



DOCTORAL THESIS

An Investigation into the Experiences and Attitudes Regarding Therapists' Verbal Self-Disclosure from the Developing Counselling Psychologists' Perspective: A Phenomenological Study

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**An Investigation into the Experiences and Attitudes Regarding
Therapists' Verbal Self-Disclosure from the Developing
Counselling Psychologists' Perspective:
A Phenomenological Study.**

by

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Abstract

This study explores the phenomenon of therapists' verbal self-disclosure in the therapeutic encounter. The purpose is to examine the clients' experiences and attitudes on therapists' verbal self-disclosure, when the clients are counselling psychology trainees or newly qualified counselling psychologists. The present study will attempt to discover what the participants believe constitutes self-disclosure and how influential their therapists' verbal self-disclosure or lack of it, has been in the development of their personal and professional stance on self-disclosure in their own work with clients. Since the researcher is interested in clients who themselves are developing counselling psychologists, the study sheds light on how their therapists' verbal disclosure (or lack of it) influences their developing professional identity. The majority of studies exploring therapists' self-disclosure have favoured quantitative methodologies; however, a case can be made for using a qualitative phenomenological approach to explore this phenomenon on the grounds that it provides a more detailed representation of the experience and allows for an in-depth phenomenological understanding of the complexity and content of self-disclosure. Nine developing counselling psychologists were interviewed for this study and the three major findings of the study are that a) developing counselling psychologists, influenced by their own personal therapy, do engage in counter-transference self-disclosure, b) the decision to engage in self-disclosure or not is made upon their intuition and 'gut feeling' and c) although training institutions or supervisors might not encourage self-disclosure, participants still engage in it. These findings raise questions concerning the role of training versus the role of personal therapy in shaping trainees' client work, as well as issues regarding the reasons why they chose to self-disclose or not and the role of intuition.

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1. Preface

The present study will examine the developing counselling psychologists' attitudes and perceptions to therapists' verbal self-disclosure. My interest in this topic began during my training as a counselling psychologist, when I was exposed to a range of different modalities while at the same time was required to undertake my own personal therapy as well as my client work. As a trainee in counselling psychology, I often had the impression that therapists' self-disclosures were against the philosophies of certain psychotherapeutic schools (e.g., psychodynamic school), as well as certain supervisors. In addition, throughout my training I had not been encouraged to self-disclose. Thus, I had associated therapists' self-disclosure with an ethical wrongdoing; namely, blurring the boundaries, shifting the focus away from the client to the therapist, or even damaging the therapeutic process. Having the impression that therapists' self-disclosure is against the rules of the profession as a whole, it felt safer to restrict myself within the known 'professional' position, rather than attempt to engage in any kind of self-disclosure that could harm my clients.

However, my personal therapy was a different experience for me. My therapist frequently self-disclosed to me by bringing examples of either her personal or clinical experience into the room. I perceived her self-disclosure quite helpful at times and found myself questioning why it is so much frowned upon by training programmes or supervisors. Also, in my own client work I frequently grappled with the question of the degree and nature of the use of self-disclosure. From the simplest question (e.g., where I come from) that my clients would ask me, to the most challenging ones (e.g., how I perceive them) my response would be the same, namely: 'let's explore your need to ask me this question'. While still in year one of my training, I was seeing a bereaved lady for about six months. In our penultimate session she asked me if I knew where she was coming from; if I could understand her pain. Having had a similar loss in my life as well, I answered that I knew very well what it meant to lose a loved one. In our last session she confessed that my self-disclosure was a moment of real connection and that she was grateful for my sharing that with her. This experience made me think that therapists' self-disclosure might have some value and meaning for clients and I became interested in wanting to explore the phenomenon of therapists' verbal self-disclosure further.

In psychoanalytic psychotherapy training, there seem to be straightforward rules, like 'do not self-disclose' (Davis, 2002). In CBT training there seems to be an encouragement to self-disclose through psycho-education (Goldfried, Burckell & Eubanks-Carter, 2003), as well as in humanistic approaches that hold that self-disclosure promotes the establishment of a real encounter (Spinelli, 1994). As a counselling psychologist immersed in daunting and challenging training that exposed me to different ranges of therapeutic modalities, I had to find my own path of being an integrative counselling psychologist and grapple with how much of my own personal and professional limits should be revealed to my clients through the inevitable mistakes that an apprentice makes. Self-disclosure was an aspect of the work that I did not want to discard thoughtlessly, nor incorporate blindly.

Searching the counselling literature in the area of therapists' verbal self-disclosure revealed that there was a considerable amount of interest in this phenomenon from both the viewpoint of the clients (e.g., Curtis, 1982a; Knox, Hess, Peterson & Hill, 1997; Hanson, 2005) as well as the therapists (e.g., Norcross, Geller & Kurzawa, 2001). However, none of these studies examined the perceptions of trainees in counselling psychology who take a dual role: that of the therapist and that of the client. As a trainee in counselling psychology, knowing that my personal therapy has shaped the way I work with my clients in many respects, I was interested in interviewing other counselling psychology trainees or those newly qualified to study their perceptions and experiences of verbal self-disclosure both in their personal therapy and in their client work. The first part of the interview attempted to explore questions regarding their own personal therapist's self-disclosure, the impact that it had (if any) on the therapeutic relationship and how that informed their own practice. The second part of the interview focused more on the participants' client work and their use (if any) of self-disclosure. Since I was more interested in gaining a better insight into the participants' experiences, I employed a qualitative methodology which allows for themes to emerge and gives a deeper phenomenological understanding of the phenomenon under study.

2. Introduction

“The world- Being-discloses itself without surcease. The world discloses itself in forms and patterns and as change. The being of the world is revealed in splendiferous variety, depending upon the nature of the ‘surface’ from which it is refracted”

(Jourard, 1968: 173)

“When I am with him, I can disclose to him how I experience him. I enter into dialogue with him; and with each of his utterances or acts, I can respond out my experience and disclose to him what it is that I am experiencing. If I remain in contact with him, consistently in dialogue, I may actually lead him to the edge of going out of his mind, thus clearing the way for the emergence of a new self”

(Jourard, 1968: 124)

Jourard uttered these thoughts almost half a century ago, but they still echo today. There has been a considerable controversy over therapists’ self-disclosure since the late 1960s (Jourard, 1971; Curtis, 1982a, 1982b; Andersen & Anderson, 1985; Watkins, 1990; Knox *et al.*, 1997; Barrett & Berman, 2001; Hanson, 2005; Bottrill, Pistrang, Barker & Worrell, 2009). Most research on therapists’ verbal self-disclosure (e.g., Lundeen & Schuldt, 1989; Barrett & Berman, 2001) has focused on analogue studies and not on real-world settings and/or has used quantitative methods of analysis (e.g., Myers & Hayes, 2006). This research aims to explore the experiences of clients in their therapist’s use of self-disclosure. However, clients in this study will have a dual role since they are trainees in counselling psychology or newly qualified, therefore they are themselves therapists.

