UTILIZATION OF SELF-DISCLOSURE BY PSYCHIATRIC NURSES

BY

Patricia Ann Sosnovec, B.S.N.

A Thesis

Presented to
The Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the requirements for the degree of
Master of Nursing

June 11, 1982

APPROVED:

[redacted]

May Rawlinson, Ph.D., Professor of Nursing, Thesis Advisor

[redacted]

Julia Brown, Ph.D., Professor of Sociology, First Reader

[redacted]

Shirley Murphy, Ph.D., Associate Professor of Mental Health Nursing, Second Reader

[redacted]

Carol A. Lindeman, Ph.D., Dean, School of Nursing

This study was supported by Traineeships from the United States Public Health Service Grant Numbers: 2 ALL NU 00250-04 and 2 ALL NU 00250-05.

ACKNOWLEDGEMENTS

Without the support, conscientiousness, and humor of May Rawlinson, this thesis might still be sitting unfinished on my dining room table. Thank you May! To Julia Brown, Sara Porter-Tibbets, and Shirley Murphy, a sincere thank you for your time and helpful criticism as readers. To Barbara Stewart, a special acknowledgement for unraveling the secrets of feeding information to the computer, and de-coding stacks of computer printouts.

On the home front, a personal note to my husband Milan, whose support and understanding, and last minute efforts helped make this and many other things possible.

p.a.s.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

The nurse-patient relationship is central in many areas of nursing practice, especially in psychiatric nursing. Within this relationship, communication becomes the vehicle for both nurses and patients to establish contact and initiate the process called nursing. Communication has been defined as the sending and receiving of messages by means of symbols, words (spoken or written), signs or gestures (Doona, 1979), which implies that the message is understood by both sender and receiver. The types of messages nurses convey to patients initiate the nurse-patient relationship, the goal of which is to meet the therapeutic needs of the patient.

In meeting the therapeutic needs of the patient, the degree to which the nurse should assume an open and reciprocal position with the patient has not received universal agreement within the nursing profession. This aspect of the nurse-patient relationship takes on even more importance in the practice of psychiatric nursing, which is the discipline of focus of the present study.

The specific component of the interpersonal process under investigation is self-disclosure by the nurse. Although self-disclosure has been variously defined, the present study will refer to self-disclosure as a voluntary act, in which the nurse chooses to make himself or herself known to the patient. Nonverbal behavior will be excluded from the definition, and only information about the self that is verbally shared with the patient will be studied. The content of self-disclosure can

include a full range of material from personal intimate facts to less personal demographic data. Some information about the self obviously remains more private and is rarely shared with others. What the nurse chooses to disclose or not to disclose to the patient has an impact on the relationship. Psychiatric nurses have been shown to self-disclose at higher levels to patients than nurses in other specialties (Johnson, 1979). However, the use of self-disclosure to patients by psychiatric nurses with advanced degrees or specialized training has not been delineated in studies thus far.

The present study was concerned with measuring the degree to which psychiatric nurses self-disclose to patients and identifying the variables that are related to this kind of interaction between psychiatric nurses and patients. Additionally the study attempted to delineate the type of information that is shared with patients. It was assumed that most psychiatric nurses share information about their professional training, but the question remains: will psychiatric nurses share information about their own interpersonal relationships, values or beliefs with patients? Although important, the impact of self-disclosure on the nurse-patient relationship will not be addressed, as it is beyond the scope of this study.

Review of the Literature

The review of the literature has been divided into two sections. Section one will review the place of self-disclosure in each of several theoretical perspectives. Specific theorists as representative of each position will be included in section one. The original psychiatric literature that deals with the use of self-disclosure in the physician-patient interaction is important to include since it refers to specific

taboos that contribute to maintaining stereotyped role behavior in the health professions. These same taboos also apply to the nurse-patient interaction and will be reviewed in this section. Section two will review selected variables that have been associated with self-disclosure.

Theoretical Orientation and Self-Disclosure

This portion of the literature review will demonstrate the connection between theoretical frameworks and sanctions or prohibitions about the use of self-disclosure by the therapist. The use of self-disclosure in therapy is a development that became widespread in the 60's and 70's. From a historical perspective, Freud was the originator of the position that the therapist must remain a neutral observer (Weiner, 1978). Partially out of a reaction to psychoanalysis and the belief that neutrality by the therapist was not the most effective way to work with patients, social psychology and the humanistic psychology movement emerged (Weiner, 1978). Here the nature of self-disclosure will be examined for its contribution to the patient-therapist interaction from the following theoretical frameworks: intrapersonal, interpersonal, existential-humanistic, behavioral, and sociological.

Intrapersonal Perspective

The most prominent example of the intrapersonal perspective is classical psychoanalysis as defined and practiced by Freud. There self-disclosure by the analyst was enjoined as contravening the primary therapy goals. Freud believed that if the relationship between therapist and patient became too personal and intimate, transference with the therapist would be interfered with and the therapist would be unable to recapture a position of neutrality (Freud, 1923).

Freud (1923) made specific suggestions about self-disclosure by

the analyst. "The young and eager psychotherapist will certainly be tempted to bring his own individuality freely into discussion, in order to draw out the patient....but this technique achieves nothing towards the uncovering of the patient's unconscious" (Freud, 1923, pp. 323, 333). According to Freud, the physician should reflect nothing but what is revealed by the patient. Self-disclosure by the analyst can only work to complicate the therapeutic process.

Psychoanalytic theory is the framework most commonly utilized in psychiatric residency programs (Singer, 1980). Psychoanalytic theory identifies the analyst as the initiator of insight through confrontation, clarification, interpretation, and working through (Greenson, 1974; Stewart, 1975). The analyst primarily listens to gain insight, and refrains from making emotional responses to the patient. Stewart (1975) noted that even with practiced restraint on the part of the analyst, realistic aspects of the analyst's personality become apparent to the patient in other ways, e.g., physical appearance, fees, schedules, etc.

Weiner (1978) also accepts the psychoanalytic position that neutrality, rather than self-disclosure, is most useful. Weiner states that most patients do not require self-disclosures by the therapist to establish an empathic bond, acceptance, or trust. Since effective treatment depends on the patient's willingness to be open, not on the therapist's transparency, he concludes that neutrality is the safest initial stance for the therapist. As mentioned in the previous section, Weiner attaches great significance to non-verbal behavior by the therapist as a form of self-disclosure. Since much of the therapist's self is revealed in this manner, Weiner maintains that verbal self-disclosure by

the therapist should be avoided under most circumstances.

The psychoanalytic therapist is trained to be sensitive to unconscious processes that occur in his or her patients. The patient's unconscious processes must be kept separate from the therapist's own emotional needs, which are recognized but not acted upon or expressed openly to the patient. From the intrapersonal perspective, maintaining the professional role for the patient's benefit is the most frequently cited justification for maintaining distance and avoiding contact which might be misconstrued as friendship and might place unrealistic expectations on the physician-therapist. The best therapeutic outcome for the patient is accordingly achieved by the therapist's not engaging in personal self-disclosure.

Interpersonal Perspective

The interpersonal orientation focuses on the relationships between and among individuals and their social environment. Many of the interpersonal or dynamic psychotherapists were originally psychoanalytically trained, but deviated from the intrapersonal focus to give more emphasis to social, interpersonal or relationship factors. The therapeutic encounter between the therapist and the patient is viewed as extending beyond working through early life experiences; it is an experience in a current relationship (Wolberg, 1977).

Hildegard Peplau (1952, 1960), developed the concept of therapeutic relationships of nurses to patients. The role of the professional nurse is to focus on the needs of the patient (Peplau, 1960). If a patient should demand to know more about the nurse, the nurse must carefully discriminate what purpose would be served by disclosing personal descriptive information. Peplau differentiates between the use of self-

disclosure in general hospital nursing and psychiatric nursing. In psychiatric work, the nurse must be especially careful in responding to demands for more information about himself or herself, as well as limiting the amount of spontaneous self-disclosure.

"The patient cannot see the nurse as a person who has a family...; he sees her through the attitudes she manifests toward his difficulty as they are perceived by him as helpful or as affronts to him as a person" (Peplau, 1952, p. 223). Any attempt by nurses to make their values or beliefs known is somehow interpreted as an attempt to convert patients to their position and is therefore unacceptable.

Peplau sees it as acceptable to orient the patient to the person of the nurse within his or her therapeutic role, i.e., name, credentials as a registered nurse, therapeutic arrangement, or frequency of contacts with the patient, and responsibilities within this context. Whenever nurses describe personal events in more detail, they are manifesting more interest in themselves than in the patients. Offering biographical data to the patient is seen as creating an additional unnecessary burden for the patient, and additionally fostering a social rather than nurse-patient relationship. Peplau (1968) advocates that the nurse function as a neutral listener, as a sounding board for the patient. It would never be appropriate for a professional nurse to use the nurse-patient relationship to talk about personal needs, beliefs or values.

Similarly, Burgess and Lazare (1973) stress the necessity to set the boundaries of the therapeutic relationship between the nurse and the patient. They hold that to talk about one's personal life and how it is changing is not therapeutic for the patient as it is strictly within the

realm of social conversation. They suggest that nurses should reveal only information to patients that is public knowledge, e.g., their position, title, hours of employment, etc.

