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DEPTH OF SELF-DISCLOSURE AS A FUNCTION OF ASSURED CONFIDENTIALITY AND VIDEO RECORDING

BY

SANFORD L. GRAVES
B.A., Columbia Union College, 1951

THESIS
Submitted in partial fulfillment of the requirements for the Master of Science degree in Clinical Psychology in the Graduate Studies Program of the College of Arts and Sciences University of Central Florida
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1982
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INTRODUCTION

Probably the most nettlesome problem facing the psychologist today is implementation of his inherent responsibility to protect the private utterances of his clients. The efficacy of the therapeutic encounter resides in the degree of disclosure of private and personal information and feelings the client will share. Without this revelation by the client, strategy and treatment cannot be formulated, and the therapist is bereft of the insight he must have for a successful therapeutic endeavor. Jourard (1959) has specified self-disclosure as the central process in personality change. Self-disclosure, in turn, is heavily dependent on the client's faith and trust in the therapist. Reynolds (1976), among others, points out that psychotherapy, by its very nature, is worthless unless the patient feels assured from the outset that whatever he may say will be forever kept confidential.

Clients generally assume that their disclosures will be kept in confidence, and psychologists may make such assurances. While protection of clients' communications is the highest of ethical standards, confidentiality, in reality, has numerous complications. Legal and ethical complications frustrate promises of absolute confidentiality. The therapist is placed in a double-bind as to where his
loyalties lie if he is working for others (institutions, etc). Clients have expectations and assumptions that may be unrealistic, and practitioners are sometimes only dimly aware of clients' ethical and legal rights. Even if practitioners are aware, there are differing opinions on what is the proper stance to assume. Seigle (1979) advocates a position of unequivocal, absolute confidentiality at all times. Others such as Szasz (1967) contend that the college psychiatrist, in his role as a double agent for both patient and institution, is so willing to break confidences whenever they consider it in the best interest of the patient, the institution, or community, that "any reference to 'confidentiality' is absurd."

These and other thorny issues beset the issue of confidentiality, leaving the client in a quandary and perhaps reluctant to share his feelings, emotions, thoughts, actions, and fears with the therapist. The counselor is then, in turn, crippled and restricted in the treatment alternatives available, while the therapeutic effort is diminished or negated altogether, and to the clients detriment. Thus, the role of inhibiting factors in confidentiality, is an important area for further research.

Disclosure

Traux and Carkhuff (1967) have, for heuristic reasons, specified "interpersonal" or "self-exploration" as a necessary antecedent for constructive personality change.
Clinical observations suggest that in successful psychotherapy, the client is indeed involved in a process of self-disclosure and self-exploration - a process of coming to verbalize and to know one's beliefs, values, motives, perceptions of others, relationships, fears, and life choices. The role of the therapist, in both traditional psychotherapy and in other more contemporary counseling approaches, has been based upon attempts to facilitate this process. Brodsky (1972) points out that the world, as the client experiences it, is a key element of evaluation.

Jourard observes that the amount of personal information that one person is willing to disclose to another appears to be an index of the closeness of the relationship and of the affection, love, or trust that prevails between two people. In more general terms, self-disclosure and cathexis for the other person may be said to be correlated. Evidence to support this proposition stems from both clinical observations and systematic research. Psychotherapists have long noted that when a patient feels warmth, trust, and confidence in his therapist, he discloses himself more freely and fully than when he perceives the therapist as hostile, punitive, or when he dislikes the therapist. Conversely, indifference or antipathy between two persons may be expected to produce the consequences of low disclosure to one another and little knowledge about one another as persons (Jourard, 1959).
The function of knowing oneself can mean power, and therefore freedom, and is one of the raisons d'etre of the therapeutic work. Those engaged in psychotherapy, both clients and therapists, are persons engaged in attempts at self-understanding. We must know about people in order to empathize with them. There is no substitute for the real flesh and blood experience of sharing intimacy with another human being. Sullivan (1953) has described the critically important function of consensual validation as a self-stabilizing phenomena in the psychotherapeutic process. As early as the 1940's, a study by Steele (1948) reported data showing that more successful patients increasingly explore their problems as therapy proceeds, while less successful patients explore their problems less as therapy progresses. Similar supporting data were reported by Blau (1953), Seeman (1949), Wolfson (1949).

The sanctity of confidentiality for the psychotherapeutic endeavor is crucial because of the inherently personal nature of its communications. These personal disclosures plumb the depths of the patient's innermost thoughts, fantasies, and feelings (Karusu, 1980). Braaten (1958), in studying individual therapy, found that when he compared early and later interviews from successful and unsuccessful cases, the more successful cases showed a greater increase in the amount of self-references,
particularly self-disclosures revealing the private self. Braaten used the process scales devised by Walker, Rablen, and Rogers (1960) to assess self-disclosure.

The same findings appear valid when applied to therapy conducted in a group mode. Yalom (1975) suggests that self-disclosure is a prerequisite for the formation of meaningful interpersonal relations in a dyadic or group situation. If self-acceptance must be preceded by acceptance by others, then the individual, if he is to accept himself, must gradually permit others to know him as he really is. Peres (1947), in a study of group psychotherapy, found that successful and unsuccessful group psychotherapy differed in that successful patients in group therapy made significantly more personal references over the course of therapy when compared to unsuccessful patients. In fact, over all, the benefited patients made almost twice as many personal references as did the non-benefited patients. Truax and Carkhuff (1965) also showed that patients' success in group therapy correlated with their transparency during the course of the group. Lieberman, Yalom, and Miles (1972) found that in encounter groups, individuals who had negative outcomes revealed less of themselves than the other participants.

Studies by Drag (1969) indicate that the two-person discussion group self-disclosed more than eight-person groups, but not more than four-person groups. Group-size interaction effects have shown that people may disclose
more or less readily in groups larger than dyads, depending on the composition of the audience (Chelune, 1976) and the mode of communication (Spinner, 1978), each seemingly dependent upon the client's perception of the dilution he might expect for protection of his personal utterances. Clearly, whether on a one-on-one relationship or varied sized group encounters, disclosure is essential to the therapeutic process with confidentiality as the linchpin of disclosure.

Protection of Clients' Communications

Those who seek counseling have problems touching on intimate personal experiences, and they turn to the professional so that they can discuss and analyze their anxiety, guilt, apprehension, fears, etc. without fear of public disclosure. Because these highly personal and private revelations may bring embarrassment, hurt, and ridicule, they do not want them to be revealed openly and usually assume that others will not have access to their disclosures without their consent. When someone enters into a counseling relationship under this assumption, a confidential relationship exists and the professional person is obligated to protect the best interests of the client by maintaining their confidentiality (Shertzer, 1980).

Three generally recognized elements under the rubric of "confidentiality," or protection of private utterances,
are: (1) privacy, (2) privileged communications, and (3) confidentiality. An understanding of these elements by the therapist is imperative for two vital reasons. First, these issues affect virtually all psychologists in one way or another, and secondly, there appears to be a general lack of understanding for these concepts in both principal and application.

Privacy recognizes the freedom of the individual to pick and choose for himself the time, circumstances, and particularly the extent to which their beliefs, opinions, and behaviors are to be shared with, or withheld, from others (Reubhausen & Brim, 1966). Privileged communication, a legal term, refers to the client's right which exists, if at all, by statute, not to have his confidences revealed publicly from the witness stand during legal proceedings without his permission. This privilege is generally narrower, in scope, than confidentiality. Confidentiality relates to matters of professional ethics rather than judicial proceedings. That is, confidentiality is an explicit promise, protecting the client from unwarranted disclosure, of any sort, by the professional, except under conditions agreed to by the source.

Legal Privilege

The concept of "privacy" dates back to the Code of Hammurabi and concern about the integrity of the personal body. It carried with it the duty to protect the indi-
individual's right to maintain control over his body and to protect it from needless exposure. This was promulgated, centuries later, in this country when Judge Cardoza stated that "every human being of adult heart and sound mind has the right to determine what shall be done with his body" (Norton, 1970). The concept of privacy evolved into more than protection of the body with the "right to privacy" based on the idea that details of a man's personal life are private and should be protected from unwarranted intrusion (Shah, 1969). It gives to the individual the right to decide for himself what matter he is willing or needs to reveal. One aspect of privacy is the right of the individual to feel that certain relationships, such as with lawyer, physician, or priest, are private and that the communications within that relationship are protected.

Fried (1968) goes further and argues that the law should protect privacy as an intrinsic human value essential to the functioning of our society. This legal philosopher maintains that privacy is essential for furthering fundamental relations involving respect, love, friendship, and trust. These relationships require a context of privacy, or the possibility of privacy, for their existence. Fried clarifies and makes explicit his notions regarding privacy when he notes,

as a first approximation, privacy seems to be related to secrecy, to limiting the knowledge of others about oneself. This notion must be refined. It is not true, for instance, that
the less that is known about us, the more privacy we have. Privacy is not simply an absence of information about us in the minds of others, rather it is the control we have over information about ourselves. The person who enjoys privacy is able to grant or deny access to others. (p. 412)

Burgess (1978) reminds that some authors have brought up the possible conflict between the citizen's right to privacy and society's right to proper administration of justice (Arnold, 1970; Dubey, 1974; McDermott, 1972; Schmidt, 1962; Shah, 1969). Hollender (cited in Dubey, 1974) goes so far as to divide psychotherapy into two categories, patient-oriented and society-oriented. In the latter case, the therapist is more or less the agent of society or agencies other than the patient. The therapist does not necessarily promise confidence in such a setting, but may instead deliberately use the client's information to exert power in influencing the patient's social milieu.

Privileged Communication

Originally, in English common law, from which our American law has evolved, a gentleman could not be compelled to testify against his will in a court of law. Early confrontation with witnesses who refused to testify on the grounds that their information was confidential gave rise to the sanctity of the attorney-client relationship. It is important to note that this concept resulted from judicial precedence and not from legislation. Similarly, the priest-penitent relationship of confidentiality
developed. The rationale in both instances is that confidentiality promotes full disclosure, better enabling the professional to provide needed help.

A vital facet is that privileged communication is a right of the client alone. Boyd (1971) points out that privilege itself is basically an extension of the Fifth Amendment privilege and hence is not the professional's, but the client's. Since it is the client's, he may waive it at any time. As Slovenko states (1966), "The psychiatrist, therefore, can be compelled to testify when his patient or ex-patient so desires. This applies even though the psychiatrist feels that disclosure will be more harmful than beneficial" (p. 153). This concept is considered by some to be on a collision course with professional ethics of the psychologist.

Not only is privileged communication the right of the client alone, but no vested interest accrues to the practitioner. Further, the privilege is extended, not to acknowledge any respect for confidentiality or information, but to secure the efficient administration of justice. For this reason, the courts have been extremely reluctant to extend the privilege to other professional fields. With the passage of time, other helping professions (medicine, mental health, social work, etc.) have evolved which have like rationale for requesting this privilege, if they are to adequately serve their clients.
Fisher (1964) classified privilege into three categories: (1) those designed primarily to protect the individual, (2) privilege designed to protect the integrity of the system of government, and (3) privilege designed to encourage freedom from fear of disclosure in persons entering into relationships whose functions are deemed important to society and which depend for their effectiveness on free mutual trust by the participating persons.

John H. Wigmore, dean of legal evidential proof, Northwestern University, sets forth four conditions to be met for granting privileged communication:

1. The communications must arise in confidence that they will not be disclosed.

2. Confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.

3. The relation must be one that in the opinion of the community ought to be sedulously fostered.

4. The injury that could inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of the litigation. (Wigmore, 1961)

Although the appropriateness of the physician-patient privilege has been seriously questioned (e.g., Baldwin, 1962; Chafee, 1943) it would seem apparent that Wigmore's criteria eminently qualify the psychotherapeutic relationship. Goldstein and Katz (1962) stated that "treatment of the mentally ill is too important, and the assurance of
confidentiality too central to it, to risk jeopardizing the whole because of the relevance of some patient's statement to some legal proceedings" (p. 735).