The research question concerns how developing counselling psychologists experience their therapist’s verbal self-disclosure or lack of it, and how that experience affects (if it does) their own client work. Since counselling psychology trainees often feel that self-disclosure is regarded with disapproval or is a taboo in the therapeutic context (Bottrill *et al.*, 2009), the present study attempts to enrich our knowledge, by exploring the phenomenon of self-disclosure from two different perspectives, that of the therapist and the client, by interviewing counselling psychologists who are still developing their professional identity. The methodology employed is a qualitative method which allows for a more in depth representation of the participants’ experiences.

The research will begin by presenting a literature review on therapists' verbal self-disclosure. A discussion on the definition, ethicality and the stance that different psychotherapeutic modalities adopt on self-disclosure will be followed by research studies that have investigated the phenomenon. At the end of this chapter, the present research study will be located within the existing literature and research. It is hoped that this first chapter will set the 'scene' for the remainder of the research. The next two chapters concern the methodology employed by the researcher and the difficulties that were encountered in attempting to locate the researcher's epistemological position as well as the method that was followed in recruiting and interviewing the participants and analysing the data. The 'Results' chapter will include the findings of the analysis. Excerpts of participants' transcripts will also be included to illustrate the different emergent themes (as interpreted by the researcher). Finally, a chapter on discussing the significance of the findings as well as the limitations of this research will follow.

It is worth noting that the research adopts a contextual constructionism epistemology. Therefore it does not assume that there is only one reality. Instead, the findings will vary depending on the context in which the data were collected and analysed. It is important, therefore, to remember that the aim of the research is not to try and discover meaning but to construct it (Crotty, 1998).

3. Literature Review

3.1. Introduction

Using *PsycARTICLES* and *PsycINFO* to search for *counselling psychology* and *self-disclosure* resulted in nil results; however when using only the key term “self-disclosure” the same databases yielded 169 results, from which 55 were related to therapy/psychotherapy. This indicated that there is no direct literature on self-disclosure and counselling psychology but there is a considerable amount of literature on *self-disclosure and therapy/psychotherapy*. Using a more specific search to target journals specific to counselling psychology yielded varying results: *British Journal of Guidance and Counselling* (1973-present) 76; *Counselling and Psychotherapy Research* (2001-present) 30; *The Counseling Psychologist* (1969-present) 81; *Counselling Psychology Quarterly* (1988-present) 36; *Counselling Psychology Review* (2004-2007) 0; *European Journal of Psychotherapy and Counselling* (formerly *European Journal of Psychotherapy, Counselling and Health*) (1998-2006/2006- Present) 19; *Journal of Counseling Psychology* (1954-present) 33; *Psychology and Psychotherapy: Theory, Research and Practice* (1920-present) 45; and, *Psychotherapy Research* (1991-present) 77. From these papers, those with a primary focus on clients’ self-disclosure were excluded. The researcher’s interest was exclusively in the verbal self-disclosure of the therapist. Also papers referring to other forms of self-disclosure were excluded since the scope of the study was to explore only verbal self-disclosure.

Therapists’ verbal self-disclosure is a subject that has received a lot of attention in the literature. There is a lot of controversy on whether self-disclosure is deemed appropriate in the therapeutic context. Also a lot of research, mostly based on analogue designs, has explored the importance and effect of verbal self-disclosure within counselling and psychotherapy. However, the literature pertaining to counselling psychology remains non-existent. The literature on self-disclosure will be summarised in this chapter with particular focus on previous research studies. Prior to this, a brief historical perspective on therapists’ verbal self-disclosure, as well as the stance that the three major theoretical strands in counselling psychology (cognitive behavioural therapy, psychoanalytic/ psychodynamic, and humanistic/ existential) adopt regarding self-disclosure will be presented. Focusing on the main question of interest, the experiences of developing counselling psychologists about

their therapist's self-disclosure and the impact of it on the therapeutic relationship and on their own client work, the researcher will attempt to establish by the end of this chapter the present research in the existing literature by investigating the role of verbal self-disclosure in counselling psychology.

3.2. Self-Disclosure: History, Definition, Types of Self-Disclosure and Ethicality

Weiner (1978) referred to self-disclosure in order to emphasise the therapist's use of self in openness and genuineness in the therapeutic encounter. For Weiner this did not mean that the therapist rejects their professional role, but rather that therapy is seen as an ongoing process in which the therapist is viewed as another human being in relation to his or her client; as a human being with both a past and personality - vital qualities for the therapeutic process. Self-disclosure on the part of the therapist is an expected aspect of the therapeutic relationship as there has been an increased public interest in understanding and promoting healthy personal relationships. The women's movement contributed fundamentally to the way in which psychotherapy has changed. Whereas in the past women had restricted their career choices to teaching or nursing, gradually they began entering the fields of medicine, law and psychology. As a result, psychotherapy became more relational and therapists became more open (Farber, 2006).