Burgess and Lazare compare the nurse-patient relationship to that of a parent and child. The child does not want to hear about his parent's problems; the child wants a "parent". The patient in comparison wants a professional nurse, and not one who will burden him with the nurse's problems. Burgess and Lazare support honesty by the nurse in relation to role-appropriate attitudes and behavior observed in the patient. Self-disclosure by the nurse is equated with burdening the patient, or using the patient for ventilation of one's own problems. Therapeutic use of honesty is not further explained by these authors.

The nurse-patient relationship has been described as one of therapeutic intimacy by Longo and Williams (1978). Interpreted within this framework, self-disclosure by the nurse is advocated, but only in instances that are reflective of the patient's needs. As distinguished from a purely humanistic approach, where mutual self-disclosure would be encouraged, nursing approaches define the limits of the relationship and discourage self-disclosure by the nurse that transgresses therapeutic limits.

Longo and Williams (1978) distinguish intimate personal relationships from intimate therapeutic relationships. In personal relationships mutual self-disclosure is important in fostering interdependency between people. Intimacy is characterized by the mutual sharing of thoughts, feelings, and ideas. Support and acceptance are available to both people who engage in an intimate personal relationship.

Therapeutic relationships of the nurse-patient type, are

characterized by active support and acceptance by the nurse. Self-disclosure is not a mutual process. The patient is encouraged and reinforced for self-disclosing. The nurse functions to facilitate closeness in the relationship by listening to the patient's thoughts and feelings. Self-disclosure by the nurse is appropriate only as a specific response to the patient.

Longo and Williams specifically state that nurses should not discuss personal problems with patients, as this is characteristic of a social relationship. Yet as the relationship between the nurse and the patient develops, deeper levels of intimacy are achieved. Except for personal problems, specific types of self-disclosure to patients by nurses are not addressed. It is difficult to determine when a comment by a patient would best be responded to by self-disclosure by the nurse.

From the interpersonal perspective, the therapeutic relationship is viewed as a two-way transaction in which feedback between the therapist and client is exchanged. Resistance and avoidance of neurotic transference are more openly handled through an active rather than passive or neutral therapeutic stance. Self-disclosure by the therapist would be considered an appropriate therapeutic tool for the interpersonal therapist, but limited to occasions in which it clearly was related to treatment of the patient's problem.

Existential-Humanistic Perspective

Existentialists stress responsibility of each individual for his or her own behavior. After striving to fulfill biological and sexual needs, the individual is motivated by higher self-actualization needs. The focus of therapy is, therefore, on the phenomenological experience or

the here-and-now. The therapist attempts to maintain a position of participation and involvement. Thoughts and feelings are expressed as a way of reaching the patient and establishing a valuable relationship (Mischel, 1971). An existential therapist would self-disclose only if by so doing the relationship would be enhanced, but not simply to ventilate his or her own feelings.

From an existential position, Travelbee (1969) identifies purposeful reciprocal communication between two participants as characteristic of meaningful dialogue. In order to establish human-to-human relatedness the role of the nurse with its barriers of title, status, and position must be transcended (Travelbee, 1971). It is through the experience of closeness in the nurse-patient interaction that caring is communicated, whereby the patient is able to experience warmth, confidence, and trust in the nurse.

Travelbee (1969) addresses the long standing prohibition in nursing to becoming overly friendly with patients, and the emphasis on professional behavior. Nurses are indoctrinated with standards defining the limits of the nurse-patient relationship, and implying that involvement results in a loss of objectivity and therapeutic effectiveness. Travelbee defines involvement as closeness, which fosters confidence and trust in the nurse without necessarily developing into a personal relationship.

The humanistic psychologists attempt to help persons fulfill their human potential. The goal of therapy is on personal growth rather than on resolution of conflict or emotional disturbances. Therapists seek to assist patients in their positive drive toward self-fulfillment. The positive growth is thus stimulated by contact with the therapist,

who is "transparent" and willing to self-disclose (Jourard, 1964). The therapist behaves and speaks according to his or her own feelings. Congruence is demonstrated by expressing these feelings directly rather than misleading or concealing them from patients (Watkins, 1978).

Humanists consider the ability to engage in self-disclosure as reflective of a healthy personality. "Man can attain health and fullest personal development only insofar as he gains courage to be himself with others" (Jourard, 1964, p. 11). Therapy is the process by which a person begins to self-disclose, and ultimately is able to share himself or herself in an authentic way with the therapist. Humanistic psychology developed from this perspective, as an alternative to the neutral stance by the analysts.

From a developmental perspective, the young child is unaware of what it is to keep thoughts and feelings to himself or herself. Eventually these spontaneous disclosures are met with variable consequences, and the child learns to withhold and express disclosures depending on external reinforcement. Piaget (1962) notes that the early relationship developed between the child and significant others is influential in his or her development of adult propensities to self-disclose to others. According to Jourard (1964) the growing child learns to expose an "expurgated" self to others, which leads to self-alienation and repression.

Sidney Jourard was one of the first advocates of openness between patients and therapists. Jourard (1964) stated that when a therapist is committed to the task of helping a patient, "He functions as a whole person, not as a disembodied intellect, computer, or reinforcement programmer. Through spontaneity and honestly conveying thoughts and

reactions, the therapist communicates not only concern, but is in effect both eliciting and reinforcing uncontrived behavior in his patient" (Jourard, 1964, p. 64). Jourard suggests that therapists must do more than listen. He states that they must be as open and disclosing with patients as they expect patients to be.

He developed the concept of self-disclosure to mean the voluntary act of making one's self known, so that others can perceive who one is. He distinguishes this from unwitting disclosure, or the disclosure of things you do not want people to know. For self-disclosure to be authentic, the person must be willing to show himself or herself to others. Jourard contends that the ability to engage in self-disclosure is a sign of a healthy personality, "That one's self grows from the consequence of being" (Jourard, 1971, p. 31).

In relating self-disclosure to nurses, Jourard (1964) observes that many nurses develop a fixed way of behaving which he describes as their bedside manner. The bedside manner functions as a form of rigid interpersonal behavior, which serves to limit spontaneity in the nurse and protect him or her from possible external hurt. Jourard speculates that nurses develop their bedside armor as a coping mechanism to deal with anxieties produced by numerous encounters with the dying, disoriented, and countless other stressful patient-nurse situations. He also adds that nurses learn this behavior through role modeling from instructors, by trial and error, or simply by finding out what type of behavioral responses provides relief from stressful patient interactions.

In order for nurses to become more individualized in their interactions with patients, Jourard (1964) suggests that nurses take time to listen to their patients, and be willing to engage in communication that

reflects the nurse's feelings, thoughts, and caring. Ultimately Jourard sees the nurse as the primary professional responsible for establishing contact with the patient. This can only be accomplished when the bedside manner is abolished and the nurse relates from a personal and individual level.

Carl Rogers (1957) identified congruence or genuineness (harmony between feelings and actions), as one of three components necessary for therapeutic personality change. He indicates that by maintaining distance in the guise of professionalism, therapists build an impersonal and thus unhealthy relationship. Distancing ourselves from clients blocks the experience of caring. Rogers sees caring as safe and acceptable to express as part of a helping relationship.

Pocituyko (1979), in his work with alcoholics, found self-disclosure on his part as a therapist to be productive in dealing with resistant and hesitant clients. His experiences, as do those of Yalom (1964), indicate that after the therapist initially self-discloses in a group (usually a more general self-disclosure), the group members do not ask for more personal information, but instead begin to initiate their own disclosures and start to work on their problems. Pocituyko concludes that any therapist who feels uncomfortable using self-disclosure as a therapeutic tool should refrain from doing so, but at the same time should question himself or herself from withholding all information to his or her clients.

Carkhuff (1969) states that one of the goals of therapy is the movement of the client toward becoming a more genuine and authentic person. Authenticity as a means of helping is one of the ways a genuine relationship is established and maintained. Carkhuff clearly states

that facilitative genuineness on the part of the therapist is made for the benefit of the client, not the therapist.

Carkhuff is one of the few authors who differentiates stages and levels of genuineness. Stage one of genuineness involves minimal congruence by the therapist, with the goal being to facilitate trust and self-exploration by the client. Full or spontaneous disclosure by the therapist during this stage is seen as insincere and unnatural. The focus should be on understanding the client in relation to himself or herself, rather than on making one's self known to the client. In stage two the therapist becomes more himself or herself, and establishes a model for self-disclosure in the relationship.

Deeper levels of self-disclosure by the therapist tend to occur during the intermediary stages of the relationship. Self-disclosure by the therapist tend to be more focused on positive feelings toward the client, whereas negative feelings may be felt but not communicated. During the emerging stages of therapy, self-disclosure by the therapist includes negative references about the client and a more conditional quality, "I will not accept you at less than you can be" (Carkhuff, 1969, p. 100). According to Carkhuff, even though one may non-verbally demonstrate acceptance of another person, until this information is shared and expressed verbally, it is not self-disclosure.

Wilson and Kneisl (1979), as do Longo and Williams (1978), differentiate between social and therapeutic relationships. In their humanistic nursing framework, a therapeutic relationship encourages patient self-disclosure to the nurse. The nurse on the other hand only self-discloses in terms of a response to the patient. Self-disclosure by the nurse is viewed as a form of direct feedback or information to the patient.

Total self-disclosure by the nurse to the patient is viewed as inappropriate in the nurse-patient relationship (Wilson & Kneisl, 1979).

Hein (1980) sees authenticity as a blending process, i.e., being one's self, as well as being aware of how being one's self might affect the patient. She notes that being one's self and being professional can be one and the same. It is the manner in which this is done, with concern for the possible outcome on the patient, that brings about a therapeutic relationship.