The law, even in those states that have passed specific legislative statutes giving legal testimony privilege, grants no absolute privilege, only varying degrees of protection at the discretion of the trial judge. For example, Humphry v. Norden (1974), a social worker covered by the right of privileged communication in New York State was nevertheless required to testify in a paternity suit because the court ruled that "disclosure of evidence related to a correct determination of paternity was of greater importance than any injury which might inure to relationships between social worker and his client if such admission was disclosed." The Watergate incident has also demonstrated that there is no such thing as total confidentiality under the law, not even under executive privilege. Other complications beset privilege within the group therapy situation. In almost no jurisdiction in the United States may a psychotherapist, with substantial certainty, assure his or her group therapy clients that their communications are privileged. Even in jurisdictions recognizing a psychotherapist-patient privilege, there is great uncertainty as to whether the privilege covers group therapy.

As of May 1975, thirty-eight states plus the District of Columbia had legal privilege communications protection
(APA 1975, pp. 34-36, cited in Burgess, 1978). Legal commentators have also noted the need for privileged communications covering group therapy situations (Braman, 1963; Cross, 1970). The legal problems related to counseling are exceedingly complex and unresolved, varying as they do from state to state. Slovenko (1966) has even become quite outspoken in expressing his opinion that privileged communication statutes are so full of loopholes that they cannot be depended upon to protect confidentiality. Legal proceedings and precedence in the immediate future may help to clarify the professional's rights and obligations, but clarity of position for the helping professions is a long-term and elusive goal.

Confidentiality

In contrast to privilege, confidentiality relates to the ethics of the professional. Its purpose is the protection of the client from unauthorized disclosure by the professional who is serving him. Maintaining confidentiality of clients' private utterances, given with conscious, or unconscious, expectation of protection, is one of the most complex and pervasive problems confronting the profession.

Each profession spells out their own ethical standards designed to prevent unauthorized disclosure of clients' personal utterances. Clients of psychologists derive protection from the Ethical Standards of the American Psychological Association, which requires psychologists to
maintain all professional confidences whether or not statutory privilege exists. Dubey (1974) maintains that when the therapist is asked, "Doctor, is what I tell you confidential?" he must be able to answer, "What you tell me I will keep confidential, even if you decide you don't want me to." Siegal (1979) takes the "absolute position that psychologists may not break the confidentiality of patient, or client, under any circumstances, supporting the concept of complete unequivocal acceptance of trust as being fundamental to this process we call psychotherapy." A less rigid stance is suggested by George Stricker of Adelphi University (from Siegal, 1976): "Confidential information may not be disclosed without the informed and specific authorization of the client or his duly authorized representative, except if required by statute, a court of competent jurisdiction, or other legally compelling authority." Stricker thus indicates agreement with the concept of absolute confidentiality within the boundaries of the law, stating that "it should not be unethical to obey the law."

Since the earliest days and the concept of the Hippocratic oath, there has been concern over protection of patient-client relationship. The Hippocratic oath contains the following pledge: "Whatever, in connection with my profession, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge as reckoning that all should be kept
secret."

For those who have accepted this oath as a guide to their professional conduct, the pledge states a clear and unmistakable "duty of silence." And even though many psychologists do not feel obligated by the oath, most will agree that the duty of silence represents a reasonable standard for ethical responsibility.

The importance of the patient's perception that the relationship with his physician is confidential was emphasized centuries ago by Chaucer, who said "Faith in the counselor is one of the greatest aids to recovery. A doctor should be careful never to betray the secrets of his patients for if a man knows that other men's secrets are well kept, he will be readier to trust him with his own."

Sincere communication is essential, and to achieve that confidentiality is imperative.

Counseling is built on personal trust and professionally based confidence. A patient or client needs to feel that he can talk freely about his problems, but in order to do this, he must feel that what he reveals will be kept in confidence. The sanctity of confidentiality for the therapeutic endeavor is crucial because of the inherently personal nature of its communications, which plumb the depth of the client's innermost thoughts, fantasies, and feelings. Without this mutuality of confidence, the therapeutic process will falter and disintegrate, perhaps to the point where maintaining it is a futile gesture. The client must
not be betrayed (Everstine et al., 1980; Karasu, 1980; Pardue, 1970; Plaut, 1974; Popiel, 1980; Slovenko, 1966).

What is disclosed within the boundaries of the professional relationship may be, and often is, traumatic, but insofar as the disclosure is essential to service, the professional has a right and a need to encourage it. Similarly, the client or patient has an obligation to be frank in his responses. Such interchange is possible only when there is mutual trust. This is the indispensable quality that lets both parties know that confidentiality will be preserved unless their own, or society's well-being is at stake. It is supported not only by personal commitment, but in the case of the professional, the Code of Ethics or "private systems of law" that are built into the professional structure by its own members (McCormick, 1978).

The efficacy of the counseling relationship exists on the foundation of personal trust in the therapist and the free exchange of information elicited by the confidential relationship. The concept of confidentiality of the client-therapist communication is at the core of the psychotherapeutic relationship. Confidentiality is an ethic that protects the client from unauthorized disclosures of information about the client by the therapist without the client's permission, except in unusual circumstances. Thus, the therapist-client communications are confidential unless
the therapist "unilaterally" in the client's best interest decides that a condition of significant danger to the patient, or others, exists (Jagim, Wittman & Noll, 1978).

Reynolds (1976) feels that psychotherapy by its very nature is worthless unless the patient feels assured from the outset that whatever he may say will be forever kept confidential. Without a promise of secrecy from the therapist, buttressed by legal privilege, a patient would not be prone to reveal personal data which he fears might evoke social disapproval. She further relates that stated convictions of Judge Edgerton of the Court of Appeals of the District of Columbia, who has pointed out that a patient may respond to the physician's treatment for many physical illnesses even though he may not trust the doctor or have confidence in him, but for the treatment of mental problems, a relationship of trust and confidence is essential. Confidentiality is basic not only to the therapeutic relationship with a particular patient but also to the image of psychotherapists in society. Unless people feel they can rely on the professional to keep what they say in confidence, many who need psychotherapy will not seek it. Dubey (1974) says that "if the therapist cannot maintain privilege, the inherent (social) power of his medical position and judgment can render him so muscle bound as to be therapeutically crippled while conducting patient-centered therapy. The treatment situation is bound to be destroyed if confi-
dentiality cannot be maintained." Hollender (1965) describes his contractually oriented "patient centered" psychotherapy as dependent upon the establishment of a confidential professional relationship.

As in the case of the one-on-one psychotherapeutic situation, group therapists have pointed to the importance of confidentiality since threat of disclosure may prevent openness in therapy (Meyer & Smith, 1977). Greene and Crowder (1972) have stated that group therapy can be effective with adolescents but that confidentiality is essential to this process.

Vorrath and Bredtro (1974) have evolved a specific group therapy for adolescents. They assert its efficacy and insist that the group must be convinced of the confidentiality of their meetings and that the members must learn they do not have the right to reveal information outside of the group. Trachtman (1972) has spoken of a similar need in the school setting.

Jagim, Wittman, and Noll (1978), in a studied survey of mental health professionals in North Dakota, found that the responding mental health professionals were unified in their agreement of an ethical obligation to keep the therapist-client information confidential. Confidentiality was seen as an important component in maintaining a positive therapeutic relationship. They also had consensus in agreement that confidentiality was an important and integral
aspect of the therapeutic encounter. Confidentiality was seen as essential in maintaining a positive therapeutic relationship by 98% of the professionals (56% very strongly agree, 25% strongly agree, 17% agree). In addition to the necessity of confidentiality for the therapeutic relationship, 98% of the mental health professionals agreed that there was a professional-ethical obligation to keep information concerning a client confidential (82% very strongly agree, 14% strongly agree, 26% agree).

In a survey (Bangs, 1971) about their confidential relationships with attorneys, laymen responded that they would be less likely to reveal information if the privilege did not exist. One might generalize this finding to estimate that counselees, in general, would be more inclined to put complete trust in counselors who had this privilege. Dubey (1974) suggests that if testimony were confined only to the medical issues of diagnosis and treatment, there would be no problem. But if testimony can be forced concerning content of communications during psychotherapy or psychoanalysis, a psychiatrist cannot assure patients of confidentiality, and the proper setting for psychiatric work cannot prevail. Slovenko (cited by Haines, 1962) asserts there should be complete immunity from cross-examination for the therapist. Otherwise, there can be no effective therapeutic examination of the defendant, unless the psychiatrist, in one way or another, deludes the
examinee into believing that there will be no confidentiality. The examiner cannot take the absurd position of warning the accused not to give him information in confidence and then expect to receive information. Likewise, a judically-forced rupture of confidentiality would be counterproductive for the court itself. As is pointed out in Morgan vs. State, Florida Appellate Court, June 13, 1962, "to strip a pre-sentence report of its confidentiality would be to divest it also of its importance and value to the sentencing judge because there might be lacking the frankness and completeness of disclosure made in confidence."

Responsibility of Counselor

Shertzer (1980) pointedly reminds us that confidentiality brings into sharp focus the issues of the responsibilities of counselors to: (1) the profession, (2) the institutions that employ them, and (3) most of all, the individuals who seek their help. From these sometimes conflicting responsibilities spring the conflicts and dilemmas often confronted by the therapist.

Responsibility to Profession

Responsibility to the profession is pointed up in various codes of ethics that have evolved. The latest Code of Ethics of the American Psychological Association (1979), Principle 5, Confidentiality, states that "safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice,
or investigation, is a primary obligation of the psychologist." The 1963 Code of Ethics provided that "the psychologist who asks that an individual reveal personal information does so only after making certain that the person is fully aware of the purpose of the interview and the ways in which the information may be used."

Burgess (1978) quotes the American Personnel and Guidance Association which also clearly supports the practice of maintaining confidentiality. Section B2 and B5 of the APGA's Ethical Standards stipulates:

The counseling relationship and information resulting therefrom must be kept confidential, consistent with the obligation of the member as a professional person. Records of the counseling relationship including interview notes, test data, correspondence, tape recordings, and other documents are to be considered professional information for use in counseling and they are not part of the public or official records of the institution or agency in which the counselor is employed. (APGA, 1974, p. 491)

The National Education Association Code of Ethics (1975-1976) also emphasizes professional responsibility in the counseling situation to honor and protect confidences. Principle 1, "Commitment to the Student," reads in part, that the educator "shall not disclose information about students, obtained in the course of professional service, unless disclosure serves a compelling professional purpose or is required by law" (NEA, 1975-1976, p. 235). Likewise, the National Association of School Psychologists (1967) has established guidelines for professional relationships in
regards to confidentiality. Principle llb of its Ethical Code emphasizes the school psychologist's responsibility to explain to students the uses to be made of information obtained and any obligation the psychologist has for reporting specific information. Principle Vd points out the psychologist's responsibility to "safeguard the personal and confidential interests of those concerned" (NASP, cited in Burgess, 1978, p. 103).

Another professional organization which has attempted to specify in broad terms a provision for guarding the confidential communications of clients in its Code of Ethics is the National Association of Social Workers (1967). The code stipulates "I respect the privacy of the people I serve," and "I use in a responsible manner information gained in professional relationships." Similarly, the American Psychiatric Association, the American Hospital Association, and the Group for the Advancement of Psychiatry, have been actively studying the issues of confidentiality and its maintenance (Reynolds, 1976).

Responsibility to Employer/Institution

The psychologist's responsibility to the institution that has employed him vis-a-vis his responsibility to the client seen in the institutional environment is particularly troublesome. Ladd (1971), quoting from the American Personnel and Guidance Association Ethical Standards of 1961, suggests that:
we have been unwilling to consider that the counselor's obligation to respect the integrity and promote the welfare of the counselees or client with whom he is working is in potential conflict with his responsibility to the institution within which he serves; and his responsibility to break confidences to the extent necessary for heading off serious danger.

To discharge either of the latter responsibilities may on occasion call for action that would injure the client.

Everstine (1980) notes the difficulty found in the impersonal situation where, despite himself, the therapist becomes the agent not only of the patient but also of the insurance company, the corporation, the mental health clinic, the university, or whatever institution employs him. When he is retained by one entity to provide service to a third person, he has a split in commitment.