Self-disclosure is defined as an utterance that refers to the speaker's experience and uses the speaker's subjective frame of reference (Stiles, 1987). Therapists' self-disclosure can be defined as any behaviour or verbalisation by the therapist that discloses information to the client (Hazel, 2006). Research on therapists' self-disclosure (Farber, 2006) has mostly focused on intentional, verbal self-disclosure. This focus excludes the effect of inadvertent or non-verbal disclosures (e.g., a therapist's style of dress or facial expression). Weiner (1972) described self-disclosure as occurring when the therapist provides the client with more than just professional expertise or when they are deliberately more open and genuine with the client in revealing feelings, opinions, experiences or personal history. Nilsson, Strassberg and Bannon (1979) differentiated between intrapersonal self-disclosure (where the therapist discloses personal information regarding their life outside of counselling) and interpersonal (where the therapist shares feelings about the client's problems or the therapeutic relationship) (Knox *et al.*, 1997). Over time these definitions have been refined and recently the literature (Knox & Hill, 2003; Knox *et al.*, 1997; Farber, 2006; Audet & Everall, 2003) distinguishes between self-

involving statements (statements that reveal the therapist's reactions, thoughts or emotions about the client during the therapeutic encounter) and self-revealing statements (statements that reveal factual and personal information about the therapist). Self-revealing therapist communication refers to personal experiences or qualities of the therapist that do not directly involve the client, whereas self-involving therapist communication refers to the disclosure of immediate feelings and reactions within the therapy context (Hendrick, 1987). Knox and Hill (2003) referred to self-involving statements as disclosures of immediacy; that is, here-and-now responses of what happens in the room, also known as counter-transference disclosures; "a form of clinical honesty that focuses on the therapist's experience of the patient in the here-and-now of the session" (Wilkenson & Gabbard, 1993: 282). Therapists, who are ambivalent about the nature of therapeutic action and feel quite vulnerable and self-conscious about exposure, often retreat from openness and honesty (Bridges, 2001). As Bridges (2001: 25) puts it: "Sometimes the more comfortable position for the therapist is to remain protected behind a professional veneer that forecloses the experience of intense affect, deep conversations, and self-disclosure".

Shadley (2000) examined the way in which therapists utilised self-disclosure and based on her findings developed a continuum of self-disclosure styles, introducing four different types of self-disclosure: a) the intimate interaction, b) the reactive response, c) the controlled response and d) the reflective feedback. The intimate interaction refers to the therapist opening up through verbal and non-verbal expressions of therapeutic responses (e.g., female therapist pregnancy). The reactive response refers to the emotional connectedness that is revealed through verbal or non-verbal responses and enhances the therapeutic relationship. It resembles Buber's (1923) idea of the 'I-Thou' relationship and involves the disclosure of strong emotional reactions (e.g., the therapist might cry at something the client has said). However, Shadley (2000) argued that self-disclosure of this type does not include a therapist's personal experience outside of the therapy setting. The controlled response involves limited self-disclosure; the therapist chooses which stories will be of more value to disclose. These self-disclosures might include anecdotes, past experiences of the therapist or literary parallels (Shadley, 2000). Finally, the reflective feedback is probably the standard behaviour taught on training courses (Rowan & Jacobs, 2002) and refers to the revelation of the therapist's opinions and

impressions but not the self-disclosure of personal information or emotional reactions.

Hill and O'Brien (1999) also distinguished four types of self-disclosure: a) disclosure of facts, b) disclosure of feelings, c) disclosure of opinions and insight and d) disclosure of personal strategies. The last three types of self-disclosure can be seen as sub-types of self-involving statements directly related to the therapeutic encounter. Jacobs, (1999: 159) noting the many different types of self-disclosure, commented that "each instance of self-disclosure must be evaluated on its own terms in the light of the clinical situation in which it occurs and its effect on the analytic process".

The risks associated with self-disclosure and the dangers of boundary violations have been examined in the literature (Weiner, 1969; Langs, 1982; Breger, 1984). A therapist's self-disclosure, with its various types, intentions, motives, merits, and limitations, has been associated with the abuse of power in therapy and has also been a source of critical concern (Chesler, 1972; Gannon, 1982). As Gutheil and Gabbard (1993) argue, the therapist's revelation about personal fantasies, dreams, and sexual or financial information, reverse the patient-therapist role and hinder the therapeutic process. Glass (2003) differentiated between 'boundary violations' which are unethical exploitations of patients and 'boundary crossings', which occur when the therapist attempts to employ tools that will foster the work in therapy. Depending on whether the sharing by the therapist is of more benefit to the patient or the therapist, it is either a legitimate boundary crossing or a boundary violation, respectively. Curtis (1982b) emphasised the importance of refraining from self-disclosure because in his view the therapist's self-disclosure would contaminate the transference process and disrupt the therapeutic bonding. A therapist's self-disclosure obstructs the exploration of the less conscious parts of the client's personality (Wachtel, 1993). As a result, the more the therapeutic interaction resembles social interaction, the more likely it is to elicit surface reactions, therefore making the client's psyche even less accessible. However, complete non-disclosure is not possible as therapists often reveal some aspect of themselves without always being conscious or aware that they are doing so (Natterson & Friedman, 1995). Therefore, even when therapists provide no explicit information about themselves, self-disclosure is a continuous, inevitable process.

A therapist's self-disclosure as a way of strengthening the therapeutic relationship is the most widely cited reason for its use (Andersen & Anderson, 1985;

Jourard, 1971). Early researchers of self-disclosure examined whether self-disclosure by an interviewer elicits a reciprocal effect from the interviewee (McAllister & Kiesler, 1975; DeForest & Stone, 1980; Doster & Brooks, 1974). Most studies involved a confederate who offered self-disclosures varying in intimacy and the responses of the interviewees were analysed. It was found that the greater the intimacy of the self-disclosure, the greater was the reciprocal effect. However, these findings should be interpreted with caution as there is a qualitative difference in context of self-disclosure in an experimental interview and that which occurs in a therapeutic encounter. Besides, as Andersen and Anderson (1985) argue, it is all too common that clients who enter therapy expect that their personal disclosure will be unreciprocated by the therapist.

A therapist's appropriate self-disclosure is viewed to consist only of those self-disclosures that are intended to be beneficial to the client as opposed to the therapist (Edwards & Murdock, 1994). According to Miller (1983), appropriate self-disclosures are those that elicit a client's disclosures, instil trust and enhance the relationship. Bridges (2001) states that self-disclosure, if psychologically attuned, may deepen the therapeutic relationship and add a new fostering dimension to the work.

Gutheil and Gabbard (1993) emphasised that therapists who engage in self-disclosure must be aware of the rationale for doing so. It is unethical to self-disclose if the therapist is using it to meet their own needs and not the needs of the client (Gabbard & Nadelson, 1995). They also argue that eliminating self-disclosure completely could even be detrimental to treatment, in some cases. The content of self-disclosure, the rationale behind it, the type of client a therapist chooses to reveal himself to and the circumstances under which they choose to do so, are all questions that need to be addressed in relation to ethicality (Peterson, 2002). As Wachtel (1993) conceptualised it, a therapist's self-disclosures can be exploitative when they refer to personal experiences outside of the therapeutic setting, whereas they can be very beneficial to the client when they involve the therapist's reactions to the client.

