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Introduction

My interest in this study arose from what I believed to be the discrepancy between the conventional wisdom about self disclosure and its occurrence in the practice of clinical social work. Bradmiller's[1] study, one of the few studies about self disclosure in the practice of social work, found that persons with masters degrees in social work (MSW's) disclose significantly more to their colleagues than do undergraduate social work majors. The MSW's in Bradmiller's study self disclosed to clients at a lesser rate than they did to other target persons. Bradmiller[2] interprets her study, "..... most simply as an indication that social workers are not knowledgeable about the use of self disclosure in the helping relationship."

In the State of California, however, there is a surplus of experimentation with many modes of implementing psychotherapeutic services. Some of these advocate and practice plentiful

self disclosure. Some clinical social workers practice within these self disclosing theoretical models. Different theoretical models spell out a range of clinicians' self disclosure from its being forbidden to its being a key ingredient of the therapeutic interaction. "The controversy over self disclosure," says Weiner,[3] "has polarized about a continuum from the "nude' position to the 'neutral' position". The Marathon group therapist can exemplify the 'nude' position while the Rogerian (Carl Rogers himself has departed from this position)[4] can exemplify the 'neutral' position. While Freud was closer to the neutral position, Weiner[5] cites examples of Freud's self disclosure. Freud's willingness to disclose about himself was tempered by his belief that if the friendly relations between patient and therapist overstep a certain boundary, this will work against therapy.[6] It has been reported[7] that in his later analyses of patients, Freud was unable to speak because of the prosthetic device that had replaced the part of his jaw that was removed because it was concerous--he could merely nod un uhs--and this was interpreted by some of his followers to mean that the therapist should say as little as possible.

My subjective impression of the "oughts" of more orthodox psychoanalysis continues to be one of a paucity of self disclosure. Similarly, the Freudian and Ego psychological influences upon social work would lead one to assume that most clinical social workers would also tend to minimize self disclosure.

Hamilton,[8] established a norm for self disclosure in case work with the following words:

Personal questions directed towards the interviewer may indicate interest in the worker--a growing sense of relationship, but perhaps more often they represent an area of emotional concern--a way of projecting one's own problem onto the worker. The client asks personal questions about the interviewer which indicate uncertainties about himself. They may be answered simply and quietly and so disposed of, but often it is bets to turn the question back so as to see what was really the client's idea when asking them. In therapeutically focused interviewer which indicate uncertainties about himself. They may be answered simply and quietly and so disposed of, but often it is best to turn the question back so as to see what was really the client's idea when asking them. In therapeutically focused interviews this is almost always necessary. It does not really help or reassure a client to know about the interviewer, who is there to understand and help him. The worker must keep in mind that his purpose is professional and should gently recall the client into the appropriate relationship--"I think I can help you best if you will go on with what you were just saying," or something of that sort. Inexperienced workers who have let the interviewing ball go into the net often take refuge in personal chat. This deflects the professional purpose and confuses the client. This is not to say that at the beginning of an interview or when making a visit "small talk" may not take place in a friendly way, but one should proceed as repidly as possible to the business of the interview.....

Hamilton's quote is the only explicit one the researcher could find in the social case work literature about self disclosure. It is for this reason I have repeated it so extensively. However, because of the crossfertilization from modes of therapy advocating increased self disclosure, its rate among social workers has also probably increased. I gathered this impression attending workshops, listening to colleagues present their cases for consultation, and reading books and papers about self disclosure.

The study, therefore, attempts to assess the current quality and quantity of self disclosure of clinical social workers in the State of California. The implications of the findings for the practice of clinical social work will be discussed in the concluding section of this paper.

Methodology

Previous research[9] about therapist self disclosure listed the following categories of disclosure: demographic; personal information; similar experiences; disagreements with a client's stated position; "here and how" aspects of the therapeutic encounter. The research also suggested that the timing of self disclosure needed study. A questionnaire[10] was constructed to assess the above mentioned categories and the timing of self disclosure by clinical social workers.

As of September 1979, the population of clinical social workers in the State of California was 5,979.[11] The questionnaire was mailed to a random sample of 200 clinical social workers.

By the closing date of return 81 or 40% of our sample returned the completed questionnaires. Given this return rate, despite the randomness of our sample, it is safer that our findings and conclusions be utilized to describe how persons in our sample self disclosed rather than our findings and conclusions be generalized to all clinical social workers in the State of California.