Popiel (1980) states that the major threats to a counselee's civil liberty are most likely to arise when a counselor works both for his client and for an organization--any organization. First, the counselor's loyalty is divided. He may become interested in protecting and enhancing the organization, its staff, resources and reputation, and may allow this interest to interfere with his dedication to serving his client. Second, organizations are composed of people with different roles and responsibilities, hence somewhat different concerns and views. Other persons within the organization may pressure the counselor to do things differently from the way he would do them if he were entirely free to practice in accord with his
professional beliefs. Powledge (1977) states that psychiatrists and psychologists who work in public or private mental institutions, those on the payrolls of public school and private corporations, and prison psychiatrists, are all clearly agents for those who pay their wages. Ladd (1971) objects to counselors being expected to help clients only insofar as it can be accomplished in ways that also contribute to the effective operation and good reputation of the institution (school). Rarely, he declares, is the typical counselor allowed to spend much time giving help in ways that have no bearing on the work of the organization that might hurt it or might make the administration's work more difficult. In court-ordered referrals, Popiel (1980) observes that crises of confidentiality are endemic in efforts of the mental health community to serve a clientele generated by the judiciary and allied agencies. By encouraging the judiciary and allied agencies to rely on them for therapeutic alternatives, the mental health professions have created circumstances that undermine the therapeutic relationship itself. The therapeutic relationship cannot full serve both client and court. The therapist's dilemma is not simply a matter to be confronted when a report is rendered to the referring agency. The client knows, for example, from the inception of the relationship that the therapist's reports in child custody cases must be favorable or the client's children will not be returned.
This knowledge is a powerful incentive to deception. Either purposefully or unconsciously, the client may withhold the worst and emphasize the best. The attempt to deceive may taint the entire relationship. Added to the usual inhibitions, it may make a therapeutic relationship impossible.

The Ethical Standards of the American Personnel and Guidance Association (cited in Burgess, 1978) stress the counselor's responsibility to the client. "The members primary obligation is to respect the integrity and promote the welfare of the counselee(s) whether the counselee(s) is (are) assisted individually or in a group relationship." It is further stated that the relationship and information resulting from it is to be kept confidential. The general section, however, maintains that "the member has a responsibility both to the individual who is served and to the institution within which the service is performed." The acceptance of employment (in an institution) implies that the member is in substantial agreement with the general policies and principles of the institution. Such double binds tax to the breaking point a therapist's loyalties, sense of responsibility, and Solomonic wisdom.

Rights of the Client

Clients accrue rights by virtue of their individual integrity of personhood. Perhaps more importantly for psychologists and psychotherapy, they accrue certain rights
by virtue of submitting themselves to the "authority" of the therapist. Thus, the expected right to protection of utterances, made in confidence, is perhaps paramount in that all other rights impact on this one crucial issue. The fact that effective counseling is built upon assumptions of confidentiality between client and therapist does not, however, mean that there are no limits involved.

The therapist's right, even duty, on occasion, to consult with other professionally competent persons about his client, the duty to disclose threats to potential victims, and lack of judicial statutory support to confidentiality, are but a few examples. Whatever the case, the counselor has ethical responsibility to explain his position to his client along with other limitations to the client's personal privacy that may exist.

Bersoff (1976) observes that the emphasis on the clinician's duty to disclose threats to potential victims has obscured the concomitant duty of clinicians to disclose to the client the limits of confidentiality. Pardue (1970) suggests that betrayal of trust can be avoided, and confidence and trust engendered instead, if at the outset of the counseling relationship, all prevailing limits are made clear, understood, and accepted. To do less could impact adversely on therapeutic credibility with a concomitant loss of confidence, not only in expected protection of
confidentiality, but more tangibly, in amount and depth of disclosure needed for therapeutic progress.

It is the opinion of Ackley (1974) that: (1) the services of a psychologist are rendered to a client and belong to the client, (2) the client is the person who has come to the psychologist for professional service whether he has come on his own initiative or has been referred by another, (3) the parent of a minor who is a client has the rights of the client, and in some cases both the minor client and his parents have those rights, (4) the rights of the client are not removed or diluted by the fact that the cost of the services is being paid by someone else, (5) the rights of the client are not removed or diluted by the fact that the psychologist is an employee of an institution, and (6) the client retains the right to determine the information the psychologist may pass on to other individuals, groups, or agencies.

Pardue (1970) considers that confidentiality is a matter of privacy and an individual right which belongs to the client himself. By explaining to the client the prevailing limits of confidentiality in the counselor-client relationship, the counselor demonstrates his belief in this personal right. Bersoff (1976) says that it is the professional's own codes of ethics that warn of the consequences of violating the moral and legal standards of the community. Developing legal requirements demand complex
decision making and unbalance between client and public interests. It is evident that there are ever-decreasing guarantees to client-clinician privacy and that the therapeutic relationship is not immune from the scrutiny of society. Such limits must clearly be conveyed to the prospective client because failure to do so can result in both loss of liberty and privacy to the client as well as loss to the clinician of reputation and money damages to unwarned victims. Bersoff (1976) also notes that to fail to disclose limits is to hold oneself open to liability. In fact, the failure to disclose the limits of confidentiality in the face of a concomitant duty to disclose threat to third parties may be to entrap the client. Clients, believing that the therapeutic relationship is inviolate, may lay bare heretofore unrevealed secrets, including the most violent urges or impulses.

While trust and confidence of client may be engendered by full explanation of possible limits to confidentiality, it seems assured that failure to advise the client and to risk subsequent revelation to client of the potential to his hurt, whether or not actualized, can only damage irreparably the confidence between patient and therapist so vital to the therapeutic endeavor. The counselor must be aware of his client's rights and further must insure his client's awareness of any limiting factors. The therapist must be aware that: (1) the school, agency or
institutions may require certain information, (2) the therapist's own professional ethics may require notification and relay of certain information to authorities, (3) statutes may require therapist forward certain information to authorities, (4) parents may have overriding rights to minors' therapy and information, and (5) absence of legislative statutes protecting confidentiality means judges can require that confidential information be disclosed in public trial. The counselor must be aware of these limits to confidentiality; he must be aware of his client's right to be informed, and further must insure his client's awareness of these limits.

While there is agreement that confidentiality must remain a basic right to every person, the nature of confidentiality must be defined in relation to various limiting factors. Firm limits must be set at some point if realistic protection is to be given to clients from whom information has been obtained with the assurance that it will remain confidential (Sprafkin, 1959). The integrity of the counselor's service to his clients is in constant jeopardy, and so, inescapably, is his client's right to privacy (Ladd, 1971). If a person is entitled by right to privacy regarding contact with a mental health center (or private practitioner), it is imperative for his acceptance of protection in assured confidentiality that he be appraised of this. Failure to advise might easily diminish
his sense of assured confidentiality and his relationship with the therapist.

Clients with alcohol or drug problems can have their sense of confidentiality enhanced by the therapist's explanation of their rights in regard to both drug abuse counseling and counseling records. Special federal regulation, published July 1, 1975, in the Federal Register, forbade disclosure of counseling records without patients' written consent. Certain state laws require parents or guardians to be notified of drug/alcohol treatment. The clients have an inherent right to this information from the therapist, as well as the protective advisement that this information cannot be disclosed further without the written consent of clients and parents/guardians. Making clients aware of this rightful information can only enhance the effectiveness of the relationship (Eberlein, 1977).

Other client rights impacting on limits to confidentiality include the right to be made aware that parents or guardians or those in loco-parentis have a legal right to know the nature of the counseling relationship, and perhaps even its content, when the client is a minor (Eberlein, 1977). Clients must also be made aware that they are entitled to privacy regarding contact with a mental health center whether or not they are receiving treatment. If minors are informed and forewarned (Pardue, et al., 1970) that parents or guardians might need to become involved
in a given situation they are then free to engage in counseling, knowing this possibility. Concomitantly, confidence in the therapist will be increased over his sincere display of concern in the client's welfare.

Even when parents agree to counseling, material given in confidence by a minor to a counselor could be legally demanded by parents. This becomes a difficult problem when a student desires to discuss a matter such as an unwanted pregnancy or drug-related problems without letting parents know. Awareness of his rights, and of any limitations thereto, will assist the client in his decision-making process. In view of limits knowingly set in confidentiality, he can consciously decide his degree of participation in the counseling process.

Eligible students and/or their parents have the right to inspect school records and to correct inaccurate information. Students not only have an inherent right to this information, but more importantly, they have an equally pervasive right to know whether or not the results of the counseling-treatment-testing process will be included in school or other institutional records. McGuire and Borowy (1978) point out that the Buckley Amendment (Public Law 93-380), designed to specify the condition under which records must be made available to students or their parents, grants legal support to the individual's right to know and to challenge personal and evaluative material
about him by various administrative, governmental, and other agents of society. This makes it imperative that counseling professionals consider more thoroughly the kinds and purposes of professional communications made to others, or maintained about an individual. When a student or individual seeks counseling or guidance with the intent of resolving personal, vocational, or other problems, then it appears critical that professional helpers be able to exercise their best judgment relative to what records or communications are revealed to the clients. It would seem equally relevant that the student be made aware of time of counseling of any limitations to confidentiality imposed by record-keeping policies.

**Expectations of the Client**

While the client has certain inherent rights, they also bring to the therapeutic encounter many expectations. Formed idiosyncratically from their life experiences, these expectations are often unrealistic. Nevertheless, such expectations must be dealt with in view of the self-disclosure they elicit, or inhibit, and the degree of confidentiality they impart to clients' perceptions.

Whether from incipient ignorance or imbued cultural instincts of our society, clients appear to expect their utterances to be kept confidential. Meyer and Smith (1977), using uncoerced and anonymous responses from a short questionnaire administered to a junior-year
university level psychology class, asked what the term "confidentiality" meant to the respondent. Sixteen percent (16%) felt that it included only a therapist avoidance of discussion of cases in general discussion or publications. The other 84% assumed that confidentiality included a refusal to testify about a case even if validly ordered to do so by a court of law. Plaut (1974) states that most people expect confidentiality when they meet with their therapists. Edelman and Snead (1972) found that subjects revealed as much information when given no instructions as when explicitly informed that the information given was to be held confidential. Subjects reported to Woods (1977) that they had assumed that what they had said would be held in confidence. Jagim, Wittman, and Noll (1978) in their survey of mental health professionals found that 95% of respondents indicated that they, as a group, felt clients expected that therapy communications would remain confidential (64% very strongly agree, 29% strongly agree, 2% agree). It is possible that due to past experiences (e.g., with lawyers or clergy) clients presumed complete confidentiality of therapeutic contacts and may be unaware of any limitations of confidentiality.

In contradiction, it appears that clients refuse, unconsciously perhaps, to accept limited or flawed confidentiality even when advised differently. Respondents in a study by Meyer and Smith (1971) were read a statement...
explaining that confidentiality is an ethical or professional concept and does not carry legal power or precedent. The subjects were then asked to indicate whether or not they would expect the therapist to keep information confidential. Eighty-eight percent (88%) responded yes, 7% could not decide, and 3% said no. Pardue (1970) pointed out that confidentiality has been viewed historically in all educational levels as implicit. This apparently includes the counseling relationship as well as the maintenance and use of student records.

Cass and Curran (1965) note the confidential relationship expected of the physician and patient and suggest that the basic ethics of the advisory professions support this concept of confidentiality. The trust of patients rests upon this expected silence. Physicians cannot otherwise demand the truth of patients. Guttmacher (1952) suggests that the psychiatric patient confides more personally than anyone else in the world. He not only exposes to the therapist what his words directly express, he also bares his entire self, his dreams, his fantasies, his "sins," and his shames. Most patients who undergo psychotherapy know this is what is expected of them. They cannot get help except on that condition. It would be too much to expect them to do so if they knew that what they say may be revealed publicly.
Even when a client seeks out a therapist, he or she may face some risk; in effect, the client may inadvisedly waive his or her right to privacy, owing to lack of knowledge concerning some inherent consequences of that decision (or refusing to understand the advisement, or receiving poor advisement). In effect, the client may inadvisedly waive his or her right to privacy merely by entering into a therapeutic relationship. The client should be given the opportunity for reflection on whether or not to waive his rights (Everstine, 1980).