Goldstein (1994) saw self-disclosure as a means of expressing empathy as long as the therapist was in tune with their client's needs and history. She appreciated the difficulty in distinguishing between the desire to self-disclose due to personal needs and sharing with the client for empathic reasons. Epstein (1994) suggested two types of clients that may be more likely to be harmed by therapists' self-disclosure,

namely, a) the accommodating type which involves clients who become healers themselves and have the need to take care of the therapist and b) the impulsive client type with poor boundaries who might use self-disclosure as an excuse to deliberately violate the therapeutic boundaries.

3.3. Therapeutic Modalities & Self-Disclosure

Different therapeutic modalities adopt different stances to a therapist's self-disclosure (Edwards & Murdock, 1994). This research study will examine the perceptions and experiences of either newly qualified counselling psychologists or counselling psychologists in training, in both their own personal therapy as well as their client work. Since counselling psychologists have been trained in a variety of different psychotherapeutic schools, it is deemed appropriate to look at each one of them separately in relation to their stance on therapists' self-disclosure.

3.3.1. Cognitive Behavioural Therapy

Kottler (1991: 61) saw therapy as “an educational process that facilitates learning about self and others” and described self-disclosure as “the single most difficult therapist skill to use appropriately and judiciously” (p.167). Cognitive behavioural therapy views self-disclosure as an effective tool for enhancing the therapeutic relationship and reinforcing client change (Goldfried *et al.*, 2003). Behavioural therapists argue that it also provides modelling for the client (Edwards & Murdock, 1994). Modelling is an important tool in behavioural techniques as it is effectively used for diminishing undesirable behaviours and reinforcing more desirable ones (Weiner, 1978). Lazarus (1985) used the example of a claustrophobic client whose therapist's self-disclosure of a similar experience proved very helpful. Lazarus (1985: 1419) described that at the moment of self-disclosure, “We had the hallmarks of good behaviour therapy - rapport, empathy, identification, specificity, and practice”.

In Albert Ellis's rational-emotive therapy (RET) (Dryden, 1990), the therapist has an educational role where he or she applies the RET methods by sharing similar experiences. By doing that, the therapist instils trust and enhances the relationship by pointing out that both client and therapist are fallible human beings who struggle with common difficulties. A therapist's self-disclosure of personal reactions to the

client can help the client realise the impact that they may have on others in their interpersonal relationships. By responding differently to different behaviours of the client, the therapist reinforces adaptive behaviours and discourages problematic ones. In this case a therapist's self-disclosure very much resembles the behavioural principles of reinforcement (Goldfried *et al.*, 2003) and the role of the therapist becomes mostly educational (Farber, 2006). Essential to people's developing hope for the future and 'formulating personal recovery goals' (Mueser *et al.*, 2002: 1273) is helping them gain mastery over their psychological problems. Basic education about mental illness facilitates their ability to regain control over their lives and to establish more collaborative and functional relationships.

In Mueser's *et al.*, (2002) paper, a number of controlled studies of coping skills training and comprehensive programs are summarised. The coping programs aimed to increase the client's ability to deal with persistent symptoms of distress, whereas the comprehensive programs incorporated a range of illness management strategies, including psycho-education, stress management, coping strategies, goal setting and problem-solving. Although the studies were quite different, both in the methods employed and in the targets of the intervention, they all employed cognitive-behavioural techniques and produced uniformly positive results in reducing symptom severity. This could constitute a case that a more collaborative stance on the part of the therapist, which involves psycho-education and provision of didactic information could provide a conducive context that could facilitate the client's change in behaviour.

Also, the therapist by modelling the process of problem-solving instils hope for the client and shows that the client's problems might be difficult but not impossible. Mahoney (1974) emphasised the importance of a therapist's self-disclosure to model his or her own thoughts, cognitions and behaviour. He believed that by thinking out loud during the therapeutic session, the therapist may provide valuable support in developing, integrating and adaptively revising the client's cognitions and beliefs. Bandura (1986) demonstrated the effectiveness of modelling by showing that certain characteristics of observers and models are optimal in facilitating the learning process. Observers who lack confidence and self-esteem are prone to adopt the behaviour of successful models of high status and competence. Goldfried *et al.*, (2003) argued that in light of such findings, the therapeutic interaction could facilitate change through modelling. However, such an argument

seems to imply that there is a power imbalance between the therapist and the client and reduces the human entity of the client into that of a mere observer who lacks confidence and self-esteem and who needs to model the therapist, who is viewed as someone of higher status and competence.

Counselling psychology holds that the psychotherapeutic relationship seeks to empower rather than to control. The neutral, emotionally distant, expert-therapist model (Worell & Remer, 1992) that had been proposed by many traditional therapies is replaced by a model that emphasises transparency, compassion and mutual respect. However, as Simon (1990: 211) states: “while it is true that both patient and client are equal in terms of their human rights, and the complexity of their psychological makeup, the therapist is more expert than the patient in the realm of emotional problems and their solutions. To deny this is to deny the validity of one’s own training”.

3.3.2. Psychoanalytic/ Psychodynamic Approach

In 1912, Freud contraindicated the use of the therapist’s self-disclosure while he supported the concept of a ‘blank screen’ posture, arguing that the therapist’s expressed personal reactions will contaminate and interfere with the patient’s transference reactions. Within the classical psychoanalytic/psychodynamic approach, the therapist is viewed as an outside observer, not as a participant in the relationship. She or he is the object of the client’s drives and tries not to use self-disclosure, which would gratify these drives. Freud’s ideas were very much influenced by his medical predecessors. “A powerful model for boundaries was aseptic surgery, in which protective barriers between the physician and the patient prevented the transmission of infection” (Dixon *et al.*, 2001: 1489). According to the psychoanalytic view, nondisclosure would allow the patient’s projections to be identified and examined in the transference. Hence, the therapist became responsible for maintaining anonymity, abstinence, neutrality and nondisclosure, thus protecting the boundary between the patient and the therapist (Dixon *et al.*, 2001). Freud (1912: 118) strongly argued that the therapist should remain “opaque to his patients, like a mirror and show them nothing but what is shown to him”. Storr (1979) makes the argument that psychotherapy is a one-sided relationship and therefore therapists should not expose themselves while being with the patient; instead they should act as a mirror in which the patient can see their own selves. Although a therapist’s disclosure may provide