The questionnaire contained fourteen questions about specific content areas of clinicians' self disclosure that required rating on a five point scale: always, often, sometimes, rarely, never. These specific content areas of clinicians' self disclosure are listed in Table 2.1. The questionnaire also contained opened ended questions about the quality and quantity of clinical self disclosure per se, as well as the timing and perceived effectiveness of disclosures. Face sheet information--age, ethnicity, marital status, years since obtaining the masters degree, years of employment as a social worker since graduation, present work setting, theoretical frame of reference, as well as other similar information found listed on Table 2.3.--was also solicited by the questionnaire. All the face sheet variables (independent) were crosstabulated via a Chi square test with our fourteen questions about the content of clinicians self disclosure (dependent variables). A new variable was constructed for each respondent by adding up the total score for the fourteen content areas of clinicians self disclosure. The sample was then divided at the median into high and low self disclosures; these groups were also crosstabulated with all the independent variables. Throughout the statistical analysis the .05 level of probability was utilized. Henceforth the findings of this statistical part of the study will be distinguished from the responses to the open ended

questions that were not statistically analyzed which I will label as the phenomonological findings.

Findings

Statistical Findings

Tables 1.1 through 1.7 describe the characteristics of our sample. An additional statistical test of the proportion of males in our sample (38.7%) when compared with the proportion of males in social work in the United States (37%)[12] revealed no statistically significant difference. This test was performed to ascertain that at least the distribution of sexes in our sample compared favorably with the distribution of the sexes in the profession as a whole. While Anglo Americans and Jewish Americans constituted 87.6% of our sample, the percentages for the minority clinicians were: Mexican American 2.5%; Other Hispanic American 1.2%; Afro American 3/7%; Asian American 2.5%. Given the higher proportion of these minority groups in Los Angeles alone, one can surmise an underrepresentation of minority persons in the sample.

In Table 1.4 medians were listed for those variables that served as the independent variables for the median test that was performed with our dependent variables--the fourteen categories of clinicians' self disclosure (These are listed on Table 2.1 through 2.3).

It is interesting to note that with the exception of a few variables, most of our sample answered that they would sometimes

self disclose about the categories of self disclosure listed in Tables 2.1 through 2.3. The frequency distributions of the data led the researcher to believe that the later crosstabulations would reveal few statistically significant differences. The writer's hunch proved to be correct. More will be said about the crosstabulations that were significant in the next paragraphs.

Crosstabulations

Because of the preponderance of "sometime" answers in response to the frequency of self disclosure about the fourteen categories of clinicians self disclosure that was our dependent variable, an adjustment was made in performing the median test. Usually one would leave out the responses to the answer "sometime" and combine the "always" "often answers indicating high self disclosure and combine the "rarely" "never" answers indicating low self disclosure. If the writer had left out the "sometime" answers there would be too small an N and too many of the cells of the Chi square test would have been less than five, rendering any statistical results questionable. Since one previous study reported that moderate and low self reporting therapists tended to be viewed similarly by clients[13] since it is acceptable research practice,[14] and since the writer wanted to see how strong self disclosure was in our sample, throughout the crosstabulations the "sometime" answers were combined with the "rarely" and "never" answers to form our low self disclosure variable. The procedure just described biased the results against high self disclosure. Therefore, only in those areas where self disclosure was strongest would a statistically significant relation occur.

The results of crosstabulating eleven independent and fourteen dependent variables plus the summary score for the fourteen dependent variables are listed in Table 2.3. The reader will observe that the crosstabulations confirmed the writer's original hunch stimulated by the frequency distributions. Most of the sample was similar in self disclosure responses; most of the crosstabulations were not statistically significant. The meaning of the significant findings are to be found in Table 2.3 and the Notes to Table 2.3.

There were only three categories of clinical social workers' self disclosure where there was not even one statistically significant relationship between the dependent and the independent variables (Table 2.3). Regardless of age, sex, ethnicity, date of birth, etc., the persons in our sample tended to be similar in their self disclosure about their age, previous work experience, and professional reactions to their clients. There was at least one statistically significant relationship for each of the twelve remaining categories of clinical social workers' self disclosure. The reader will notice (Table 2.3) that the therapist's religious orientation emerges as an almost taboo area of self disclosure. This is followed closely by the therapist's sexual orientation, and, the clinicians' sharing with their clients any information about a death in their families. Looking at the columns of Table 2.3, the reader will observe that one's theoretical orientation related significantly to clinicians' self disclosure about their sexual orientation or a death in their families. Clinical social workers with more of a Freudian orientation tended to disclose less to their clients about their political, sexual, and personal orientations. Also, clinical social workers who received their masters degree in social work prior to and including the year

1967 were compared with persons who received their degrees after 1968. Both groups were significantly low in self disclosing about their sexual and religious orientations. On all variables (Summary score of 14 items), as one might expect, Freudian oriented clinicians tended to be lower in self disclosure when compared with clinicians whose orientation was somewhat other than Freudian.

