client self-referent behaviors. This defining characteristic is highlighted in an episode of the television series *Roseanne.* Roseanne and her sister Jackie are having a conversation about a crisis Jackie is experiencing. Jackie mentions she is seeing a therapist to help her with this crisis. Roseanne responds, "How come you're talking to a therapist about your problems? Why can't you talk to me?" Jackie replies, "Because whenever I tell *her* what's bothering me, we don't spend the next hour talking about how that makes *her* feel."

Research indicates that 90% of therapists engage in self-reference (Henretty & Levitt, 2010), although it is unclear what proportion is self-disclosure and what proportion is self-involving responses. Counseling and psychotherapy theories provide philosophical underpinnings for therapists' use of self—the why's and the why not's—and self-reference seems particularly compatible with certain theories (e.g., humanistic, feminist, interpersonal theory, multicultural approaches) (see Hill and Knox (2004) for a discussion of theoretical views on processing the therapeutic relationship). However, regardless of theoretical orientation, literature regarding the frequency of self-reference indicates a conservative bias against use of self (Henretty & Levitt, 2010; McCarthy & Oakes, 1998). Regarding self-disclosure, in particular, ethical arguments posit that it places clinicians at risk of being on a "slippery slope" to boundary crossings and boundary violations in therapy (cf. Henretty & Levitt, 2010; McCarthy & Oakes, 1998) and in supervision (cf. Gu, McCarthy Veach, Eubanks, LeRoy, & Callanan, 2011). Self-involving responses also pose potential risks. Some authors speculate that revelations of here-and-now reactions and feelings may be threatening for clients, making them feel vulnerable (e.g., Kasper et al., 2008); self-involving responses may cause confusion for supervisees if they do not understand their supervisor's intentions (Knox et al., this issue).

Research findings support this conservative approach to the use of self-reference. Studies have shown that individuals trained in helping skills use significantly less self-disclosure than untrained individuals (e.g., McCarthy, Danish, & D'Augelli, 1977; Knapp & McCarthy, 1985; Swartwood, McCarthy Veach, Kuhne, Lee, & Ji, 2011). Hill and Knox (2004) reviewed several studies that classified therapist responses from actual therapy sessions and found an average of 3.5% were self-disclosure or self-involving responses (the range of self-referent responses was 1–13%). So, although self-referent responses are prevalent among practitioners, they occur relatively infrequently. Self-disclosure and self-involving responses appear to be *low frequency* but *high salience* therapist behaviors. Prevalence and frequency of supervisor self-reference has yet to be empirically established.

Functions

It is well documented that counseling processes and outcomes are enhanced when therapists are perceived by clients as expert, socially attractive, and trustworthy (cf. Corrigan & Schmidt, 1983), and self-referent responses may enhance perceptions of these therapist characteristics (Henretty & Levitt, 2010; McCarthy & Betz, 1978; McCarthy, 1979, 1982). Therapists who engage in self-reference generally are viewed as being transparent/open, congruent, and genuine (Hanson, 2005; Knox et al., 1997). Henretty and Levitt (2010) qualitatively reviewed studies of the effects of therapist self-reference. They found, for instance, that in 20 studies of perceptions of therapists who self-disclosed, disclosing therapists were viewed as less socially attractive than nondisclosing therapists in only one study. These authors also conclude that therapist self-disclosure may encourage client disclosure. However, they do not distinguish between self-disclosure and self-involving responses for a majority of their paper because the studies they reviewed do not make these distinctions.

Self-involving responses may enhance clinician genuineness, likability, and trustworthiness (McCarthy, 1982), and they can decrease client anxiety (McCarthy, 1982; McCarthy Veach et al., 2003). Hill et al. (2008) concluded that self-involving responses may variously encourage client self-involvement, establish rules and boundaries in therapy, and repair therapeutic ruptures. A study by Knox et al. (this issue) suggests supervisor self-reference has primarily positive effects that include supervisees feeling supported and guided in their clinical work.