Social Behavioral Perspective

Behavioral therapy takes the position that behavior is learned, and since it is learned, it can be unlearned and replaced with more appropriate behavior. Therapists tend to select specific symptoms or behaviors as targets for change, rather than focus on the subjective experiences of the patient. Within this framework the therapist focuses more on monitoring behavior and using specific behavioral approaches to eliminate or reduce symptoms. The relationship between the therapist and the patient is important, but is definitely not emphasized as a part of behavioral therapy.

Certain authors consider nonverbal as well as verbal behavior as part of self-disclosure (Freud, 1923; Stewart, 1975; Weiner, 1978). The behavioral technique of modeling clearly incorporates both elements of self-disclosure by the therapist. Through modeling, the behavioral therapist offers some aspect of his or her self with which the patient may identify. Modeling can be a planned intervention, such as demonstrating a certain behavior such as assertiveness, or can occur spontaneously through the patient's identification with the therapist (Mischel, 1971). In either case the behavioral therapist discloses

simply by using himself or herself as a consistent model of appropriate behavior for the patient through vicarious or observational learning.

Sociological Perspective

Various authors address the necessity to keep the patient-practitioner interaction complementary, i.e., where the medical person is the acknowledged expert and the patient is the one in need of assistance or support (Bloom & Wilson, 1972, 1979; Burgess & Lazare, 1973; Peplau, 1960). The reasons for developing and maintaining an asymmetrical communication relationship are based on the concept that the patient needs a professional therapist, not a friend. Therefore, from this perspective, professional boundaries must be established and maintained.

Talcott Parsons is a sociologist who studied the physician-patient interaction and elaborated on the meaning of illness and social roles that are played out in this interaction. He identified four major features of the therapy relationship as follows: (1) support, (2) permissiveness, (3) manipulation of reward, and (4) denial of reciprocity (Bloom & Wilson, 1972). In providing support and acceptance to the patient, the therapist withholds from the patient his or her own full interpersonal responsiveness. The asymmetrical process is maintained by refusing to allow the patient access to the physician's feelings.

Interpreting this position further, it is understandable that revealing all of one's feelings, particularly anger or hate, could be counter-productive and anti-therapeutic. But Parsons takes the position that the patient role is a passive one, with the competence and expertise of the physician unquestioned. Affective responses of any type on the part of the professional within this framework would tend to

remove role barriers and as Parsons sees it, decrease treatment objectivity (Bloom & Wilson, 1972).

Szasz and Hollender's (Bloom & Wilson, 1979) interpretation differs somewhat from Parsons's interpretation of the physician-patient relationship. They identified three possible types of the relationship: (1) activity-passivity, where the patient is helpless and the physician is active; (2) guidance-cooperation, where the patient is capable and willing to follow directions offered by the physician; and (3) mutual participation, in which the patient is assisted by the physician to help himself or herself. Within this framework existence of an asymmetrical relationship is acknowledged, but not considered the sole possibility.

Arguments For and Against the Use of Self-Disclosure

In reviewing the literature in support of self-disclosure, most authors stress the importance of authenticity with some level of self-disclosure as part of the therapist-patient relationship. Differences of opinion exist as to whether nurses, in attempting to maintain their therapeutic effectiveness, should emphasize their role separateness, or transcend it to become more personally visible. The degree to which the therapist should engage in self-disclosure is not agreed upon by the authors cited. Specifically, Jourard (1971), Carkhuff (1969), Pocituyko (1979), and Yalom (1964), advocate a more revealing yet limited type of self-disclosure. Longo and Williams (1978), Travelbee (1969), and Wilson and Kneisl (1979) seem to advocate a more limited use of self-disclosure. All authors who support the use of self-disclosure in therapy whether it be highly revealing or limited, agree that self-disclosure must be used in a thoughtful manner which is therapeutically beneficial to the patient.

Arguments against the use of self-disclosure by the therapist are most strongly advocated by the intrapersonal and some sociological theorists. Their position contends that maintaining the professional role for the patient's benefit is the safest and most therapeutic position for the therapist. The interpersonal theorists assume the position that self-disclosure, at times, can be an appropriate therapeutic tool to be used only in situations that are of benefit to the patient.

Variables Related to Self-Disclosure

Although the therapist's theoretical orientation influences his or her viewpoint on self-disclosure, other variables have also been identified that may determine to what degree the therapist will be open and disclosing. Travelbee (1969) notes that the ability of the nurse to relate seems contingent on certain characteristics both of the nurse and the patient, and the interaction of these traits. The nurse's attributes include his or her character structure such as life experiences, background, the knowledge he or she brings to the situation, as well as the ability to use this knowledge wisely for the good of the patient.

Experience

Travelbee (1969) describes meaningful dialogue between the nurse and the patient as reciprocal, in which the nurse is able to "give of self" (Travelbee, 1969, p. 80) in the encounter. The ability to engage in meaningful dialogue is blocked when nurses hold stereotyped views of patients based on lack of professional experience or theoretical orientation of practice. The only nursing research which supports this position is that of Johnson (1979). Her results indicate that nurses

with more than five years of nursing experience reported higher levels of self-disclosure to patients.

Sex

Women have been reported to have higher self-disclosure scores than males (Jourard & Lasakow, 1958). These results have been replicated by a number of researchers (Diamond & Munz, 1967; Himelstein & Lubin, 1965; and Pederson & Higbee, 1969). Other studies have reported no sex differences in self-disclosure (Diamond & Hellkamp, 1969; Wiegel & Wiegel, 1969). Jourard (1971) speculates that conflicting findings on sex differences may be the result of taking samples from different geographic areas in which sex role expectations may differ considerably.

Age

Jourard (1961) describes the changes in self-disclosure patterns that occur with age as almost "self-evident". With age, the amount of self-disclosure to parents and same-sex friends gradually diminishes. Self-disclosure to opposite-sex friends or spouse increases from the age of 17 to about 45, but thereafter appears to decrease. These findings indicate a trend for persons to limit interpersonal contact to less intimate levels at older ages.

Target Person

Many studies reveal that people are selective and discriminating in their choice of people to whom to disclose. It would be safe to say that no one had disclosed the same amount or the same kinds of information about himself or herself to all people in one's life. Various studies indicate that mothers receive more disclosure than fathers (Himelstein & Lubin, 1965; Jourard & Lasakow, 1958; Diamond & Munz,

1967). Married people disclose most to their spouses. Married men disclose most to their mates, married women in addition to disclosing to their husbands, disclose at high levels to mothers and other women friends (Jourard, 1960).

Liking and Knowing

Knowing and liking someone has been linked to self-disclosure. Jourard (1959) found that for female nursing school faculty that disclosure toward another member and knowledge about that member were positively correlated with liking of that member. The same study was replicated using male graduate students, and yielded a similar finding, that knowing another and disclosing to that person were correlated positively (Jourard & Landsman, 1960).

Subject Matter

The material one discloses may vary from impersonal to intimate. Some material will more obviously be discussed with a special friend or partner; other information may never be shared or may even be misrepresented. Jourard (1960) indicates that this is an area in need of further research. Jourard points out that whether a person is in, or has been through, psycho-therapy will influence the type of subject matter he or she will disclose to others. No research was found to support the position that persons who have been through therapy are more in touch with their real selves and therefore are more comfortable about disclosing intimate information to acquaintances and friends.

Jourard and Laskow (1958), in a study conducted on three college populations, found that higher disclosing appeared in the areas of tastes and interests, attitudes and opinions, and work. Low disclosing behavior was concentrated in the areas of money, personality, and body. Fitzgerald

(1963) also noted that high disclosing behavior clustered in the areas of attitudes and opinions, tastes and interests, and work; and low disclosing behavior clustered in the areas of money, personality, and body.

Nursing Education

In formal and informal interviews conducted by Johnson (1980), she found that nurses educated at the graduate level in various specialties were more comfortable with incorporating self-disclosure as a part of their treatment than undergraduate students, or nurses working at the staff nurse level. Junior and senior nursing students viewed self-disclosure by the nurse as an infrequent occurrence. Staff nurses revealed that they refrain from revealing information about themselves to clients. No other literature could be found which supports Johnson's observations that graduate level nurses are more likely to self-disclose to clients.

The last section of the literature review has identified important variables that have been related to self-disclosing behavior. Only the following variables will be utilized as part of the present study; years of nursing experience, type of nursing education, theoretical orientation, age, and identified target person.

Purpose of the Study

Self-disclosure is a concept that has been studied primarily in the fields of psychology and counseling. This study will apply the concept of self-disclosure to the nurse-patient relationship, to determine whether psychiatric nurses educated at an advanced level incorporate self-disclosure as part of their treatment and assessment with individual clients.

Hypotheses

1. Nurses who assess and treat patients from an intrapersonal framework, will manifest less self-disclosure to patients than nurses who assess and treat patients from all other theoretical frameworks (interpersonal, existential-humanistic, social-behavioral, or sociological).

2. Self-disclosure will be highest in the areas of work, tastes and interests, and attitudes and opinions, and lowest in the areas of money, body, and personality.

3. Psychiatric nurses trained at the master's level or certified as psychiatric mental health nurse practitioners will have higher levels of self-disclosure to patients than nurses not educated or trained at an advanced level.

4. Higher levels of self-disclosure by psychiatric nurses to patients will be associated with more years of general nursing practice.

