Disclosure to Spouses – What Patients Reveal About Their Individual Psychotherapy

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ABSTRACT

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The primary aim of this study was to investigate the content and extent of psychotherapy patients' disclosures to their spouses or significant others about their experiences in therapy, the perceived impact of disclosure about therapy on the spousal relationship, and its perceived impact on the therapeutic relationship and on treatment satisfaction. Adult psychotherapy patients ($N = 84$) in individual treatment, who identified themselves as either married or in a significant romantic relationship completed the Disclosure About Therapy Inventory – Revised (DATI-R; Khurgin-Bott & Farber, 2014), a revision of the Disclosure About Therapy Inventory (see Khurgin-Bott & Farber, 2011). This 52-question survey was designed to explore the extent and content of patients' disclosures to their therapists, and the extent and content of their disclosures about therapy to their spouses or significant others ("partners"). The DATI-R also includes three outcome measures: the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crand, & Larson, 1995) measures the quality of participants' relationships with their partners, the Working Alliance Inventory – Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) assesses the quality of their relationships (alliances) with their therapists, and the outcome items of the Disclosure to Therapist Inventory-III (DTI-III) assess their satisfaction with their treatment.

Findings indicate that overall, patients were very disclosing to their therapists and moderately disclosing to their partners about their therapy. No demographic variables (including gender, marital status, duration of psychotherapy, and duration of marriage/relationship) were

significantly associated with or predictive of the extent of patients' self-disclosure about therapy. A significant positive association was found between the extent of disclosure to partners about therapy and the extent of self-disclosure to therapists. Greater extent of disclosure about therapy to partners was also associated with better quality of therapeutic alliances and with higher relationship satisfaction (with partners). Additionally, the quality of therapeutic alliances was strongly predictive of better treatment outcomes.

These findings suggest that married (or coupled) patients in individual psychotherapy may benefit from the open discussion of their experiences in therapy with their spouses or significant others, or at least that such openness is characteristic of patients in satisfactory relationships (both therapeutic and marital). These findings are discussed in the context of the methodological limitations of the current study and the particular characteristics of the sample, and clinical implications and directions for future research are explored.

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Introduction

The primary aim of this study is to investigate the content and extent of psychotherapy patients' disclosures to their spouses or significant others about their experiences in therapy, the perceived impact of disclosure about therapy on the spousal relationship, and its perceived impact on the therapeutic relationship and on treatment satisfaction. This study serves to explore in greater depth some of the findings described in Khurgin-Bott and Farber's (2011) preliminary study of patient disclosure about therapy.

To date, the study of self-disclosure has followed two parallel tracks: self-disclosure within the therapeutic relationship (i.e., disclosure by patients and disclosure by therapists in the therapy session), and self-disclosure in relationships outside of therapy (e.g., self-disclosure to friends, family, romantic partners, and strangers). Seldom has research delved into the intersection of these two tracks: the place where therapy meets "real life". What is known is that couples who disclose more and communicate better tend to report higher levels of relationship satisfaction (Farber & Sohn, 2007; Finkenauer, Engels, Branje, & Meeus, 2004; Hendrick S. S., 1981; Komarovsky, 1964; Rubin, Hill, Peplau, & Dunkel-Schetter, 1980; Sprecher & Hendrick, 2004; Vera & Betz, 1992). Despite some debate regarding the relationship between self-disclosure and therapeutic outcome (see Kelly, 2000), it is also generally understood that greater levels of self-disclosure in therapy are associated with stronger therapeutic alliances and more positive therapeutic outcomes (Farber, 2006; Hill, Gelso, & Mohr, 2000; Kahn, Hucke, Bradley, Glinski, & Malak, 2012; Kahn & Hessling, 2001; Mental Health: Does Therapy Help?, 1995). But until recently, talking *about* therapy has not been subjected to scientific study. Thus, while the general benefits (and risks) of openness in therapy and in personal relationships are relatively

well-investigated, the personal and therapeutic implications of discussing one's therapy in the context of intimate relationships remain unknown.

Khurgin-Bott and Farber (2011) used a sample of 135 psychotherapy outpatients to examine several topics related to patients' disclosures about their therapy, including the extent to which patients engaged in disclosure about their therapy to confidants, their attitudes about such disclosures, their emotional experiences immediately after disclosing deeply personal information about their therapy to their confidants, and the relationship between the extent of their disclosures about their therapy to their confidants and the extent of their disclosure to their therapists. Since the sample varied in marital status (it included married patients as well as single patients and patients in significant romantic relationships), the patients' confidants included spouses, significant others, and best friends. That study found that in general, most patients were moderately self-disclosing about their therapy to their confidants, held highly positive attitudes about the benefits and appropriateness of such disclosures, and experienced mostly positive feelings immediately after sharing personal material from their therapy with their confidants. It was also found that there was a significant positive correlation between the level of patients' self-disclosure to their therapists and the level of their disclosures to their confidants about therapy.

Several important areas, however, were outside the scope of that study and remained uninvestigated. First, the relationship between disclosure about therapy and patients' level of satisfaction with their relationships—both the therapeutic relationship and the relationship with the confidant—was not adequately addressed; while an initial link was found between level of disclosure about therapy and perceived benefits to therapy and to the relationship with the confidant, more information is needed about the nature and quality of both alliances. Second, the

actual content of patients' disclosure about their therapy was not addressed. And finally, due to the varied nature of the patients' primary confidants (which included spouses and significant others in addition to best friends), it was not possible to focus on the particular nature of intimate romantic relationships (marital or otherwise) in the context of disclosure about therapy. Psychotherapy is a profound, and profoundly intimate, aspect of patients' lives; the way they communicate (or fail to communicate) about this part of their lives with their most significant partners is likely to have far-reaching implications to themselves, their therapies (and therapists), and their relationships with their significant others. The current study is intended to address gaps in our knowledge about the consequences of this specific kind of disclosure.

As noted by Khurgin-Bott and Farber (2011), the process of translating or generalizing insights and understandings gained in therapy to a patient's "real life" remains one of the most significant (and daunting) goals of psychotherapy; it is also perhaps one of the most common criticisms leveled against psychotherapy (i.e., that it remains "divorced" from life outside the boundaries of its sessions). While "the exact mechanism by which such translation takes place remains unknown" (Khurgin-Bott & Farber, 2011, p. 6), the success of this process may depend, at least in part, upon patients' ability to openly discuss their therapy with their intimate partners.

The clinical implications of this research, therefore, are significant. It may suggest particular therapeutic interventions (e.g., broaching the topic of disclosure about therapy to significant others) for the many patients who struggle to translate their therapeutic progress to other areas of their lives – especially, perhaps, to their marital relationships. It may also suggest the clinical benefit of inquiring more explicitly or frequently about patients' extra-therapeutic disclosures—that doing so, for example, might lead to fresh avenues of therapeutic dialogue, including the means to put into practice specific clinical insights. Thus, encouraging greater

openness about the therapy in the context of patients' most intimate relationships (where appropriate) may assist patients who struggle to connect their therapy with their outside worlds. At the least, therapists should gain greater awareness of the prevalence of these types of disclosures and their potential addition as "grist for the therapeutic mill".

The state of the research into self-disclosure mirrors the clinical isolation of the therapeutic setting: here, too, self-disclosure is studied separately in therapy and outside of it. With psychotherapy research already richly engaged in the parallel exploration of these two arenas of disclosure, bridging the two settings with a greater understanding of how patients discuss their therapy with their closest confidants is an area that is ripe for thorough investigation.

Literature Review

While self-disclosure has been investigated in the context of marital relationships (Hendrick S. S., 1981; Chelune, Waring, Vosk, Sultan, & Ogden, 1984; Davidson, Balswick, & Halverson, 1983) as well as of multiple psychotherapeutic dyads—e.g., patient to therapist, therapist to patient, supervisee to supervisor, and supervisor to supervisee (see Farber, 2006, for a review)—surprisingly little has been written about the nature, extent, content and correlates/consequences of disclosure by patients about their own therapy. In particular, the nature of such disclosures in the context of committed romantic relationships (marital or otherwise) and their potential effects on patients' therapeutic and marital relationships remain largely uninvestigated.

The nature of self-disclosure

Sidney Jourard (1971), with whom the contemporary scholarly investigation of self-disclosure originated, described self-disclosure as permitting one's true self to be known; more specifically, self-disclosure can be defined as the "verbal revelation of one's thoughts and feelings to another person" (Hendrick S. S., 1981, p. 1150). These revelations, which "can range from the mundane to the profound" (Farber, 2006, p. 4), are an important aspect of communication in all intimate relationships. Furthermore, disclosing oneself to another person may serve the even more fundamental function of coming to know oneself (Jourard, 1971) – a basic tenet of the psychotherapeutic enterprise.

Jourard created the first modern self-disclosure questionnaire, called the Jourard Self-Disclosure Questionnaire (JDSQ; Jourard & Laskow, 1958), to assess the extent of self-disclosure to other people about a variety of topics. This 60-item, self-report instrument consisted of six categories (Attitudes and Opinions, Tastes and Interests, Work, Money, Personality, and Body) each containing ten questions. The JDSQ was designed to measure the degree of disclosure to each of five people related to the respondent: mother, father, spouse (when married), female friend, and male friend. Jourard proceeded to use the JDSQ (sometimes in modified form) to study a multitude of questions related to self-disclosure. Among his most germane findings was that of the dyadic effect of self-disclosure: the more one disclosed to a particular person, the more that person disclosed to one in return.

Since Jourard's seminal research in this area, the positive and negative aspects self-disclosure have been studied in greater depth, leading to a more nuanced view of the benefits of self-disclosure. The potential benefits (and risks) of self-disclosure depend on countless details

of context and circumstance, including the questions of who, to whom, when, why, and how to disclose (Farber, 2006).

The capacity to self-disclose is a basic interpersonal skill, and may be regarded as a requisite in the formation and maintenance of close relationships. Self-disclosure has been found to foster caring and mutual understanding (Berg & Derlega, 1987). Conversely, a self-perceived lack of intimate self-disclosure has been found to be significantly related to loneliness (Chelune, Sultan, & Williams, 1980; Solano, Batten, & Parish, 1982; Berg & McQuinn, 1989). Solano, Batten, and Parish (1982) found that lonely undergraduate students had more difficulty and were less effective at making themselves known to others, and suggest that these students' constricted style of self-disclosure interferes with the formation and development of social relationship. Along similar lines, the tendency to conceal personal information (self-concealment) has been shown to correlate with self-reported distress and with an avoidance of needed psychological services (Cepeda-Benito & Short, 1998).

The association between self-disclosure and psychological health has been written about long before there were modern experimental inquiries to scientifically support it. The essential element of Freud and Breuer's "talking cure" (1895) involved allowing (even demanding) the un-self-censored disclosure of thoughts, feelings, and traumatic experiences in the attempt to relieve hysterical symptoms through the cathartic method. "Free association" as a therapeutic method demands full and uninhibited self-disclosure in the service of (and as a precursor to) therapeutic progress.

Outside of the therapeutic setting, people's confident expectation of warmth and responsiveness from others and the value they placed on interpersonal closeness and intimacy are associated with a healthy (secure) attachment style (Mikulincer & Nachshon, 1991). Securely-

attached individuals have been found to both disclose more and be more responsive to the disclosures of others than insecurely-attached people (Mikulincer & Nachshon, 1991); they are also more likely to be attracted to others who are self-disclosing. The concept of attachment "working models", or expectations about the responsiveness and emotional availability of others that are based on early experiences with caregivers (Bowlby, 1973), can help to explain why securely-attached people would exhibit these behaviors and preferences: based on their early experiences with warm and emotionally responsive caregivers, their attachment working models allow them to both value interpersonal intimacy as a goal and to believe that this goal is achievable.