Clinician reasons for and against use of self-reference have been identified empirically. Reasons for using self-disclosure across disciplines (e.g., psychotherapy, genetic counseling [a communication process in which trained professionals help individuals and families deal with issues associated with the risk of or occurrence of a genetic disorder {Resta et al., 2006, p. 77}]) include to: respond to client requests for disclosure (Peters, McCarthy Veach, Ward, & LeRoy, 2004; Thomas, McCarthy Veach, & LeRoy, 2006); help client feel s/he is not alone; convey understanding of client's situation; decrease client anxiety; build rapport/working alliance; normalize client's feelings/reactions; encourage client

and instill hope; increase clinician's credibility; build trust; suggest/model coping strategies; encourage client disclosure; increase client awareness of alternative viewpoints; provide a rationale for clinician-initiated topics; connect with clients whose cultural background encourages such disclosure; encourage client to express emotions; challenge the client; and prevent client idealization of the counselor (Henretty & Levitt, 2010; Peters et al., 2004; Simone et al., 1998; Thomas et al., 2006).

Reasons for clinicians to refrain from self-reference include to: avoid blurring boundaries; stay focused on client; prevent concern about clinician welfare; prevent merging; prevent premature closure; avoid information overload and confusion; prevent client feeling burdened by clinician problems; avoid interfering with transference; prevent client demoralization by clinician successes/failures; avoid giving client information to manipulate clinician; and avoid clinician discomfort (e.g., Henretty & Levitt, 2010; Simone et al., 1998). Further research should be done to determine whether self-disclosure and self-involving responses (or their absence) differ in their effectiveness for achieving these goals.

Multidimensional Nature of Self-Reference

Research on self-reference at times has yielded conflicting findings. Different definitions may explain some of these conflicting results. Another possible factor concerns the nature of the phenomenon. Self-referent behaviors may seem straightforward, until one considers their multidimensional nature. Self-reference dimensions include: intimacy level (degrees of revealingness); revelations of past versus current clinician issues/experiences; whether self-disclosure agrees or disagrees with client/supervisee experience; whether self-involving responses contain positive or negative clinician affect/reactions (cf. Robitschek & McCarthy, 1991); professional versus personal disclosure; hypothetical versus actual disclosure (If I were you . . . vs. I actually have . . .); voluntary versus client/supervisee-requested self-reference; expressed self-reference versus perceived self-reference (what we reveal vs. what clients/supervisees hear); clinician strengths versus weaknesses; frequency of self-reference; direct (verbal) versus indirect (nonverbal) self-reference; and intentional versus unintentional self-reference. In the next sections, I expand upon four dimensions that have received limited research attention: direct versus indirect self-reference that is either intentional or unintentional; voluntary versus requested self-reference; professional versus personal self-disclosure; and hypothetical versus actual disclosure.

Direct Versus Indirect Self-Reference

Although the emphasis of this paper in on direct, verbal self-referent responses, it is important to also consider indirect self-reference. Some authors differentiate between direct self-disclosures (clinicians' verbalizations which reveal information about themselves), and indirect disclosures [information clinicians consciously (intentionally) or unconsciously (unintentionally) communicate], such as wearing a wedding band (McCarthy Veach, LeRoy, & Bartels, 2003; Paine et al., 2010). I would argue that clinicians continually disclose information indirectly over the course of their professional relationships. For instance, in a study my colleagues and I conducted a few years ago (Simone et al., 1998) one therapist participant commented:

"I thought I had never disclosed with this depressed client, but when she was ready to terminate, she bought me three books as a parting gift. I was totally shocked by how much she knew about me based on the books she selected. She knew so much about my likes and dislikes, my interests, and my feelings that I was truly taken aback." (p. 182).

As this example illustrates, indirect self-disclosure may affect clients'/supervisees' perceptions of a clinician's background, opinions, and experiences. Clinicians may also indirectly engage in self-involving behaviors, expressing their feelings and reactions through nonverbal behavior (e.g., facial expression, intonation, word choice, etc.).

A related dimension is unintentional versus intentional self-reference. Unintentional self-reference includes information about the clinician and/or feelings about the client/supervisee that occur without the clinician's full awareness. Nonverbal behaviors are a prime example (e.g., an observant client or supervisee can figure out the clinician had a "late night" from the dark circles under her/his eyes, or interpret (accurately or not) that a slight hesitation before speaking suggests the clinician's disapproval). Some types of self-disclosure are inevitable (for example, obvious pregnancy [Silverman, 2001]). A common thread in self-reference that is indirect and/or unintentional is the diminished control clinicians have over its occurrence and the effort required for them to be aware of it. Another common thread is that clinicians must make decisions about whether or not to verbally discuss indirect and/or unintentional self-references as they become aware of them. These self-reference dimensions warrant further research attention.