Everstine supports Noll's (1974) assertion that even when clients are informed of the conditions of confidentiality, they are often neither aware of, nor informed of, the potential consequences of release of information. Thus, several professionals (Seigal, 1979; Slawson, 1969; Szasz, 1967) have taken the positions that the therapist should not have any communications with any third party. Szasz noted that this rule binding the therapist to absolute confidentiality should be known by the client at the initiation of therapy.

The client assumes that he can expect help. Although some degree of positive expectation or hope is regarded as requisite for producing therapeutic effects in all psychotherapies, the patient may get the erroneous impression that therapy and the therapist can solve everything. This can perpetuate unrealistic expectations and goals that
are ultimately deleterious to the patient. Misleading impressions may be imbued by the therapist when his need to instill hope in the patient and the omniscience endowed him (by himself and/or the patient) become intertwined (Karusu, 1980).

Halleck (1971, p. 82) suggests that a patient usually assumes that the doctor has no purpose but to help him. The Journal of the American Medical Association states that it is not necessary in order to create the relation of physician and patient that the doctor actually treat the patient. If he makes an examination with the patient's knowledge and consent, believed by the patient to be for the purpose of treatment, the relationship is created by the implication. Everstine (1980) also points out that the patient can and does expect competence in the practitioner.

It appears that clients have higher expectations for mental health professionals than for many others who might be delving into their personal histories (employment, interviews, job clearances, etc.). Studies by Edelman and Snead (1972) investigated avowed self-disclosure of personal information in a simulated psychiatric interview. The results indicated that subjects would reveal more personal information to mental health professionals than they would in a controlled employment interview situation. An analysis of variance was used to determine if the mental health
professionals differed from the control (personnel managers) group in the extent of confidential information they avowedly elicited. This analysis revealed statistically reliable differences across roles and indicated that all mental health professionals differed from the personnel manager in the intimacy of the information subjects indicated they would have revealed, clearly indicating that subjects in this study expect they would reveal more intimate information to mental health professionals than they would to a potential employer.

Client expectations of confidentiality appear as inherent to group sessions as they do in one-on-one relations. Sixty-one percent (61%) of respondents in the Meyer and Smith study (1977) indicated they would expect other group members to keep information divulged in group sessions confidential. The vast majority of therapists and clients apparently assume the validity of the axiom that confidences divulged in group therapy have the same protection under the laws of privileged communications as do those revelations made in individual therapy. Meyer (1974) brings this into question, a point reaffirmed by Foster (1980). Meyer noted a technicality in the legal tradition of privileged communication whereby a privilege may be voided through disclosure to a third party even where there is a statutory provision for privileged communication in psychotherapy. The reason for the existence
of the privilege, that is, confidentiality, is "lost" because the person possessing the privilege has made the communication public by revealing it. There are exceptions to the third party rule (i.e., third party expert present, in presence of other parties, whose interests are mutual, parallel and not conflicting—United States vs. Kovel, 296 F 2nd 918-2nd Cir., 1971). Exceptions to the third party rule, however, do not easily gain recognition from the courts inasmuch as privilege tends to keep important evidence from the courts.

In the study by Meyer and Smith (1977), 82% percent of the respondents stated they would either decide not to enter a group, or would enter but with substantially less inclination to reveal information in the group, when they had been advised that the information discussed in the group would not be considered confidential. When confidentiality was pledged by the therapist and group members, and the therapist stated that though very unlikely, if he were validly ordered by a court of law to reveal specific information, he would do so, 47% stated they would either not enter a group or would enter with substantially less inclination to reveal relevant information. It is clear that, based on expectations of these respondents, either statement on confidentiality would be likely to lessen the effectiveness of the group therapy process because of both an inclination to avoid entering therapy and a loss of
substantial information to the group. It is worthy of note that there is still a substantial loss when the therapist reflects the law as most therapists understand it at present (47% loss).

Generally, an expectancy of confidentiality by the client seems high, even when advised otherwise by the professional. History, precedent, and our own culture combine to produce a mental set of assured confidentiality protection that seems intractable. It appears irrefutable that a large percentage of clients expect the therapist to help and with this expectation obtain a concomitant certainty that their disclosures will be protected.

Factors Impacting Protection of Confidentiality

Modern technocratic society brings the individual's established right to privacy and protection of confidential disclosures increasingly into society's right to know. The resultant inhibition of confidence by clients, increasingly knowledgeable of the complexities of a technical society, can only be counterproductive in regards to the effectiveness of treatment the client might rightfully expect. Various third parties are demanding increasing amounts of private and personal information about clients. Increasingly sophisticated interlocking data systems store more and more of this information for later retrieval and use. As a result, while fearful and concerned over the potential for damage in uncontrolled and proliferating use
of personal information, uncertain as to which agencies have access to data, and uncertain regarding its potential use, knowledgeable individuals are increasingly guarded and reluctant to disclose personal and private information. At the same time, third parties (e.g., insurance carriers, government agencies, etc.) are demanding more and more information to satisfy their individual requirements. The dilemma (Slovenko and Usdin, 1961) for the professional is sharpened with the recognition that in some situations to release confidential information when it is not necessary could result in actions for damages for defamation or for invasion of privacy. But to not release information in other situations could result in a charge of contempt of court and going to jail.

Plaut (1974) suggests that an escalating conflict exists between the right to privacy and the right to information because of: (1) increasing government involvement in areas that were previously considered private affairs, (2) the electronic revolution in data collection, storage, retrieval, and (3) the prevailing atmosphere of high suspicion between individuals and government authorities for whom knowledge has always meant power.

Issues of confidentiality and the deleterious effect of inhibiting self-disclosure through diminution of confidentiality are faced by both practitioner and client. The therapist must wrestle with troublesome decisions
regarding his protection of the client's confidences. Simultaneously, the client is faced with the double-bind dilemma of erosion of the therapeutic effort on his part and disclosure to varied unauthorized agents of numerous governmental and private organizations with potential to hurt his person through either advertent or inadvertent failure to maintain his personal disclosures in confidence.

**Record keeping**

The manner in which client records are maintained and the identifying information thereon impacts drastically on the client's right to protection of his confidential disclosures. Noll and Hanlon (1976) found that over half (51%) of the mental health centers they surveyed report to various governmental agencies, one or more of the following: name, address, social security numbers. Sixty-six percent (66%) of the state health directors reported this same information. In further support of these data, 60% of the state directors reported receiving information that could potentially identify the individual served. Thirty-six percent (36%) of the mental health centers that acknowledged reporting identifying information did not inform their clients that they did so. Sixty-one percent (61%) of mental health centers also reported that individuals were not advised that identifying information might be reported. The extent to which identifying information was reported is somewhat surprising in view of the growing concern over client's
rights to privacy. Reporting of this nature appears to be contrary to the ethical stance of all three major mental health professions, especially when the information is provided without the client's full and informed consent.

Noll and Hanlon consider the matter of client records to be an area begging for correction. The most frequent policy governing client records was to store them indefinitely, whether at the state or local level. "We are constrained," they comment, "to ask why records are kept as if they are valuable as gold coin collections. The potential violation of the individual's right to privacy and confidentiality is too great not to explore this area thoroughly."

Cornelius E. Gallagher (Dem., N.J.), Chairman, Special Inquiry, House Government Operations Committee expressed his concern over permanency of records in congressional hearings (1974):

What I do object to is this test questionnaire remaining a part of the individual personnel file and following him for the rest of his career. So-called confidential files (in government) do not solve this problem. Our investigation shows that confidentiality of government files is a myth. Such files float from agency to agency as federal investigators are given access to information for removal from the subject of their inquiry. (p 828)

Permanency of records with a wide variety of necessary, useful, and helpful information combined with communications that are unrelated, extraneous and incriminating
impact on protection of client confidences. Wilson (1978) avers that there is certain data that does not belong in any case record regardless of type of recording material used because: (1) potential use of such material is against best interests of client or agency should material be subpoenaed, and (2) possible effect upon the client himself should he see the entries. In her opinion, there are eleven kinds of material that should not be found in any case record:

1. Narrative recordings should not be stored in a case record, even temporarily.

2. Any information regarding a client's political, religious, or other personal views does not belong in a case record unless it has a direct and very important bearing on the treatment process.

3. Intimate, personal details which have little or no relevance to the helping process.

4. Extreme details about a physical illness. A brief summary style of recording would be more appropriate.

5. "Gossipy" information about other clients.

6. Recording of too much "process." It should be presented in a very brief summary style.

7. Problems and frustrations in contacting and relating to other social workers, agencies, and members of other disciplines. Likewise, the worker must refrain from putting into writing his criticisms of the operations of his own agency's service-delivery system.

8. Any details which might be misinterpreted or misused by others in the agency with formal or informal access to the case record.
9. Any information that could conceivably be used against the client in a court of law.

10. Material that could be damaging to the client if he were to exercise his right to read his record.

11. Entries that might be incriminating to the agency should the client bring a suit for any reason.

McGuire and Borowy (1978) recommend that record keeping limit the use of technical language, diagnostic labels, etc., and maintain only that information critical to the purposes of the report or decisions being made. They point out quite clearly that it is explicitness and the use of professional and technical language that makes information easily misinterpreted and potentially harmful.

Reynolds (1976) enumerates six situations in which use of client records would endanger confidentiality and consequently the therapeutic endeavor: (1) standards review groups, (2) eligibility for insurance, (3) collections of bills, (4) taxes, (5) information to employers, and (6) litigation.

Standards review group

Professional Standards Review Organizations (PSRO's) and other review boards (Medicaid, Medicare, etc.) have been established by Federal law to assure the quality and standards of health care availability. To do this, patient/client records are reviewed and their cases discussed. How this can be done without endangering confidentiality is a
problem that requires further consideration. Guidelines must be established that will provide assured protection for information given in confidence.

Eligibility for insurance

It is not unreasonable for an insurance company to demand information to ascertain whether they are liable for the condition claimed by the patient, and whether the methods and frequency of treatment are appropriate and justified by the condition. Likewise, it might not be unreasonable to refuse to accept the lack of confidentiality of this situation without regard to protection of confidences of the client.

Collection of bills

The Group for the Advancement of Psychiatry (GAP) expressed concern that turning over a patient's unpaid bills to an agency for collection may be a breach of confidence and that the patient should be in control of who knows that he is in therapy. The courts ruled otherwise (Yoder vs. Smith, 111 NW 2nd 862, Iowa, 1962) holding that the attempt to collect unpaid bills of client was reasonable, even though it may have resulted in an invasion of privacy.

Taxes

When the Internal Revenue Service needs the records of a taxpayer privilege may not apply. Although protection of confidentiality might be provided by state law, such a law
does not apply to Federal income tax matters, if needed to resolve a federal tax agreement.

Informing an employer

There is almost unanimous legal agreement that disclosure of a person's medical records can constitute an invasion of privacy. To the contrary in Clark vs. Geraci (208 NYS 564 Sup Ct, 1960), the court ruled there was a right, and a duty, to disclose facts indicating an Air Force employee was unable to carry out his job properly because of alcoholism, in spite of patient's vigorous objections to such disclosure.

Litigation

Professionals who assure their clients that their communications will be held in confidence may not be able to keep their word, or may be held in contempt of court if they try. The Lifschutz decision in the California Supreme Court is considered a landmark decision. Dr. Lifschutz, a psychiatrist, refused under subpoena, to even admit the plaintiff had ever been his patient, for which he was jailed three days until the matter could be adjudicated.

There are cases in which wording of the judicial deliberation indicates that if a physician or psychotherapist knows a patient has assaultive tendencies he has a legal duty to warn those who are caring for the patient. For example, in December, 1974, the California State Supreme Court held that a physician or psychotherapist has a duty
to warn a third person who is endangered by the patient (Tarasoff vs. Regents of University of California). Giving such a warning is not considered a breach of confidentiality by the court. The ruling concluded that the privileged nature of the patient-psychotherapist must be over-ridden when disclosure is essential to prevent immediate danger to others.