According to Pennebaker's theory of inhibition and psychosomatic disease (Pennebaker, Hughes, & O'Heeron, 1987), the lack of self-disclosure of traumatic personal experiences causes significant stress and is related to long-term problems in health. Further, the prolonged avoidance or suppression of self-disclosure of thoughts and feelings is correlated with increased disease and even higher rates of mortality (Blackburn, 1965; Derogatis, Abeloff, & Melisaratos, 1979; Kissen, 1966; McClelland, 1979; Petrie, Booth, & Pennebaker, 1998). Conversely, the ability to disclose traumatic personal events reduces the physiological work of secret-keeping and inhibition, lowers the stress on the discloser's body, allows (at least temporary) relief and even leads to a sustained reduction in symptoms of illness. For the long-term benefits of self-disclosure to manifest, it appears necessary for the disclosers to share their feelings about the traumatic events they experienced, rather than merely to recount the dry facts as they occurred (Pennebaker et al., 1987). Healthy undergraduate students who were randomly assigned to a group instructed to write about both the facts surrounding their traumatic experiences and their accompanying feelings, exhibited fewer visits to the infirmary for illness at six-months follow-up than did students who were instructed to write only about the facts; the students who wrote about

their feelings also reported better health, fewer illnesses, and fewer days of restricted activity caused by illness six months after the writing experiment (Pennebaker & Beall, 1986). Furthermore, it appears that the exploration of feelings and thoughts by the disclosers is more crucial than the details or accuracy of the facts described: traumatized students who were asked to write about an *imaginary* trauma as though they had experienced it themselves, enjoyed similar health benefits to those experienced by students who wrote about traumas they experienced directly (Greenberg, Wortman, & Stone, 1996).

In addition to reducing doctor visits and sick days, written forms of emotional self-disclosure have been related to higher grades in college students, lower rates of depression among students taking professional-level exams, shorter intervals of unemployment following job lay-offs for engineers, and even significantly improved immune function as measured by t-helper cell growth and antibody response to the Epstein-Barr virus and to hepatitis B vaccinations (see Pennebaker & Seagal, 1999, for a summary of writing studies).

Wei, Russell, and Zakalik (2005) studied the association between self-disclosure, loneliness, attachment avoidance and depression in a sample of 308 college freshmen. They found that after controlling for the initial level of students' depression, self-disclosure mediated the association between attachment avoidance and feelings of loneliness and subsequent depression. Specifically, while students with high levels of attachment anxiety and attachment avoidance may find it particularly risky to engage in the self-disclosure of distressing feelings and events to others, it is precisely this kind of emotional disclosure which allows them opportunities to decrease their feelings of loneliness and subsequent depression (Wei et al., 2005).

Self-disclosure in intimate relationships

Jourard (1971) believed that the optimal marital relationship is one in which each spouse can self-disclose "without reserve" (p. 46), and found that people were more self-disclosing with their spouses than with anyone else. Indeed, numerous studies confirm the positive relationship between self-disclosure and satisfaction in marriage and in intimate relationships (Farber & Sohn, 2007; Finkenauer, Engels, Branje, & Meeus, 2004; Hendrick S. S., 1981; Komarovsky, 1964; Rubin, Hill, Peplau, & Dunkel-Schetter, 1980; Sprecher & Hendrick, 2004; Vera & Betz, 1992).

Komarovsky (1964) found that self-disclosure was positively related to marital satisfaction in working-class couples. Hendrick (1981) examined the effect of self-disclosure on relationship satisfaction in a nonclinical sample of college-educated married couples and found a consistent positive relationship between self-disclosure and marital satisfaction, as well as evidence that self-disclosure is a significant predictor of marital satisfaction. Sprecher and Hendrick (2004) found that self-disclosure within dating relationships was positively correlated with relationship satisfaction, love, and commitment, as well as with the individual characteristics of self-esteem, relationship esteem (one's confidence in oneself as a partner in an intimate relationship), and responsiveness (one's ability to elicit self-disclosure in others). Farber and Sohn (2007) found that overall disclosure to spouses, as well as low discrepancies between extent and perceived importance of disclosure, were predictive of marital satisfaction.

Sprecher and Hendrick (2004) conducted a longitudinal study of young dating couples (mostly university students) to examine the associations between self-disclosure in intimate relationships and measures of relationship quality (relationship satisfaction, love, and commitment), as well as the associations between self-disclosure and individual characteristics

such as responsiveness and self-esteem. A large sample (101 couples, 202 individual respondents) was followed over the course of five years, with each partner completing a lengthy relationship questionnaire once a year. The extensive questionnaire included the Self-Disclosure Index (Miller, Berg, & Archer, 1983) to assess the extent of disclosure in various topic areas, the Hendrick Relationship Assessment Scale (Hendrick, Dicke, & Hendrick, 1998) to assess general relationship satisfaction, the Braiker and Kelley (1979) love scale to measure the construct of "love", selected items from the Lund (1985) commitment scale to measure personal commitment to the relationship, the Miller et al. (1983) Opener Scale to measure "responsiveness" (defined as the ability to elicit self-disclosure in others: "high openers" tend to elicit greater self-disclosure), the Rosenberg (1965) self-esteem scale to measure self-esteem, and a portion of the Snell and Finney (1993) Relationship Assessment Questionnaire to measure the construct of "relationship esteem", or the confidence in oneself as a partner in an intimate relationship. Positive associations were found both between self-disclosure and relationship quality, and between self-disclosure and the individual characteristics examined (self-esteem, confidence as an intimate partner, and responsiveness). These positive associations persisted over time, though they tended to diminish and in some cases were no longer significant in follow-up waves. It was also discovered that certain aspects of self-disclosure were predictive of couples staying together: the more women perceived their partners as disclosing during the initial administration of the questionnaire, the less likely the couple was to break up by the second administration (Sprecher & Hendrick, 2004).

Chelune, Waring, Vosk, Sultan, and Ogden (1984) studied multiple dimensions of self-disclosure (including amount, self-references, intimacy of content, affect, and rate of disclosure) in married couples and examined the relationship between self-disclosure and marital intimacy. They found that self-disclosure variables accounted for nearly 72% of the variance in couples'

intimacy ratings, as measured by the Victoria Hospital Intimacy interview (VHII), a structured interview developed by Waring and his associates (Waring, et al., 1978).

Vera and Betz (1992) examined the interrelationships of emotional self-disclosure, self-esteem, gender, and relationship satisfaction in 200 college students involved in serious dating relationships (all heterosexual). In an attempt to improve upon previous studies of the constructs of affective self-disclosure and relationship satisfaction, Vera and Betz (1992) administered two measures of self-disclosure: the Emotional Self-Disclosure Scale (ESDS) (Snell, Miller, & Belk, 1988) and the Affective Self-Disclosure Scale for Couples (ASDC) (Davidson, Balswick, & Halverson, 1983), as well as two measures of relationship satisfaction: the Relationship Assessment Scale (RAS; (Hendrick S. S., 1988) and the Quality Marriage Index (QMI; Norton, 1983). The Emotional Self-Disclosure Scale (ESDS) is a self-report measure of forty items, designed to assess the willingness to disclose specific emotions within the context of intimate relationships. Respondents indicate, on a 5-point Likert scale, their willingness to discuss each of the forty items with their significant others; each item describes a topic written to measure one of eight distinct emotions: depression, happiness, jealousy, anxiety, anger, calmness, apathy, and fear (Snell, Miller, & Belk, 1988). The Affective Self-Disclosure Scale for Couples (ASDC) measures the frequency of emotional self-disclosure to intimate partners: respondents rate each of 16 different emotions, on a 4-point Likert scale, according to their frequency of disclosure to their significant other. These sixteen emotions yield four subscales measuring the affective self-disclosure of love, happiness, sadness, and anger. Summing the four subscales produces an overall score for affective self-disclosure (Davidson, Balswick, & Halverson, 1983). The Quality Marriage Index (QMI) asks respondents to rate their agreement with items on a 7-point Likert scale, as well as to rate their perceived level of happiness with their relationship on a scale from 1 (unhappy) to 10 (perfectly happy). It seeks to measure overall subjective happiness in the

marital relationship, rather than to focus on specific reported behaviors, which may or may not correlate with relationship satisfaction.

Vera and Betz (1992) found that in both men and women, emotional self-disclosure was positively (linearly) related to relationship satisfaction. In fact, affective self-disclosure was found to be the strongest predictor of relationship satisfaction, regardless of gender and regardless of the instrument used to measure the construct of relationship satisfaction. The level of participants' self-disclosure of emotions to their partners was a better predictor of their relationship satisfaction than were participants' ages, their partners' ages, the length of the relationship, and the level of participants' self-esteem. They concluded that couples experiencing relationship problems may benefit from learning self-disclosure skills, as a technique to enhance relationship intimacy.

Finkenauer, Engels, Branje & Meeus (2004) conducted a study involving 1,048 individuals (262 intact families consisting of two children and two adult parents) to examine the social mechanisms of disclosure and its connection with relationship satisfaction in families. Self-disclosure to partners was assessed using an adaptation of the Self-Disclosure Index (Miller, Berg, & Archer, 1983). Family members rated on a five-point Likert scale (1 = never, 5 = almost always) the extent to which they disclosed nine topics to their partners: positive things that happened during the day, disappointments and setbacks, future plans, secrets, other family members, fears and insecurities, friends, health, and finances. These were found to be relevant topics of disclosure, and the internal consistency on items was satisfactory (mean Cronbach's alpha was .88 over all scales). To assess relationship satisfaction, Finkenauer et al. (2004) were careful to choose a measure that does not mention relationship behaviors related to communication (such as the ability to "talk openly" with one's partner), in order to avoid inflated

correlations between disclosure and relationship satisfaction. Participants rated their relationships with their partners on four qualities: good, pleasant, valuable, and difficult, using five-point scales (from 1 = not at all, to 5 = very much).

Finkenauer et al. (2004) found that, in line with Jourard's observations regarding the reciprocal nature of self-disclosure, married partners appear to match each other's level of disclosure: i.e., the more the wife reported disclosing to her husband, the more the husband reported disclosing to his wife. The same dyadic reciprocity in self-disclosure was found in other horizontal relationships (i.e., relationships characterized by an egalitarian and reciprocal interaction between partners, such as sibling-sibling or parent-parent dyads). Additionally, higher levels of self-disclosure in married couples were positively related to greater marital satisfaction; this was true for both the discloser and the recipient of the disclosure. In other words, those participants (married parents) who were more satisfied with their marriages disclosed more to their spouses than those participants who were less satisfied; and the more a married person disclosed to his or her spouse, the more satisfied the *spouse* was with the relationship.

In examining both self-disclosure and relationship satisfaction, Finkenauer et al. (2004) were interested in distinguishing the effects of dispositional (characterological) factors and relational (relationship-specific) factors. They found that when it comes to the spouse's relationship satisfaction, the relative importance of characterological self-disclosure was significantly lower than that of relationship-specific self-disclosure: "in horizontal relationships, a partner's relational disclosure is more important to the recipient's relationship satisfaction than is the partner's general disposition to disclose" (Finkenauer et al., 2004, p. 205). In other words, what mattered more to the marriage satisfaction of one's partner was the level of disclosure to the partner within the dyad, regardless of one's general tendency to disclose.

Rubin, Hill, Peplau, and Dunkel-Schetter (1980) examined patterns of self-disclosure, including gender differences, in 231 college-student dating couples (all opposite-sex couples). They used Jourard's (1971) general format to measure self-disclosure: respondents indicated, on a 3-point Likert scale, the extent to which they had revealed themselves to their partners on 17 potential topics of self-disclosure. Topics included their feelings about the current relationship, past romantic relationships, relationships with parents and friends, self-concept and life view, attitudes and interests, and daily activities. Since Rubin et al. (1980) found a general factor in the self-disclosure reports, respondents' answers across all 17 items were also averaged to generate a "Total Disclosure Index". To assess the quality of the couple's relationship, Rubin et al. (1980) administered the 9-item Love and Liking Scales (Rubin, 1973). These scales distinguish between love, which is described as consisting "of interrelated components of attachment, caring, and intimacy" and liking, which refers to "one person's unilateral evaluation of another on various dimensions" (Rubin et al., 1980, p. 312).

Overall, Rubin et al. (1980) found very high levels of self-disclosure by both men and women, with more than half of all respondents (58 percent of the women and 57 percent of the men) reporting that they had disclosed themselves "fully" to their partners. While they caution that all studies of self-disclosure that use retrospective self-reports necessarily involve subjective reconstructions of disclosure rather than "totally objective phenomena" (p. 309), they report a substantial degree of matching in levels of self-disclosure among dating partners; these findings are, again, consistent with Jourard's formulation of dyadic reciprocity. High levels of self-disclosure were found even among couples who have been dating only for a short while (less than six months), though there was a small correlation (r = .23) between Total Disclosure and the duration of a couple's relationship. In terms of the association between self-disclosure and relationship quality, Rubin et al. (1980) found moderately high correlations between total

disclosure to one's partner and love, as measured by Rubin's Love Scale (r = .51 for women and r = .46 for men). Lower correlations were found between self-disclosure and scores on Rubin's Liking Scale (r = .37 for women and r = .21 for men).