Voluntary Versus Requested Self-Reference

Decisions to engage in voluntary self-disclosure and self-involving responses probably are easier than decisions about how to respond to client/supervisee requests that clinicians share themselves. The vast majority of research on therapist self-reference involves therapist-initiated disclosure, but some research has examined how clinicians respond to client requests for disclosure and how their responses affect processes and outcomes. Hanson (2005) interviewed 18 former long-term therapy clients about times when their therapists did and did not self-disclose (she considered both self-disclosure and self-involving responses as self-disclosure) and the extent to which the clients perceived those responses as helpful or unhelpful. Clients were much more likely to perceive disclosures as helpful, and nondisclosures as unhelpful, especially nondisclosures that suggested therapist rigidity (e.g., having an across-the-board nondisclosure policy regardless of client characteristics and/or situations). Hanson found that skillfulness of the therapists' responses was more influential than whether or not they disclosed. She recommended that therapists explain nondisclosure compassionately, so clients can understand and accept their response.

Peters et al. (2004) surveyed genetic counselors about the effects of receiving genetic counseling services on their provision of genetic counseling to others. Of the 93 individuals who had received genetic counseling themselves, close to half disclosed about this experience to clients. The majority, however, did so only rarely. The most prevalent reason for their disclosure was because the client asked them. Thomas et al. (2006) interviewed 11 participants from the study by Peters et al. and found the frequency and nature of their self-disclosure varied widely. Disclosure topics

included demographics, personal beliefs and practices, and receipt of genetic counseling services. A prevalent factor affecting their disclosure decisions was client-requested self-disclosure. Their participants speculated that client motivations for requesting self-disclosure included: to seek guidance regarding challenging decisions, to draw upon counselor expertise, to seek validation about decisions, to build the relationship, to feel understood, and to avoid personal responsibility for their decisions.

Chavey and colleagues (Chavey, McCarthy Veach, Bemmels, Redlinger-Grosse, & LeRoy, 2010) interviewed 21 prenatal genetic counselors about their responses to client requests for self-disclosure. Participant responses variously included self-disclosure and nondisclosure (e.g., redirection of client question). Commonly endorsed factors influencing their responses were: self-disclosure topic, perceived client motivation for disclosure request, timing of self-disclosure request (e.g., before or after client decides to have a prenatal test), quality of counselor-client relationship, client characteristics (e.g., cultural background, age), and ethical/legal responsibilities (e.g., desire to be nondirective).

As mentioned previously, in her study of client perceptions of therapist disclosures and nondisclosures, Hanson (2005) concluded that skillfulness of how one responds is much more important than whether or not one uses self-reference. Additional research is needed to assess client and supervisee requests for self-involving responses, differentiated from requests for self-disclosure. Clinician reactions to such requests as well as client/supervisee perceptions of the reasons they do/do not engage in self-reference merit investigation.

Personal Versus Professional Disclosure

Another dimension, specific to clinician self-disclosure, concerns the extent to which their disclosure is personal (e.g., describing one's views on abortion) versus professional (e.g., talking about how other clients in a similar situation felt or what they did). Drawing upon earlier analog research, Paine et al. (2010) studied this dimension of self-disclosure as well as the dimension of client-requested self-disclosure. They asked undergraduate and graduate students to read 1 of 3 descriptions of a hypothetical genetic counseling session. The client, at risk for a form of inherited cancer was considering whether to pursue genetic testing or surveillance procedures. Dialogue was identical, except for a final response to the client question: "What would you do if you were me?" The counselor either revealed what she would do (*Personal Disclosure*), what other clients have done (*Professional Disclosure*), or she deflected the question (*No Disclosure*). Imagining they were the client, participants wrote a response to the counselor and evaluated her expertness, social attractiveness, and trustworthiness.

Participants rated the *nondisclosing* counselor significantly lower in social attractiveness (warmth, likability) than either disclosing counselor. Satisfaction with information given in the session was significantly higher for the professionally disclosing genetic counselor versus the nondisclosing counselor. There were no significant differences in written responses for any counselor condition. These findings are consistent with those of earlier studies of therapist self-disclosure, suggesting self-disclosure may enhance client perceptions of the practitioner. They also suggest when clients understand the relevance of the disclosure to their concerns (in this study, disclosure about treatment decisions), they are more likely to respond favorably to it.