The earnings of the clinician made a difference for any variables (Table 2.3; Notes Table 2.3). Upper income professionals were more apt to disclose about marital status; family composition; death in the family; and on all fourteen categories (Summary score of 14 items). Lower income clinicians were more prone to self disclosing about their place of birth than upper income clinicians. Both high and low earners didn't want to share any information about their personal finances with their clients. While higher earners had a higher self disclosure index score, females and Freudians tended to have a low self disclosure index score.

The implications of the statistical findings as well as the implications of the responses to the open ended questions, the next section of this paper, will be discussed in the concluding paragraphs of the paper.

Phenomenological Findings

It is important to remind the reader that the responses to the open ended questions lack statistical significance. They merely describe how persons in our sample responded to the open ended questions about self disclosure.

Clinicians in our sample were divided about their own utilization of self disclosure as indicated by their responses to most of the issues raised by the open ended questions. Some patterns emerged. Clinical social workers were reluctant to self disclose if they felt that by doing so they would be yielding to client manipulations. Workers were particularly concerned about the client avoiding therapy by provoking them to self disclose. A consistent theme emanating from most of our respondents was that the clinician had to be aware of both clients' motives for eliciting workers' self disclosure and their own motives for disclosing. Only one respondent in our sample thought that the clinical social worker should never self disclose.

While some therapists felt more confortable disclosing when transference was positive, others felt the self disclosure would provoke a positive transference. Some self disclosed only to their healthier clients and were most concerned about self disclosing to psychotic clients. Others reversed this process. While some clinicians believed that self disclosure at the beginning phase of therapy helped to build a therapeutic relationship, others felt the opposite.

The content areas clinical social workers felt most comfortable self disclosing about were as follows. Many therapists talked to their clients about some of their own problems with lonliness, the single life, aging, and other developmental issues of adulthood. Many talked freely about their marital status, the composition of their families, their parenting, their education, and their work. The most significant content area for sharing was grief work around significant losses either through separation, divorce, or death.

Those clinicians who were more positive about the utilization of self disclosure thought about doing so for many reasons. Probably the most important reason given for self disclosing was as a method of universalizing the problem for clients. The self disclosing respondents tended to do so in the middle phase of therapy when clients were more fully engaged and tended to increase the quantity and the quality of self disclosure in the termination phase of therapy when clients were more fully engaged and tended to increase the quantity and the quality of self disclosure in the termination phase of therapy. Therapist trust in their clients was another criteria for self disclosure. Many of our social workers disclosed to clients they felt were similar to themselves. One therapist was quite frank about self disclosing to gain the client's approval. In most instances of self disclosure the motivation was to encourage therapeutic rapport. It was felt that therapist self disclosure would encourage real person, equalitarian relatedness between the clients and clinicians. As one respondent wrote:

> I'm not a blank screen; if I'm to be a mirror for them, they're entitled to see my cracks.

Conclusions

The sample of respondents in this study can be described as "guarded' self disclosers. Whether or not this describes the population of clinical social workers for the State of California, given that our return rate of 40% is too small from which to generalize, must be left to others to ascertain. The findings of the study can be viewed as "sensitizing".

Our research should point the conventional wisdom toward accepting that a good deal of self disclosure by the therapist, albeit guarded, takes place in the confines of the clinician's office. If this is so perhaps the findings of this study can be a beginning for helping us develop the proper disciplined utilization of self disclosure in the practice of clinical social work specifically and in social work generally.

It is my conclusion that many of the content areas of low self disclosure reflected the clinicians' reluctance to diminish what they believed to be their charismatic power vis a vis their clients. These content areas include: a death in their family; a minor health problem; sexual, religious, and political orientation; and their own financial status. For many to be too human meant giving up their therapeutic authority and their therapeutic advantage. And yet, those clinicians that self disclosed felt, in congruence with Bradmiller's[15] findings, mentioned at the outset and elsewhere in this paper, that therapists' self disclosure made them more human to their clients and helped to build the therapeutic relationship. An interesting follow up study that could test the validity of self disclosure building therapist-client rapport may be to attempt to assess the outcome results of high and low disclosures. This has been suggested by another study[16] and is once again suggested by the findings of this study.

When therapists felt more secure they tended toward greater self disclosure. Some of the areas they felt more comfortable about included information about the composition of their families, their marital status, and a somewhat higher inclination to disclose about all the categories of self disclosure as determined by the

self disclosure index score.

The open ended questions revealed that all the respondents in our sample, save one, self disclosed. Our respondents were split in their views about the wisdom of self disclosure at each phase of the treatment sequence: beginnings, middles, and endings. Grief, loss, parenting, and the developmental tasks of adulthood emerged as content areas where therapists increased their self disclosure.