**Third party elements and computer usage**

If they could be prioritized, probably the two most significant factors tending to inhibit disclosure and jeopardizing confidentiality are third party payments and computerized programming with data banks that can gather, store, and release collated personal information at staggering electronic speeds, to an unlimited number of users, with insatiable voracity.

Having to meet current demands for detailed record keeping in anticipation of the requirements and wishes of third party payers, peer review groups, and others, means that the confidential boundaries of traditional dyadic relationships between therapist and patient have greatly enlarged and eroded (Karusu, 1980).

Insurance coverage as payment for psychotherapeutic services seems to be a mixed blessing. It provides wider availability of mental health services to those who heretofore might not have been able to avail themselves of such services. At the same time, however, the intrusion of the
payer into the therapeutic relationship presents unresolved questions concerning confidentiality and maintenance of disclosed information. Given that there are aspects of legitimacy in the third party's requirement for information needed to establish the liability for claims, there remains the incontrovertible element of interference with the therapeutic benefit derived from the assurance to the patient that anything he says will be absolutely inviolate. There is bound to be disturbing questions about possible misuse of the information transmitted (Chodoff, 1978).

Even though the majority of psychiatrists recognize the legitimate need of the insurance carrier to have certain facts about the cases for which they are authorizing payments, they may be troubled by this requirement, and by the possible effect in breaching the trust the patient must have that he can say anything at all to his therapist without fear of disclosure to others (Chodoff, 1972).

Third party payers may often demand the claimant's diagnosis as a condition of decision on eligibility for insurance payment. Plaut (1974) suggests that there is an inevitable element of "he who pays the piper calls the tune," whether it be a private insurer or the government. Plaut also points out that due to the impact of potential loss of confidentiality to the client, the profession, when demanding inclusion under health insurance programs, "may be selling its birthright for a mess of pottage."
Not all third party elements are insurance carriers. Due to their relation with the client, the threat to confidentiality may be even increased by several orders of magnitude, if the demands of significant others are not met. Relatives, parents, spouses, lovers, employers, institutions, schools, etc., each might have, to varied degrees, by virtue of economic interest, legitimate interest in information concerning client records, in return for payment of services. Minimally, progress reports might be demanded. Regardless, the client's confidentiality is put at risk by any third party who can exert financial, or psychological, or social leverage. Wohl (1974) asserts that any intrusion by any third party makes it harder to defend and justify the position of secrecy for a patient, since in many instances, the main secret is the fact of his status as a patient. It is well known that this information alone can suffice to damage a person irreparably. For example, Reynolds (1976) points out that the psychiatric problems of a vice-presidential nominee (Senator Eagleton) which made the public news, caused his withdrawal from nomination. Also, Reynolds notes that health care providers constantly receive requests for information about patients or former patients for such reasons as to judge suitability for college or for adoption, to obtain security clearances for employment, to establish eligibility for disability benefits, and so on.
An increasing amount of information is being stored in computers making it more accessible to people other than those for whom it was originally intended. Concern exists because of both inadequate control of accessibility and through direct cross-feed from inter-connected electronic data processing systems.

In an age of continuing technological progress, when networks of data banks can provide instantaneous information on private citizens, the potential for mischief through error or deliberate calculation has increased (Everstine, 1980).

Mary McCormick (1978) reminds that

there has been considerable concern over leakage of information through computerized data banks, with national health insurance, and perhaps, national health data systems around the corner. Appropriate legislation is needed to make these data sufficiently secure to prevent unauthorized access. It is also important to destroy data that are not essential and to record only minimum data if they are likely to become public.

There is validity in the argument that the use of mechanical techniques is unavoidable in a bureaucratic society. There is also validity in the fact that such approaches pose a threat to human beings. It is necessary to reckon with human error. Identifying data can elude the most careful editing, and once in the public domain, their privacy is nullified. The intent of such techniques is laudable and practical, but the potential threat to privacy is always present. For example, the entire social security system depends for its implementation on computerized techniques that makes the personal information easy to communicate. Facts and figures become readily available to private organizations and individuals as well as various branches of the government. It can be assumed that requests for information are evaluated
and found to be legitimate before they are honored, but the difficulty is that no agency can predict the eventual impact of personal disclosure on individual lives. Helpful at the moment, they may be disasterous in the future. Certainly the individual has little voice these days in what is known and who knows what about him. (pp. 211-220)

This incipient fear of disclosure to the public can only be harmful to the concept of confidentiality and its part in the therapeutic process.

Summary

The practitioner's responsibility to the profession, to the institution who employes the therapist, to society, and more importantly to the client, require explanation and education of confidentiality factors that may drastically diminish effectiveness of the therapeutic relationship through sharply reduced protection of clients' confidential disclosures. The quantitative repercussions of many of these factors remain conjecture. Much research is needed to quantify the suggested deleterious effect on therapy, of these factors, if indeed they do produce a negative effect. It is an area ripe for analysis. For example, Singer (1978) found that only a request for signatures on data release forms had a significant effect on probability of responding. What impact the myriad of other potentially inhibiting factors might have needs exploration. This is an attempt to explore the impact of some inhibiting factors on the client's readiness to divulge personal and private information.
On the basis of reported research to date, considerable information is available concerning the relationship of self-disclosure and confidentiality as perceived by the discloser. Previous research has indicated inconsistent results regarding the relation of gender and depth of self-disclosure (Dimond & Hellkamp, 1969; Jourard & Lasakow, 1958; Woods & McNamara, 1980). Further investigation is required for resolution of this issue. Additionally, there has been no controlled studies reported in which the possible influence of interviewer gender, vis-a-vis the interviewee, has been examined (Cozby, 1973). Other aspects of interviewer/interviewee relationships that might impact self-disclosure such as video recording have not been studied. Woods (1977), however, did find that audio tape recording of an interview significantly effected anxiety level of the interviewee as well as level of disclosure among females. This study examines some of these issues for which there has been no study to date, or for which results have been inconclusive or inconsistent. Additionally, the effects of self-disclosure and degree of assured confidentiality, video versus non-video taping, and interviewer gender on depth of self-disclosure in a dyadic interview situation were examined.
HYPOTHESES

One area of exploration was the hypothesis that clients will self-disclose to a greater depth when they are assured that their utterances will be kept confidential (high assured confidentiality) as opposed to the experimenter sharing their communications with a supervisor (moderate assured confidentiality). A second hypothesis is that clients will self-disclose to a greater depth when communications are shared with experimenter and supervisor (moderate assured confidentiality) than they would if the review of confidential information is expanded to include an indiscriminate number of researchers, graduate students, etc. (low assured confidentiality). A third area examined was the hypothesis that clients would disclose to a greater degree when proceedings were only manually recorded by the interviewer for analysis, as opposed to having their confidences video recorded. A fourth question that was addressed was the hypothesis that females disclose less than males under any condition of assured confidentiality.
METHOD

Subjects

A pool of ninety-six students (forty-eight male and forty-eight female) was drawn from the undergraduate student body of the University of Central Florida during the 1982 spring semester to participate in what was described as an interview experiment. Each subject was asked to sign an experimental agreement outlining the conditions of the experiment, his/her individual rights of privacy and withdrawal, and consent to participate in the experiment (see Appendix A). At the conclusion, following post-participation debriefing (see Appendix B), each participant was given the opportunity to sign a release of data form (see Appendix C). This double consent process follows the procedures introduced by Woods and McNamarra (1981).

Procedures

Sixteen subjects, eight male and eight female, were randomly assigned by the experimenter to one of six experimental conditions. Each subject's participation consisted of a two-part interview involving ten questions each. Since reaction to video recording was a factor being examined, half the subjects were video recorded for the first half of their interview (Phase I), with video recording deleted
during the last half (Phase II). For the other half of the subjects, this sequence was reversed with no-video recording first, followed by the video recording condition during the last half of the session.

Experimental conditions were as follows:
1. Low Assured Confidentiality: No Video/Video
2. Low Assured Confidentiality: No Video/Video
3. Moderate Assured Confidentiality: No Video/Video
4. Moderate Assured Confidentiality: Video/No Video
5. High Assured Confidentiality: No Video/Video
6. High Assured Confidentiality: Video/No Video

Inasmuch as gender was a control variable, one-half of each of the male and female subjects were randomly assigned to a male and to a female interviewer. To minimize experimenter-introduced bias and error, subjects were contacted by volunteer workers other than the experimenter and given appointment times "in the blind." The various experimental conditions were tested sequentially, alternating between male and female so that randomization of subjects selection could be further enhanced. Thus, volunteers had no way of ascertaining which condition a potential subject would be assigned to when making appointments.

Prior to participation, all subjects were individually interviewed in the experimental area by the experimenter, who provided a brief orientation and had subjects read and sign the agreement of participation form (see Appendix A).
Subjects were then randomly assigned to an experimental condition and given appropriate instructions by the experimenter. In giving the instructions, the experimenter emphasized which part of the interview was being video-taped and who would have access to the data analysis and the video tapes. The exact instructions given to subjects in each of the six experimental conditions are given in Appendices D through I.

**Interview procedures.** Following delivery of the orientation, signing of the agreement to participate, and the discrete instructions appropriate to each subject's assigned condition of confidentiality, the interviewer was called in to the experimental room, introduced to the subject, and the experimenter withdrew. Introduction of both interviewer and subject was by first name only. The interviewer was unaware of the discrete condition of confidentiality to which any individual subject had been assigned by the experimenter.

The interview was conducted in two brief phases (Phase I and Phase II, approximately 25 minutes each) with a short three-minute break between individual phases. Each phase of the interview consisted of a set of ten questions to which the subjects had the opportunity to verbally respond as the interviewer recorded their answers.

The interview questions (see Appendices J and K) developed by Jourard (1971) and Woods (1977) consist of two
sets of open-ended questions which have previously been rated and matched for level of intimacy. These questions are divided equally, according to level of intimacy, into two ten-question interviews. Their composition includes four questions at a low level of intimacy, two questions judged to be moderately intimate, and fourteen categorized as highly intimate. Each phase of the interview begins with two low-intimacy items, followed by a moderate item, which were used as introductory questions. Seven high-intimacy questions were then asked. These questions are split to approximately equal duration of questions, topic areas covered (such as sexuality or interpersonal relationships, level of intimacy, and tendency to pull negative responses). Examples cited by Woods (1977) include "What are the sources of strain in your relationship with the opposite sex?" for Phase I of the interview, which has been balanced in Phase II by "What disappointments have you experienced with the opposite sex?"

The interviewer was instructed to question and wait for a reply. If no reply was forthcoming in fifteen seconds, the interviewer administered a probe. Woods (1977) followed Matazarro's suggestion (1962) that in a structured interview all probes should be open-ended and non-directive. Probes that seemed capable of eliciting a discussion but were not content specific were derived from those used in research by Chapple (1953) and Webb (1958).
and in therapy by non-directive therapists (Benjamin, 1969; Snyder, 1947). These remarks included non-directive leads, reassurances, rephrasing of the interviewee's last statement, and several "emergency" probes (see Appendix L). If the individual seemed to have completed his/her answer, the next topic was then introduced.

Upon completion of Phase I of the interview, there was a short three-minute break during which time refreshments (cola or coffee) were made available. The interviewer withdrew from the experiment room during the break, and the experimenter returned to provide additional instructions needed for accomplishment of Phase II.

Subject and interviewer were seated across from one another at a small table. The TV monitor was on another small table to the right of the interviewer approximately five feet from the subject and out of the range of the video camera behind the one-way mirror. Interview table and monitor were oriented in such a manner that the subject faced the video camera at about thirty degrees, while observing the monitor and sitting in a normal position relative to table and interviewer.

Prior to giving instructions for each phase, the experimenter turned the TV monitor on or off (as appropriate) in the subject's presence, so as to insure subject's awareness of being video-taped. Although subjects were able to observe themselves on the TV monitor during the
portion of their session that was appropriate to those instructions, none of the interviews were actually recorded.