Hypothetical Versus Actual Disclosure

Self-disclosure can be educational when done hypothetically. For example, a clinician might say, "I can't tell you what you should do, but here is what I would be thinking about if I were you . . ." My colleagues and I are in the process of analyzing genetic counseling graduate students' and practicing genetic counselors' written responses to a hypothetical client's request for self-disclosure in two parallel prenatal genetic counseling sessions (Redlinger-Grosse, McCarthy-Veach, & MacFarlane, in preparation). The client is considering undergoing prenatal genetic testing. In one situation she requests hypothetical self-disclosure ("What would you do if you were me?"), and in the other she asks for actual disclosure ("Have you ever had an amniocentesis?"). Respondents also provided reason(s) for their responses. Respondents self-disclosed at a significantly higher rate in response to the question, "Have you ever had an amniocentesis?" than to the question, "What would you do if you were me?" Disclosures included *personal revelations* and *professional revelations* (e.g., what other clients do). Nondisclosures included redirection of the client's question, validation of the question, and asking why the client requested self-disclosure. Three prevalent reasons for disclosing included fostering rapport, honesty, and facilitating decision-making, and one prevalent reason for not disclosing was to maintain a nondirectiveness stance. Differential effects of hypothetical versus actual disclosure on therapy clients and on supervisees is a promising research area.

Practice Implications

Despite somewhat equivocal findings, research results concerning self-reference suggests several practice implications. Henretty and Levitt (2010) offer a number of useful guidelines for therapist self-reference. Additional suggestions include:

• Focus on relevant content. One risk of therapist self-reference, shifting the focus to the clinician, is illustrated in the movie *Beaches.* Bette Midler sees her childhood friend, Barbara Hershey, after several years have passed. Following an extended monologue in which Bette details her life since last seeing Barbara, Bette says, "Enough about *me*. Let's talk about *you*. What do *you* think of me?" Although not a therapist, her behavior provides a caution about narcissistic, self-focus. Self-reference must be done strategically and with self-awareness (Henretty & Levitt, 2010; McCarthy Veach et al., 2003). Clinicians should reflect upon whether their self-reference is for themselves (gratifying a personal need for catharsis, unconscious countertransference, etc.), or whether it is intended to achieve the goals of therapy for a given client or the goals of supervision for a supervisee (McCarthy & Oakes, 1998; McCarthy Veach et al., 2003). In an early study (McCarthy, Kulakowski, & Kenfield, 1991), we found that a prevalent source of dissatisfaction among postdegree supervisees involved supervisors using too much supervision time to discuss their own cases. When using self-referent responses, it may be helpful to provide a rationale for shifting the focus. This strategy may promote self-reference that is relevant to the client or supervisee.

• Return the focus to the client or supervisee after using self-disclosure or self-involving responses. One strategy is to add a tentative interpretation to the end of a self-revelation. An example of "refocused" self-disclosure to a client is: "When I experienced my first relationship break-up, I felt very alone. I wonder if that is how you are feeling?" An example of a refocused self-involving response to a supervisee is: "As I listen to you describe the client, I'm aware that I'm feeling anxious. Perhaps I'm mirroring how you are feeling?"

• Avoid TMI (too much information). Clinicians need to be aware of the intimacy level of their self-revelations, avoid confidentiality breaches (e.g., talking in detail about their work with other clients or other supervisees), refrain from disclosing current conflicts when possible, anticipate client/supervisee likely reactions to self-reference, pace revelations of their reactions to avoid overwhelming clients/supervisees, and reflect on times when they may wish to preserve their own confidentiality (clients and supervisees can tell anyone what clinicians reveal). For instance, some research (Knox et al., 1997) suggests disclosure of current issues results in therapists being seen as less helpful, and intense self-involving responses may threaten or confuse clients (Kasper et al., 2008).

• Know your own reactions. Clinicians should anticipate how they will feel as they engage in various sorts of self-reference (McCarthy Veach et al., 2003). For example, they should identify topics they would never, sometimes, and usually share with clients and supervisees, and the personal reactions they would feel comfortable sharing.