Self-disclosure in psychotherapy

While research into the general nature of self-disclosure in daily life began around the middle of the twentieth century, research about the particular nature of self-disclosure in the context of psychotherapy is relatively new (Farber, 2006). However, patient self-disclosure is almost by definition an essential element of the therapeutic process. If "no man can come to know himself except as an outcome of disclosing himself to another person" (Jourard, 1971, p. 6), and one of the most fundamental goals of psychotherapy is the increase and deepening of self-knowledge, then self-disclosure in therapy is necessary not only as a method of interpersonal communication, but also as a way to learn about one's self. Kahn, Hucke, Bradley, Glinski, & Malak (2012) have described emotional self-disclosure as "a linchpin connecting various aspects of well-being, positive adjustment, and successful psychotherapeutic treatment" (p. 134).

A 1995 Consumer Reports survey of 4,000 psychotherapy patients found that progress in therapy was more likely for those patients who formed real alliances with their therapists – by being open and revealing information even about painful subjects (Mental Health: Does Therapy Help?, 1995). Kahn et al. (2012) report that the tendency to disclose distressing personal information, as measured by the Distress Disclosure Index (DDI; Kahn & Hessling, 2001) is associated with well-being, positive attitudes to seeking professional help, and good outcomes in brief psychotherapy. Farber and Sohn (2007) found that overall disclosure to therapist was a significant predictor of outcome in psychotherapy. This positive relationship between patient

self-disclosure and outcome in therapy has been found in several studies (Farber, 2006; Hill, Gelso, & Mohr, 2000; Saypol & Farber, 2010), although the association is probably dependent upon additional factors, including length of therapy and patient personality (i.e., characterological proclivity towards self-disclosure). Farber, Berano and Capobianco (2004) found that intimate disclosures in therapy may initially generate some anxiety, but ultimately produce feelings of safety, pride, authenticity, and relief from tension.

Saypol and Farber (2010) studied the relationship between patient self-disclosure in psychotherapy and adult attachment style, and found significant positive relationships between the level of self-disclosure and both the intensity and security of attachment to the therapist. As expected, levels of self-disclosure were significantly lower among patients whose attachment to their therapists was dismissing in style. People with an avoidant attachment style also tend to have low levels of emotional self-disclosure (Garrison, Kahn, Sauer, & Florczak, 2012), which concords with their tendency to avoid and suppress both distressing emotions and intimate relationships in favor of a self-reliant coping style.

Disclosures to therapists were also found to facilitate subsequent disclosures to family and friends. Relatedly, Farber and Sohn (2007) found that there was significant correlation between length of time in therapy and overall disclosure to spouses: the longer patients have been in therapy, the more they tended to disclose to their spouses. This finding led Farber and Sohn to suggest that future research should focus on two important (and related) questions: the extent to which psychotherapy fosters general openness (self-disclosure) in patients, and the extent to which married patients discuss their therapy with their spouses. The current study aims to investigate the latter question.

In contrast to these positive reports of the benefits of openness in psychotherapy, Kelly (1998; 2000) found that patients withhold personal information and emotional reactions from their therapists, and that keeping relevant secrets in therapy is associated with positive therapy process and outcomes. Explaining these results through a self-presentational view of psychotherapy, Kelly contends that people often avoid sharing painful or difficult personal information with others due to (often justified) concerns that such disclosures may lead to negative reactions from their confidants, which in turn places the disclosers "at risk of constructing unwanted images of themselves" (Kelly, 2000, p. 475). These same risks, Kelly contends, are present in self-disclosure to therapists: while therapists may be trained professionals who aim to provide a safe and nonjudgmental environment to encourage openness, they may still threaten their patients' positive self-representations by judging unpalatable disclosures harshly (albeit often implicitly), pathologizing patient behaviors, and making broad (and negative-sounding) diagnoses. If anything, the dangers of self-disclosure to a therapist may be even higher than those of disclosing to other confidants, since therapists are perceived as expert, knowledgeable confidants whose negative reactions and opinions hold greater sway and may cause greater damage to patients' images of themselves (Kelly, McKillop, & Neimeyer, 1991). If therapeutic progress is dependent upon patients' perceptions that their therapists hold favorable views of them, and if therapists are incapable of holding (and exhibiting) such views while knowing unfavorable information about their patients, then it would be reasonable to discourage the disclosure of negative personal information in therapy. Kelly (2000) believes that these findings should lead to a reevaluation and questioning of the benefits of self-disclosure in therapy and a focus on finding the optimal amount and type of therapeutic self-disclosure – particularly limiting the type of self-disclosure (i.e., negative reactions and the revelation of objectionable secrets) that interferes with the formation of a favorable self-presentation.

Disclosure about therapy

Brody and Farber (1989) investigated the ways in which one partner's therapy affects the other partner in a romantic relationship. They both interviewed and surveyed a small sample (N = 20) of significant others, never themselves in therapy, whose spouses or live-in partners were currently in individual psychotherapy. The interview consisted of twenty open-ended questions, divided into three general sections: respondents' knowledge and feelings about aspects of their partners' therapy (such as confidentiality, time, and money spent), respondents' perceptions of the effects of the therapy on their relationships with their partners, and respondents' perceptions of the effects of their partners' therapy on themselves. Respondents also completed the Spouse's Perception of Therapy Scale (SPOTS), a 40-item, Likert-type questionnaire measuring significant others' perceptions of changes in themselves, their partners, and their relationships with their partners as a consequence of their partners' therapy. Overall, Brody and Farber (1989) found that most significant others expressed mixed and conflicted reactions to their partners' therapy. The positive findings included improved communication in their relationship with their partners, an improved ability to understand their partners, a feeling that their partners became more open and empathic, and a feeling that they themselves became more introspective thanks to their partners' therapy. The negative findings included reported feelings of exclusion, resentment, and inadequacy related to their partners' therapy, as well as displeasure about the financial cost of therapy.

In a pilot study, Khurgin-Bott and Farber (2011) investigated patterns of disclosure by psychotherapy patients about their own therapy to "confidants": their spouses, significant others, or best friends. A total of 135 patients in individual psychotherapy completed the Disclosure About Therapy Inventory (DATI), a 90-item Likert-type questionnaire created for the study and

designed to explore patients' emotions and attitudes about disclosing aspects of their experiences in individual psychotherapy to important people in their lives. According to their indicated relationship status, respondents answered these items about disclosing to their respective confidants: married participants answered about disclosing to their spouses, those in significant relationships answered about disclosing to their significant others, and single respondents answered about disclosing to their best friends. The respondents, whose average age was 29, were highly educated (78.5% had a college degree or higher), mostly Caucasian (85.9%), and predominantly female (86.7%). Almost half (45.9%) of the sample consisted of single patients, who answered the survey questions about disclosure to their best friends, and not to their romantic partners. The remaining participants were either married (23.7%) or in a significant relationship (29.8%). Due to a problem with the online survey design, data regarding the duration of treatment was available for only one third of the total sample; the average length of therapy for those 33% was longer than two years (27.2 months).

Findings indicated that most patients were quite self-disclosing to their confidants about their therapy (M = 5.30 on a 7-point Likert scale with 1 labeled "very reluctant to discuss", 4 labeled "neutral/mixed", and 7 labeled "very willing to discuss"), and perceived their confidants as very willing to engage in such discussions about the participants' therapy (M = 5.34 on the same scale). Neither patients' willingness to discuss their therapy with their confidants nor their perception of their confidants' willingness to listen was found to significantly differ as a function of relationship status. Patients endorsed highly positive attitudes regarding disclosure about therapy, believing that such disclosures were "appropriate or right" (M = 5.11 on a 7-point scale, where 1 = "very", 4 = "mixed/neutral", and 7 = "not at all") and "beneficial" to them (M = 4.72 on the same scale). They also reported primarily positive feelings after disclosing personal information about their therapy to their confidants. Asked to rate on a 7-point Likert scale the

extent to which they experienced 25 different emotions (10 positive and 15 negative) following the disclosure of "deeply personal" material about their therapy, patients were most likely to endorse feeling "connected/intimate" to their confidant ($M = 4.68$), "authentic" ($M = 4.56$), and "safe" ($M = 4.23$). Additionally, a significant (positive) relationship was found between the extent to which patients disclose about their therapy to their confidants and the extent to which they disclose to their therapists, $r = .23$ (121), $p < .05$. However, despite these interesting preliminary findings, several key aspects of disclosure about therapy remain unexplored. In particular, three significant areas of investigation related to disclosure about therapy were outside the scope of the 2011 study. First, the actual content (i.e., specific topics of discussion) of patients' disclosures about their therapy was not investigated. Second, the association between married (or coupled) patients' disclosures about therapy to their spouses (or significant others) and their level of satisfaction with their marriages (or romantic relationships) was not investigated. And third, the association between such disclosures about therapy and patients' level of satisfaction with their therapy has not been adequately addressed.

Research Questions and Hypotheses

The present study uses a sample of outpatients in individual psychotherapy who are also either married or in significant relationships, in order to investigate patterns of disclosure about therapy to intimate partners and the perceived impact of such disclosure on the quality of patients' relationships with both therapists and partners. Specifically, the following research questions and hypotheses are posed:

Research Question #1: To what extent do patients share with their partners what they have discussed in their therapy sessions?

Research Question #2: Which, if any, demographic and relationship variables are significant predictors of self-disclosure about psychotherapy to partners?

Research Question #2A: Is marital status a significant predictor of extent of self-disclosure about therapy to partner? (Do married psychotherapy patients disclose more to their spouses about their psychotherapy than do unmarried patients to their partners?)

Research Question #2B: Is duration of treatment a significant predictor of extent of self-disclosure about therapy to partner?

Research Question #2C: Is duration of relationship a significant predictor of extent of self-disclosure about therapy to partner?

Research Question #2D: Is gender a significant predictor of extent of self-disclosure about therapy to partner? (Do women disclose more about their therapy to their partners than men do?)

Hypothesis # 1: Patients who disclose more about their therapy to their partners will report significantly greater self-disclosure to their therapists.

Hypothesis # 2: Patients who disclose more about their therapy to their partners will report significantly stronger therapeutic alliances (better therapeutic relationships).

Hypothesis # 3: Patients who disclose more about their therapy to their partners will report significantly greater treatment satisfaction.

Hypothesis # 4: Patients who disclose more about their therapy to their partners will report significantly greater relationship satisfaction.

Method

Participants

Participants in this study were 84 adult patients over 18 years of age in individual psychotherapy or counseling, who identified themselves as either married or in a significant romantic relationship. Participation was voluntary and all information was provided anonymously. Participants were recruited via bulletin board-style online sites including psychsurveys.org and by posting links to the survey on Psychological Research on the Net, as well as contacted through personal networking (i.e., links to the online questionnaire were e-mailed to members of graduate programs in clinical and counseling psychology). Participation was limited to Internet users who were sufficiently fluent in English to complete the questionnaire. Patients in couples therapy or group therapy (rather than in individual psychotherapy) were not eligible to participate. Tables 1 and 2 summarize the demographic data for participants in this study.

The mean age of the sample was 36.32 years (*SD* = 9.09), 75.0% of the respondents were female, and 86.9% were white. (Though 21.4% identified as something other than white, the percentages don't add up to 100% since several respondents chose more than one race to describe themselves). In terms of marital status, 65.5% were married, 6.0% were in a civil union or domestic partnership, 1.2% were engaged to be married, and the remaining 27.4% were in a "significant relationship". Regardless of their marital status, 85.7% of respondents reported that they were living with their partners. Most respondents were in long-term relationships with their partners (average length of current relationship was 8.26 years, *SD* = 6.00), and also in long-term psychotherapy (average length of current treatment was 3.72 years, *SD* = 3.26). Moreover, most of the participants reported that this was not their first experience in therapy: 75% had been in

therapy previously, and the average duration of their total time in treatment (including their current therapy) was 9.64 years.

Across four categories of income, 10.8% reported annual incomes under $20,000, 22.9% in the $20,001-60,000 range, 28.9% in the $60,001-100,000 range, and the remaining 37.4% reported incomes over $100,000. In terms of educational attainment, this was a highly educated sample, with 38.1% holding doctoral or postdoctoral degrees, 36.9% holding master-level degrees, 15.5% having bachelor (college) degrees, 3.6% having associate degrees, and only 2.4% having high school diplomas as their highest degree.