Upon completion of Phase II of the interview, the interviewer departed the room and the experimenter returned to debrief the subject on the actual intended purpose and expected results of the experiment. The debriefing information is given in Appendix B.

Following the debriefing and obtaining subject's signatures on the data release form (Appendix C), subjects were given an opportunity to ask any questions they might have had concerning the experiment.

The interviewers (a male and a female, undergraduate psychology majors doing Independent Research Study) were trained by the experimenter and staff supervisor. They were told the purpose of the experiment and trained in the techniques required of an interview to support the experiment properly. This included such areas as voice control requirements, techniques for a non-judgmental and detached composure, and recording requirements including use of equipment. Additionally, five subjects were interviewed in the determined experimental format, on a trial basis prior to actually processing volunteer subjects. This served the purpose of both insuring that the interviewers were properly trained, and ferreting out any unforeseen difficulties with the procedures.
Scoring Results

Interview responses were subsequently scored by a panel of three judges (two undergraduate females and one graduate male, all psychology students) trained by experimenter and staff supervisor, to assess depth of self-disclosure using a nine-point Likert-type scale developed by Derlega, Chaikin, and Hernodn (cited in Woods, 1977). Previous uses of these scales indicates an inter-rater reliability in the .70's and .80's (Chaikin et al., and Derlega, cited in Woods, 1977). Judges operated in the "blind" using procedures developed by Woods (1977) to judge and score responses.

In training the judges in the use of the scoring system, it was emphasized that "intimacy" reflects two major criteria (Wood, 1977). First, emphasis was placed on the uniqueness of the material disclosed. Demographic information, e.g., where one is born, major subject in school, numbers of brothers and sisters, etc., were considered to be less intimate than a description of personal feelings, e.g., anxieties, difficulties with parents, views on issues, etc. Second, emphasis was placed on how guarded one might be in divulging material to various people, i.e., would the subject want most people to know about the information, or would he be embarrassed to divulge this material to anyone but a trusted associate. Appendix M shows the
Likert scale used and examples of the major scoring categories.

Judges were trained by the experimenter and an arbitrary standard of .80 inter-rater reliability was established as a minimum acceptable level of training. A rating tool, elaborating on each of the Likert scale points was developed to assist the judges. Numerous didactic sessions were employed and the five trial sessions previously mentioned were actually scored in practice.

An operational definition of agreement between the three judges' scoring was established requiring agreement within one scale point to be an acceptable score (for training purposes). For instance, a score of 4, 5, 6 on a given response by the three judges would be acceptable. This definition permits a maximum of two scale points deviation between judges in training. As an example 4, 5, 6, or 4, 5, 5 scores would be acceptable, while a scoring of 4, 6, 6 would not be acceptable inasmuch as it did not prescribe to the one-scale-point maximum differential requirement. Using this operational definition as a training requirement, the three judges were trained until an inter-rater reliability of .84 was achieved, this being higher than the established minimum of .80.

All three judges scored each of the responses of the 96 subjects (20 responses each X 96 subjects = 1920 responses) providing three scores for each response. A mean
score was then derived for each response and this data was used in analyzing the experiment for test results. A percent agreement interrater reliability score was calculated on the 5880 rated responses (96 subjects X 20 questions). Agreement was defined as ratings between any pair of judges being no more than one Likert-scale step apart on any given question. Using this operational definition of "agreement," the judges concurred on all but 201 responses, a 96.6 percent agreement. On those 201 responses in which agreement was not initially achieved, the raters subsequently discussed their ratings until "agreement" was obtained. This procedure was followed with the exception of one response, representing .02 percent of the total on which "agreement" could not be achieved.

Following the manner of self-disclosure measurement designed and executed by Woods (1977), the first three "warmup" questions (low and moderate intimacy) of each of the two self-disclosure questionnaires were deleted from quantitative calculations for each subject.

During the training and evaluation period, considerable discussion arose over the proper disclosure value to be assigned to responses for question 7 ("How often do you have sexual experiences and what are the nature of these experiences?") on the Phase I questionnaire (Appendix J) when respondents answered that they had little or no sexual experience since they were virgins, or some variation of
that answer. The discussion arose over whether this was a high disclosure or a low disclosure response. Quantitatively it might be a low response, but several on the panel considered this to be a high intimacy disclosure inasmuch as it might take considerable courage to announce that one was a virgin given the moral clime of current society and the general outlook of their peers. After considerable consultation and debate (including phone conversations with Kathrine Woods), it was arbitrarily decided by the experimenter, that such answers to this question would be rated between 5 and 8 on the Likert scale used for scoring responses. Proper scoring might then require consideration of subject's response to questions 8, 9, and 10 also. A consensus, well within desired interrater reliability desired, was easily obtained once this arbitrary grading criteria was established.

Equipment

Interviews were conducted in an experimental room on the campus of the University of Central Florida. This room is approximately sixteen feet square, is sound proofed and can be isolated from exterior view. It is provided with appropriate lighting and a special one-way mirror approximately 4 by 10 feet. Behind the mirror is a small room in which the audio-video equipment is located and from which proceedings can be observed unobtrusively.
A Hitachi CCTV camera, Model HV620U, was utilized to provide TV monitor capability which was displayed for the subject on a Panasonic VTR Monitor Model No CT-911VA. High impedance microphones were placed unobtrusively in the experimental room. No other special equipment was involved.
RESULTS

The first two hypotheses stated that individuals will self-disclose to a greater depth when they are assured that their utterances will be kept completely confidential (High Assured Confidentiality) as opposed to the experimenter sharing their communications with his supervisor (Moderate Assured Confidentiality) or others (Low Assured Confidentiality). Table 1 shows total mean disclosure scores to be highest for subjects in the High Confidentiality condition (M = 36.10), intermediate for subjects in the Moderate Confidentiality condition (M = 34.16, and lowest for subjects in the Low Confidentiality condition (M = 32.87). However, statistical analysis of mean differences among treatment groups was not statistically significant, F (2,90) = .87).

While mean disclosure scores for males conformed to expectancies, an examination of mean disclosure scores for females (Table 1--Moderately Assured Confidentiality versus Low Assured Confidentiality) shows a very slight reversal of the expected trend (Low $\bar{X} = 32.19$, Moderate $\bar{X} = 32.05$) with female disclosures less (-.14) under the increased protection of Moderate Assured Confidentiality.

A third hypothesis advanced was that clients would self-disclose to a greater degree when the interview
session is recorded manually (no video) by the interviewer as opposed to having the session video-recorded (video) with client's knowledge. Table 2 presents mean disclosure scores for the video and non-video condition within sex and treatment conditions. As can be seen in Table 2, total mean disclosure scores were higher in the non-video condition in each of the treatment conditions. However, analysis of male/female differences in self-disclosure scores in the video/non-video condition (Tables 2 and 3) reveals that while female scores conform to expectation, i.e., higher scores in the no-video condition; for males generally, higher mean disclosures scores were obtained in the video condition. Two-way ANOVA revealed a significant sex-by-video interaction, $F(1.90) = 5.33, p < .05$.

A fourth hypothesis explored suggested that females would disclose less information than males under any condition of assured confidentiality. Table 1 reflects mean disclosure scores for males and females. Mean disclosure scores are higher for males than females in each of the three confidentiality-treatment conditions. Two-way variance of data from all 96 interviews supports this conclusion $F(1.90) = 5.66, p < .05$.

Mean disclosure scores were higher for male subjects with both male and female interviews (see Table 5). A $t$ analysis revealed that males disclosed significantly more
to the male interviewer than to the female interviewer ($t (46) = 2.76, p = .05$). There were no significant differences in disclosure scores for female subjects between male and female interviewers.
DISCUSSION

The primary hypothesis advanced was that the amount of client's self-disclosure is directly dependent on the degree of confidentiality the client perceives that he is assured. Although results were not statistically significant, a trend consistent with this hypothesis was supported by the experimental results. Thus, both male and female subjects disclosed more under a high degree of assured confidentiality than they did when the assured rate of protection was low. This trend conforms to the experimenter's expectations.

The overall trend and the trend for males progresses with increased assured confidentiality, in a linear fashion; however, examination of female mean disclosure scores shows an unexpected response pattern in that the female mean disclosure scores decreases slightly ($\bar{X} = 32.19$ to $\bar{X} = 32.05$) as confidentiality rate is increased from Low Assured Confidentiality to Moderate Assured Confidentiality. This is a slight difference (-.14) and there is no ready explanation for this response pattern. Additional research would be needed to determine if this is in fact correct, and if so, what variables are involved that produce this situation. Impact of possible sex differences is discussed later.
It is of interest to note the very small overall difference between Low Assured Confidentiality disclosure rates, regardless of gender, and Moderate Assured Confidentiality conditions. It would appear, from the results of this experiment, that individuals perceive as much negative impact from only two other people (experimenter and the supervisor) having access to their intimate disclosures as they do when it is made available to an indiscriminate number of additional people. Considering the difference in magnitude between that of the High Assured Confidentiality condition, and Low/Moderate Confidentiality condition disclosure rate (7.0 versus 4.22 and 3.37), it would appear that this population, at least, has placed considerable reliance on the confidentiality they expect when only one person is involved with their utterances. Expressing this another way, there appears to be little difference in the inhibition of disclosure rate whether two people or an indiscriminate number of individuals are privy to their private utterances, and only when there is assurance that only the interviewer will have access to their responses do the subjects become open in their communications.

While mean self-disclosure scores were higher in the no-video condition overall as expected, there was in fact a significant interaction between sex of subject and video condition. Specifically, while males disclosed more than females in both the video and no-video conditions, males
disclosed most in the video condition (contrary to ex­pectations) while females disclosed most in the no-video condition.

One possible subjective explanation of increased disclosure rate in the video-taped modality for males is the male tendency to brag and boast about real and fancied sexual escapades and adventures as a means of increasing self-image. Various authors suggest that boasting of sexual prowess or adventure is often engaged in by males intent on demonstrating their ability to achieve the mas­culine role (Sorenson, 1973; Hurlock, 1955; Rogers, 1962). While this appears more endemic to adolescents, the same suggestions would hold true for the young adult population in this experiment. While no demographic data pertaining to age was collected, most subjects were in their late teens and early twenties at the time of the interviews. Although all the high intimacy questions were not of a sexual nature, this was the predominate theme in these questions, and it would appear that sexual overtones might have some bearing on the explicitness of disclosures regardless of modality (video/no-video). Le Francois (1976) speaks of the dissonance arising from conflict between peer expectations and pressures, and the instances where a young male will have to lie to his friends in order to maintain his image of manliness. Rosen (1977) reported
that males more often said they did not care what would be done with interview information. She suggested that it appears that in the cost/reward balance, possible release of confidential information is less negatively balanced for males than for females.

Another possibility lies in the male need to establish control and power. It is also suggested that the male might have a tendency to avoid self-disclosure as a ploy to maintain control in that control might be hampered by self-disclosure. It would seem that these same arguments might be employed compellingly as an attempt to establish power and control, when advanced before an indiscriminate number of individuals who the young man has reason to believe comprise his audience. When only the interviewer hears his utterances (High Assured Confidentiality), and he has reason to believe the contents of his communications will be held in trust by the interviewer (that is, the audience on which he attempts to exert power and control is limited to only one person), there might be less reason to disclose. When an endless number of individuals are available to potentially see and hear his utterances, perhaps he might be inclined to present a greater amount of information to bolster his power play before the larger group.

Another possibility lies in the fact that in spite of post-interview instructions not to discuss mechanics of
the interview, the procedure may have been compromised, and some subjects may have been aware a priori that they were not actually being video-taped. This aspect is discussed later in more detail.

These suggestions are admittedly subjective attempts to explain possible reasons for the unexpected results obtained in the experiment. The scientific literature to date has not offered any reasons that would explain or support these data, and there is no readily supportable objective explanation available. Additional research is needed to explore this finding and whatever variables might impact on such results.

Sex Differences

Not only did males disclose significantly more across all conditions of assured confidentiality than did females, the differences were such that even the highest mean amount of disclosure by females under any given condition was less than the lowest amount disclosed by males under any condition. Even under the video condition where males disclosed more than when they were not being video-recorded, the male mean disclosure score exceeded that for females. This would seem to clearly indicate that males are either more open or more easily made trusting, or both (Tables 1 and 2).