5. Higher levels of self-disclosure by psychiatric nurses to patients will be associated with more years of psychiatric nursing practice.

6. Lower levels of self-disclosure by psychiatric nurses to patients will be associated with increasing age.

CHAPTER II

METHODS

Subjects and Setting

The subjects for this study were registered nurses with advanced degrees or special training in psychiatric nursing, who were designated as either (1) Psychiatric Mental Health Nurse Practitioners currently certified in the State of Oregon, or (2) Psychiatric Clinical Nurse Specialists in the State of Oregon.

Psychiatric nurse practitioners and clinical nurse specialists currently practicing in Oregon were surveyed in total. A list of Psychiatric Mental Health Nurse Practitioners currently certified in the State of Oregon was obtained from the State Board of Nursing. A list of psychiatric clinical nurse specialists was obtained from the following sources; The School of Nursing Oregon Health Sciences University, University of Portland, Psychiatric Nurses in Advanced Practice, and a survey of all the psychiatric hospitals and units in the Portland area(St. Vincents, Providence, Oregon Health Sciences University, Cedar Hills, Riverside, Portland Adventist, and the Veterans Hospital).

A total of 107 nurses were invited to participate in this study. The study population consisted of 75 female nurses. As only one male nurse qualified to serve as a subject, he was not included in the study. All of the nurses in the study were currently practicing as psychiatric nurses, or had practiced psychiatric nursing within the last year.

Design and Procedure

The design of the study was descriptive and correlational. The relationships between self-disclosure and theoretical orientation, subject matter, education, years of general nursing practice, years of psychiatric nursing practice and age were examined.

Subjects for this study received a letter explaining the purpose of the study, an informed consent (Appendix A), a request for results of the study when completed, and a questionnaire with instructions (Appendix B). A stamped addressed envelope was included for the return of completed questionnaires. Subjects who did not respond in two weeks were sent a postcard with a reminder to return the questionnaire, to request a replacement questionnaire, or to decline to participate in the study.

Data and Data Gathering Instruments

The data for this study were obtained through a two-part questionnaire. The first section was designed to provide background information about the subject and the second part contained the self-disclosure self-report instrument.

Background Information

Selected demographic and practice-related information on each subject was gathered including: (1) age, (2) advanced psychiatric nursing degree or training, (3) number of years in general nursing and psychiatric nursing practice, (4) theoretical framework used in their clinical assessment and treatment of clients, and (5) current area of practice as a psychiatric nurse (see Appendix B for a copy of the background information form).

Age was included, because the literature reflects that people disclose

less about themselves with increasing age. The effects of advanced training or education on self-disclosure have not been documented. Inasmuch as nurses educated at the master's level are more likely to have been exposed to different personality theories and psychiatric nursing theories, it was assumed that nurses exposed to these theoretical orientations would advocate different levels of self-disclosure by the therapist, and would incorporate and utilize self-disclosure to varying degrees. Nursing experience has been shown to be positively correlated to self-disclosure (Johnson, 1979). Johnson found that the highest self-disclosure scores of nurses to patients occurred in those with 11 plus years of experience. Additional information about case supervision was collected to determine whether this affects how nurses actually practice.

The Self-Disclosure Questionnaire (JSDQ)

The JSDQ was developed by Jourard in 1958. It was designed to measure verbalized aspects of self-disclosure defined as the process of making the self known to another person. The original questionnaire was designed as a 60-item Self-Disclosure Inventory which was divided into six topic areas: work, money, body, personality, tastes and interests, and attitudes and opinions. Subjects were asked to indicate to what extent they had discussed the content in each of the 60 statements with specific target persons (mother, father, etc.).

The validity of the JSDQ has been determined by several research studies. Panyard (1971) used 26 pairs of subjects (friends) to indicate on the JSDQ the amount of information each disclosed to and received from the other. Correlations between .61 and .95 ($p < .01$) were obtained. Panyard concluded that consensual validation of the amount of personal

information exchanged between friends suggest that the JSDQ is a valid measure of self-disclosure to a specific target person.

Graham (1971) demonstrated the predictive validity of the Jourard self-report questionnaire. Subjects completed the self-disclosure questionnaire and they participated in an interview in which they were asked to disclose or to decline to disclose on five selected topics. The total past disclosure score (parents and friends combined) was significantly correlated with the interview scores for subjects who were identified as existentialists.

The self-disclosure questionnaire used in the present study was condensed to 30 items, using only the odd numbered items from the original JSDQ. This decision was based on the large number of responses subjects would be required to make if all 60 items were used. Jourard (1971) reported that when entries were divided into halves by the odd-even method and the sub-total sums were correlated with each other, the Pearson r correlation was .94. Based on his findings and Johnson's study (1979) that subjects found 60 items too tedious and time consuming, 30 items were used in this study.

Directions to respondents requested them to rate each item (see Appendix B) on the questionnaire and then indicate the number which best represented the degree to which they had talked about each item to each target person.

Identified Targets	Number of Items
1. Male Patient	30
2. Female Patient	30
3. Significant Male Other	30
4. Significant Female Other	30
Total number of scored items =	120

Although all targets were identified on the self-disclosure questionnaire, it was beyond the scope of the present study to examine the relationship between self-disclosure to significant others and patients.

The following code was used in scoring:

0 = Have told the other person nothing about this aspect of the self.

1 = Have talked in general terms about this aspect. The other person has only a general idea about this aspect.

2 = Have talked in full and complete detail about this item to the other person. The other could accurately describe this aspect to other persons.

X = Have deliberately given an incorrect answer to other persons.

A total self-disclosure score constitutes the sum of all values (x's were counted as 0) of each item to each target persons. The possible range of scores for each of the identified targets was from 0 to 60, the highest score indicating maximum self-disclosure.

Partial self-disclosure scores were calculated by six content areas which are contained in the following items on the JSDQ:

	Items
1. Work	15-19
2. Money	20-24
3. Body	25-29
4. Personality	30-34
5. Tastes and Interests	35-39
6. Attitudes and Opinions	40-44

Scores were tabulated by content areas. Scores may range from 0 to 10 for each content area, the highest score indicating maximum self-disclosure. For consistency in calculating self-disclosure scores, subjects were required to complete 3 out of 5 items in each content area. If 2 or less items were completed, the subject was removed from the final statistical analysis.

Analysis of the Data

For Hypothesis 1, analysis of variance was utilized to test for differences between the amount of self-disclosure by nurses who assess and treat patients from an intrapersonal perspective and those who assess and treat patients from the other theoretical perspectives. For Hypothesis 2 analysis of variance was used to test for significant differences in self-disclosure scores of psychiatric nurses to patients among the 6 content areas. For Hypothesis 3 a t-test was conducted between the overall self-disclosure scores for the two designated groups of psychiatric nurses. For Hypotheses 4, 5, and 6, Pearsonian correlation coefficients were computed to determine if significant correlations existed between levels of self-disclosure and years of general nursing experience, years of psychiatric nursing experience, and age.

CHAPTER III

RESULTS AND DISCUSSION

Selected Characteristics of the Subjects

The study population consisted of 75 female nurses. All nurses were currently practicing as psychiatric nurses, or had practiced within the last year. The majority of nurses were educated at the master's level and were certified as psychiatric mental health nurse practitioners. One-third of the subjects were prepared at the master's level but were not certified as psychiatric mental health nurse practitioners. A smaller number of subjects was neither trained at the master's level nor certified as nurse practitioners. The fewest subjects were certified as nurse practitioners but had no academic preparation at the master's level.

Most of the nurses were married and had general nursing and psychiatric nursing experience. The ages were fairly evenly distributed throughout the range from 26 to 57 years. The previous characteristics are presented on Table 1. In assessing and treating individual patients, the majority of nurses ranked themselves as interpersonally focused.

Theoretical Framework and Self-Disclosure

For Hypothesis 1, analysis of variance was conducted and no significant statistical differences in self-disclosure were found between nurses who assess individual male and female patients from an intrapersonal theoretical perspective and those who assess from an interpersonal, social-behavioral, existential-humanistic, or sociological perspective. See Table 2 for these results. Also, no significant

Table 1

Selected Characteristics of the Subjects (n=75)

Characteristics	Values
Age in Years	
Mean	38.8
Range	26-57
Marital Status Number	
Married	48
Not Married	27
Nursing Experience in Years	
In General Nursing	
Mean	13.9
Range	2-35
In Psychiatric Nursing	
Mean	8.3
Range	1-22
Professional Preparation	
Master's & Certified	32
Master's, not Certified	21
No Master's, Certified	6
No Master's, Not Certified	16

Table 2

Mean Self-Disclosure Scores of Psychiatric Nurses Using Selected Theoretical Frameworks for Assessment and Treatment to Male and Female Patients

Theoretical Framework	n	Self-Disclosure To Male Patients $\bar{X}$	Rank Order	Self-Disclosure To Female Patients $\bar{X}$	Rank Order
			For Assessment		
1. Intrapersonal	6	.50	1	.53	1
2. Interpersonal	29	.38	4	.43	4.5
3. Existential-Humanistic	18	.44	3	.49	3
4. Social-Behavioral	10	.49	2	.52	2
5. Sociological	0	--	6	--	6
6. Other	11	.43	5	.43	4.5
			For Treatment		
1. Intrapersonal	1	.43	2.5	.50	2
2. Interpersonal	26	.38	4	.41	4
3. Existential-Humanistic	19	.55	1	.60	1
4. Social-Behavioral	13	.43	2.5	.47	3
5. Sociological	0	--	6	--	6
6. Other	13	.37	5	.38	5

statistical differences were found in self-disclosure between nurses who treat individual male and female patients from an intrapersonal theoretical perspective and those who treat from an interpersonal, social-behavioral, humanistic-existential, or sociological perspective. See Table 2 for these results. Hypothesis 1 was rejected.