Table 1

Participants: Descriptive Data (Categorical Variables) (N = 84)

Characteristic	*N*	%
Gender		
Male	21	25.0
Female	63	75.0
Income		
under $20,000	9	10.8
$20,001–60,000	19	22.9
$60,001–100,000	24	28.9
over $100,000	31	37.4
Race		
Asian	2	2.4
White	73	86.9
African-American/Black	2	2.4
Latino/a	6	7.1
American Indian/Alaska Native	2	2.4
Other	6	7.1
Marital Status		
Married	55	65.5
Engaged	1	1.2
In a Civil Union/Domestic Partnership	5	6.0
In a Significant Relationship	23	27.4

(Table 1 continues)

(Table 1 continued)

Characteristic	*N*	%
Education		
High School/GED	2	2.4
Associate Degree	4	3.6
Bachelor Degree	13	15.5
Masters Degree	31	36.9
Doctoral Degree	34	38.1

Table 2

Participants: Descriptive Data (Continuous Variables) (N = 84)

Variable	*M*	*SD*
Age	36.32	9.09
Years in relationship	8.26	6.00
Years in therapy	3.72	3.26

Instruments

Participants in this study completed the Disclosure About Therapy Inventory – Revised (DATI-R; Khurgin-Bott & Farber, 2014), a revision of the Disclosure About Therapy Inventory (see Khurgin-Bott & Farber, 2011). This 52-question survey was created for the current study and designed to explore the extent and content of patients' disclosures to their therapists, the extent and content of their disclosures about therapy to their spouses or significant others ("partners"), the quality of their relationships with their partners, the quality of their relationships (alliances) with their therapists, and their satisfaction with their treatment. This questionnaire, which takes approximately 20 minutes to complete, is divided into four sections.

Section I. The first section, titled "Section I – Questions about you", consists of 12 general demographic questions, including questions about age, gender, race, and sexual orientation.

Section II. The second section, titled "Section II – Questions about your relationship with your partner", begins with four basic questions about the nature of the participant's relationship (e.g., duration of the relationship, whether it is the participant's first significant relationship). Three questions are presented asking for demographic information about the partner (age, gender, and race/ethnicity). Then, five questions are presented asking about the partner's participation in therapy, (e.g., is the partner in individual psychotherapy now or in the past, are the partner and participant in couples or family therapy now or in the past).

Section II – RDAS. Section II continues with the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crand, & Larson, 1995), a brief measure of the quality of participants' relationships with their partners. This measure, for use with both distressed and nondistressed couples, consists of 14 questions (rated on a 6-point Likert scale, from 1, "never",

to 6, “all the time”) grouped into four categories. It is the current (revised) version of the Dyadic Adjustment Scale (DAS), which it is designed to replace. Busby et al. (1995) examined the reliability of the RDAS measure and reported a split-half reliability coefficient of .94, a substantial improvement over the .88 reliability coefficient of the DAS, as a result of the reorganization of the DAS subscales into homogenous pairings. Additionally, they found evidence of construct validity for RDAS when used alongside other measures. The RDAS was chosen for this study because it is a short, valid and reliable measure for assessing the quality of the relationship between participants and their spouses or romantic partners.

Section III – DTI-III and WAI-SR. The third section, “Questions about your therapy”, is in part an adaptation of the Disclosure to Therapist Inventory-III (DTI-III; Farber, Hall, & Sohn, 1997), a self-report measure that assesses the extent to which clients discuss a wide array of topics in psychotherapy. It begins by asking about the duration and frequency of therapy, and continues with three questions about participants’ therapists (gender, race/ethnicity, and approximate age). These are followed by a question about the topics discussed in therapy, which presents two sets of topics. The first set of eleven items consists of the most common topics discussed in individual psychotherapy (e.g., “aspects of my personality that I dislike/worry about”, “My feelings of rage or anger toward my parents”) (Farber, 2006), taken from the DTI-III (Farber, Hall, & Sohn, 1997). The second set of six items consists of marital/relational topics commonly discussed in couples therapy (e.g., “My feelings about my sexual relationship with my partner”, “My feelings about how my partner and I communicate”, “Power struggles in my relationship with my partner”).

Then, to assess the patients’ satisfaction with their therapy, they are asked five questions about their therapeutic outcome to date, such as “Overall, how successful do you feel your

therapy has been at reducing the severity of your symptoms?" The other outcome questions reflect different outcome domains, including the perceived success of therapy in increasing self-acceptance, self-understanding, the capacity to relate well to others, and the capacity to work productively. Each outcome item is rated on a one to seven Likert- type scale (1 = minimally successful; 4 = moderately successful; 7 = greatly successful). Farber and Sohn (2007) reported high internal consistency for these outcome questions (Cronbach's alpha was .91).

Finally, the quality of participants' therapeutic relationships is assessed via the Working Alliance Inventory – Short Revised (WAI-SR; Hatcher & Gillaspy, 2006), a refined and abridged version of the widely used Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). This brief inventory evaluates the quality of the therapeutic relationship using 12 statements (e.g., "My therapist and I respect each other") to be rated on a 5-point Likert scale. Hatcher and Gillaspy (2006), working with a sample of American outpatients, examined the validity and reliability of the WAI-SR for measuring the Goal-Task-Bond dimensions of the therapeutic alliance: agreement on the goals of therapy, agreement on the tasks of therapy, and the development of an affective bond between patient and therapist (Bordin, 1979). Munder, Willers, Leonhart, Linster, and Barth (2010) replicated Hatcher and Gillaspy's good initial findings in a different setting (German outpatients and inpatients) and confirmed that the WAI-SR demonstrates good psychometric properties in psychotherapy clients, both outpatients and inpatients.

Section IV. The fourth section of the DATI-R ("Questions about discussing your therapy with your partner") consists of fifteen questions focusing on participants' disclosures to their partners about their therapy. Many of the questions in this section are adapted from the Disclosure About Therapy Inventory (DATI), created for use in the 2011 Khurgin-Bott and

Farber study. It includes five questions, to be rated on a 7-point Likert-scale, about the nature of participants' disclosures to their partners about their therapy (e.g., "I discuss the positive feelings I have for my therapist"), and about the topics from therapy disclosed to the partners (e.g., "My reaction to others' criticism of me"). The topics listed echo the list of topics in Section 3, "Questions about your therapy". They are similarly comprised of eleven topics commonly discussed by patients in individual psychotherapy, adapted from the Disclosure to Therapist Inventory-III (DTI-III; Farber, Hall, & Sohn, 1997), and six marital/relational topics commonly discussed in couples therapy.

Respondents are also asked, in a multi-part matrix question, about the reasons for leaving out details when discussing their therapy with their partners (e.g., "I feel these details are too shameful to disclose"). Finally, respondents' attitudes regarding such disclosures are examined (e.g., "How appropriate or "right" do you feel it is to discuss your therapy with your partner?"). Validity for these questions has not been established.

Procedure

Participants completed an anonymous online questionnaire on surveymonkey.com. The questionnaire had to be completed using a computer, tablet, or smartphone, with a limit of one respondent per device. After reading the exclusion criteria, participants clicked on a link in the recruitment e-mail, which directed them to the informed consent form. After reading the informed consent form, they were informed that by pressing the "Next" button and continuing on to the survey, they are indicating their consent to participate, and reminded that they may stop at any time if they so wish. Those who clicked their consent were then presented with the participant's rights statement, after which the survey proper began with Section I ("questions about you").

In terms of the survey's layout, each section was separated across multiple pages, with no more than one section per page. Some questions were paired with follow-up questions, including questions 11 and 12 ("Do you and your partner live together?" and "If yes, how long have you and your partner lived together?"), and questions 20 and 21 ("Is your partner currently in therapy?" and "If so, for how long?"). Question 46 asked respondents to describe the nature of their conversation with their partners about their therapy, including the statement "I withhold certain details about my session from my partner." Following this, respondents were asked to skip the next question if they answered "not at all" to this statement.

The cover letter and informed consent statement (Appendix A) described to participants the purpose of the information gathered, and advised them of the questions to be asked and the potential risks and benefits of participating in the survey. Anonymity and confidentiality were ensured based on the survey design: no specific identifying information was collected at any point, and the survey hosting site gathered only IP addresses (which are not traceable to specific individuals) from the devices used to take the survey.

Results

As noted above, the content of self-disclosure to therapists and to partners was measured by the extent of discussion of 17 topics (11 of the topics most frequently discussed in individual psychotherapy, and six additional "relational" topics commonly discussed in couples or marital therapy). Extent of discussion for each topic was reported on a 7-point Likert scale ranging from 1 (not at all) to 7 (to a great extent). The Cronbach alpha coefficient for the 11 Disclosure-to-Therapist items was .80. Alpha for the 11 Disclosure-to-Partner-about-Therapy items was .88. The overall extent of self-disclosure to therapists and to partners was measured in two ways: first, as a composite score derived from the mean scores on the list of topics discussed in each

setting, and then as the answer to the "global" items "Overall, how self-disclosing have you been to your therapist?" and "Overall, how self-disclosing have you been about your therapy with your partner?" Each of these questions was rated on a 7-point scale wherein 1 = "minimally self-disclosing", 4 = "moderately self-disclosing", and 7 = "greatly self-disclosing".

Alpha level was set at .05 throughout data analysis, in accordance with contemporary convention. Accordingly, only results at the .05 level will be considered significant; however, results approaching the .05 level (below .07) will be discussed as data trends, in order to avoid missing interesting directional findings with possible implications for future research.

Means and standard deviations of scores were computed and presented for each of the measures used in this study—disclosure to therapist, disclosure about therapy to partner, therapeutic alliance, treatment outcome, and relationship satisfaction with partner. To check for demographic variables that may be predictive of extent of disclosure about therapy to partners, correlational analyses were conducted, to determine whether there were any significant associations between extent of disclosure about therapy to partners and the following variables: gender, marital status, duration of psychotherapy, and duration of relationship with partner.

For each of the four hypotheses examining the relationship between the extent of disclosure about therapy to partners and the various outcome measures (disclosure to therapist, quality of therapeutic alliance, treatment outcome, and relationship satisfaction with partners), simple bivariate regressions were conducted in which the focal variable, disclosure about therapy to partners, was used to "predict" these various outcomes. (The use of the word "predict" here is meant in the statistical sense only: it does not change the nonexperimental nature of this study or make any implications of causality). Conducting a regression analysis allowed for the testing of both the significance of the association between the focal variable and the various outcome

variables, using the *F*-ratio and its *p*-value, and the strength of each relationship, using the standardized regression coefficient (β) and the r^2 (which is also the square of *r*, the Pearson correlation coefficient). Note that the *p*-value for beta, the standardized regression coefficient, is the same as the *p*-value for the Pearson correlation coefficient (*r*). This statistic (the Pearson correlation coefficient), which is a measure of linear association between two variables, is also a measure of the standardized slope in simple linear regression (Demaris, 2004). In other words, while there are differences in emphasis between regression and correlation (i.e., regression focuses on prediction while correlation focuses on association), the mathematical computations are identical. Following the results of the regression analyses conducted to answer the four hypotheses, a full correlational matrix will be presented in order to show how all of the variables in this study (the two measures of disclosure to therapist, the two measures of disclosure about therapy to partner, therapeutic alliance, treatment outcome, and relationship satisfaction) are related to each other.

Prior to conducting the analysis, all data were checked for skewness, outliers, and missing data. One respondent reported being in therapy for 35 years, a length of treatment that lay far outside the sample mean of 3.72 years. As a compromise between keeping this outlier unchanged and discarding it, it was dealt with by Winsorizing (Ghosh & Vogt, 2012) – replaced with a value of 14 years in therapy (one longer than the next longest in the sample). Besides this statistical correction, none of the other responses had to be discarded or altered. Findings are presented below, in the order of the research questions and hypotheses.

Research Question #1:

To what extent do patients share with their partners what they have discussed in their therapy sessions?

In order to address this question, means and standard deviations were computed for each of the 11 individual and six relational topics of disclosure to therapist and then to partner about therapy. These numbers are presented in Tables 3 and 4. Results indicated that overall, patients are highly self-disclosing to their therapists (on a scale of 1 to 7, $M = 5.98$, $SD = 1.01$) and moderately self-disclosing to their partners about their experiences in therapy ($M = 4.24$, $SD = 1.75$). The topic patients discussed to the greatest extent *with their therapists* was "Aspects of my personality that I dislike/worry about" ($M = 5.57$, $SD = 1.38$), followed by "Characteristics of my parents that I dislike" ($M = 5.26$, $SD = 1.75$) and "Feelings about having my own needs met vs. meeting the needs of others" ($M = 5.12$, $SD = 1.48$).