• Always be truthful. The essence of self-reference is authenticity.

• Never take client requests at face value. A question is almost never just a question. Clinicians must attempt to intuit client/supervisee motivations and address those motivations. Advanced empathy (interpretation) is one strategy for exploring motivations for self-reference requests, for example, suggesting they might be asking in order to figure out if anyone else feels the way they do. Questions also can be used to elicit motivations (e.g., "I wonder what you are hoping I will say?").

• Avoid shaming/punishing a client or supervisee for requesting self-reference. Whether or not they engage in self-reference, clinicians should discuss client and supervisee motivations for the request and process what they heard/think/feel about the self-reference, or lack thereof (Paine et al., 2010; Redlinger-Grosse et al., in preparation).

• Process self-referent behaviors with clients and supervisees, not only to elicit their thoughts and feelings about it, but also to provide a rationale for shifting the focus to one's self or to the here-and-now relationship.

• Engage in activities that encourage recognition of indirect and/or unintentional self-reference. Clinicians should continually reflect upon how they appear to each client and supervisee, thereby anticipating projections of who clients and supervisees wish them to be. An important question is when to use self-reference either to reinforce or to dispel those projections. Clients and supervisees may or may not correctly perceive self-referent behaviors. Moreover, clinicians vary in their awareness of the self-reference they are communicating. Thus, peer supervision and consultation are important professional activities.

Research Directions

This section contains issues and topics I regard as important for expanding the knowledge base about clinician self-reference.

Definitional Precision and Design Issues

Previous research on clinician self-reference is limited by varying definitions of the variables of interest. For instance, self-disclosure and self-involving statements often are considered to be self-disclosure, and some researchers fail to distinguish clearly between clinician immediacy that does and does not contain self-involving responses. Research in the late 1970s and 1980s that attempted to clarify the differences between self-disclosure and self-involving responses (e.g., McCarthy & Betz, 1978; McCarthy, 1979, 1982) was designed in the midst of the microskills zeitgeist, with its emphasis on specific, observable behaviors. Currently, a microskills approach is under fire for reasons that include reliance on analog designs and use of dependent measures that lack demonstrated psychometric properties (cf. Ridley, Kelly, & Mollen, 2011). These limitations have been partially addressed in recent research using more realistic analog designs (Yeh & Hayes, this issue), investigating actual therapy situations (Kuutmann & Hilsenroth, 2011), and using measures with demonstrated reliability and validity (e.g., Kasper et al., 2008; Kuutmann & Hilsenroth, 2011; Hill et al., 2008). Moreover, studies in which researchers ask participants to put themselves in the client's place and respond as they believe the client would are still valuable, especially for initial explorations of self-reference dimensions and/or contexts and populations for which little prior research has been done (cf. Paine et al., 2010; Redlinger-Grosse et al., in preparation).

Qualitative approaches to therapist self-reference attempt to capture complex and subtle aspects of these responses and their effects on therapy process and outcomes. It seems, however, that in conducting these studies, some researchers (e.g., Hanson, 2005; Hill et al., 2008; Kasper et al., 2008) have lost the definitional precision of early analog research. More circumscribed definitions would allow readers to determine the extent to which researchers are "speaking the same language," that is, investigating similar phenomena and using similar terms to refer to those phenomena. Although more limited with respect to external validity, I suggest researchers retain a "microskills" approach when operationalizing the variables of interest. I agree with Yeh and Hayes (this issue. p. 326) that their ". . . findings of significant differences in the effects of two types of therapist self-disclosure point out the importance of careful differentiation in further research on the use of self-disclosure".

Researchers walk a fine line in their attempts to design studies with both internal validity (e.g., using precisely defined and controlled variables) and external validity (e.g., obtaining thick descriptions of complex phenomenon that apply to "real world" people and situations). In experimental analogs, variables often (but not always) are clearly defined, yet their artificial nature raises questions about the generalizability of findings to actual therapy or supervision settings. Results of such studies potentially lead to simplistic, cookbook recommendations: "If I say this, then the client will say . . ." In addition to their artificiality, earlier analog studies typically used simpler statistical analyses. Researchers might examine one or two variables (e.g., clinician and client/

supervisee gender; clinician professional status), along with self-referent behaviors. Those studies are unable to account for the multitude of clinician, client/supervisee, and contextual variables that potentially interact with self-reference. Increasingly popular multiple variable designs (e.g., logistic regression) will allow researchers to determine unique and combined effects of several independent (predictor) variables.