the client with momentary relief, it was viewed to have a negative effect and provided the basis for 'therapeutic misalliances' (Lane & Hull, 1990). Therapists' self-disclosure, therefore, is seen as a sign of counter-transference difficulties (Tantillo, 2004). Conversely, anonymity provides a full opportunity for projection by the client and gives a sense of safety to the therapeutic relationship by keeping the boundaries clear. A contemporary argument against self-disclosure is that analysts, despite their psychological mindedness and insight, cannot always be aware of their motivations for engaging in self-disclosure and are, therefore, prone to blur their needs with their patient's needs, misusing the relationship for their satisfaction, or desire for narcissistic gratification, eventually damaging the therapeutic environment (Farber, 2006).

Sandor Ferenczi (Jacobs, 1997) gave a bad name to self-disclosure with his experiments in mutual analysis, his boundary manipulation and entanglements with his patients. He believed that healing was the result of a relationship in which both participants openly shared their thoughts and feelings. Self-revelation became associated with confessions of love and sexual attraction to the patient on the part of the analyst. Research on sexual intimacies in therapeutic relationships does indeed show that physical intimacy and sexual intercourse begins with the therapist revealing strong feelings about their patient (Farber, 2006). Epstein (1994) stated that frequent self-disclosure by the therapist about personal issues could lead to the therapist's sexual involvement with their clients. He also pointed out that this kind of self-disclosure can lead to suicidal behaviour in clients because they might perceive their therapist as exploitative. However, he argued that self-disclosure concerning the therapist's training, the therapeutic orientation and the treatment procedure is entirely legitimate according to the ethical principle of autonomy.

Langs (1982) viewed self-disclosure as being on a continuum. On one end of the continuum exists the disclosures that are inevitable and do not impact on the therapeutic relationship and on the other end of the continuum exists those self-revelations that are deliberate and disrupt the relationship between the therapist and the patient. Kohut (Farber, 2006: 127), viewed self-disclosure as a 'problematic countertransference intrusion that prematurely exposed patients to the analyst's separateness and individuality'. Unlike Freud who thought that self-disclosure of the analyst obstructs neutrality, Kohut thought that it strengthens the separateness of analyst and patient. However, Kohut's views have been reviewed and contemporary

self-psychologists suggest that engaging in self-disclosure with patients who are narcissistic, as a result of distant and detached parents can be very helpful (Goldstein, 1997).

Hoffman (1991) believed that the asymmetry in the psychoanalytic relationship was necessary for the client's change process because it protected a certain aura or mystique that should characterise the role of the analyst. Self-disclosure could interfere, shifting the attention away from the client and blur the boundaries. Lehrer (1994) arguing against Hoffman's view, did not find this mystique as uniquely therapeutic or that it existed only in a non-symmetrical relationship. Kanzer (1963) referring to the problem of answering patients' questions, stated that the questions are never 'innocent'; therefore, they are better left unanswered. Instead, the therapist should attempt to explore the drive of the patient in asking the specific question. Meissner (2000: 839) describing his own experience, states that a lot "depends on the nature of the question and how it is asked", while Jacobs (1999) emphasises that refusal to answer questions can lead to a standoff and a disruption of the therapeutic relationship. On the other hand, Meissner (2000) points out that too much gratification of the patient's wish to know information about the therapist might reinforce and collude with old patterns and enactments around the transference, therefore, making it less available to explore.

Ehrenberg (1995: 214), in his attempt to emphasise the power of unconscious communication, noted that:

"If we recognize our own vulnerability to unconscious responsiveness in the analytic interaction, then we must consider that anything we say or do, including remaining silent, can be a form of countertransference enactment. Remaining silent, for example, which is often considered a safe response when we are in doubt, can be sadistic, based on our own anxiety, or a form of compliance or submission, to name only a few possibilities, whether or not we have any grasp at the time that this might be so. Similarly, interpretation can be a form of harassment, impingement, competition, seduction, manipulation, or gratification, among other possibilities. The same is true for any other form of participation, including disclosure of any nature, not just countertransference disclosure. Any kind of response can be authoritarian, assaultive, blaming, sadistic, collusive, gratifying, or whatever. Any response also always has multiple levels of impact and meaning, so what may seem

analytically sound on one level may also be used manipulatively, seductively, destructively, etc., on another level. Even our efforts to monitor for countertransference enactment may themselves be forms of countertransference enactment on another level. We simply cannot ignore the power of unconscious communication, affective communication, and enactment in the analytic relationship”.

His words are in line with the idea that we can confidently assert that in therapy, therapists, whether consciously or unconsciously, deliberately or unintentionally, explicitly or implicitly, verbally or non-verbally, reveal themselves (Natterson & Friedman, 1995). Greenson (1971) seems to value this argument by suggesting that it is inevitable that personal information will be revealed because everything a therapist does or says, or does not do or say, reveals something about their real self. Even while making interpretations, therapists reveal more of themselves than they intend to. Even the most antiseptic of presentations conveys an impression, whether accurate or not, about the therapist. It is interesting to note that despite Freud’s disapproval of the use of self-disclosure, case histories and patient’s reports of analysis show that he often spoke of himself and his family (Stricker, 1990).

According to Schachter (1996), Gill’s major contribution to psychoanalysis was his realization that the therapeutic relationship is a two-person relationship; that is, a human relationship. That realization ‘freed’ him from the vestments of the analytic process such as abstinence and neutrality and enabled him to see the analyst as a person who offered help to an individual in trouble. Also, Renik (1995) referred to anonymity as pretence and self-disclosure as an inevitable part of a dyadic encounter.

Some psychoanalysts (Rowan & Jacobs, 2002) suggest that self-disclosure is likely to jeopardise transference in the beginning of therapy but actually may help by dissolving the transference in preparation for the end of the therapeutic relationship. Ehrenberg (1984) believed that the expression of affective reactions to the patients; that is, sharing counter-transference feelings, might be helpful to clients becoming aware of their actual impact on others. Also, it gives the psychoanalyst a more human dimension; the therapist is viewed as someone with feelings who can empathise and be understanding. Not responding affectively can lead to feelings of detachment, abandonment or increased resistance (Ehrenberg, 1984).