When it came to sharing with their partners various topics that have been discussed with their therapists, the topic discussed to the greatest extent was "My expectations and hopes for the future" (on the same 1-7 scale, $M = 4.67$, $SD = 1.80$), followed by "Aspects of my personality that I dislike/worry about" ($M = 4.55$, $SD = 1.70$) and "Characteristics of my parents that I dislike" ($M = 4.50$, $SD = 2.01$).

To assess their global perceptions about the extent of their disclosure, respondents were asked to rate the overall extent of their self-disclosure to their therapists and to their partners about their therapy. Findings indicate that patients were very self-disclosing to their therapists (on a 7-point scale with higher numbers denoting greater disclosure, mean disclosure to therapist was 5.98, $SD = 1.75$) and moderately disclosing about their therapy to their partners (on the same 7-point scale, mean disclosure about therapy to partner was 4.24, $SD = 1.01$). After computing the means and standard deviations, an independent groups t-test was conducted to assess the discrepancy in overall extent of disclosure between the two settings. The findings from this t-test indicate that, as expected, overall disclosure to one's therapist is significantly greater than overall disclosure about therapy to one's partner, $t\ (83) = -8.89$, $p < .001$.

Table 3

Disclosure to Therapists: Means and Standard Deviations (N = 84)

Variable	Disclosure to Therapists	
	M	*SD*
Total disclosure score (composite)	4.49	1.05
Overall, how self-disclosing have you been to your therapist? (single)	5.98	1.01
To what extent do you discuss the following topics? (Individual topics)		
Aspects of my personality that I dislike/worry about	5.57	1.38
Characteristics of my parents that I dislike	5.26	1.75
Feelings of depression or despair	4.93	1.80
Feelings about having my own needs met vs meeting needs of others	5.12	1.48
My feelings of rage or anger toward my parents	4.29	2.21
My feelings of rage or anger toward my partner	3.45	1.94
My feelings about my achievements to this point in my life	4.53	1.58
My reaction to others' criticism of me	4.39	1.86
My expectations and hopes for the future	4.99	1.61
My experience of feeling rejected by my partner	3.15	2.11
My feelings about my friends	3.71	1.75
To what extent do you discuss the following topics? (Relational topics)		
My feelings about my sexual relationship with my partner	3.51	1.63
My feelings about members of my partner's family (my in-laws)	3.11	1.88

(Table 3 continues)

(Table 3 continued)

Issues related to money/finances	3.53	1.89
Problems with substance abuse or other addictive behaviors	2.16	1.68
My feelings about my partner's ambitions/achievements in life	3.62	1.66
My feelings about how my partner and I communicate	4.32	1.94

Note: All Disclosure items were measured on a 7-point scale wherein 1 = *not at all*; 4 = *somewhat*; 7 = *to a great extent*. Alpha for the 11 Disclosure to Therapist items = .80. Alpha for the 11 Disclosure to Partner about Therapy items = .88

Table 4

Disclosure to Partners about Therapy: Means and Standard Deviations (N = 84)

Variable	Disclosure to Partners about Therapy	
	M	*SD*
Total disclosure score (composite)	3.91	1.28
Overall, how self-disclosing have you been to your partner about your therapy? (single)	4.24	1.75
To what extent do you discuss the following topics? (Individual topics)		
Aspects of my personality that I dislike/worry about	4.55	1.70
Characteristics of my parents that I dislike	4.50	2.01
Feelings of depression or despair	3.76	1.78
Feelings about having my own needs met vs meeting needs of others	4.07	1.80
My feelings of rage or anger toward my parents	3.87	2.15
My feelings of rage or anger toward my partner	2.93	1.78
My feelings about my achievements to this point in my life	3.88	1.66
My reaction to others' criticism of me	4.11	1.89
My expectations and hopes for the future	4.67	1.80
My experience of feeling rejected by my partner	2.79	1.82
My feelings about my friends	3.59	1.95

(Table 4 continues)

(Table 4 continued)

To what extent do you discuss the following topics? (Relational topics)		
My feelings about my sexual relationship with my partner	2.81	1.80
My feelings about members of my partner's family (my in-laws)	2.72	1.73
Issues related to money/finances	3.37	2.03
Problems with substance abuse or other addictive behaviors	2.19	1.82
My feelings about my partner's ambitions/achievements in life	3.17	1.61
My feelings about how my partner and I communicate	3.89	1.92

Note: All Disclosure items were measured on a 7-point scale wherein 1 = *not at all*; 4 = *somewhat*; 7 = *to a great extent*. Alpha for the 11 Disclosure to Therapist items = .80. Alpha for the 11 Disclosure to Partner about Therapy items = .88

Research Question #2:

> Which, if any, demographic variables—including gender, marital status, duration of treatment, and duration of relationship—significantly predict the extent of self-disclosure about psychotherapy to partners?

In order to answer this question, correlations between each of the four predictor variables (gender, marital status, duration of treatment, and duration of relationship) and the extent of disclosure to partners about therapy were computed. As displayed in Table 5, none of the demographic variables are significantly associated with or predictive of the extent of self-disclosure about psychotherapy (for all correlations, $p > .05$). This was true both when "extent of self-disclosure about psychotherapy" was defined as the composite of the disclosure topics and when it was defined as a single "global" item.

Table 5

Correlations between predictor variables and measures of disclosure to partner about therapy

Variable	DATI-R Total Disclosure to Partner about Therapy (Composite)	Overall Disclosure to Partner about Therapy (Single Item)
Marital Status	.05	.18
Duration of Therapy	.06	.07
Duration of Relationship	-.15	-.02
Gender	.16	.11

Note: $N = 83$. None of the correlations were significant at the $p < .05$ level.

Hypothesis #1:

> Patients who disclose more about their therapy to their partners will report significantly greater self-disclosure to their therapists.

The variables "extent of self-disclosure to therapist" and "extent of self-disclosure to partner about therapy" were operationalized in two ways: first, as composite scores derived from the lists of DTI-III topics disclosed to each, and then as the scores on the individual "global" questions "Overall, how self-disclosing have you been to your therapist?" and "Overall, how self-disclosing have you been about your therapy with your partner?" A simple bivariate regression was conducted to test whether the extent of disclosure about therapy to partners could predict the extent of disclosure to therapists. As seen in Table 6, the results indicate that there is a statistically significant positive relationship between extent of self-disclosure to partner about therapy and extent of self-disclosure to therapist, regardless of how the variables were operationalized. In other words, the more patients share with their partners about their therapy, the more self-disclosing they are to their therapists – as hypothesized. When "extent of self-disclosure" is defined as a composite of the disclosure topics, this relationship is moderately strong ($\beta = .34$, $F\,(1,81) = 10.25$, $p < .002$). Although the strength of this relationship becomes more modest when "extent of self-disclosure" is defined as a single global item ($\beta = .25$), it remains positive and significant ($F\,(1,82) = 5.43$, $p = .02$).

Table 6

Regression Analysis Summary for Disclosure to Partner about Therapy Predicting Disclosure to Therapist

Variable	R^2	β	*F(df)*	*P*
Disclosure to partner about therapy (composite)	.11	.34	10.25(1,81)	.002
Disclosure to partner about therapy (single item)	.06	.25	5.43(1,82)	.02

Note: The DTI-III was used to measure "composite" disclosure scores to therapist and to partner about therapy. Single item disclosure scores were based on the questions, "Overall, how self-disclosing have been to your therapist?" and "Overall, how self-disclosing have you been to your partner about your therapy?"

Hypothesis #2:

> Patients who disclose more about their therapy to their partners will report significantly stronger therapeutic alliances (better therapeutic relationships).

In order to address this hypothesis, the quality of patients' therapeutic alliances was assessed, using the Working Alliance Inventory – Short Revised (WAI-SR). Internal consistency for this 12-item measure was high, with Cronbach's alpha for the entire questionnaire equaling .91. All items were measured on a 5-point scale on which 1 = *seldom*; 2 = *sometimes*; 3 = *fairly often*; 4 = *very often*; and 5 = *always*. Means and standard deviations for the WAI-SR are reported in Table 7. Overall, these numbers show that respondents as a whole enjoyed strong alliances with their therapists: mean score for all WAI-SR items was 3.66 (*SD* = .73) on the 5-point scale.

Then, the extent of patients' disclosures about their therapy to their partners was again measured in two different ways: as a composite score derived from the means of the DTI-III disclosure topics, and as the score on the individual "global" question "Overall, how self-disclosing have you been about your therapy with your partner?" Next, a simple (bivariate) regression was conducted in which each of the average extent of disclosure to partner scores (global and composite) was used to predict the strength of patients' alliances with their therapists, as measured by the WAI-SR. As can be seen in Table 8, there is a statistically significant positive relationship between extent of self-disclosure to partner about therapy, as measured by the composite score, and quality of the therapeutic alliance, F (1,81) = 6.91, p = .01. This means that, as hypothesized, the more patients disclosed to their partners about their therapy, the stronger were their alliances with their therapists. Though highly significant, however, the strength of this relationship was modest, (β = .28). The relationship between the extent of disclosure to partners about therapy and the quality of patients' therapeutic alliances

was no longer significant when "extent of disclosure" was measured as mean responses to the single global item "Overall, how self-disclosing have you been about your therapy with your partner?" (F (1,82) = 1.45, p = .23).

Table 7

Therapeutic Alliance (WAI-SR): Means and Standard Deviations

Variable	*n*	*M*	*SD*
As a result of my therapy sessions I am clearer as to how I might be able to change.	84	3.14	1.04
What I am doing in therapy gives me new ways of looking at my problem.	84	3.62	.98
I believe my therapist likes me.	84	3.87	.83
My therapist and I collaborate on setting goals for my therapy.	84	2.82	1.35
My therapist and I respect each other.	84	4.48	.72
My therapist and I are working towards mutually agreed upon goals.	84	3.21	1.47
I feel that my therapist appreciates me.	84	3.92	.85
My therapist and I agree on what is important for me to work on.	83	3.69	1.06
I feel my therapist cares about me even when I do things that he/she does not approve of.	84	4.01	.94
I feel that the things I do in therapy will help me to accomplish the changes that I want.	84	3.76	1.01
My therapist and I have established a good understanding of the kind of changes that would be good for me.	84	3.65	1.07
I believe the way we are working with my problems is correct.	84	3.77	.91
WAI-SR Total	84	3.66	.73

Note: Therapeutic alliance was measured by the Working Alliance Inventory – Short Revised (WAI-SR). Alpha for the entire measure (12 items) = .91. Items were measured on a 5-point scale on which 1 = *seldom*; 2 = *sometimes*; 3 = *fairly often*; 4 = *very often*; and 5 = *always*.

Table 8

Regression Analysis Summary for Disclosure to Partner about Therapy Predicting Therapeutic Alliance

Variable	R^2	β	*F(df)*	*P*
Disclosure to partner about therapy (composite)	.08	.28	6.91(1,81)	.01
Disclosure to partner about therapy (single item)	.02	.13	1.45(1,82)	.23

Note: Therapeutic Alliance was measured using the Working Alliance Inventory – Short Revised (WAI-SR).

Hypothesis #3:

Patients who disclose more about their therapy to their partners will report significantly greater treatment satisfaction.

Treatment Outcome items in the Disclosure to Therapist Inventory-III (DTI-III). The internal consistency for these 5 items was good (α= .85). All items were measured on a 7-point scale on which 1 = *minimally successful*, 4 = *moderately successful*, and 7 = *greatly successful*. Means and standard deviations for the DTI-III Treatment Outcome measure are reported in Table 9. These numbers indicate that as a whole, respondents were highly satisfied with their treatment outcomes (composite mean for all outcome items was 5.21 on the 7-point scale). In particular, respondents felt that their therapies had been very successful at increasing their levels of self-understanding ($M = 5.92$, $SD = 1.92$).