Subject Matter and Self-Disclosure

Hypothesis 2 stated that among the six content areas, self-disclosure would be highest in the areas of work, tastes and interests, and attitudes and opinions and lowest in the areas of money, body, and personality. The rank order of the means of the six content areas indicated that this prediction was correct. Refer to Table 3 and Figure 1 for these results. Analysis of variance was conducted to test for statistical differences between the means and revealed that there were significant differences among content areas of self-disclosure to both male and female patients. These results are presented on Table 4. The Scheffé test was performed to determine which content areas were significantly contributing to this difference. The results of the Scheffé test are presented in Table 5.

For both male and female patients, the pairs of scales on which self-disclosure was not significantly related were: work with tastes and interests; body with personality; and personality with attitudes and opinions. These findings are presented on Table 5. Hypothesis 2 was partially accepted; the exception was of no difference between attitudes and opinions which was predicted to be an area of high self-disclosure, and personality which was predicted to be an area of low self-disclosure.

Table 3

Rank Order and Means of Self-Disclosure Scores According to Subject Matter by Psychiatric Nurses (n=74) to Male and Female Patients

Subject Matter	Rank[a] Order	Self-Disclosure To Male Patients $\bar{X}$	SD	To Female Patients $\bar{X}$	SD
Tastes and Interests	1	.76	.47	.77	.47
Work	2	.68	.42	.72	.43
Attitudes and Opinions	3	.48	.49	.51	.50
Personality	4	.41	.37	.44	.38
Body	5	.26	.34	.33	.39
Money	6	.03	.09	.04	.12

[a] = rank order presented in this table is the same for male and female patients

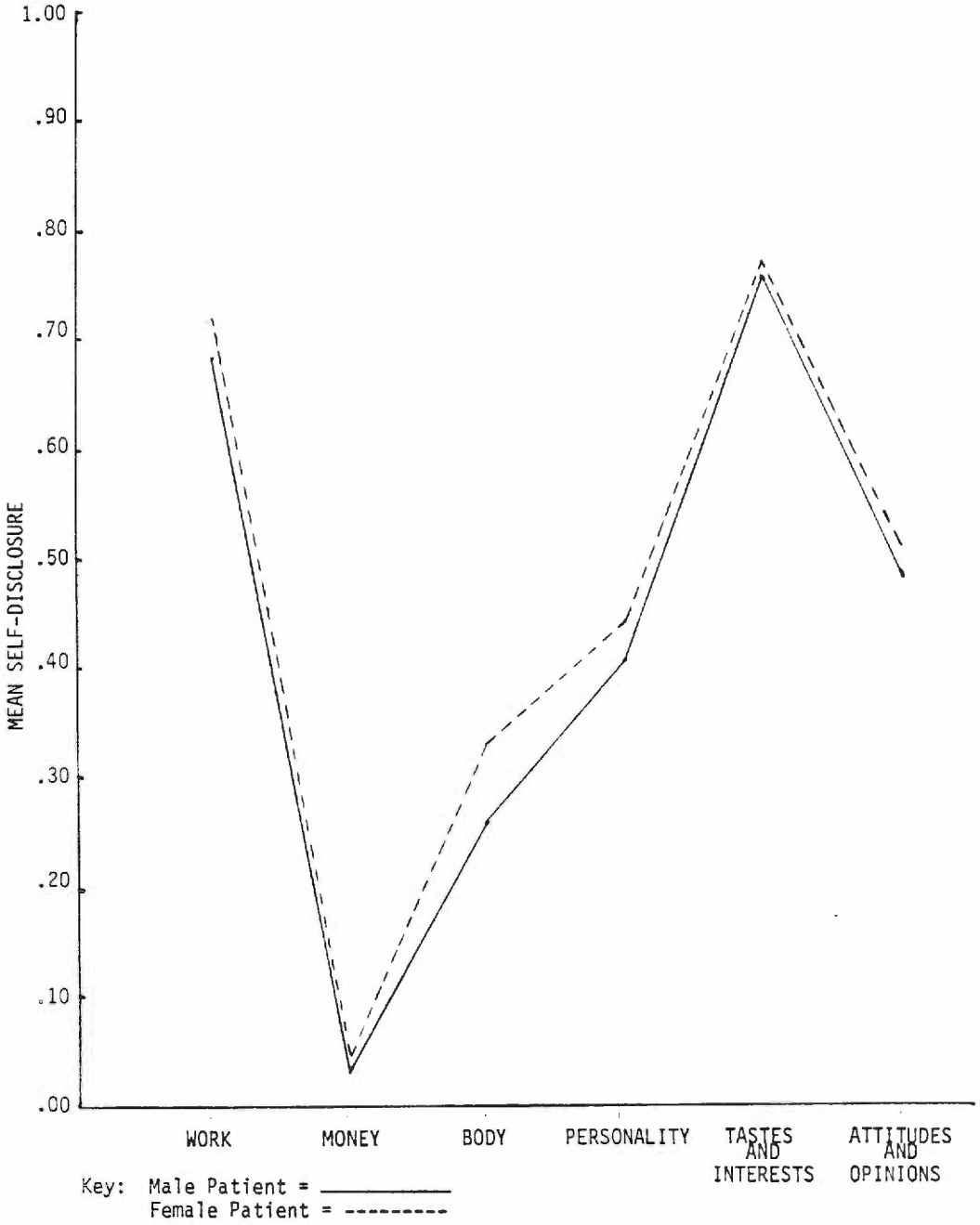

Figure 1 Mean Scores of Psychiatric Nurses on Self-Disclosure Scales: Comparison of Amount of Disclosure to Male and Female Patients

Table 4

Analyses of Variance Among Content Areas of Self-Disclosure to Male and Female Patients by Psychiatric Nurses

Source of Variation	SS	df	MS	F
		To Male Patients		
Between People	33.64	73	.46	
Within People	59.15	370	.16	
Between Measures	26.88	5	5.38	60.81*
Residual	32.27	365	.08	
Nonadditivity	4.36	1	4.36	56.88
Balance	27.91	365	.08	
Total	92.79	443	.21	
		To Female Patients		
Between People	37.06	73	.51	
Within People	60.42	370	.16	
Between Measures	26.96	5	5.39	58.84
Residual	33.45	365	.09	
Nonadditivity	3.81	1	3.81	46.73
Balance	29.65	364	.08	
Total	97.47	443	.22	

*$p \leq .05$

Table 5

Scheffé Test Comparing Mean Scores on Self-Disclosure of Psychiatric Nurses to Male and Female Patients in Different Content Areas

Pairs of Content Areas	Male Patients F	Female Patients F
Work/Money	179.15*	187.20*
Work/Body	73.33*	60.84*
Work/Personality	31.05*	31.81*
Work/Tastes & Interests	2.04	1.08
Work/Attitudes & Opinions	16.66*	17.30*
Money/Body	23.01*	33.64*
Money/Personality	60.48*	64.64*
Money/Tastes & Interests	220.83*	214.91*
Money/Attitudes & Opinions	84.37*	90.63*
Body/Personality	8.51	4.76
Body/Tastes & Interests	102.09*	78.15*
Body/Attitudes & Opinions	20.00*	13.25*
Personality/Tastes & Interests	50.75*	44.09*
Personality/Attitudes & Opinions	2.22	2.07
Tastes & Interests/ Attitudes & Opinions	31.74*	27.04*

*$p \leq .05$
Critical F = 11.3

Professional Training and Self-Disclosure

Nurses with advanced professional education and certification as psychiatric mental health nurse practitioners demonstrated overall higher levels of self-disclosure to both male and female patients, than nurses without specialized training. In Hypothesis 3 it was predicted that nurses with advanced education or training would demonstrate higher levels of self-disclosure. A t-test was conducted on the two groups of nurses, and for male patients the difference was statistically significant, with scale 1 (work) contributing the most to this finding. For female patients a t-test was conducted, but no statistically significant differences were found on levels of self-disclosure between the two groups of nurses. Hypothesis 3 was accepted with regard to self-disclosure to male patients, and rejected with regard to self-disclosure to female patients. These findings are presented on Table 6 and 7.

Self-Disclosure and Nursing Experience

Hypothesis 4 predicted that higher self-disclosure scores would be related to years of general nursing practice. Pearsonian correlation coefficients demonstrated that the number of years of general nursing experience was not related to self-disclosure scores in any content area. This finding was true for both male and female patients. Therefore, Hypothesis 4 was rejected. These findings are presented in Table 8.