Self-disclosure in psychotherapy can also be understood as a developmental analogue between the infant-mother dyad and the client-therapist dyad. In respect to the 'Self Psychology' as developed by Kohut (1971), 'the self', develops as the child grows through processes of internalisation. The pleasure that a child perceives in his mother's face as she enjoys his/her activity and accomplishments is internalised and becomes his own image of himself in which he can take pleasure, feel nourished and secure. Conversely, in familial situations that lack nourishment and mirroring, the child fails to grow a cohesive and integrated self (Kohut, 1971). The therapist's task then is to "strengthen the self by making good those emotional deficits of the patient's childhood that resulted in his or her failure to form a securely consolidated self. This is achieved through the analyst's clear affirmation of the *person* of the patient" (Menaker, 1990: 114). When the analyst reveals something about himself/herself "it becomes an echo, or an elaboration of an echo, of the patient's own experience, and thus serves to cement a bond between the patient and the analyst". The analyst, then functions as a self-object that serves to sustain and further the patient's growing self.

In the light of Kohut's contributions, Atwood and Stolorrow (1984: 34) have given one of the most clear definitions of the self:

"The self, from the vantage point of psychoanalytic phenomenology, is a psychological structure through which self-experience acquires cohesion and continuity, and by virtue of which experience assumes its characteristic shape and enduring organization". Self as a psychological structure (i.e., self-as-structure) is an enduring trait of the personality which originally arises in the context of the intersubjective matrix of the mother-child dyad. Winnicott (1965: 39) suggested that "there is no such thing as an infant; meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant". Self-experience which refers to the immediate content of consciousness (i.e., I think this; I feel this; I fantasise this) is intertwined with the self-as-structure (Josephs, 1990), as each forms the other. The self-as-structure provides a schema through which self-experience is interpreted and assimilated, while each new self-experience provides the data base from which an evolving yet enduring representation of self is constructed. In psychotherapy, both therapist and client construct representations of each other through the many instances of mutual self-disclosure.

Stern (1985) saw the mother-infant dyad as engaged in an intricate dance of mutual self-regulation through which they each discover the self of the other. In Josephs' (1990: 78) words then "self disclosure requires a self-regulatory other whose function is to evoke, facilitate, receive, and mirror the self-disclosure, as well as one who is open to revealing the self". Stern (1985: 47) described the emergent sense of self as the "experience of organization-coming into being" which typifies the infant's sense of self in the first two months of life. The infant (and later the adult) is a constructionist; namely he/she integrates and constructs new experiences through a process of creative discovery. Without the emergent self, life would be a disorganised collection of disparate and disconnected events. The infant gradually develops a sense of self-coherence and self-agency, but is still very much dependent on the mother's facilitating responsiveness. Her affective attunement and responsiveness supports self-coherence and self-affectivity. Analogously, in psychotherapy, the patient's emergent self is effectively collecting the manifold experiences of treatment, gradually integrating them into a coherent and meaningful whole. The therapist's role, like the mother's, is to facilitate this integrative process by providing what Winnicott (1965: 45) called a "holding environment" -a secure, and supportive space that allows for the unfolding of innate maturational processes. In psychotherapy, over time the patient develops representations of experiences with the therapist as a "self-regulating other who in absence is reconstituted as an evoked companion" (Joseph, 1990: 79). The therapist uses her/his understanding of the natural reparative processes that instinctively occur between the infant-mother dyad and applies these as 'principles' in the adult to adult therapeutic relationship. The therapist then, serves as a growth-promoting self-regulating other who shows a highly personal empathic immersion in the experience of the patient. Such an empathic immersion inevitably expresses and reveals some aspect of the self of the self-regulatory other.

Object-relations theorists (e.g. Fairbairn, Winnicott, Guntrip) have argued for the importance of the new object relational experience the patient has with his analyst. From their perspective, the psychotherapeutic experience is not merely a reliving of the patient's old object relationships, but a "reworking of the old conflicts in the safety of a new growth-producing relationship, which allows for a new experience that had not been previously possible" (Papouchis, 1990: 161). In the therapeutic encounter, selective "interpersonal" self-disclosure on the part of the

analyst facilitates the interpersonal-object relationship that develops by helping to define more clearly the analyst as a new object. Sullivan's (1953) conceptualisation of the therapist's role has been concisely captured in his description of the therapist's involvement as one of "participant observation"; meaning that one cannot participate without revealing some aspect of the self, and one cannot observe the therapeutic interaction without observing some aspect of the self in interaction.

Regardless of the theory or conceptual system, the therapist functions as an enhancer of change. He or she, as both a participant and an observer, can gain enormously rich ways of understanding the client in the interaction and access the client's inner world. A therapist's feelings and body sensations often provide him with emotional ways of knowing the patient—ways that go beyond the verbal content (Ginot, 1997). According to Mearns and Cooper (2005: 129), for many therapists, regardless of their approach, self-disclosing their own here-and-now felt responses is the "key to a relational deep encounter". Josephs (1990: 88) viewed self-disclosure as an inter-subjective process, in which the self that one discloses is not identical with the self the listener receives and then mirrors to the discloser. There will always be an inevitable discrepancy because empathy as "our only tool for grasping the self of the other, is an imperfect instrument that can aim at approximation but can never achieve absolute identity".

3.3.3. Humanistic/ Existential Approach

Those who adopt a humanistic approach to treatment believe that a therapist's self-disclosure is a way to express their genuineness and positive regard for clients by making the therapeutic process less mysterious (Knox & Hill, 2003). The philosophical underpinning of the humanistic approaches holds the concept of the 'I-Thou' relationship in which two unique human beings meet and truthfully accept and respect each other's essential humanity (Buber, 1923). For Buber (1985), the ultimate expression of the 'I-Thou' relationship was the act of confirming the 'other'. Mutual confirmation was viewed as a key element in the definition of the self. Self-revelation in therapy seems to be closely associated with the Rogerian quality named 'congruence' or 'genuineness', which means both the degree to which the therapist is self-insightful and the extent to which he or she communicates that to the client without a facade (Rogers, 1961). Humanists emphasise genuineness and openness on

the part of the therapist and suggest that if the therapist engages in self-disclosure, they offer the gift of intimacy to their client (Fisher, 1990; Tantillo, 2004). Congruence demystifies the therapist. The illusion of power is elicited by mystery and diffused by transparency (Mearns & Thorne, 2007).