As in the previous analyses, the extent of patients' disclosures about their therapy to their partners was measured in two different ways: first as a composite score derived from the means of the DTI-III disclosure topics, and second, as the score on the individual "global" question "Overall, how self-disclosing have you been about your therapy with your partner?" Next, a simple (bivariate) regression was conducted in which each of these "extent of disclosure to partner" scores (global and composite) was used to predict patients' therapeutic outcomes. The results of the regression analysis for disclosure to partners about therapy predicting treatment outcome are displayed in Table 10. As can be seen in Table 10, the extent of self-disclosure to partners about therapy was not significantly related to the degree of treatment satisfaction. When extent of disclosure was measured using the single global question, no significant relationship was found, $F(1,82) = .001$, $p = .98$. However, when extent of disclosure was measured using the composite scores from the disclosure topics, there was a trend towards significance, $F(1,81) = 3.77$, $p = .056$.

Table 9

Treatment Outcome (DTI-III): Means and Standard Deviations

Variable	*N*	*M*	*SD*
Total treatment outcome (composite)	84	5.21	1.12
Overall, how successful has your psychotherapy been at:			
Giving you a greater sense of self-acceptance?	84	5.51	1.30
Increasing your capacity to relate well to others?	84	5.11	1.46
Increasing your capacity to work productively?	83	4.52	1.66
Increasing your self-understanding?	84	5.92	1.22
Reducing the severity of your symptoms?	83	4.98	1.34

Note: Treatment outcome was measured by the Disclosure to Therapist Inventory-III (DTI-III). Alpha for these 5 items is .85. Items were measured on a 7-point scale on which 1 = *minimally successful*; 4 = *moderately successful*; and 7 = *greatly successful*.

Table 10

Regression Analysis Summary for Disclosure to Partner about Therapy Predicting Treatment Outcome

Variable	R^2	β	*F(df)*	*p*
Disclosure to partner about therapy (composite)	.04	.21	3.77(1,81)	.056
Disclosure to partner about therapy (single item)	<.001	.003	.001(1,82)	.98

Note: Treatment outcome was measured using the Disclosure to Therapist Inventory – III (DTI-III) Outcome items.

Hypothesis # 4:

> Patients who disclose more about their therapy to their partners will report significantly greater relationship satisfaction.

In order to address this hypothesis, relationship satisfaction was measured using the Revised Dyadic Adjustment Scale (RDAS). Mean scores and standard deviations for this measure of relationship satisfaction are reported in Table 11. Good internal consistency was found, with Cronbach's alpha for the entire measure (14 items) equaling .88. Overall, respondents scored very highly on the RDAS (mean total score was 60.81), meaning that as a whole, this was a sample of respondents who enjoy high levels of satisfaction in their relationships with their partners (total RDAS scores below 48 denote "distressed" couples). The extent of patients' disclosures about their therapy to their partners was again measured in two ways: as a composite score derived from the means of the DTI-III disclosure topics, and as the score on the individual "global" question "Overall, how self-disclosing have you been about your therapy with your partner?"

A simple (bivariate) regression was then conducted in which each of the overall average extent of disclosure to partner scores (global and composite) was used to predict patients' satisfaction with their relationships with their partners (as measured by the RDAS). The results of this regression analysis are presented in Table 12. As can be seen in **Error! Reference source not found.**, there is a statistically significant relationship between extent of self-disclosure to partner about therapy, as measured by the global item, and reported relationship satisfaction as measured by the RDAS ($R^2 = .22$, $F\,(1,81) = 23.38$, $p < .001$). More specifically, and consistent with expectation, this relationship is positive and moderately strong ($\beta = .47$, $p < .001$). In other words, patients who disclosed more to their partners about their therapy had significantly better

relationships with their partners. Though the association between extent of disclosure to partners about therapy and relationship satisfaction was no longer significant at the .05 level when the extent of disclosure was measured using the composite disclosure scores (as opposed to the global measure scores), there was still a trend toward significance (F (1,80) = 3.38, p = .07).

Table 11

Relationship Satisfaction (RDAS): Means and Standard Deviations

Variable	*N*	*M*	*SD*
Total RDAS	83	60.81	8.06
Consensus Items [a]	83	28.69	3.94
The extent of agreement or disagreement between you and your partner			
Religious matters	84	4.90	.89
Demonstrations of affection	84	4.73	1.03
Making major decisions	83	4.87	.79
Sex relations	84	4.39	1.19
Conventionality (correct or proper behavior)	84	4.76	.94
Career decisions	83	5.07	.81
Satisfaction Items [b]	83	18.95	2.67
How often do you discuss or have you considered divorce, separation, or terminating your relationship?	84	5.12	.92
How often do you and your partner quarrel?	84	4.35	.65
Do you ever regret that you married (or lived together)?	83	5.23	.98
How often do you and your partner "get on each other's nerves"?	83	4.29	.77

(Table 11 continues)

(Table 11 continued)

Variable	*N*	*M*	*SD*
Cohesion Items	84	13.13	2.78
Do you and your partner engage in outside interests together? [c]	84	3.39	.62
How often would you say the following events occur between you and your partner? [d]			
Have a stimulating exchange of ideas	84	3.38	.97
Work together on a project	84	2.33	1.11
Calmly discuss something	84	4.02	.99

Note: Relationship satisfaction was measured by the Revised Dyadic Adjustment Scale (RDAS). Alpha for the entire measure (14 items) = .88. Total RDAS scores below 48 denote "distressed" couples.

[a]Consensus items were measured on a 6-point scale on which 1 = *always disagree*; 2 = *almost always disagree*; 3 = *frequently disagree*; 4 = *occasionally agree*; 5 = *almost always agree*; 6 = *always agree*.

[b]Satisfaction items were measured on a 6-point scale on which 1 = *all the time*; 2 = *most of the time*; 3 = *more often than not*; 4 = *occasionally*; 5 = *rarely*; 6 = *never*.

[c]The first Cohesion item was measured on a 5-point scale on which 1 = *never*; 2 = *rarely*; 3 = *occasionally*; 4 = *almost every day*; 5 = *every day*.

[d]The remaining Cohesion items were measured on a 6-point scale on which 1 = *never*; 2 = *less than once a month*; 3 = *once or twice a month*; 4 = *once or twice a week*; 5 = *once a day*; 6 = *more often*.

Table 12

Regression Analysis Summary for Disclosure to Partner about Therapy Predicting Relationship Satisfaction

Variable	R^2	β	F	df	p
Disclosure to partner about therapy (composite)	.04	.20	3.38	1,80	.07
Disclosure to partner about therapy (single item)	.22	.47	23.38	1,81	<.001

Note: Relationship satisfaction was measured using the Revised Dyadic Adjustment Scale (RDAS).

Additional Analyses – Correlational Matrix

During the course of the data analysis, additional questions arose regarding the outcome scores. In order to clarify the nature of the relationships between the various measures and outcome variables, a correlational analysis—using Pearson product-moment correlation coefficients—was conducted on all of the measures used in this study. These include the four disclosure measures (single and composite scores of disclosure to therapist, and single and composite scores of disclosure to partner about therapy) and the three outcome measures (therapeutic alliance, treatment outcome, and relationship satisfaction). The results of this correlational analysis are presented in Table 13 below. Several significant correlations emerged, which will be presented in the order of their magnitude.

The strongest relationship was the statistically significant, positive correlation between the quality of the therapeutic alliance, as measured by the WAI-SR, and treatment outcome, as measured by the DTI-III outcome items. The stronger the therapeutic alliance, the better the treatment outcome ($r = .60$, $p < .001$). The relationship between the extent of disclosure to partner about therapy, as measured by the single global question "Overall, how self-disclosing have you been about your therapy with your partner?" and the level of relationship satisfaction, as measured by scores on the RDAS, was also strong, with a positive and highly significant correlation. The more self-disclosing respondents were to their partners about their therapy, the more satisfied they were with their relationship to their partners ($r = .47$, $p < .001$). The two measures of disclosure to partner about therapy (composite and single item), were significantly positively correlated ($r = .42$, $p < .001$). Disclosure to therapist, as measured by the single global question "Overall, how self-disclosing have you been to your therapist?" was significantly positively correlated with treatment outcome, as measured by the DTI-III, $r = .37$, $p < .01$.

There was also a significant, positive correlation ($r = .34$, $p < .01$) between the extent of disclosure to partners about therapy (as measured by the composite score derived from the mean scores on the list of disclosure topics from the DTI-III) and the extent of disclosure to therapists (again, as measured by the composite score). The more respondents disclosed to their partners about their therapy, the more disclosing they were with their therapists. This finding was repeated when extent of disclosure to therapist was measured using the single global question, again with significant positive results ($r = .31$, $p < .01$). The correlation remained positive and significant, though less strong ($r = .25$, $p < .05$) when levels of disclosure were measured using the single global questions in both settings (to therapists and to partners).

Extent of disclosure to therapists, as measured by the single global question, was significantly positively correlated to quality of the therapeutic alliance, as measured by the WAI-SR ($r = .33$, $p < .01$). Finally, there was also a significant positive correlation between extent of disclosure to partners about therapy (measured by the composite score) and quality of the therapeutic alliance (measured by the WAI-SR), $r = .28$, $p < .01$. The correlation between extent of disclosure to partners about therapy (composite score) and treatment outcome was a positive but nonsignificant one ($r = .21$, $p = .056$).

Table 13

Correlations between measures of self-disclosure, therapeutic alliance, treatment outcome, and relationship satisfaction

	Disclosure to Therapist		Disclosure to Partner about Therapy		Therapeutic Alliance	Treatment Outcome	Relationship Satisfaction
	composite	single item	composite	single item			
Disclosure to Therapist							
Composite	1	.05	.34**	-.08	.11	.14	-.22
single item		1	.31**	.25*	.33**	.37**	.14
Disclosure to Partner about Therapy							
Composite			1	.42***	.28**	.21	.20
single item				1	.13	-.00	.47***
Therapeutic Alliance					1	.60***	.01
Treatment Outcome						1	-.04
Relationship Satisfaction							1

*$p < .05$. **$p < .01$. ***$p < .001$.

Note: Disclosure to Therapist and Disclosure to Partner about Therapy composite scores were derived from the means of the Disclosure to Therapist Inventory – III (DTI-III) disclosure topics. Disclosure "single item" scores were based on mean scores to the individual "global" questions "Overall, how self-disclosing have you been to your therapist?" and "Overall, how self-disclosing have you been about your

therapy with your partner?" Therapeutic Alliance was measured using the Working Alliance Inventory – Short Revised (WAI-SR). Treatment outcome was measured using the DTI-III Outcome items. Relationship satisfaction was measured using the Revised Dyadic Adjustment Scale (RDAS).

Discussion

The primary aim of this study was to investigate the content and extent of psychotherapy patients' disclosures to their spouses or significant others about their experiences in therapy, the perceived impact of disclosure about therapy on the spousal relationship, and its perceived impact on the therapeutic relationship and on treatment satisfaction. Areas of focus included the degree to which particular topics discussed in therapy were shared with partners, and patients' overall sense of their openness in therapy and to their partners about their therapy. Additionally, the relationship between disclosure about therapy to intimate partners and the quality of patients' relationships (both with partners and with therapists) was examined. These questions were studied with the goal of furthering the understanding of patterns of self-disclosure and satisfaction in the context of intimate relationships.

Alpha level was set at .05 throughout the data analysis, as a standard compromise between the likely risks of making Type I and Type II errors. Accordingly, only results at the .05 level will be considered significant. Given the exploratory nature of this study, however, results approaching the .05 level (below .07) will be discussed as data trends, in order to avoid missing interesting directional findings with possible implications for future research.

The first research question investigated the extent to which patients discussed with their partners various individual and relational topics that have been discussed with their therapists. It was found that overall, patients were very disclosing to their therapists and moderately disclosing to their partners about their therapy. The second research question investigated relationships among several demographic variables (gender, marital status, duration of therapy, and duration of relationship with partner) and extent of disclosure about therapy. None of these demographic

variables were found to be significantly associated with or predictive of disclosure, whether measured as a composite of disclosure topics or as a global question.

Hypothesis one, which posited a significant positive association between the extent of disclosure to partners about therapy and the extent of disclosure to therapists, was confirmed. Hypothesis two, which posited a significant positive relationship between the extent of disclosure to partners about therapy and the strength of the therapeutic alliance, was also confirmed, but only when using the composite (rather than the single-item) scores to measure extent of disclosure. Hypothesis three, which posited a significant positive relationship between the extent of disclosure to partners about therapy and treatment satisfaction, was not confirmed, although there was a trend towards significance when using the composite scores to measure extent of disclosure. Hypothesis four, that patients who disclose more to their partners about their therapy will report experiencing greater relationship satisfaction, was confirmed, when using the global measure of disclosure; results approached significance when using the composite measure of disclosure.