Hypothesis 5 predicted that higher self-disclosure scores would be related to years of psychiatric nursing practice. Pearsonian correlation coefficients indicated that years of psychiatric nursing prac-

Table 6

Differences Between the Means of Self-Disclosure Scores of Nurses with Specialized Training and Those Without

Variable	Disclosure to Male Patients		
	n	$\bar{X}$	t-Value
Work			
Group 1[a]	16	.50	-1.97*
Group 2[b]	59	.73	
Money			
Group 1	16	.01	-1.01
Group 2	59	.03	
Body			
Group 1	16	.19	-.94
Group 2	59	.28	
Personality			
Group 1	15	.31	-1.20
Group 2	59	.43	
Tastes & Interests			
Group 1	15	.63	-1.19
Group 2	59	.79	
Attitudes & Opinions			
Group 1	16	.39	-.80
Group 2	59	.50	
Overall Self-Disclosure			
Group 1	16	.33	-1.66*
Group 2	59	.46	

Key: Group 1[a] = Nurses without masters or nurse practitioner certification
Group 2[b] = Nurses with masters and/or nurse practitioner certification

* $p \leq .05$

Table 7

Differences Between the Means of Self-Disclosure Scores of Nurses with Specialized Training and Those Without

Variable	Disclosure to Female Patients		
	n	$\bar{X}$	t-Value
Work			
Group 1[a]	16	.54	-1.97*
Group 2[b]	59	.77	
Money			
Group 1	16	.03	-.65
Group 2	59	.04	
Body			
Group 1	16	.30	-.32
Group 2	59	.34	
Personality			
Group 1	15	.36	-.92
Group 2	59	.46	
Tastes & Interests			
Group 1	15	.64	-1.24
Group 2	59	.81	
Attitudes & Opinions			
Group 1	16	.41	-.85
Group 2	59	.53	
Overall Self-Disclosure			
Group 1	16	.37	-1.44
Group 2	59	.49	

Key: Group 1[a][b] = Nurses without masters or nurse practitioner certification
Group 2 = Nurses with masters and/or nurse practitioner certification

* $p \leq .05$

Table 8

Pearsonian Correlational Coefficients of Age,
Years of Nursing Experience,
Years of Psychiatric Nursing Experience,
With Content Areas

Content Areas	Years General Nursing Experience		Years Psychiatric Nursing Experience		Age	
	M	F	M	F	M	F
Work	.12	.12	.20*	.17	.16	.16
Money	-.11	-.14	.00	-.05	-.07	-.07
Body	-.04	-.05	.14	.06	-.01	-.02
Personality	.14	.15	.31**	.31**	.19	.23*
Tastes & Interests	.17	.19	.26**	.27**	.26**	.29**
Attitudes & Opinions	-.02	-.02	.09	.07	.14	.14
Overall	.09	.09	.25*	.21*	.19	.19

Key: M = Male
F = Female

* $p \leq .05$
** $p \leq .01$

tice were correlated significantly to the overall self-disclosure scores to male patients (r=.25) and to female patients (r=.21). The scales that contributed significantly to this outcome of disclosure to male patients were: 1 (work), 4 (personality), and 5 (tastes and interests). In disclosure to female patients the scales that contributed significantly were 4 (personality), and 5 (tastes and interests). Hypothesis 5 was accepted. These results are presented on Table 8.

Age and Self-Disclosure

Hypothesis 6 predicted that older nurses would self-disclose less to patients. A Pearsonian correlation coefficient was calculated. In disclosing to male patients, increasing age was not statistically related to overall levels of self-disclosure. In disclosing to female patients, increasing age was not statistically related to overall levels of self-disclosure. Hypothesis 6 was rejected for both male and female patients. These findings are presented on Table 8.

Discussion

From the review of the literature, it was predicted that an intrapersonal perspective in the treatment and assessment of individual patients would be predictive of lower levels of self-disclosure. The outcome of testing Hypothesis 1 reflected no significant differences between nurses with different theoretical frameworks in respect to self-disclosing behavior. This finding suggests that the degree to which nurses self-disclose to individual patients is independent of the theoretical perspective to which nurses subscribe.

The fewest number of nurses selected an intrapersonal framework. For nurses who selected an intrapersonal framework for assessment,

their overall self-disclosure scores were not significantly different from nurses in the other groups. This finding did not support the position of neutrality offered by Weiner (1978), Stewart (1975), and Greenson (1974). Interpreting this finding further indicates that a psychoanalytic framework may be used by nurses to understand the presenting dynamics of patients, but not as a basis for their behavior with patients.

For treatment, nurses who selected an existential-humanistic framework disclosed more to patient. However this result was not statistically significant, but reflects a trend supported by the literature. In working with individual patients, an existential-humanistic approach would allow for nurses to be more disclosing in their interactions with patients (Jourard, 1964; Travelbee, 1971).

The majority of nurses rated themselves as interpersonally focused in both their treatment and assessment of patients. Nurses who selected an interpersonal framework for assessment, had the lowest mean self-disclosure scores to patients. For treatment, nurses who selected an interpersonal framework, also had the lowest mean self-disclosure scores to patients. This finding indicates that self-disclosure is used less by nurses who practice from an interpersonal framework. The interpersonal framework stresses the professional role of the nurse and the importance of establishing and maintaining a therapeutic not personal nurse-patient relationship. Self-disclosure would be used to establish general guidelines for therapy, and to orient the patient to the role of the nurse.

The findings on subject matter were similar to those found by Jourard (1960). Psychiatric nurses shared more information in the areas of work, tastes and interests, and attitudes and opinions. In the more personal and intimate areas of money, body, and personality, nurses shared less overall information. The findings of the present study support Weiner's (1979) suggestion to limit self-disclosure to the most obvious and unavoidable information.

Beyond predicting which areas would have higher levels and which would have lower levels of self-disclosure, subject matter had not been reported more specifically in the literature. In the study by Johnson (1979) with nurses from various specialties, subject matter was not addressed. She measured overall levels of self-disclosure, but did not consider trends in the type of information nurses would disclose to patients. The present study demonstrated that there are definite differences between the amount of self-disclosure and subject matter discussed.

It was predicted that the use of self-disclosure would be greater for nurses with graduate education. Johnson (1980), speculated that instead of taking a specific stance against using self-disclosure with patients, that nurses with graduate training would be better prepared to recognize when self-disclosure would be therapeutically useful, thus they would utilize self-disclosure in their work. Johnson did not test her proposal, but did find that when compared to nurses in other specialties, psychiatric nurses demonstrated overall higher levels of self-disclosure to patients.

In the present study, specialized training did make a difference

in disclosing to male patients, but not to female patients. This finding was difficult to interpret. Married women in addition to disclosing most to their husbands, also disclose at higher levels to other women friends (Jourard, 1960). With patients, it might be expected that female nurses would share similar experiences or provide information about themselves as part of the nursing process to female patients; this was not confirmed by this study.

As predicted, psychiatric nursing experience was more reflective of self-disclosing behavior than general nursing experience. This interpretation includes the possibility that psychiatric nursing experience has exposed nurses to a different nurse-patient relationship, one in which self-disclosure is more frequently utilized. Additionally, working in the field of psychiatry would encourage nurses to look at themselves and how they impact patients with their therapy skills rather than through task oriented procedures.

With increasing age, the amount of self-disclosure to patients and same sex friends gradually diminishes (Jourard, 1961). Jourard noted a general trend for self-disclosure to decrease after the age of 45. In the present study, self-disclosure scores were not statistically affected by age. Older nurses did not demonstrate lower levels of self-disclosure as had been predicted, in fact, the trend was in the opposite direction; with older nurses displaying greater amounts of self-disclosure with this relationship nearly reaching statistical significance ($r=.19$).

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Self-disclosure is a concept addressed and recognized as an integral part of psychotherapy, and the nurse-patient relationship. The utilization of self-disclosure by psychiatric nurses to patients was the focus of the present study. This study measured levels of self-disclosure by psychiatric nurses to both male and female patients. Relationships were examined between self-disclosure and the following variables: theoretical framework, subject matter, graduate education and training, general nursing experience, psychiatric nursing experience, and age. Six hypotheses were tested.

The subjects for this study were registered female nurses in the State of Oregon with advanced degrees or special training in psychiatric nursing. All subjects were currently practicing or had practiced psychiatric nursing within the last year. Demographic data were collected and the Jourard Self-Disclosure Questionnaire was utilized to measure self-disclosure scores.

It was expected that nurses who practiced from an intrapersonal framework would self-disclose less to patients. Analysis of variance revealed no significant differences between nurses using different theoretical frameworks to assess and treat patients, and in the amount of self-disclosure. Self-disclosure by nurses were highest in the areas of work, tastes and interests, and attitudes and opinions; the lowest in the areas of money, body, and personality.

Female nurses with professional education or training disclosed significantly more to male patients. Years of psychiatric nursing experience was more predictive of self-disclosure by nurses to both male and female patients, than years of general nursing experience. Age was not predictive of the amount of self-disclosure by psychiatric nurses to patients.

Conclusions

Based on the results of the study it can be concluded that:

1. The theoretical framework used by nurses to assess and treat patients was not predictive of the amount of self-disclosure by nurses to patients.

2. Overall levels of self-disclosure by nurses to patients were low.

3. Nurses shared most in the less personal areas of work, tastes and interests, and attitudes and opinions. In the more personal areas of money, body, and personality, nurses shared significantly less information.

4. Nurses with master's level education and nurse practitioner certification did disclose more to male patients across all areas of subject matter than nurses without specialized training.

5. Years of general nursing experience was not predictive of self-disclosure by nurses to patients.

6. Psychiatric nursing experience did make a significant difference in the amount of self-disclosure by nurses. Those nurses who had practiced longer as psychiatric nurses, had higher self-disclosure scores.

7. Older nurses did not demonstrate lower levels of self-disclosure to patients.

Recommendations

It was assumed that the theoretical framework employed by the nurses in this study would be related to their self-disclosures scores. What emerged was the finding that no matter what theoretical framework the nurses subscribed to, self-disclosure scores were basically the same. Graduate school promotes exposure to different psychological as well as nursing theories, but how this is translated into practice remains unclear.