O'Kelly and Schuldt (1981) found that males do disclose more than females; however Cozby (1973) asserts that
his review of the literature shows no study (to that date) that reports greater male disclosure. Contrary to findings of this experiment, Jourard and Lasakow (1958) reported that females have higher disclosure scores than males. This effect has been replicated in numerous investigations (Dimond & Munz, 1967; Himelstein & Lubin, 1965; Hood & Back, 1971; Jourard & Landsman, 1960; Jourard & Richman, 1963; Pederson & Breglio, 1968; Pederson & Higbee, 1969). Pederson and Briglio (1968), using written self-descriptions, found that females did not use more words to describe themselves than males, but they disclosed more intimate information about themselves than did males. Jourard (1964, chap. 6) attributed considerable importance to the obtained sex differences. The low disclosure of males was seen to be directly associated with less empathy, insight, and shorter lifespan than females. However, a number of studies have reported no sex differences in self-disclosures (Dimond & Hellkamp, 1969; Doster & Strickland, 1969; Plog, 1965; Rickers-Ovsiankina & Kusmin, 1958; Vondracek & Marshall, 1971; Weigle, Weigle, & Chadwick, 1969).

Cozby again reports that Jourard (1964) and Plog (1965) have suggested that conflicting findings concerning sex differences may be the result of samples from different geographical areas with concomitant differences in sex role
expectations. Sex differences would be found in the southern United States. However, an examination of the studies which tested for sex differences yields no consistent pattern which would allow the conflicting results to be explained by differences in geographic locale or type of instrument used.

Kobocow, in an unpublished study (1981, University of Central Florida) found that both males and females produced differences in variance under different conditions of confidentiality. Males showed less defensiveness and greater openness in responding to questions of greatest sensitivity, producing the highest self-disclosure protocols. Females, on the other hand, showed less variance and a more conforming, less disclosing, response style. She also showed that during an oral interview dyad, defenses are activated by attempts to elicit personal and sensitive information and that levels of personal defensiveness for male and female adolescents are affected by the confidentiality conditions in which such attempts are made. Thus, Kobocow found that females were lower self-disclosers across all conditions than were males, suggesting that females are more cautious, have a higher level of self-protective need, and place a greater value on confidentiality than do males.
Woods (1977) found depth of disclosure was lower for females than for males under conditions of non-confidentiality, but in the confidential condition, disclosure was about the same for males and females. Rosen (1977) found that females were more likely than males to refuse to sign release of information forms. Singer (1978) found that although women like to talk more, men were more willing to face the "risks" associated with being interviewed for surveys requesting personal and sensitive information.

**Race, Ethnic Group, and Social Class Factors**

Cozby (1973, citing Jourard, 1961) reports that numerous demographic characteristics of the discloser (such as age, sex, education, ethnicity, race, religion, socio-economic status, vocational affiliation, etc.) are known to have a significant relationship to self-disclosure. Franco and Levine (New Mexico State University, 1981) concluded that Hispanics and Blacks are less disclosing than Anglo-Americans. Jourard and Lasakow (1958) reported less disclosure by Blacks than by Whites. This finding has been replicated by Dimond and Hellkamp (1969) who report less disclosure by Mexican-Americans than by Blacks.

Dimund & Munz (1967), showed that later-borns show a higher self-disclosure score than first-borns. Jourard (1961) found that Jewish males were significantly higher in disclosure than Baptists, Methodists, and Catholics,
none of which differed significantly from one another.

Some of these factors might have impacted the young Caucasian college student population of this study and thus might explain some of the unexplained and variant results encountered. Further research is needed to determine the extent to which findings in this restricted population might be accurately extended to a more general population and what differences, if any, might be found in an older, more homogeneous, more ethnically diverse group.

Other Factors

At the conclusion of each interview, each subject was completely debriefed as to the purpose of the experiment, the fact that she/he was not actually video-taped regardless of instructions, and that they had an opportunity to ask any questions prior to deciding whether or not to sign the Release of Data Form. Before leaving, subjects were urged to maintain the experimental environment; they were specifically asked not to discuss the experiment with anyone (see Appendix B). One potential area of criticism is lack of control over whether or not subjects did, in fact, maintain the details of the experiment in confidence as requested, and whether there would be an impact on results if they did not. In the relatively small and closed community of a college campus, with subjects derived from one of three classes, it is possible that test construction might have been compromised. Such an occurrence might
explain certain aspects of the findings, e.g., males disclosing more on television. Only one such occurrence came to the attention of the experimenter, but there was again no accurate way to assess this potential variable. There is, however, the distinct possibility that the experiment could have been compromised in order to comply with ethical responsibilities to individual subjects.

In addition to socio-cultural variables not taken into account, a valid criticism of the experiment construct might be the absence of behavioral antecedents in evaluating responses. Woods (1977) observed behavioral responses, in an assessment to informally assess level of anxiety, taking cognizance of such behavioral actions as shifting of position, hand movement, nervous laughter, clearing throat, etc. Woods suggests that high anxiety tended to go with less self-disclosure and that subjects tended to exhibit more anxious behavior with lessened assured confidentiality. Anxiety manifestations noted during interviews in this study included such actions as nervously changing position in chair, becoming flustered and embarrassed, extraordinarily long delays in responding, etc. The eventual response, as recorded, might appear non-committal without benefit of the behavioral manifestation. This could result in a quantitative rating made out of context and at variance with feelings of subject. A correlation of a behavioral measure of anxiety with depths
of disclosure might have provided some different scoring results. Additional research utilizing behavioral manifestations would be needed to determine whether this would be a valid criticism.

A unique contribution of this study was the assessment/control of same-sex and cross-sex interviewer dyad effects of self-disclosure. It was found that not only did males disclose more than females (see Table 4) with both the male and female interviewers, but that males disclosed significantly more to the male interviewer than to the female interviewer. Females, on the other hand, disclosed equally to male and female interviewers.

A search of the literature revealed only one study (O'Kelly & Schuldt, 1981) in which results of self-disclosure as a function of interviewer's sex were examined. Contrary to the findings in this experiment, O'Kelly and Schuldt found that no significant effect occurred as a function of the examiner's sex. In contrast again, Dion & Dion (1978) did find that in a sixth-grade classroom, girls were more willing than boys to disclose to a female teacher.

One subjective explanation for experimenters' findings might have been differing personalities of the female and male interviewer. A vigorous attempt was made during interviewer training to produce and maintain a neutral stance with consistency in non-verbal behavior between the
male and female interviewers. The two interviewers, however, based on subjective impressions, were quite different personalities, with the male interviewer probably communicating a more neutral stance. Interestingly, the female interviewer tended to communicate and project a more warm, open, receptive style. It is suggested that a more neutral stance is less threatening, especially in an interview with many personal/sexual leads and may have therefore resulted in the increased disclosure rate. There is no measure to support this conjecture, and additional research is needed to examine the various effects of examiner qualities as they pertain to rate of disclosure.

Resneck and Amerikaner, in the Encyclopedia of Clinical Assessment (Woody, 1980), point out that authenticity of disclosure is another dimension that needs more attention in assessment procedures. Along these lines, Gitter and Black (1976) have operationalized the term "gliding" which they define as a communication behavior to falsify what the speaker believes to be true. These same researchers found that high disclosers have been found not only to reveal more but to be more sincere than their low disclosing counterparts who reveal less and are more likely to falsify the image that they present, using it to mask what they do not wish to reveal.

Validity of subject responses in this experiment was accepted throughout at face value, since there was little
or no objective means in the experimental tool to assess veracity of answers. Contextually, there appears to be legitimate reason to doubt veracity of some few subjects' answers. In addition to gliding, several other possible reasons might be offered for such a situation (pranks, sexual adventuring, boastfulness, etc.). These attempted explanations are all quite subjective and not amenable during this experiment, to any type scientific evaluation. Consequently, all responses were accepted, recorded, and scored at face value.

Implications for Therapy

Woods (1977) points to several difficulties when an analogue study is extended to practical therapy. The situation is artificial, since in therapy material usually emerges spontaneously over a period of time and is not the result of structured questions about intimate topics. Volunteers in an experiment are not asking for help with their problems. The experiment is a one-time interview instead of a series of sessions and more closely parallels an intake interview than on-going therapy. In spite of these limitations, there does appear to be some generalizations applicable to the therapeutic situation.

It does appear from this and other studies that an understood promise of confidentiality does impact on degree of self-disclosure. While Slovenko (1966) points out that patients seem to assume confidentiality in a profes-
sional relationship, these various studies suggest that an early explanation of confidentiality might expedite the therapeutic process. While such an explanation is required by the ethical standards of the American Psychological Association, Woods suggests it may reflect an ideal that is rarely met.

In addition, it seems that therapists might well develop their sensitivity toward the patient's possible reaction to a cross-gender therapist. Being aware of possible reasons for resistance might facilitate an examination of these issues with the patient. It would seem further that a situation could conceivably arise in which antipathy toward a therapist of the opposite sex might be so pervasive as to ethically require the therapist to terminate his/her therapeutic attempts for the patient's well-being.

Finally, an understanding of the dynamics behind self-disclosure as it relates to confidentiality will give the therapist one more tool with which to evaluate the patient's derivative communications and plan the proper intervention.
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<th>Moderate Assured Confidentiality</th>
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TABLE 3
Mean Overall Disclosure Scores

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<td>37.53</td>
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<tr>
<td>Female</td>
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<td>30.39</td>
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<tr>
<td>Total</td>
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<td>33.96</td>
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<tr>
<td>Group</td>
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<td>Moderate Assured Confidentiality</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Male</td>
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<td>36.27</td>
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<tr>
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<td>32.05</td>
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<td>Difference Between Male &amp; Female</td>
<td>3.37</td>
<td>4.22</td>
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</table>
APPENDICES
APPENDIX A

AGREEMENT OF PARTICIPATION
Appendix A

Agreement of Participation

I agree to participate in this experiment that is to consist of two short personal interviews. I understand that all information concerning this study will not be available to me before my participation, but that I will be fully informed of the study purpose and results before the end of the project. I am aware that I will be able to terminate either of the interviews at any time, by saying so, without negative consequences.

Witness ___________________________ Signature ___________________________ Date ____________
APPENDIX B

DEBRIEFING STATEMENTS
Appendix B

Debriefing Statement

For successful psychotherapy to take place, complete and open disclosure to the therapist is considered to be an essential part of the therapeutic process.

The purpose of this research is to measure the amount of information a person will disclose about themselves, under differing degrees of assurance that what they say will not be passed on to other people who have no need to know these personal facts.

Today we are attempting to measure how much more or less, a person is willing to disclose when they know that their information is being video-taped as opposed to merely being manually recorded. Therefore we set up just such a situation to measure your responses. Actually, you were not recorded on video-tape and the only record available is what the interviewer wrote down in your presence. There is no video-tape.

To utilize this data, now we need your permission on this form (hand data release form). As the form says, you will remain completely anonymous because your responses are not related in any way to your name, there is no video-tape, and the questionnaire will be destroyed at the end of the experiment.

To maintain the integrity of the experiment, you are requested NOT to discuss this debriefing information with
anyone. You may discuss that it was an interview concerning your opinions about yourself, but you are urgently requested NOT TO DISCUSS anything else about the time we spent together, so that we can maintain the atmosphere needed to conduct the experiment. Thank you for your participation. Are there any questions?
APPENDIX C

DATA RELEASE FORM
Appendix C
Data Release Form

I agree to allow the experimenter to use the transcripts of my interviews for data analysis. I understand that my identity will remain anonymous and that the transcripts will be destroyed when the analyses are completed.