A number of survey studies have been done assessing therapists' reported use of self-reference (e.g., Robitschek & McCarthy, 1991; Simone et al., 1998). Strengths of these studies include large samples of experienced clinicians, but they suffer from a reliance on brief responses to survey items. The growing number of qualitative studies on this topic (e.g., in-depth interviews) comprises a promising research direction for obtaining rich descriptions of clinician self-reference. Studies that involve audio and videotaped sessions of actual therapy (Hill et al., 2008; Kasper et al., 2008; Kuutmann & Hilsenroth, 2011) also are a tremendous addition to the research base, especially given their increased external validity. They are time and labor intensive, however, when they involve more than a single case study and/or long-term therapy. Nevertheless, these types of studies *open the door wider* to understanding therapist self-revelations and client perceptions and reactions.

Hill and Knox (2004) describe several types of research designs for investigating clinician attempts to process the therapeutic relationship. They are most favorably disposed toward qualitative studies because of their potential for generating rich descriptions of complex interactions. They recommend interviewing clients or therapists about their recollection of events related to processing of their relationship. They also suggest combining interview analysis with an examination of actual session(s). Interpersonal Process Recall (IPR; Kagan, 1971; Kagan & Kagan, 1990) is an ideal approach for understanding therapist and client and supervisor and supervisee behaviors, thoughts, and feelings in sessions. In IPR, both parties independently review the videotaped session with a researcher as soon after the session as possible, and they respond to a series of interview questions about what they were thinking, feeling, and doing. This method would yield data about clinician's motivations for engaging in self-reference, client, and supervisee reasons for requesting self-reference, and their perceptions of the reasons for clinician self-reference and its impact on them. Data collected during the IPR process could then be compared with external judges' analyses of the sessions.

I believe all of these research designs have a place in furthering our understanding of self-reference. Alone and in combination, they have the potential to yield important insights for practice and for further research. Researchers should, however, aim for uniform definitions of self-reference regardless of the design they select for their investigations.

Self-Reference Research Topics

Typically research has involved one or two self-reference dimensions along with one or two clinician characteristics, client/supervisee characteristics, and/or contextual variables. I agree with researchers who have demonstrated the effects of self-reference are dependent on multiple factors that must be examined together for their unique and combined impact (Audet & Everall, 2003; Henretty & Levitt, 2010). Previously studied clinician variables include: sex, age, professional status, ethnicity, theoretical orientation, and sexual orientation (Henretty & Levitt, 2010). Previously studied client characteristics include: sex, age, cultural background, diagnosis; ego strength; and expectations about therapist disclosure (Henretty & Levitt, 2010; Simone et al., 1998). Although a few studies have investigated cultural aspects of therapist self-reference (see Henretty and Levitt [2010] review of this variable), the questions in that regard are far from answered, especially with respect to self-involving responses.

Contextual issues have included point in the therapeutic relationship when self-reference occurs and strength of the existing working alliance (Henretty & Levitt, 2010). As mentioned previously, multiple variable analyses will allow for consideration of a greater number of variables in quantitative studies. The next sections contain descriptions of selected variables that I believe warrant future research.

Clinician competence. Based on a review of studies of empirically supported treatments, Ahn and Wampold (2001) recommend that emphasis be placed on the skill of the therapist rather than on the particular technique. Ridley, Mollen, and Kelly (2011) state, "Competent therapists select [a given response] only when they have considered the range of effects as well as contextual variables that may increase or decrease the effectiveness of the intervention" (p. 851). I believe clinician *relationship skills* (in particular, self-referent responses) are a prime area of study, given the importance of facilitative conditions and the working alliance.