In the present study, the nurses were instructed to pick the framework they utilized most. It did not take into consideration the influence of other frameworks that might also be influencing the use of self-disclosure. It would be useful for further research to consider how to incorporate an eclectic approach, and whether nurses actually change or modify their approach dependent on the patient and the situation.

Personality traits of the subjects were not controlled for in this study. Johnson (1979) found that higher self-disclosure scores by nurses to patients were related to lower levels of trait anxiety. This is an area that could be pursued further, to note if any relationships exists between other personality traits and self-disclosure scores by nurses.

Some subjects suggested that it would be helpful to make the questionnaire specific to a certain category of patients. In psychiatric nursing, it would be possible to ask the nurses to fill out the questionnaire only as it applied to male and female patients with a certain diagnosis, e.g., schizophrenia, psychotic depression, etc. With this specificity incorporated into the questionnaire it would be easier to

identify if patient diagnosis affected self-disclosure scores by nurses or whether subject matter discussed varied across patient categories.

Some subjects reported that they often share information not included in the Jourard questionnaire, e.g., how they practice, examples from their own life that are related to what the patient has shared. Being asked to share information is different than openly sharing it, without an invitation,and this distinction was not made in the questionnaire. It would be productive to explore with psychiatric nurses in practice the following concerns: 1) what type of information might you share with patients that was not included in the questionnaire, and 2) does your willingness to disclose change if you are asked to disclose versus offering the information with no request from the patient?

Future studies could explore the influence of self-disclosing behavior by nurses to significant others to determine if it is related to self-disclosure to patients. Self-disclosure by nurses to patients may be related to a more general tendency by some nurses to disclose more or less to significant others, and this would then be reflected in their approach to patients.

REFERENCES

Bloom, W., & Wilson, R. W. Patient practitioner relationships. In H.L. Freeman & S. Levine (Eds.), Handbook of medical sociology. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972, 1979.

Burgess, A.C., & Lazare, A. Psychiatric nursing in the hospital and the community. New Jersey: Prentice-Hall, Inc., 1973.

Carkhuff, R.R. Helping and human relations (Vol. 1). New York: Holt, Rinehart and Winston, Inc., 1969.

Carkhuff, R.R. Helping and human relations (Vol. II). New York: Holt, Rinehart and Winston, Inc., 1969.

Diamond, R.E., & Hellkamp, D.T. Race, sex, ordinal position of birth and self-disclosure in high school students. Psychological Reports, 1969, 25, 235-238.

Diamond, R.E., & Munz, D.E. Ordinal position of birth and self-disclosure in high school students. Psychological Reports, 1967, 21, 829-833.

Doona, M.E. Travelbee's intervention in psychiatric nursing. Philadelphia: F.A. Davis Company, 1979.

Fitzgerald, M.P. Self-disclosure and expressed self-esteem, social distance and areas of the self revealed. Journal of Psychology, 1963, 56, 405-412.

Freud, S. Recommendations for physicians on the psychoanalytic method of treatment, 1923. In Collected papers of Sigmund Freud,(Vol.11), New York: Basic Books, 1959.

Graham, S. Attitude toward death and self-disclosure. In S.M. Jourard, An experimental analysis of the transparent self. New York: Wiley & Sons, Inc., 1971.

Greenson, R.R. The theory of psychoanalytic technique. In S. Arieti (Ed.)., The American handbook of psychiatry (Vol. I). New York: Basic Books, Inc., 1974.

Hein, E.C. Communication in nursing practice. Boston: Little, Brown and Co., 1980.

Himelstein, P., & Lubin, B. Attempted validation of the self-disclosure inventory by the peer nomination technique. Journal of Psychology, 1965, 61, 13-16.

Johnson, M.N. Relationships between and among selected nurses and patients on measures of state anxiety, trait anxiety and self-disclosure in a clinical setting. Unpublished doctoral dissertation, Texas Woman's University, 1977.

Johnson, M.N. Anxiety/stress and the effects on disclosure between nurses and patients. Advances in Nursing Science, 1979, 1,(1-2), 1-20.

Johnson, M.N. Self-disclosure and anxiety in nurses and patients. Issues in Mental Health Nursing, 1979, 2,(1), 41-56.

Johnson, M.N. Self-disclosure: a variable in the nurse-client relationship. JPN and Mental Health Services, 1980, 18,(1), 17-20.

Jourard, S.M. Self-disclosure and other cathexis. Journal of Abnormal and Social Psychology, 1959, 59, 428-431.

Jourard, S.M. Some implications of self-disclosure research for counseling and psychotherapy. A paper presented to the University of Florida Conference on Personality Theory and Counseling Practice, 1960.

Jourard, S.M. Age trends in self-disclosure. Merrill-Palmer Quarterly, 1961, 7,(3), 191-197.

Jourard, S.M. Self-disclosure scores and grades in nursing college. Journal of Applied Psychology, 1961, 45,(4), 244-247.

Jourard, S.M. The transparent self. Princton: D. Van Nostrand Co., Inc., 1964.

Jourard, S.M. Disclosing man to himself. New York: D. Van Nostrand Co., Inc., 1968.

Jourard, S.M. Self-disclosure an experimental analysis of the transparent self. New York: Wiley-Interscience, 1971, 168-172.

Jourard, S. The transparent self. New York: D. Van Nostrand Co., 1971.

Jourard, S.M., & Landsman, M.J. Cognition, cathexias, and the dyadic effect in men's self-disclosing behavior. Merrill-Palmer Quarterly, 1960, 6, 178-186.

Jourard, S.M., & Laskow, P. Some factors in self-disclosure. Journal of Abnormal Social Psychology, 1958, 56,(1), 91-98.

Longo, D.C., & Williams, R.A. Clinical practice in psycho-social nursing: assessment and intervention. New York: Appleton-Century Crofts, 1978.

Mischel, W. Introduction to personality. New York: Holt, Rinehart and Winston, 1971.

Panyard, C.M. Method to improve the reliability of the Jourard self-disclosure questionnaire. Journal of Counseling Psychology, 1971, 18, 602-606.

Pederson, D.M., & Higbee, K.L. Personality correlates of self-disclosure. Journal of Social Psychology, 1969, 68, 81-89.

Peplau, H. Interpersonal relationships in nursing. New York: Putman, 1952.

Peplau, H. Talking with patients. The American Journal of Nursing, 1960, 60, 964-966.

Peplau, H. Psychotherapeutic strategies. Perspectives in Psychiatric Care. 1968, 6(6), 264-270.

Piaget, J. The language and thought of the child. New York: World, 1962.

Pociluyko, P.J. The therapists use of self-disclosure in counseling and psychotherapy: implications and considerations for its use. Maryland State Medical Journal, 1979, 28,(5), 77-82.

Rogers, C.R. The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 1957, 21, 95-103.

Singer, J.L. The scientific basis of psychotherapeutic practice: a question of values and ethics. Psychotherapy: Theory, Research and Practice, 1980, 17, 372-383.

Stewart, R.L. Psychoanalysis and psychoanalytic psychotherapy. In A.M. Freedman, H. Kaplan & B. Sadock (Eds.), Comprehensive textbook of psychiatry (Vol. II). Baltimore: The William & Wilkins Co., 1975, 1799.

Travelbee, J. Intervention in psychiatric nursing: process in the one-to-one relationship. Philadelphia: F.A. Davis Co., 1969.

Travelbee, J. Interpersonal aspects of nursing. Philadelphia: F.A. Davis Co., 1971.

Watkins, J.S. The therapeutic self. New York: Human Sciences Press, 1978.

Weiner, M.F. Therapist disclosure. Boston: Butterworths, 1978.

Wiegel, R.G., Weigel, V.M., & Chadwick, P.C. Reported and projected self-disclosure. Psychological Reports, 1969, 24, 283-287.

Wilson, H.S., & Kneisl, C.R. Psychiatric nursing. Menlo Park, California: Addison-Wesley Publishing Co., 1979.

Wolberg, L.R. The technique of psychotherapy. New York: Grune & Stratton, 1977.

Yalom, I.D. The theory and practice of group psychotherapy. New York: Basic Books, Inc., 1975, 204-218.

APPENDIX A

Cover Letter

Dear

I am writing to request your help in a study that I am conducting in partial completion of a Masters of Nursing degree at the Oregon Health Sciences University. The topic of my study is self-disclosure by psychiatric nurses to patients. The aim of my study is to explore self-disclosure as a component of the nurse-patient relationship. In searching the literature, I found that some authors disagree about what is appropriate for nurses in general to disclose about themselves to patients; while others maintain that nothing should be disclosed. Very little is presently known about the use of self-disclosure by psychiatric nurses in advanced practice. As a psychiatric nurse in advanced practice, you are asked to participate in this study by completing the enclosed questionnaire.

Your answers will provide descriptive data about yourself, as well as the degree to which you self-disclose to patients and identified target persons. It is important for you to answer all items, in cases where you are not sure of your answer, choose the answer that most nearly corresponds to your views. It will take approximately 30 minutes to complete the questionnaire.

All information contained in the questionnaire will be handled confidentially. Your anonymity will be maintained on all documents, which will be identified by code numbers.

Your participation in this study will help increase our knowledge about the use of self-disclosure as a therapeutic part of the nurse-patient relationship. I would appreciate your enclosing the completed questionnaire in the stamped envelope which has been provided and returning it to me within one week. Please feel free to contact me at 225-7846 if you have any questions regarding this study.