Though not directly posed as a research question, a correlational analysis was conducted to further clarify the relationships among all the measures and outcome variables in this study. Consistent with the results of the research hypotheses, significant positive correlations were found between disclosure to partners about therapy and the following three variables: disclosure to therapists, therapeutic alliance, and relationship satisfaction. The correlation between disclosure to partners about therapy and treatment outcome was also positive but only approaching significance. In addition, strong positive correlations were found between extent of disclosure to therapists and both therapeutic alliance and treatment outcome. Finally, consistent with past research, the therapeutic alliance was found to be strongly (and positively) correlated with treatment outcome.

These findings will be further discussed below, in the order of the research questions and hypotheses. The implications of this research will be explored, followed by a discussion of the general limitations of the current study and suggestions for future research.

Extent and Content of Disclosure to Partners about Therapy

The extent of patients' disclosure to their partners about their therapy was measured in two ways: as an overall, global sense of how disclosing they've been to their partners about their therapy, and as a composite score derived of the means of a list of 11 salient disclosure topics. Both measurements led to the conclusion that patients were moderately disclosing to their partners about their experiences in therapy. This finding is consistent with the results of Khurgin-Bott and Farber's (2011) study, which found moderately high levels of disclosure about therapy to "confidants" (spouses, significant others, and best friends) in a demographically similar sample of psychotherapy patients. Moderately high levels of disclosure to partners about therapy are also congruent with the finding that patients in the current study were highly disclosing to their therapists. This may reflect a dispositional or characterological tendency to self-disclose, especially in the context of intimate relationships (Kahn, Achter, & Shambaugh, 2001)

Extent of self-disclosure about psychotherapy to partners and demographic variables—gender, marital status, duration of treatment, and duration of relationship

The extent of patients' disclosure to their partners about their therapy was measured in two ways: as an overall, global sense of how disclosing they've been to their partners about their therapy, and as a composite score derived of the means of a list of 11 salient disclosure topics. It was found that none of the demographic variables (gender, marital status, duration of treatment,

or duration of relationship with partner) were significantly associated with or predictive of the extent of self-disclosure about psychotherapy. This was true both when "extent of self-disclosure about psychotherapy" was defined as the composite of the disclosure topics and when it was defined as a single "global" item.

The finding that gender was not significantly associated with the degree of disclosure to partners about therapy was in line with other studies that investigated gender differences in self-disclosure. Generally, any sex differences in overall levels of disclosure were found to be mild and inconsistent (Dindia & Allen, 1992; Hall, 1993; Hosman, 1986; Pattee & Farber, 2004; Sohn, 2001). In more recent studies, gender has not been found to be a significant factor in regard to either the extent or types of disclosure in therapy (Pattee & Farber, 2004). Moreover, gender differences in self-disclosure (when any have been found) have likely been in the process of declining for several decades (Hosman, 1986). In a meta-analysis of 73 studies on sex differences in self-disclosure, Hosman (1986) found that studies published between 1960 and 1969 reported greater sex differences than studies published between 1970 and 1986. Given the extensive cultural changes that have taken place in recent decades with respect to sex role attitudes and norms, it is not surprising that more recent samples have exhibited similar levels of self-disclosure in women and men.

The lack of a significant correlation between marital status and extent of disclosure to partners about therapy is consistent with the findings of Khurgin-Bott and Farber (2011). In that study, which investigated patterns of disclosure about therapy to confidants in 135 patients in individual psychotherapy, no significant differences in either overall extent of disclosure about therapy or willingness to discuss "deeply personal" material from therapy was found in patients across three relationship categories: married, in significant relationships, or single (disclosing to best friends). The sample of the current study is demographically similar to that of Khurgin-Bott

and Farber (2011), and potential discrepancies in extent of disclosure across relationship categories are likely more difficult to detect given the overall high levels of self-disclosure in both samples.

Neither the duration of therapy nor the duration of patients' relationships with their partners was significantly related to the degree of disclosure about therapy to partners. While length of therapy was not found to be significantly correlated with willingness to disclose about therapy to confidants in Khurgin-Bott and Farber's 2011 study, Sohn (2001) reported a significant positive association between length of current treatment and overall disclosure to therapist, as well as between total months in therapy across all treatments and disclosure to therapist about several topics (Existentiality, Sexuality, and Competition). The idea that greater self-disclosure is facilitated by longer treatments and relationships, in which trust and comfort have had time to grow, is both intuitively appealing and aligns with clinical experience. The fact that length of therapy and length of relationship were not predictive of disclosure about therapy in this sample may be due to the long average durations of these respondents' therapies and relationships. Respondents reported an average of almost four years in their current treatments, and three quarters of respondents reported that they had also been in treatment previously. The average duration of their total time in treatment (including the current treatment) was almost ten years. Since the average length of relationships with partners was over eight years, it is likely that both treatments and romantic relationships have lasted long enough for optimal levels of comfort and trust to develop. This possibility is borne out by the high overall levels of disclosure among participants, both to their therapists and to their partners about therapy. These findings, therefore, do not contradict well-established clinical lore regarding the importance of time in treatment to the formation of trusting therapeutic alliances and to the facilitation of patient self-disclosure. Instead, they are likely merely an artifact of the unique characteristics of the current

sample: highly disclosing patients in long-lasting relationships with their partners who are in long-term individual therapy and have also had previous experiences in other long-term therapeutic relationships.

Disclosure about therapy to partners and self-disclosure to therapists.

Results indicate that, regardless of how the disclosure variables were operationalized, there is a statistically significant positive relationship between extent of self-disclosure to partners about therapy and extent of self-disclosure to therapists. Patients who disclosed more to their partners about their therapies reported greater levels of disclosure to their therapists. This finding is consistent with Khurgin-Bott and Farber's 2011 study, which used a demographically similar sample of psychotherapy outpatients (i.e., highly-educated, white, and predominantly female). As discussed in that study, these findings do not support the classical (Freudian) notion that sharing information about therapy with (even intimate) others is a practice patients should be warned to avoid. Freud himself (1958) famously suggested that prior to beginning "the talking cure", patients should be advised to resist the temptation to discuss their treatments with anyone, "no matter how close they may be, or how inquisitive" (p. 136). This perspective, which is based on the idea that such extra-therapeutic disclosures "deplete" the available content and affective valence of disclosures to be shared in the therapy, would suggest that disclosure about therapy leads to lower levels of disclosure within therapy. However, the current findings indicate the opposite to be true. Given that higher levels of disclosure to therapists have been found to predict better therapeutic alliances and better treatment outcomes, it would seem unlikely that discouraging disclosure about therapy to intimate partners would lead to improved therapeutic outcomes.

The classical admonition against "diluting" the treatment is premised upon the idea that disclosure to others serves as a defense against a full, deep, and perhaps terrifyingly intimate engagement in the therapeutic relationship. If self-disclosure (and by extension, intimacy) is perceived as a finite resource, then disclosure in one setting invariably reduces disclosure in another setting. The fact that levels of disclosure in therapy and about therapy are positively correlated suggests that disclosure may be better conceptualized as a relatively stable trait or personality characteristic (namely, a characterological tendency to be "open" and highly-disclosing across settings, and particularly in the context of significant intimate relationships).

Extent of disclosure about therapy to partners, quality of the therapeutic alliance, and treatment outcome

The quality of patients' therapeutic alliances was assessed using the Working Alliance Inventory – Short Revised (WAI-SR). Scores on this measure revealed that respondents as a whole enjoyed strong alliances with their therapists. Treatment satisfaction was measured using the Treatment Outcome items in the Disclosure to Therapist Inventory-III (DTI-III), which indicated that as a whole, respondents in this sample were highly satisfied with their treatment outcomes. In particular, respondents felt that their therapies had been very successful at increasing their levels of self-understanding. The extent of patients' disclosures about their therapy to their partners was measured both as a composite score derived from the means of the DTI-III disclosure topics, and as the score on the individual "global" question "Overall, how self-disclosing have you been about your therapy with your partner?" As previously reported, and consistent with Khurgin-Bott and Farber's 2011 study, patients were found to be moderately disclosing to their partners about their experiences in therapy. They were also found to be highly disclosing in therapy (to their therapists).

When disclosure to partners about therapy was measured using the composite scores, a statistically significant (though modest) positive relationship was found between the extent of self-disclosure to partners about therapy and the quality of the therapeutic alliance (i.e., those patients who disclosed more about their therapy to their partners had better alliances with their therapists). Although the extent of disclosure about therapy to partners was not found to be a significant predictor of treatment satisfaction, there was a trend toward significance when disclosure was measured using the composite (rather than global) scores. Additionally, given the strong positive correlation between the quality of therapeutic alliances and the level of treatment

satisfaction (strength of the therapeutic alliance was, in fact, the strongest predictor of treatment satisfaction), it seems reasonable to assume a positive (if indirect) "chain reaction": higher levels of self-disclosure, both to therapists and to partners about therapy, are associated with better therapeutic alliances, which are in turn associated with better treatment outcomes. In other words, whatever positive influence disclosure about therapy may have on treatment outcome is likely related to the positive association between disclosure about therapy and strong therapeutic alliances.

The association between higher levels of patient self-disclosure (particularly of the intimate variety) and better therapeutic outcomes has been noted in several studies (Farber, 2006; Hill, Gelso, & Mohr, 2000; Saypol & Farber, 2010). Psychotherapy patients who were more open with their therapists, including disclosing about painful subjects, reported better progress in therapy (Mental Health: Does Therapy Help?, 1995). This connection between disclosure and good therapeutic outcomes holds true even when self-disclosure is assessed outside the context of the therapeutic relationship (i.e., when the overall tendency to disclose, rather than the sheer extent of disclosure to one's therapist, is measured). The tendency to disclose "distressing personal information", for example, has been found to be positively correlated with good outcomes in brief psychotherapy, as well as with a greater willingness to seek professional help in the first place and with a greater overall sense of well-being (Kahn & Hessling, 2001). The current findings of better therapeutic relationships in patients who disclosed more to their partners about their therapy are, therefore, both unsurprising and consistent with the reported findings in the scientific literature.

One possible explanation for the consistency of this positive relationship is rooted in the idea of self-disclosure as a fundamental personal skill, vital to the formation and maintenance of meaningful intimate relationships. In other words, the capacity for appropriate self-disclosure (as

opposed to indiscriminate, compulsive, or unreciprocated disclosure outside the context of intimate relationships) can, in itself, be seen as a signifier of good psychological health. High levels of self-disclosure in the context of intimate relationships imply a confident expectation of acceptance, warmth, and responsiveness from one's confidante. The disclosure of meaningful personal information to trusted others also suggests an attitude of prizing interpersonal closeness and intimacy. Not surprisingly, people with secure attachment styles have been found to both disclose more and be more responsive to the disclosures of others than insecurely-attached people (Mikulincer & Nachshon, 1991). Having enjoyed warm and emotionally responsive relationships with their early caregivers, securely-attached individuals have developed good attachment "working models" (positive expectations about the emotional availability and responsiveness of significant others; Bowlby, 1973). These attachment working models lead securely-attached people both to prize interpersonal intimacy and to pursue it via appropriate levels of self-disclosure.

As a group, the participants in this sample were highly self-disclosing, both to their therapists and to their partners about their experiences in therapy. Indeed, this tendency toward openness and disclosure is evident in their voluntary participation in a study of therapy and disclosure, which required providing thoughtful (though anonymous) answers to personal questions about their most intimate relationships. They were also, on average, in satisfying long-term relationships, both with their therapists and with their partners. All of these findings are congruent with an overall picture of healthy psychological functioning, and particularly with positive attachment working models—facilitating a well-developed capacity to engage in appropriate intimate disclosures and to reap the relational benefits of such disclosures.

Extent of disclosure about therapy to partners and relationship satisfaction with partners

Relationship satisfaction was measured using the Revised Dyadic Adjustment Scale (RDAS). Respondents had very high scores on this instrument, meaning that this was a sample of people who not only had "nondistressed" relationships with their partners, but enjoyed high levels of satisfaction in their relationships. The extent of patients' disclosures about their therapy to their partners was measured both as a composite score derived from the means of the DTI-III disclosure topics, and as the score on the individual "global" question "Overall, how self-disclosing have you been about your therapy with your partner?" On both measures, patients were found to be moderately disclosing to their partners about their experiences in therapy. This pronounced tendency to disclose intimate information to spouses and partners (rates of disclosure were not found to vary significantly by marital status) aligns with Jourard's (1971) finding that people are generally more self-disclosing with their spouses than with anyone else in their lives.