Although Rogers had essentially adhered to the existential tenets of psychotherapy, he formulated a position based on theoretical research data from psychotherapy rather than on philosophical underpinnings (Mathews, 1988). 'His view was more pragmatic than philosophical, and his work represents a divergence from the historical issues of detachment versus involvement in self-disclosure' (p. 522). Rogers supported a 'mirror' posture for the therapist, which was analogous to the 'neutral' position or 'blank screen' proposed by Freud. This 'mirror' position would allow, according to Rogers (1957), the therapist to feed back to the client whatever the client said or did and thus be reflective in his responses. However, Rogers was criticised by May (Rowan & Jacobs, 2002) that he never expressed any negative feelings to his clients, whereas a real relationship should also include openly admitting feelings of anger and frustration.

Self-disclosure plays a great part in the therapist becoming congruent and responsive to the client's needs. Congruence is a state of being in which the therapist reveals to the client how she (the therapist) experiences him (the client) (Mearns & Thorne, 2007). Thus, referring to the therapist's openness and genuineness is a necessary ingredient for a trusting relationship. Mearns and Thorne (2007) differentiate self-disclosure from congruence. Although self-disclosure can be part of congruence, congruence is viewed as the genuine felt response that the therapist gives to the client's experience at that particular moment. The focus, therefore, would strictly remain on the client and only in rare cases should the therapist reveal information about their own personal life. There is some concern that the therapist's self-disclosure might distract the client and hinder the therapeutic process since it can easily lead to focusing on the therapist while shutting off the client's experience (Basescu, 1990). These views imply that self-disclosure should relate to the here-and-now experience exclusively. Mearns and Thorne (2007) suggest that some clients find their therapist's self-disclosure helpful since it instils hope and trust, while others might find it destructive since they might not be interested in their therapist's self-disclosure if they are very much involved in their own internal processes.

The context of dialogic anthropology (Schnellbacher & Leijssen, 2009) has very much influenced person-centred and experiential therapies. Dialogic anthropology holds that human existence always occurs in relation with the other. “In the encounter with the other, we encounter our own self and in the encounter with our own self, we encounter the other” (Schnellbacher & Leijssen, 2009: 209). It is via this encounter that we see ourselves reflected on the other and it is through this process that we experience our own human being and learn about ourselves. It is a genuine, existential encounter that takes place in the-here-and-now and is what Buber (Clarkson, 2003) referred to as the ‘I-Thou’ relationship. In an encounter, two people ‘face’ each other; they do not merge or fuse or objectify each other (Schnellbacher & Leijssen, 2009). It involves participation from both sides in the process and the recognition that no one emerges from an encounter the same as he entered it. “Its field therefore is not object relations but subject relations” (Clarkson, 2003: 17).

3.4. Counselling Psychology & Therapeutic Relationship

3.4.1. Introduction

Postmodern thinking, in the field of philosophy (Gergen, 1999, Cooper, 2004) has fundamentally challenged the assumption that human beings are independent and autonomous organisms. Instead, it proposed that we are inextricably intertwined with others in the world and that to deny that is to deny our own nature. All human transactions are intersubjective in nature (Natterson & Friedman, 1995). This principle also applies to therapy as it emphasises the idea that in the therapeutic encounter, two individuals co-create the relationship with the mutual influence of their conscious and unconscious subjectivities. It follows from this idea that the more the participants in therapy are aware of their joint subjective contribution, the richer the therapeutic experience will be. The next section will focus on intersubjectivity and the overriding importance of the therapeutic relationship within counselling psychology. In acknowledging the centrality of the two subjective individuals within the therapeutic dyad, one could also argue that the therapist’s subjectivity is as an essential component as that of the client’s and that one way to come to the foreground is through self-disclosure. These ideas will be explored in the following section.

3.4.2. Relational Counselling Psychology

Though using different terminology, most contemporary approaches to psychotherapy attribute the source of and solution to human psychopathology to interpersonal relationships.

In contemporary psychoanalysis, there has been a shift from a primary focus on intra-psychic conflicts to an emphasis on interpersonal issues. The therapist is no longer viewed as the only expert in the therapeutic room observing and analysing a patient's thoughts, feelings and behaviour. Instead, he or she is part of a bidirectional field (Farber, 2003) in which both the therapist and the client co-construct meaning and both observe the nature of what it is they are experiencing. A shift from an intra-psychic to a more relational model focuses on the two-person field in which there is mutual interaction and in which self-disclosure plays a significant role (Bridges, 2001). 'The concept of intersubjectivity involves the idea that therapist and client form two separate, mutually influencing and interacting psychological systems producing a complex matrix of transference-counter-transference phenomena influencing therapeutic process and outcome' (Rizq, 2005: 455). Within any intersubjective field, two subjective worlds are constantly being exposed and constantly trying to hide. Even withholding is a form of exposure, a form of disclosure or a form of communication (Orange & Stolorow, 1998). Having fully accepted the inevitability of one's own subjectivity, then the question according to Ginot (1997) is how the therapist can best utilise it in the therapeutic room. Intersubjective theorists argue that self-disclosure from the part of the therapist is inevitable, and emphasise the importance of this disclosure in the therapeutic relationship (Bridges, 2001). Therapists 'carry' their whole being into the room; not just their knowledge and professionalism but above all, their identity, their personality, their soul and their spirit. Therefore, therapeutic genuineness is strongly interconnected with sincere involvement (Lietaer 2001; Wyatt, 2001). The therapist is viewed as interactive and actively engaged in the process that promotes openness. The authentic therapist does not put up a facade, role-play, blindly reproduce a model or engage in impersonation of the sole expert in the room. Instead, he or she is willing to respond outwardly his experience and disclose to the client what it is that he or she (the therapist) is experiencing (Jourard, 1968).