Sincerely,

Pat Sosnovec, R.N.

If you would like a copy of the results of this study, please complete the following information and return it with your completed questionnaire.

Name _____

Current Mailing Address

_____

APPENDIX B

Background Information Form

Self-Disclosure Questionnaire

Part I: Background Information

Directions: place a check mark ( ) or fill in the space provided to indicate the answer that pertains to you

1. Sex

___ Male

___ Female

2. Birthdate (day, month, and year)

_____

3. Marital Status

___ Married

___ Single

___ Divorced

___ Widow

4. TOTAL number of years of nursing experience?

___ (Fill in EXACT number)

5. TOTAL number of years of PSYCHIATRIC nursing experience ONLY?

___ (Fill in EXACT number)

6. Basic Nursing Education

___ AD

___ Diploma

___ BSN

7. Year of Graduation from Basic Nursing Program?

___ (Fill in year of graduation)

8. Are you certified as a Psychiatric Mental Health Nurse Practitioner in the State of Oregon?

___ Yes

___ No

9. Do you have a Masters Degree?

____ No (Move to question #10)

____ Yes- - - - - - -A. If YES, in what specialty?

____ Nursing

____ Other, SPECIFY_____

_____

10. Do you have a Doctoral Degree?

____ NO (IF no move to question #11)

____ YES - - - - - - A. If YES, fill in the following

Degree_____

Discipline_____

11. Are you currently practicing as a PSYCHIATRIC Nurse?

____ NO- - - - - - - A. If NO, How long has it been since you practiced as a PSYCHIATRIC NURSE?

____ (EXACT number of years)

____ YES - - - - - - A. If YES, How long have you been practicing at your current position?

____ (EXACT number of years)

B. What type of setting do you practice in ?

____ Inpatient

____ Outpatient

____ Academic

____ Private Practice

____ Other, SPECIFY _____

_____

12. In your current clinical practice which of the following theoretical frameworks do you utilize MOST in your ASSESSMENT of INDIVIDUALS?

A. Circle the framework you utilize MOST often in your ASSESSMENT of individuals, see Column I below.

B. Rate how much you utilize EACH framework in your ASSESSMENT, circle the appropriate number for EACH ITEM in the grid below, see Column II.

ASSESSMENT OF INDIVIDUALS

Column I Circle only ONE item in numbers (1-6)	Column II Circle the appropriate number for each item in the grid below				
	Always Use	Frequently Use	Seldom Use	Never Use	Do Not Know
1. Intrapersonal (ex. psychoanalytic)	4	3	2	1	0
2. Interpersonal (ex. psychodynamic, Peplau)	4	3	2	1	0
3. Existential-Humanistic (ex. client-centered, Travelbee)	4	3	2	1	0
4. Social-Behavioral (ex. social learning, behavioral modification, behavioral therapy)	4	3	2	1	0
5. Sociological (ex. role theory)	4	3	2	1	0
6. Other, SPECIFY _____ _____	4	3	2	1	0

13. In your current clinical practice which of the following theoretical frameworks do you utilize MOST in your TREATMENT of INDIVIDUALS?

A. Circle the framework you utilize MOST often in your TREATMENT of individuals, see Column I below.

B. Rate how much you utilize EACH framework in your TREATMENT, circle the appropriate number for EACH ITEM in the grid below, see Column II.

TREATMENT OF INDIVIDUALS

Column I Circle only ONE item in numbers 1 through 6.	Column II Circle the appropriate number for each item in the grid below				
	Always Use	Frequently Use	Seldom Use	Never Use	Do Not Know
1. Intrapersonal (ex. psychoanalytic)	4	3	2	1	0
2. Interpersonal (ex. psychodynamic, Peplau)	4	3	2	1	0
3. Existential-Humanistic (ex. client-centered, Travelbee)	4	3	2	1	0
4. Social-Behavioral (ex. social learning, behavioral modification, behavioral therapy)	4	3	2	1	0
5. Sociological (ex. role theory)	4	3	2	1	0
6. Other, SPECIFY _____ _____ _____	4	3	2	1	0

14. Does your treatment orientation differ from the treatment orientation of your agency or case supervision you receive?

_____ NO

_____ YES ----------A. If YES, How does this affect your practice?

_____

_____

(Continue your answer on the reverse side if you need more room).

Part II. Information Sharing

DIRECTIONS: People differ in the extent to which they share information with others. Please read each item on the questionnaire, and then indicate (circle) the number that best represents the degree to which you have talked about that item to each person - that is, the extent to which you have made yourself known to that person. Use the following code:

0 = Have told the other person NOTHING about this aspect of me.

1 = Have talked in GENERAL TERMS about this. The other person has only a general idea about this aspect of me.

2 = Have talked in full and COMPLETE DETAIL about this item to the other person. He or she knows me full in this respect and could describe me accurately.

X = Have deliberately given an INCORRECT answer to the other person.

Statements	MALE PATIENT	FEMALE PATIENT	SIGNIFICANT MALE OTHER	SIGNIFICANT FEMALE OTHER
15. What I find to be the worst pressures and strains in my work.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
16. What I enjoy most and get the most satisfaction from in my present work.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
17. What I feel are my special strong points and qualifications for my work.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
18. My ambitions and goals in my work.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
19. How I feel about the choice of career that I have made- - whether or not I am satisfied with it.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X

Statements	MALE PATIENT	FEMALE PATIENT	SIGNIFICANT MALE OTHER	SIGNIFICANT FEMALE OTHER
20. How much money I make at my work, or get in benefits.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
21. Whom I owe money to at present; or whom I have borrowed from in the past.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
22. Whether or not others owe me money; the amount, and who owes it to me.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
23. All of my present sources of income; wages, fees, allowance, dividends, etc.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
24. My most pressing need for money right now, e.g., outstanding bills, some major purchase that is desired or needed.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
25. My feelings about the appearance of my face- - things I don't like and things that I might like about my face and head- - nose, eyes, hair, teeth, etc.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
26. My feelings about different parts of my body- - legs, hips, waist, weight, chest, or bust.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
27. Whether or not I now have any health problems- - e.g., trouble with sleep, digestion, female complaints, heart condition, allergies, headaches, piles, etc.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
28. My past record of illness and treatment	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X

Statements	MALE PATIENT	FEMALE PATIENT	SIGNIFICANT MALE OTHER	SIGNIFICANT FEMALE OTHER
29 My present physical measurements, e.g., height, weight, waist, etc.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
30. The aspects of my personality that I dislike, worry about, that I regard as a handicap to me.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
31. The facts of my present sex life-including knowledge of how I get sexual gratification; any problems that I might have with whom I have relations, if anybody.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
32. Things in the past or present that I feel ashamed and guilty about.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
33. What it takes to get me feeling real depressed and blue.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
34. What it takes to hurt my feelings deeply.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
35. My favorite foods, the ways I like food prepared, and my food dislikes.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
36. My likes and dislikes in music.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
37. The kinds of movies that I like to see best; the TV shows that are my favorites.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X

Statements	MALE PATIENT	FEMALE PATIENT	SIGNIFICANT MALE OTHER	SIGNIFICANT FEMALE OTHER
38. The style of house and the kinds of furnishings that I like best.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
39. My favorite ways of spending spare time, e.g., hunting, reading, parties, dancing, etc.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
40. What I think and feel about religion; my personal religious views.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
41. My views on the question of racial intgration in schools, transportation, etc.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
42. My personal views on sexual morality how I feel that I and others ought to behave in sexual matters.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
43. The things that I regard as desirable for a woman to be- - what I look for in a woman.	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X
44. The things that I regard as desirable for a man to be - - what I look for in a man	0 1 2 X	0 1 2 X	0 1 2 X	0 1 2 X

AN ABSTRACT OF THE THESIS OF

PATRICIA ANN SOSNOVEC

For the MASTER OF NURSING

Date Receiving this Degree: June 11, 1982

Title: Utilization of Self-Disclosure by Psychiatric Nurses

Approved: [redacted]
May Rawlinson, Ph.D. Thesis Advisor

Self-disclosure is a concept addressed and recognized as an integral part of psychotherapy, and the nurse-patient relationship. The utilization of self-disclosure by psychiatric nurses to patients was the focus of the present study. This study measured levels of self-disclosure by psychiatric nurses to both male and female patients. Relationships were examined between self-disclosure and the following variables: theoretical framework, subject matter, graduate education and training, general nursing experience, psychiatric nursing experience, and age. Six hypotheses were tested.

The subjects for this study were 75 registered female nurses in the State of Oregon with advanced degrees or special training in psychiatric nursing. All subjects were currently practicing or had practiced psychiatric nursing within the last year. Demographic data were collected and the Jourard Self-Disclosure Questionnaire was utilized to measure self-disclosure scores.

It was expected that nurses who practiced from an intrapersonal framework would self-disclose less to patients. Analysis of variance

revealed no significant differences between the theoretical framework utilized to assess and treat patients, and self-disclosure by nurses. Self-disclosure by nurses was the highest in the areas of work, tastes and interests, and attitudes and opinions; the lowest in the areas of money, body, and personality.

Nurses with professional education or training disclosed significantly more to male patients than nurses without such training. Years of psychiatric nursing experience was more predictive of self-disclosure by nurses to both male and female patients, than years of general nursing experience. Age was not predictive of the amount of self-disclosure by psychiatric nurses to patients. Recommendations for further study are offered.