Returning to the statistical data, the reader is reminded that only three of our fourteen categories of clinicians' self disclosure failed to crosstabulate statistically significantly with at least one of our independent variables. These three categories were: age, previous work experience, and personal reactions to the client. The other eleven categories crosstabulated statistically significantly with at least one or more of our independent variables (Table 2.3). The reluctance of self disclose about other content areas expressed as percentages of our sample who were reluctant to do so, is illustrated in Table 2.2. Several taboo areas of self disclosure emerge. These are: religious, sexual and political orientation; a death in the clinician's family; and countertransference reaction.

It is my philosophic belief that no content area should remain absolutely taboo for clinicians' self disclosure. One of my reasons for so believing are the studies[17] which report that therapist self disclosure increases client self disclosure and builds therapeutic rapport, both of which are desirable therapeutic

objectives. The other reason for my stance is based upon Jung's approach to therapy. This requires some elaboration.

Jung[18] viewed the therapy session as an alchemical vessel. Neither therapist nor client could predict what "prima materia" what content consciousness and unconsciousness would bring to that interactional process called the therapeutic interview. Jung[19] describes how he sat one of his young adult patients on his lap and told her stories, danced with her, and by using these modalities helped her find her way back to health. We clinicians are the heirs of the witch doctors:[20] it is our task to deal with the dark underside of our society and culture. This latter point is translated into Jung's theory when he states that the first phase of therapy usually consists of the client exploring his or her shadow.[21] Based upon the research and Jungian theory it is my opinion that no content area of self disclosure should be anathema to the social work clinician.

Let me share with you some of my conclusions about why clinicians failed to self disclose about some of the content areas that persons in our sample viewed as most threatening to them.

Countertransference is usually written about and viewed in its negative aspects by most clinicians. Some authors[22] offer positive prescriptions for the effective utilization of the therapist's countertransference. It can make clinicians aware that the reactions they are having to their clients may be the same effects their clients induce in others. Given that the expression of countertransference is a form of clinical projection, Jung[23] warns against being too defended against our projections because oversensitivity to them, "may easily act as an impediment to our

relation with others for there is then no bridge of illusions across which love and hate can stream off so relievingly." Our study seems to contain a contradiction. Countertransference is frowned upon by most of the persons in our sample and yet self disclosure is reported. It can be argued that self disclosure is at least projection and at most countertransference, faulty or not. Given this contradiction it is my belief that the persons in our sample responded to the term countertransference as a dirty word and opted to answer in a manner reflecting their best professional foot forward.

Given the secularism of our society, and given the logical positivist stance of most clinical theories, one could almost predict that our sample would be reluctant to self disclose about their religious beliefs. As reported earlier in this paper Freud's difficulty in speaking because of the prosthesis on his jaw led his followers to overinterpret his behavior as modelling therapist neutrality. Certainly politics and religion must then become areas where the therapist is reluctant to self disclose. Writing about his analysis with Freud, Wortis[24] reports many conversations where he talked to Freud about Judaism and communism. It is my belief, based upon what fellow clinicians have shared with me in conversation, that clinical social workers increasingly recognize and are beginning to work with the spiritual dilemmas their clients speak about in therapy. With reference to politics and consistent with my theme throughout, politics like any other content put into the alchemical vessel has archetypal meaning for the client's psyche. Political content like any content can be analyzed for its meaning to the client. It is probably the therapists' fear of

revealing too much about their own religious and political preferences, ipso facto their own humanness, that leads them to close off these content areas.

There are many reasons why therapists may withhold information about their sexual orientation. Of course therapists whose sexuality deviates from the societal norms may fear losing their clients if their sexual preferences were known. Similar to what one study[25] reports about revealing being single to a client, therapists may be concerned that sharing their sexual preference may be viewed as their suggesting personal or sexual relationships with clients. Even those persons in our sample who scored high for self disclosure were wary about indiscriminate self disclosure and were acrupulously concerned that it be in client's behalf. The sexual orientation of the therapist can be approached within similar responsible parameters.

A future conference of Jungian analysis will focus upon money and its role in therapy. Similar to sex first, death second, money seems to be the third taboo subject that will probably emerge from the closet as legitimate content for therapy. Clinicians withholding information about personal finances may be counter-productive. This is probably particularly true if clinicians' reasons for doing so may be to maintain secrecy about how well they are doing if their clients are less affluent than they are, or may be to maintain a pseudo superordinate authority stance if their clients are more affluent than they are.