Ridley, Mollen et al. (2011) suggest researchers need to expand beyond the body of microskills studies to examine therapist metacognitions of purposefulness; therapist motivation; and therapist selection, sequencing, and timing of responses (see the case studies by Hill et al., (2008) and Kasper et al. (2008) that investigate these types of competencies in interviews with therapists). In addition to exploring therapists' metacognitions, clients perceptions of these five aspects of therapist self-reference could be assessed. Knox et al. (this issue) investigated these types of competencies in their study of supervisee experiences and perspectives regarding supervisor self-disclosure. However, I would again urge researchers to separate self-disclosure from self-involving responses. Whether in therapy or in supervision, disclosing about one's self (e.g., what one's other clients/supervisees have felt in similar situations, or what the clinician did or felt in a similar situation) is dramatically different from sharing how the clinician feels about the client/supervisee and/or their behavior.

Competent use of self-reference involves not only metacognitive skills (e.g., knowing when to reveal oneself and when to refrain from doing so); the behaviors themselves must be skillful. Hence, additional studies need to determine the *skillfulness* with which clinicians self-disclose or use self-involving responses. As Hanson (2005) concluded, clinician competence/skillfulness may be more important than what the therapist actually says/does. Relatedly, studies of clients' and supervisees' perceptions of authentic versus feigned clinician self-reference should be done, especially self-involving responses in which the clinician denies, minimizes, or pretends to have a certain reaction. Authenticity is an essential ingredient of self-involvement; it comprises an important research topic and an important component of therapist training and supervision.

Studies of "received" self-reference. Associations between psychotherapeutic relationship and outcome are strongest when measured by client ratings of both dimensions (Lambert & Barley,

2001). Thus, research should assess client and potential client perceptions of the therapist's self-reference and their perceptions of its effects on counseling outcomes. Yeh and Hayes' (this issue) study illustrates the importance of assessing client perceptions of therapist self-reference, in this case, self-disclosure. The researchers defined self-disclosure as "therapist self-disclosure of relatively more and less resolved countertransference (CT) issues" (p. 323). Their study also shows how early analog methods of the 1970's and 1980's can be updated to include more detailed transcripts along with videotapes and the inclusion of a particular type of self-disclosure (i.e., therapist CT). My only concerns about their study are that 3 disclosures seems like a lot in a 12 minute segment, and the parallel versions of their two therapy segments (resolved CT vs. unresolved CT) might have been standardized to a greater extent with respect to length and content. Nonetheless, their findings suggest the importance of assessing, from therapist, client, and external judges' perspectives, the extent to which therapist self-disclosure contributes to the goals of therapy for a given client (If so, how? If not, why not?). Similar work should be done with supervision dyads.

All clients and supervisees to some extent project onto clinicians who they wish them to be. Researchers could examine whether and when clinicians should use self-reference to either reinforce or dispel those projections. Relatedly, although researchers have investigated self-reference and the working alliance (cf. Henretty & Levitt, 2010), more data are needed to establish how self-reference affects each component of the working alliance (i.e., goal, task, and bond). Yeh and Hayes' (this issue) research approach might be used to investigate client transference reactions to therapist self-reference.

Outcome research. Early research on therapist self-reference consisted primarily of process studies investigating, for instance, effects on perceptions of the therapist and on client behavior during the session (e.g., McCarthy & Betz, 1978; McCarthy, 1979, 1982). Current research is headed in a promising direction with its more direct focus on therapy outcome (e.g., Kuutmann & Hilsenroth, 2011). Studies that examine the effects of clinician self-reference on both process and outcome will yield fruitful data for guiding practitioners and educators.

Purpose of self-reference. Ridley, Mollen et al. (2011) state: "A microskill without a distinct purpose is useless, and therefore, irrelevant to therapeutic change" (p. 852). They further state, "If we cannot specify a microskill's purpose, we should neither expect a sound definition to come forth nor to ascertain how it is integral to counseling competence" (p. 853). Researchers must continue to articulate the common purposes therapist self-reference serves and to distinguish the unique purposes of self-disclosure and self-involving responses with respect to counseling process and outcomes.

Self-involving responses. Supervisor self-involvement in particular has received far less research attention than self-disclosure, and thus, more research on therapist and supervisor self-involvement is needed. Support and guidance comprise two major dynamics in clinical supervision (Hart & Nance, 2003). Studies could be done of supervisor self-referent responses that indicate high versus low guidance and support and their effects on the supervisory alliance, supervisee self-efficacy, and clinical performance.