Findings indicated that there is a statistically significant, and moderately strong, positive relationship between extent of self-disclosure to partner about therapy, as measured by the global item, and relationship satisfaction. In other words, those patients who disclosed more to their partners about their therapy reported significantly better relationships with their partners. Though this association between extent of disclosure to partners about therapy and relationship satisfaction was no longer significant at the .05 level when the extent of disclosure was measured using the composite disclosure scores (as opposed to the global measure scores), it remained positive and there was still a trend toward significance.

The positive association between extent of disclosure about therapy to partners and greater relationship satisfaction is in line with numerous studies showing a positive relationship

between self-disclosure and satisfaction in marriage and in intimate relationships (Farber & Sohn, 2007; Finkenauer, Engels, Branje, & Meeus, 2004; Hendrick S. S., 1981; Komarovsky, 1964; Rubin, Hill, Peplau, & Dunkel-Schetter, 1980; Sprecher & Hendrick, 2004; Vera & Betz, 1992). The current study focuses on a particular type of self-disclosure in intimate partnerships (disclosure to partners about one's experiences in individual psychotherapy). This type of disclosure is, almost by definition, both deeply personal and highly emotionally laden. Emotional (or "affective") self-disclosure in particular, has been found not merely to positively correlate with relationship satisfaction, but to be the strongest predictor of relationship satisfaction, regardless of gender and regardless of the instrument used to measure the construct of relationship satisfaction (Vera & Betz, 1992). Vera and Betz (1992) found that the level of participants' self-disclosure of emotions to their partners was a better predictor of relationship satisfaction than were their ages, their partners' ages, the length of the relationship, and the level of participants' self-esteem. Another study (Sprecher & Hendrick, 2004) found that certain aspects of self-disclosure were even predictive of couples staying together: when women perceived their partners as more disclosing, the couple was less likely to break up by follow-up.

Limitations of this research

This research was undertaken with the goal of exploring a minimally-investigated field of study within the domain of self-disclosure research: disclosure about individual psychotherapy to intimate partners. In addition to the testing of hypotheses, research questions were asked, and pilot instruments were used to measure two of the variables (including the focal variable, extent of disclosure about therapy to partners). Alpha values were set at .05, and results that were significant at the .07 level were discussed as data trends. These decisions were made in order to generate as much information as possible about this type of disclosure and its potential

correlates. Additional limitations of this research stem from its methodology, including certain characteristics of the sample and of some of the instruments used. These categories of limitations will be discussed below.

Limitations of the sample

The demographic characteristics of participants in this sample mean that the generated findings are representative of, and applicable to, a fairly narrow population. Participants in this study were about 87% white (compared with about 76% of the U.S. population), with an average age of 36 years; three quarters were women. Two thirds of participants made more than $60,000 a year, and over a third (37%) made more than $100,000. They were very highly educated, with 38% holding doctoral or postdoctoral degrees, 37% holding master-level degrees, 16% having bachelor (college) degrees, 4% having associate degrees, and only 2% having high school diplomas as their highest educational attainment. This is in stark contrast with the general population of the US, where only 34% have college degrees and fewer than 8% have Masters degrees or above. In terms of marital status, 65.5% were married, and the remaining 34.5% were in a civil union, domestic partnership, engaged to be married, or in a committed "significant relationship". About 86% of respondents were living with their current partners. Most respondents were in long-term relationships with their current partners (average length was 8.3 years), and also in long-term psychotherapy (average length of current treatment was 3.7 years). Moreover, 75% had extensive previous experience in therapy, with the average duration of their total time in treatment (including their current therapy) almost ten years.

The high average socioeconomic status of these participants, along with their high rates of marriage and of long-term significant relationships, sets them apart from vast swaths of the general population (as of the 2015 census estimate, only about 48% of the U.S. population were

married), and may be indicative of greater stability and perhaps of better overall psychological functioning (at least in terms of lifestyle). The fact that they were in such long-term psychotherapeutic treatments (and moreover, that 75% of them were in analytically or dynamically-oriented treatments) indicates both a choice and a preference for long relationships with their therapists, which necessarily entail a degree of comfort with intimacy. It indicates as well the capacity to pay for this kind of treatment, which for many (especially outside of large metropolitan areas) remains both an unaffordable luxury and an undesirable or even stigmatized endeavor.

In addition to the unique demographic characteristics of the participants, the size of the sample is also a factor limiting the generalizability of the results. Future research into the nature of disclosure about therapy and its associations with relationship satisfaction (both marital and therapeutic) should focus on larger and more diverse samples. This will allow for greater confidence in the ability of the results to reflect the nature of disclosure about therapy in the context of these intimate relationships.

Finally, the fact that this was an all-volunteer sample likely sets it apart from non-volunteer groups. Martin (1996) found that volunteers tend to be generally more cooperative and more eager to help achieve the objectives of the research. They may also have a special interest in the areas of investigation: in this case, therapy, marriage, and intimacy in general. Since this study is focused on self-disclosure, the volunteer participants' greater-than-average tendency to self-disclose necessarily affects the results in the direction of greater openness. These built-in biases are characteristic of all social science research that depends upon volunteer participants and relies on self-report measures.

Limitations of the instrument

While efforts were made to limit the total length of the survey, and thus lower the demands of participation for the volunteers, the Disclosure About Therapy Inventory – Revised remains a lengthy measure that often requires deep and complex thoughts about topics that are naturally highly personal and may be emotionally provoking. Estimated completion times, based on the average completion times of participants who piloted this version of the DATI, were 15-20 minutes for the entire packet. But the actual average completion time turned out to be longer (over 21 minutes), with several participants failing to complete the survey in a single sitting and others taking over an hour to finish answering all the questions. Out of the 105 people who began filling out the survey, 84 completed it – a response rate of 80%. The sheer length and depth of this instrument may have discouraged participation and completion by less cooperative and conscientious respondents. As a consequence, the sample may skew even further towards the type of introspective, psychologically-inclined individuals likely to volunteer for a study on self-disclosure in the first place.

In addition to its length and the emotional demands it places upon respondents, the DATI-R is a pilot measure – though it benefits from previous findings using an older version investigating similar topics (the DATI). The creation and use of this measure were necessitated by the lack of any validated measures designed to investigate disclosure about therapy to spouses or significant others (or, in fact, to anyone). Being a self-report measure, it suffers from the shortcomings frequently attributed to all self-report measures: primarily, that they are inferior to direct behavioral observations and entirely dependent upon the honesty of participants. However, when it comes to research about self-disclosure, several meta-analyses have found no significant differences between behavioral measures (such as live or videotaped observations of self-

disclosure in married couples or in psychotherapy) and self-report measures (see Dindia & Allen, 1992, for a survey of self-disclosure studies).

Additional methodological limitations

The methodology (measurement and correlational analyses of variables, lack of longitudinal follow-up) of this study precluded the investigation of several interesting questions regarding disclosure about therapy to partners. Based on the current findings, for example, it is impossible to know whether patterns of disclosure about therapy wax and wane during the course of patients' individual psychotherapeutic treatments. There is only a static picture of disclosure at a particular point (generally, years into the treatment). A longitudinal design, following patients from the early sessions with their therapists and measuring the extent of their disclosures to their partners about their experiences in therapy over time, could reveal such patterns.

Additionally, while the current methodology was useful in gathering data about particular topics of disclosure to partners about therapy, as well as about patients' overall sense of their openness with their partners regarding their experiences in therapy, other important aspects of disclosure were not examined. Most significantly, neither the emotional tone of patients' disclosures nor their motivations for disclosing were investigated. This leaves open the possibility that some disclosures about therapy to partners may fall under the category of "toxic disclosures": i.e., ones motivated not by a desire for intimacy or a genuine attempt to be authentically known, but rather by a desire to manipulate, hurt, or otherwise attack one's partner. It is possible that some patients may, either purposely or inadvertently, "twist" and distort their accounts of their sessions for various reasons (for example, they may use their therapists' purported reactions as examples of "expert" support for their own positions and perspectives in

disagreements with their partners). Less nefariously, there are types of disclosure about therapy (besides specific therapy topics) that could not be captured by the instruments used in this study. Examples include patients' reporting general therapy-related impressions to their partners—such as a sense that a session was productive or uneventful, feelings of resentment about a therapist's absence or about the financial cost of treatment, etc.

Finally, factors affecting disclosure about therapy may well include others besides the ones examined in the current study (gender, marital status, length of therapy, and length of relationship). For example, patients' diagnoses and motivations for seeking (or remaining in) therapy may be significantly associated with patterns of disclosure about therapy to their partners. Future studies that examine these factors and their relationship with both extent and type of disclosure about therapy may reveal interesting patterns.

Implications of findings and directions for future research

The significant findings from the present study, especially in regards to the positive correlates of disclosure about therapy to spouses and significant others, have important clinical implications. Several specific therapeutic interventions may be warranted, given the better therapeutic attachments and higher levels of relationship satisfaction seen among patients who disclose more to their significant others about their experiences in therapy. In particular, therapists may find it beneficial to broach the subject of disclosure about therapy to partners directly with their married (or coupled) patients. Doing so may be especially helpful to the many patients who struggle to translate their therapeutic progress to other areas of their lives – especially, perhaps, to their relationships with their partners. Inquiring more explicitly or frequently about patients' extra-therapeutic disclosures might lead to fresh avenues of

therapeutic dialogue, including the means to put into practice specific clinical insights. Thus, encouraging greater openness about the therapy in the context of patients' most intimate relationships may assist patients who struggle to connect their therapy with their outside worlds. This may be one method of combatting the frequently lamented isolation of the therapeutic setting.

This is an area where future research could be both interesting and fruitful: the investigation of direct clinical interventions by therapists aimed at learning about their patients' patterns of disclosure about therapy, possibly encouraging relevant discussions of their therapeutic insights and struggles in therapy with their significant others, and generally adding and incorporating these types of discussions and disclosures into the therapeutic endeavor. It would be interesting to examine whether such clinical interventions result in higher overall levels of disclosures about therapy to partners, and if so, which particular topics are discussed more frequently or more deeply. If disclosure about therapy to partners is indeed increased by direct therapeutic inquiry or encouragement, future studies should focus on examining whether this increase in disclosure translates into enhancements in patients' relationship satisfaction with their partners and into better therapeutic alliances with their therapists. Even when broaching the topic of disclosure about therapy with their patients is not deemed appropriate or timely, therapists should gain greater awareness of the prevalence of these types of disclosures by their patients and their potential inclusion as future "grist for the therapeutic mill". More broadly, the findings of the present study are in line with a view of therapy as a system of communication, one that transcends the therapeutic dyad.

Additionally, given the current sample's high scores on all of the administered measures (i.e., given that participants in the current study were both highly disclosing across settings and

highly satisfied with both relationships) it remains to be seen whether disclosure about therapy to partners is associated with better outcomes in patients who are not naturally high disclosers. In other words, future research could examine the possibility that higher levels of disclosure about therapy to partners are a function of an overall tendency to be highly disclosing, and that the positive correlates of this type of disclosure seen in the current study may be explained (at least in part) by high disclosers' natural "penchant" for interpersonal intimacy.

However, although the tendency to disclose clearly varies greatly among individuals, there are some interesting preliminary indications that an individual's characterological tendency to disclose plays less of a role in the amount of disclosure between married partners than do factors unique to their relationship; likewise, relationship-specific disclosure, rather than characterological or dispositional disclosure, seems more important to relationship satisfaction in married couples (Finkenauer, Engels, Branje & Meeus (2004). Finkenauer et al. (2004) found that "relationship effects" were found to account for 41% of the variance in marital disclosure, while "actor effects" (a married person's overall tendency to disclose across settings) accounted for 37% of the variance. Moreover, a family member's "dispositional disclosure" was not positively correlated (was, in fact, slightly negatively related) to their partner's relationship satisfaction; in contrast, the correlation between a married person's relationship satisfaction and his or her partner's disclosure *in that relationship* was significant, "indicating that the more an individual family member in a marital or sibling relationship discloses, the more the relationship partner is satisfied with the relationship" (Finkenauer et al., 2004, p. 205).

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