A theme that may provide an explanatory overview for the avoidance of all the aforementioned topics by clinicians is that they can

be just as much a part of the mass psyche as their clients. This point is not new and has been made earlier by Fromm[26] when he wrote about therapists wittingly or unwittingly becoming the agents of conformity. Jung[27] was concerned about how "Our fearsome Gods have only changed their names: they now rhyme with--ism". The "isms" create a mentality where the individual is perceived to be an anonymous interchangeable member of the collective, a mere contributing unit of a mass organization. And, says Jung, "looked at rationally and from outside, that is exactly what he is, and from this point of view it seems positively absurd to go on talking about the value of the meaning of the individual." By withholding information about themselves in all the content areas just discussed, clinicians reflect how they both conform to the mass psyche and perpetuate it. Their "ism" is a "professionalism" with its concomitant admonition to avoid self disclosing about subjects such as death, sex, politics, and finances. This removes them from meeting the individuated needs of their clients. Such clinicians have come a long way from Freud's admonition to give to society that which is due society and to give to the individual that which is due the individual.[28] It has also come a long way from Freud's practice which included judicious self disclosure. Wortis[29] describes many such examples from his analysis with Freud. The "wolf man" Freud's famous analysand of 1910-1914, recalled several self disclosures made by Freud:

> Once during an anlytic hour Freud told me that he had just received word that his youngest son had broken a leg skiing, but that luckily it was a mild injury with no danger of lasting damage. Freud went on to say that of his three sons, the youngest was most like him in character and temperament.[30]

In addition Freud[31] once spoke to the "wolf man" about another one of his patients, lent money to the "wolf man", complimented him by saying it would be good if all his pupils could grasp analysis as well as him, and gave his opinion in literature from time to time.

In conclusion this study has confirmed by hunch that clinical social workers self disclose in their practice. One can say that the pendulum has swung back to the self disclosure stance of the early pioneers of the profession. When Jane Addams lived at Hull House her very presence midst her clients, including the laundry she hung out to dry, was the manner in which she self disclosed.[32] When the friendly visitors visited self disclosure by the worker seemed an appropriate tool in helping clients.[33] The neutrality of clinical social workers was a product of poorly applied psychoanalysis. Minuchin[34] writes that when analyzing the transference neurosis was the goal of therapy, neutrality was the appropriate clinical stance; when change in family structure, ipso facto enhanced individual social functioning is the goal of therapy, the active involvement of the therapist is the appropriate clinical stance. Within this stance Minuchin[35] self discloses as an important part of therapy. In addition to Minuchin's theory, theories such as the Existential, Jungian, as well as others also advocate the judicious use of self disclosure by clinicians.[36] We know from previous studies[37] that therapist self disclosure indices client self disclosure. Further research is needed, however, to ascertain the relationship between client self disclosure and the outcome of therapy.

Although I cannot generalize from the random sample in this

study because of the 40% return rate, the study suggests, however, that clinical social workers guardedly self disclose. If it has become an ingredient of therapy in general and clinical social work in particular, it behooves us to develop the appropriate use of self disclosure. If we do it, let us do it well. Beginnings toward such development have been suggested throughout this paper and can also be found in the body of the study[38] from which this paper has been derived.

I close by allowing one of our respondents to speak for himself about the judicious use of self disclosure by clinical social workers. He says:

> Overall I view self disclosure like spice in cooking--a little bit goes a long way--and it should embrace not overwhelm. Cooking like therapy is an act that is learned through experience and an unknown quality. Mostly its use is dictated by the situation. One may love garlic but not in cherry pie.

FOOTNOTES

[1] Linda L. Bradmiller, "Self Disclosure in the Helping relationship," Social Work Research & Abstracts (New York: NASW, 1978), pp. 28-35.

[2] Ibid.

[3]Myron F. Weiner, Therapist Disclosure: The Use of Self in Psychotherapy (Boston: Butterworths, 1978), p. 16.

[4]Ibid. pp. 10-11.

[5]Ibid. p. 11.

[6]Ibid.

[7]Dr. Norman Mirsky, "Talk About Sigmund Freud", University of Southern California, Hiller Foundation, April 9, 1980.

[8]Gordon Hamilton, Theory and Practice of Social Casework, Second Edition (New York: Columbia University Press, 1951), pp. 32-33.

[9]Kay Bliss; Michael Griffin; Janice Hazeltine; Sara Jiminez McSweyn; Virginia Tapanes Perrin; Julie Tutelman, "Self Disclosure of Clinical Social Worker," (Los Angeles: University of Southern California, Schoo- of Social Work, 1980, Unpublished), pp. 12-20.

[10]My thanks to Kay Bliss, Michael Griffin, Janice Hazeltine, Sara Jiminez McSweyn, Virginia Tapanes Perrin, and Julie Tutelman for their help in doing this research.

[11]Ibid. Appendix.
My thanks to the Board of Behavioral Science Examiners of the State of California for lending us their mailing list which made this study feasible.

[12]Alfred Kadushin, "Men in a Woman's Profession" Social Work (New York: NASW, November 1976, Vol. 21, #6), p. 440.

[13]Bliss, et al, Op. Cit. p. 19.