Client and supervisee self-reference. Khurgin-Bott and Farber (this issue) studied patient disclosure to others about their therapy experience. Their study suggests a fruitful line of research. Specifically, studies could be performed to determine whether therapist use of self affects the nature and frequency of client disclosures to significant others. Future investigations might explore Khurgin-Bott and Farber's speculations that client disclosure to significant others constitutes a positive sign that clients are doing the work of therapy between sessions and/or reviewing the messages they glean from their therapy sessions. I would also suggest studies that assess the extent to which clients, through their disclosure to significant others, are seeking validation of some aspect of therapy with trusted others, passing along valuable "tips" learned in therapy, and/or are transferring the working alliance established with their therapist to significant others in anticipation of the end of the therapy relationship. Similar questions could be studied with supervisees.

Questions About Therapist Self-Reference That Warrant More Research

Having taught basic counseling skills for more than 35 years, I am continually impressed by the thoughtful questions students pose about self-reference. Their questions should continue to inform research on therapist self-referent behaviors. They also could easily be adapted for investigations of supervision relationships.

Self-disclosure. Examples of questions students bring to the training arena indicate they have concerns about giving the *right* answer to client requests for self-disclosure. They also express concerns about setting and maintaining appropriate boundaries. For example:

- Can I use personal stories to encourage clients?
- How often can I use my personal life experiences to help counsel others?
- When is it appropriate to self-disclose?
- How clear or up front should you be in informing your client about your own informational boundaries? Should you be upfront or do you wait until the situation arises?
- What information should you give about yourself? How personal should you get?
- How do you respond when a client asks you about your personal life?
- When and how is it appropriate to show empathy and understanding to a client by sharing information about yourself? If it is a resolved issue, can it be helpful to mention something that you found useful?
- What are good guidelines for appropriate therapist self-disclosure with clients?

Self-involving responses. Students worry about sounding sincere when they say, for example, "I'm sorry" when learning a client has experienced a significant loss. Some have difficulty believing a client would care about what they feel. They also worry about losing control of themselves and believe that behaving professionally means they can and should hide their reactions to clients. Examples of student questions about self-involving behaviors include:

- In the counseling process, if the counselor makes a mistake, what is the best way to address it? Should you own up to it?

• When someone discloses something painful or traumatic, what kind of reaction is appropriate, and what sort of verbal statement would be helpful and not offensive?

• How do you separate your personal feelings and emotions about situations from the counseling session? Or when is it appropriate to incorporate them, if ever?

• How do I control my own reaction to what the client says?

• How do you keep your emotion in check during a particularly challenging situation?

• Is it ok to be emotional when you have the same personal issues as your client?

• Are there ever situations where a client makes a counselor feel uncomfortable? What do you do in that situation?

• What happens if you cry in front of a client? How do you handle that type of situation?

• Will I learn how not to cry when a client is crying? Is it ever appropriate to cry along with your client?

Conclusion

Due to definitional inconsistencies, research findings regarding self-reference are limited in their utility for both research and practice. Microskills training and related research offer precise definitions of clinician self-referent behaviors. Adoption of uniform conceptual and operational definitions of self-disclosure and self-involving responses will promote research that is likely to yield less equivocal results, and thus generate findings that more easily translate to practice.

Early self-reference research relied heavily on experimental analogs and surveys. While these designs provide greater control over variables, their artificial nature means the findings "fall short" of the complexity of self-reference as it plays out in actual therapy and supervision relationships. Use of more sophisticated analog designs, such as those currently being used to study clinician self-reference, along with qualitative designs to obtain "thick descriptions" of the phenomenon, will advance the knowledge base. Given the low frequency of self-referent behaviors, it is difficult to conduct research that assesses a large number of clinicians and clients/supervisees and/or sessions. Mixed method designs might help to address that difficulty. For example, researchers could pose hypothetical situations to participants who put themselves in the client/supervisee role. Participants could then be interviewed to assess their reactions.

Self-reference, similar to other clinician interventions, is complex, and "one size does not fit all." In addition to definitional inconsistencies, major challenges continue to include decisions about what to say, when and how to say it, and for what anticipated outcome. Researchers interested in investigating clinician self-reference would do well to continue anchoring their research questions in the classic quotation by Gordon Paul. Paul (1967) reviewed the psychotherapy literature over 40 years ago and concluded that outcome research should address: "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" (p. 111).

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