Witness __________________________ Signature __________________________ Date __________
APPENDIX D

LOW ASSURED CONFIDENTIALITY: NO VIDEO/VIDEO
Appendix D
Low Assured Confidentiality: No Video/Video

Phase I - No Video
This will be a short, two-part interview in which you will be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. You will have a couple of minutes after each question to make your verbal response. The interviewer will be writing down your responses to each of the questions as the interviewer proceeds. After completion of the first ten questions there will be a short break and you will be given additional instructions at that time.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

This interview is part of a larger study of attitudes of young adults about certain issues, so I want you to know what will happen to your interview responses after the interview. Your responses of this sessions will be transcribed by a secretary for data analysis and will be made available to the investigators and students involved in this study, the faculty and graduate students in the Psychology Department, and certain other authorized university personnel. Thank you in advance for your willingness to participate in this project. Are there any questions?
Phase II - Video

During the next short set of interview questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life, your responses will be video-taped by a camera behind the one-way mirror in front of you for additional analysis of your responses. You can watch on this monitor.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the video-taping of this portion of the interview.

This video-taped portion of the interview is again a part of a larger study of attitudes of young adults about certain issues, so I want you to again be reminded of what will happen to the video tapes after the interview. The video tapes of this interview will be transcribed by a secretary for data analysis and will be made available to the investigators and students involved in this study, the faculty and graduate students in the Psychology Department, and certain other authorized university personnel. Are there any questions?
APPENDIX E

LOW ASSURED CONFIDENTIALITY: VIDEO/NO VIDEO
Appendix E

Low Assured Confidentiality: Video/No Video

Phase I - Video

This will be a short, two-part interview in which you will be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. The interviewer will be writing down your responses to each of the questions as the interview proceeds. In addition, your responses will be video-taped by a camera behind the one-way mirror in front of you for additional analysis of your responses. You may watch on this monitor. After completion of the first ten questions there will be a short break and you will be given additional instructions at that time.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

This video-taped interview is part of a larger study of attitudes of young adults about certain issues, so I want you to be reminded of what will happen to the video tape after the interview. The video tape will be transcribed by a secretary for data analysis and will be made available to the investigators and students involved in this study, the faculty and graduate students in the Psychology Department, and certain other authorized university personnel. Are there any questions?
Phase II - No Video

During the next short set of interview questions, you will again be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. You will have a couple of minutes after each question to make your verbal response. The interviewer will again be writing down your responses to each of the questions as the interview proceeds, but the video equipment will be turned off.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

This interview is part of a larger study of attitudes of young adults about certain issues, so I want you to be reminded again of what will happen to your interview responses after the interview. Your responses of this session will be transcribed by a secretary for data analysis and will be made available to the investigators and students involved in this study, the faculty and graduate students in the Psychology Department, and certain other authorized university personnel. Thank you again for your willingness to participate in this project. Are there any questions?
APPENDIX F

MODERATE ASSURED CONFIDENTIALITY: VIDEO/NO VIDEO
Appendix F

Moderate Assured Confidentiality: Video/No Video

Phase I - Video

This will be a short, two-part interview in which you will be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. The interviewer will be writing down your responses to each of the questions as the interview proceeds. In addition, your responses will be video-taped by a camera behind the one-way mirror in front of you for additional analysis of your responses. You may watch on this monitor. After completion of the first ten questions, there will be a short break and you will be given additional instructions at that time.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

This study is part of a larger study of attitudes of young adults about certain issues, so I want you to be reminded of what will happen to the video tape after the interview. The video tape of this interview will be analyzed by the experimenter and Dr. John McGuire, a university staff member of the Department of Psychology, who is the project supervisor. No one else will have access to the tapes. Are there any questions?
Phase II - No Video

During the next short set of interview questions, you will again be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. You will have a couple of minutes after each question to make your verbal response. The interviewer will again be writing down your responses to each of the questions as the interview proceeds, but the video equipment will be turned off.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

This interview is part of a larger study of attitudes of young adults about certain issues, so I want again to remind you of what will happen to your interview responses after the interview. The transcripts of this interview will be analyzed by the experimenter and Dr. John McGuire, a university staff member of the Department of Psychology, who is the project supervisor. No one else will see your responses. Thank you again for your willingness to participate in this project. Are there any questions?
APPENDIX G

MODERATE ASSURED CONFIDENTIALITY: VIDEO/NO VIDEO
Appendix G

Moderate Assured Confidentiality: Video/No Video

Phase I - Video

This will be a short, two-part interview, in which you will be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. You will have a couple of minutes after each question to make your verbal response. The interviewer will be writing down your responses to each of the questions as the interview proceeds. After completion of the first ten questions there will be a short break and you will be given additional instructions at that time.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

This interview is part of a larger study of attitudes of young adults about certain issues, so I want you to know what will happen to your interview responses after the interview. The transcripts of this interview will be analyzed by the experimenter and Dr. John McGuire, a university staff member of the Department of Psychology, who is the project supervisor. No one else will see your responses. Thank you in advance for your willingness to participate in this project. Are there any questions?
Phase II - No Video

During the next short set of interview questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life, your responses will be video taped by a camera behind the one-way mirror in front of you for additional analysis of your responses. You may watch on this monitor.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the video-taping of this portion of the interview.

This video-taped portion of the interview is again a part of a larger study of attitudes of young adults about certain issues, so I want you to be reminded again of what will happen to the video tape after the interview. The video tape of this interview will be analyzed by the experimenter and Dr. John McGuire, a university staff member of the Department of Psychology who is the project supervisor. No one else will have access to the tapes. Are there any questions?
APPENDIX H

HIGH ASSURED CONFIDENTIALITY: NO VIDEO/VIDEO
Appendix H

High Assured Confidentiality: No Video/Video

Phase I - No Video

This will be a short, two-part interview in which you will be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. You will have a couple of minutes after each question to make your verbal response. The interviewer will be writing down your responses to each of the questions as the interview proceeds. After completion of the first ten questions, there will be a short break and you will be given additional instructions at that time.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is important that you be as open and honest as you can during the interview.

I want you to be assured that everything you say will be held in the strictest confidence. Only the interviewer will know whose responses are yours, and the questionnaire will be destroyed as soon as the data is analyzed. Thank you in advance for your willingness to participate in the project. Are there any questions?
Phase II - Video

During the next short set of interview questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life, your responses will be video-taped by a camera behind the one-way mirror in front of you for additional analysis of your responses. You will be able to watch on this monitor (point).

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the video taping of this portion of the interview.

I want to assure you again that everything you say will be held in the strictest confidence. It will be between you and the interviewer and (s)he is bound by ethics never to reveal the identity of any subject including showing anyone your video tape. Are there any questions?
APPENDIX I

HIGH ASSURED CONFIDENTIALITY: VIDEO/NO VIDEO
Appendix I

High Assured Confidentiality: Video/No Video

Phase I - Video

This will be a short, two-part interview in which you will be asked some questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. The interviewer will be writing down your responses to each of the questions as the interview proceeds. In addition, your responses will be video-taped by a camera behind the one-way mirror in front of you for additional analysis of your responses. You may watch on this monitor (point). After completion of the first ten questions, there will be a short break and you will be given additional instructions at that time.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

I want to assure you again that everything you say will be held in the strictest confidence. It will be between you and the interviewer and (s)he is bound by ethics never to reveal the identity of any subject including showing anyone your video tape. Are there any questions?
Phase II - No Video

During the next short set of interview questions, you will be asked some more questions concerning yourself, your opinions on various subjects, and how you feel about certain things in your life. Again, you will have a couple of minutes after each question to make your verbal response. The interviewer will continue to write down your responses to each of the questions as the interview proceeds but the video-equipment will be turned off.

I want you to remember that you are free to end the interview at any point or to refuse to answer any question just by saying so. It is extremely important that you be as open and honest as you can during the interview.

I want you to be assured that everything you say will be held in the strictest confidence. Only the interviewer will know whose responses are yours and the questionnaire will be destroyed as soon as the data is analyzcd. Thank you again for your willingness to participate in the project. Are there any questions?
APPENDIX J

INTERVIEW QUESTIONS - PHASE I
Appendix J

Interview Questions - Phase I

1. How do you like to spend your spare time? (L)
2. What are your personal goals for the next ten years or so? (L)
3. How do you react to criticism and praise by others? What things do people criticize and praise you for? (M)
4. What characteristics of your parents do you dislike? (H)
5. What aspects of your body are you most satisfied or dissatisfied with? (H)
6. What things in your life are you most ashamed of? (H)
7. How often do you have sexual experiences and what are the nature of these experiences? (H)
8. What are your favorite forms of erotic play and sexual love-making? (H)
9. What are the sources of strain in your relationships with the opposite sex? (H)
10. How can you tell when you are getting sexually aroused? (H)

(Letters in parenthesis indicate Low, Moderate, or High rated level of intimacy.)
APPENDIX K

INTERVIEW QUESTIONS - PHASE II
Appendix K

Interview Questions - Phase II

1. What are some of the places you would like to live or work? (L)

2. What aspects of your daily work (or school) satisfy and bother you? (L)

3. What are your usual ways of dealing with depression, anxiety and anger? (M)

4. What disappointments have you experienced with the opposite sex? (H)

5. How do you feel about your sexual adequacy? Why? (H)

6. What are your guiltiest secrets? (H)

7. What aspects of your personality do you dislike, worry about, or regard as a handicap? (H)

8. With whom have you been sexually intimate? What were the circumstances of each of your relationships? (H)

9. What are your most common sexual fantasies or daydreams? (H)

10. Who are the persons in your life you most resent? Why? (H)

(Letters in parenthesis indicate Low, Moderate, or High rated level of intimacy.)
APPENDIX L

PROBES
Appendix L
Probes

1. Nondirective leads, reassurances
   a. Do you want to tell me a little more about that?
   b. Would you like to carry that on a bit further?
   c. I'm not exactly sure if I understand exactly what you mean. I wonder if you might be able to tell me a bit more about the sort of thing you had in mind?
   d. Could you give me an example of that?
   e. That's interesting. Tell me more.
   f. Could you continue on some more about that?
   g. It gets complicated sometimes. I wonder if you could give me an example of the kind of thing you mean.
   h. I know it's hard to talk about these things, but please go on.
   i. Some of these questions aren't easy to answer, but please go on.
   j. You're doing fine. Why don't you go on?
   k. Um-hmmm. I can see how you feel.

2. Emergency probes
   a. Just start wherever you want...say whatever comes to you.
   b. pacing session: We only have a short time left to talk about this.
Is there anything that you want to add? That's interesting and I hope we can get back to it, but now there are a few other things I'd like to ask first.

c. refusal to answer: Of course you don't have to answer, but is there anything you'd like to say about it?

We can get back to that later, if you want.

d. changing topics: To change the subject a bit, here is another question.

OK, are you ready for the next question? Let's go back to an earlier topic.
APPENDIX M

SCORING SYSTEM FOR RATING DISCLOSURE INTIMACY
Appendix M

Scoring System for Rating Disclosure Intimacy

A. Instructions: Use the scale below to rate the most intimate material which the subject talked about. In other words, how personal was the information which the individual revealed?

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Little information</td>
</tr>
<tr>
<td>2</td>
<td>Superficial</td>
</tr>
<tr>
<td>3</td>
<td>Midpoint</td>
</tr>
<tr>
<td>4</td>
<td>Moderately intimate</td>
</tr>
<tr>
<td>5</td>
<td>Intimate</td>
</tr>
<tr>
<td>6</td>
<td>Extremely intimate</td>
</tr>
</tbody>
</table>

B. Examples of the Major Scoring Categories

1. The person refuses to talk about himself; continually asks the other person to talk about himself; sits quietly, rarely says anything.

3. The person talks the entire length of time about superficial content. For instance, he mentions what movies he has seen, what classes he is taking, where he works part-time, superficial description of siblings.

5. The individual talks about personal feeling, but not at an intimate level. For instance, he talks about career goals, what his girlfriend is like, views on dating and the value of education. This category will be appropriate when it is difficult to decide if the person talks intimately or not.

7. The person talks at a moderately intimate level. For instance, the person might go into detail about problems in getting dates, nervousness when speaking in class, problems about being too fat, feelings of guilt.

9. The person talks about material which is very personal, embarrassing, or emotional. For instance, the person mentions specific details about sexual experiences, wanting to commit suicide, details of family disruption because of an alcoholic parent, or description of homosexual feelings.
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