[14]Herman J. Loethes, Donald G. McTavish, Descriptive and inferential Statistics (Boston: Allyn and Bacon, Inc. 1976), p. 549. My thanks to Dr. Barbara Solomon of the University of Southern California, School of Social Work who referred me to this text and helped me with this research problem.

[15]Bliss, et al., Op. Cit. p. 19.
Bradmiller, Op. Cit.

[16]G. T. Barrett-Lennard, "Dimensions of Therapist Response as Causal Factors in Therapy Change Psychological Monographs 1976, p. 562.

[17]Kenneth A. Bundza, Norman R. Simonson, "Therapist Self Disclosure: Its Effect on Impressions of Therapist and Willingness to Disclose" Psychotherapy: Theory, Research and Practice, 10 (Fall 1973), pp. 215-217.

[18]C. G. Jung, "Psychology of the Transference", The Practice of Psychotherapy (New York: Pantheon Books, 1954), pp. 163-321.

[19]Laurens Van Der Post, Jung and The Story of Our Time, (New York: Pantheon Books, 1975), p. 57.

[20]John Sanford, "The Wounded Healer" (Los Angeles: C.G. Jung Institute), Cassette Tape.

[21]Edward F. Edinger, Ego and Archetype (Baltimore: Penguin Books, Inc., 1973).

[22]Robert Michels, Roger A. MacKinnon, The Psychiatric Interview (Philadelphia: W. B. Saunders Company, 1971).

[23]Volodmyr Walter Odajnyk, Jung and Politics (New York: Harper Colophon Books, 1976), p. 75.

[24]Joseph Wortis, Fragments of an Analysis with Freud (New York: McGraw Hill, 1975).

[25]Bradmiller, Op. Cit.

[26]Erich Fromm, Escape From Freedom (New Uork: Rinehart & Company, Inc. 1941), p. 246.

[27]Odajnyk, Op. Cit. p. 36.

[28]Phillip Rieff, Freud: The Mind of the Moralist (Gordon City, N.Y.: Doubleday Anchor Books, 1961).

[29]Wortis, Op. Cit.

[30]Weiner, Op. Cit. p. 11.

[31]Weiner, Op. Cit.

[32]Bliss et. al., Op. Cit.

[33]Ibid.

[34]Salvador Minuchin, Families and Family Therapy (Cambridge: Harvard University Press, 1974).

[35]Ibid.

[36]Bliss et. al., Op. Cit. pp. 4-9.

[37]Bradmiller, Op. Cit.

[38]Bliss, et. al., Op. Cit.

TABLE 1.1: CHARACTERISTICS OF SAMPLE BY SEX

Sex	Percent of Sample
Male	38.3
Female	60.5
No Answer	1.2
	100.0
	(N=81)

TABLE 1.2: CHARACTERISTICS OF SAMPLE BY ETHNICITY

Ethnicity	Percent of Sample
Anglo-American	58.0
Jewish-American	29.6
Mexican-American	2.5
Other Hispanic-American	1.2
Afro-American	3.7
Asian-American	2.5
Australian	1.2
No answer	1.2
	99.9

(N=81)

TABLE 1.3: CHARACTERISTICS OF SAMPLE BY MARITAL STATUS

Marital Status	Percent of Sample
Married	50.6
Single	13.6
Divorced	27.2
Separated	6.2
Living Together	2.5
	100.1

(N=81)

TABLE 1.4: CHARACTERISTICS OF SAMPLE BY YEAR OF BIRTH MSW CONFERRED, YEARS OF SOCIAL WORK PRACTICE SINCE MSW, YEARS OF CLINICAL PRACTICE, AND EARNINGS FOR THE YEAR 1979.

(N=81)

		Range		
	Median	Maximum	Minimum	No Answer
Year of Birth	1938	1952	1910	0
Year MSW Conferred	1968	1976	1947	0
Years of Practice since MSW	10	32	2	0
Years of Clinical Practice	10	32	2	4
Earnings for 1979	$20,000	$75,000	$1,500	12

TABLE 1.5: CHARACTERISTICS OF SAMPLE BY WORK SETTING

Work Setting	Percent of Sample
Private Practice	19.8
Private Agency	25.9
Public Agency	37.0
Educational Institution	6.2
Other Work Setting	4.8
No Answer	6.2
	99.9

(N=81)

TABLE 1.6: CHARACTERISTICS OF SAMPLE BY FIELD OF PRACTICE OF WORK SETTING

Field of Practice	Percent of Sample
Mental Health	60.5
Family & Child Services	19.8
Health	8.6
Social Work Education	2.5
Community Organization/ Public Administration	1.2
Other Field of Practice	6.0
No Answer	1.2
	99.8

(N=81)

TABLE 1.7: CHARACTERISTICS OF SAMPLE BY PSYCHOLOGICAL ORIENTATION IN CLINICAL PRACTICE

Psychological Orientation	Percent of Sample
Freudian-Based	32.1
Ego Psychological	23.5
Rogerian/Client-Centered	3.7
Behavioral	7.4
Eclectic	11.1
Behavioral & Ego Psychological	3.7
Other Orientations	12.5
No Answer	6.2
	100.2

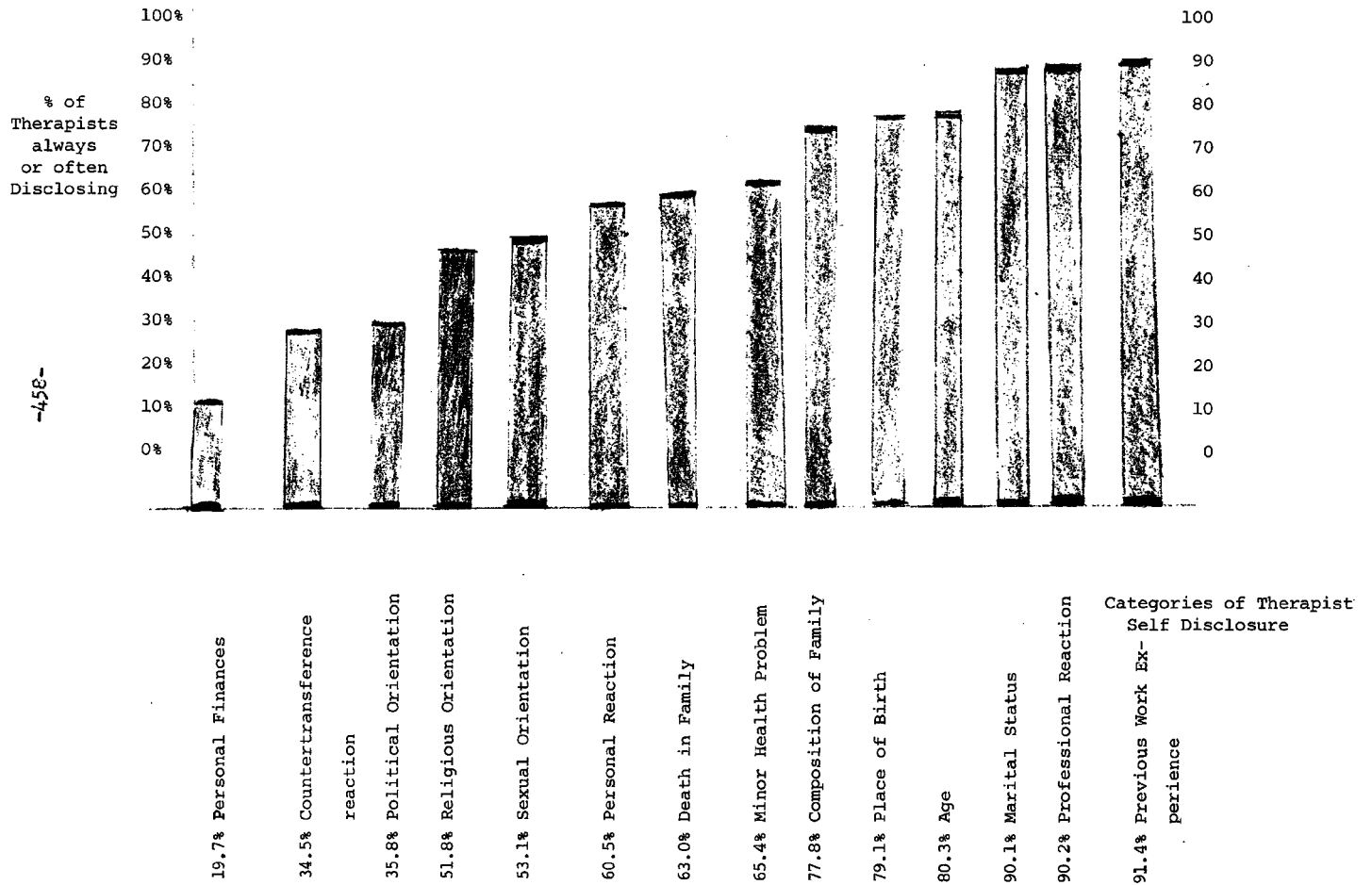
(N=81)

TABLE 2.1: CATEGORIES OF THERAPIST SELF DISCLOSURE AND DEGREE OF WILLINGNESS TO SHARE THIS INFORMATION

Category of Therapist Self-Disclosure	Percent of Therapists						
	always	/ often	/ sometimes	/ rarely	/ never	/ no answer	TOTAL
Marital Status	35.8	27.2	25.9	7.4	2.5	1.2	100.0
Composition of Family	29.6	23.5	23.5	18.5	3.7	1.2	99.9
Political Orientation	8.6	6.2	18.5	28.4	35.8	2.5	100.0
Minor Health Problem	13.6	7.4	43.2	23.5	11.1	1.2	100.0
Religious Orientation	17.3	6.2	27.2	30.9	17.3	1.2	100.1
Age	24.7	17.3	37.0	16.0	3.7	1.2	99.9
Personal Finances	1.2	4.9	11.1	23.5	56.8	2.5	100.0
Place of Birth	30.9	16.0	30.9	16.0	4.9	1.2	99.9
Sexual Orientation	23.5	4.9	23.5	16.0	30.9	1.2	100.0
Previous Wk Experience	32.1	24.7	34.6	7.4	1.2	0.0	100.0
Death in Family	18.5	13.6	28.4	24.7	12.3	2.5	100.0
Countertransference reaction	2.5	8.6	19.8	38.3	27.2	2.7	100.1
Professional reaction	18.5	39.5	28.4	8.6	1.2	3.7	99.9
Personal reaction	3.7	19.8	34.6	29.6	9.9	2.5	100.1

(N=81)

TABLE 2.2: CATEGORIES OF SELF-DISCLOSURE IN INCREASING ORDER OF WILLINGNESS TO DISCLOSE



Key: NS = No Significant; SL = Significant in the Direction of Low Seld Disclosure; SH = Significant in the Direction of High Disclosure.

TABLE 2.3.: CROSS-TABULATION OF CHARACTERISTICS OF SAMPLE AND CATEGORIES OF SELF DISCLOSURE

Characteristics of Sample

	Worker's Sex	Ethnicity	Marital Status	Date of Birth	Yr MSW	Yrs Wk Since MSW	Yrs Wk (Clin) Since MSW	Ear lings	Theo Orien	Work Set.	Practice Setting
Marital Status	NS	NS	SH[1]	NS	NS	NS	NS	SH[2]	NS	NS	NS
Composition of Family	NS	NS	NS	NS	NS	NS	NS	SL[3]	NS	NS	NS
Political Orientation	NS	NS	NS	NS	NS	NS	NS	NS	SL	NS	NS
Minor Hlth Prob.	NS	NS	NS	SL	NS	NS	NS	NS	NS	NS	NS
Religious Orientation	NS	NS	NS	SL	SL[4]	SL[5]	SL[6]	NS	NS	NS	NS
Age	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Personal Finances	NS	NS	NS	NS	NS	NS	NS	SL	NS	NS	NS
Place of Birth	NS	NS	NS	NS	NS	NS	NS	SL[7]	NS	NS	NS
Sexual Orientation	NS	NS	NS	NS	SL[8]	NS	NS	NS	SL[9]	NS	NS
Previous Wk: Experience	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Death in Family	NS	NS	NS	NS	NS	NS	NS	SL[10]	SL[11]	NS	NS
Counter-Transference Reaction	NS	NS	NS	NS	NS	NS	NS	NS	SL	NS	NS
Professional Reaction	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Personal Reaction	NS	NS	NS	NS	NS	NS	NS	NS	SL[12]	NS	NS
Summary score of 14 items	SL[13]	NS	NS	NS	NS	NS	NS	SL[14]	SL[15]	NS	NS

N = 81 $p < .05$

NOTES: TABLE 2.3:

1--with married more disclosing

2--with upper income more disclosing

3--with upper income more disclosing

4--early degree holders more disclosing

5--with those more experienced more disclosing

6--with those more experienced more disclosing

7--with lower income more disclosing

8--with early degree more likely to disclose

9--with non-Freudians more disclosing

10--with upper income more disclosing

11--with non-Freudians more disclosing

12--with non-Freudians more disclosing

13--with males more disclosing

14--with upper income more disclosing

15--with non-Freudians more disclosing

CALL FOR PAPERS

Articles and essays are now being solicited for a forthcoming issue (late 1982) on "The Political Economy of Social Work." Possible topics include (but are not limited to) : the class character of social work in the United States; the position of social work in the U.S. occupational hierarchy; the social worker's role as producer in the political economy; the influence of political economic factors on (a) the nature, purpose and structure of social work services; (b) the nature of social work method; (c) the nature of social work education; (d) the definition of the knowledge base of social work practice; the impact of ideology on the social work profession, social work services or social work education; and the organization of social workers as workers.

Papers should not exceed 18-20 typed, double-spaced pages in length and should use standard citation and bibliographic notation. Please send three (3) copies of papers to Dr. Stanley Wenocur and Dr. Michael Reisch
School of Social Work & Community Planning
University of Maryland at Baltimore
525 West Redwood Street
Baltimore, Maryland 21201

The deadline for receipt of papers is December 31, 1981.

Please address all inquiries to Drs. Wenocur and Reisch at the above address.