As defined by the BPS's *Division of Counselling Psychology Professional Practice Guidelines* (2006b: 1), counselling psychology emphasises a “value base grounded in the primacy of the counselling or psychotherapeutic relationship” and within this, suggests that counselling psychologists “engage with subjectivity and intersubjectivity, values and beliefs”. Research studies (Lambert & Barley, 2001) have shown that the therapeutic relationship is considered one of the most important factors that determine the effectiveness of therapy. Successful counselling psychologists of every orientation pay considerable attention to aspects of relationship (Hendrick, 1987). Indeed “there appears to be no effective way of separating techniques from relationship factors via research; the two are inseparably intertwined” (Strupp, 1984: 22). A psychotherapeutic relationship can be conceptualised as one in which the therapist “voluntarily enters into a kinship relationship with the patient” (Clarkson, 2003: 5) and, therefore, provides the grounds for understanding, healing and reparation of previous painful relationships.

Clarkson (2003: 4) points out that “of all the forces of nature it is our familial relationships that often cause the most damage”. The psychotherapeutic relationship, thus, can be seen as a replicate of the early familial maladaptions but provides the space and ground for reparation and healing. Clarkson (2003: 12) used the term “the reparative/ developmentally needed relationship” to emphasise the relational aspect of the therapeutic relationship which can be reparative or corrective of previous early relationships that were abusive, neglectful or unresolved. She also used the term “the person-to-person relationship”, also referred to as the “real relationship”, to highlight the healing qualities of the “I-Thou” (Buber, 1923) relationship in the therapeutic context. In this “real relationship” both parties engage in emotional involvement and both “stand in mutuality to each other” (Clarkson, 2003: 16). Clarkson (2003) brings the example of an introverted patient who has kinesthetic problems and a difficulty in differentiating right from left. The psychotherapist bends down to show a scar on her leg which helped her as a little girl to differentiate right from left. Clarkson (2003: 16) says that “the moment is unforgettable” and “the bonding person-to-person”.

The ‘fully-fledged communicational context’, a concept developed by Broucek and Ricci (1998), involves a two-person relationship in which the therapist participates more authentically, in his or her full personhood, in an intersubjective process characterised by affective attunement. According to Basescu (1987), the mutuality of relevant self-revelation helps in demystifying the experience in the

therapeutic relationship, instils intimacy and trust and enhances the therapeutic alliance. Self-disclosure, when disciplined and reflected, moves the therapist from a position of professional expert to the position of a reflective human being completely devoted to the co-construction of the fully-fledged communicational context (Broucek & Ricci, 1998). Harry Stack Sullivan (1954) adopted an interpersonal approach which held that one cannot become aware of what another person does without becoming personally involved. The therapist was viewed as a 'participant observer'; a stance that included spontaneous and genuine responses on the part of the therapist and even in some cases gestures of affection and reassuring touch (Clarkson, 2003). Sullivan (1954) believed that the analyst's participation should involve self-disclosure, confirmation of the patient as worthy of respect and meeting on the basis of mutual human equality. He emphasised the importance of the analyst's overt openness of his or her role in the therapeutic environment, including at times the acknowledgement of mistakes, oversights and feeling states. These ideas can also be applied to counselling psychology as they are in accordance with its philosophical underpinnings that counselling psychologists are 'not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (BPS, 2006: 2).

3.5. Research Body on Self-Disclosure

3.5.1. Introduction

Self-disclosure has become a familiar concept in psychotherapy, even though practitioners differ in the way they employ it or endorse it. A considerable amount of research (e.g., Reynolds & Fischer, 1983; McCarthy & Betz, 1978), has focused on the differential effects of self-involving versus self-revealing statements; on the reciprocity effect of self-disclosure in therapy (e.g., Bundza & Simonson, 1973), on the perceived therapist's expertness, attractiveness and trustworthiness (e.g., Lee, Uhlemann & Haase, 1985), and on the effect of the therapist's self on the therapeutic outcome (e.g., Barrett & Berman, 2001). With a few exceptions (e.g., Hanson, 2005; Bottrill *et al.*, 2009), most of the research conducted was based on quantitative methods and relied on analogue studies (e.g., Nilsson *et al.*, 1979). Furthermore, none of the research studies in the existing literature has focused on the perceptions and experiences on therapists' self-disclosure by individuals who have a dual role;

that of the client and that of the developing counselling psychologist. The present study will attempt to examine those answers by employing a qualitative research method in order to gain an in-depth exploration of the phenomenon under study. The next section is a critical review of the existing literature on the phenomenon of therapists' verbal self-disclosure. The aim is to give the reader a comprehensive review of the existing body of research on therapists' verbal self-disclosure, discuss the problems and gaps in the literature and conclude by making a case for the present research study.

3.5.2. Existing Research Studies

The study of self-disclosure began by Jourard over 40 years ago (Jourard, 1964; Jourard 1968; Jourard 1971). Jourard's own existential quest and interest in knowing what it means to be the 'real self', led him to study the phenomenon which, according to him, was the root of most problems in the society, namely lack of communication and understanding between people. He was greatly influenced by the ideas of Fromm, Horney and Riesman (Farber, 2006) who wrote about alienation in people and their tendency to pretend or impersonate. Jourard believed that when we hide our being, we lose touch with our real selves; therefore, he viewed self-disclosure as a vital ingredient for a successful and satisfying relationship with others (Jourard, 1971). By self-disclosure, Jourard referred to the process of openly and honestly sharing thoughts and feelings that may be of a personal nature (Jourard, 1964). One of his points of emphasis, strongly supported by evidence (Bundza & Simonson, 1973), was that self-disclosure from one person regarding their experience begets self-disclosure from the other person in the conversation. Jourard (1971) called this reciprocity the 'dyadic effect'. The disclosure of personal material by the client may be accompanied by feelings of embarrassment or shame due to their perceptions that their experiences and feelings are abnormal. The therapist who wishes to make therapy an intersubjective experience between two people may use self-disclosure as a way of communicating respect and positive regard for the client. This act of sharing suggests that the therapist cares for the client enough to bring information of a personal nature into the therapy as a means of promoting a more even-handed and equitable sharing of control within the session (Andersen & Anderson, 1985).

In one study, (Antaki, Barnes, & Leudar, 2005), it was found that reciprocating self-disclosures can have a stronger impact than mere utterances of understanding (e.g., 'I know what you mean'), and that it is important for therapists to show their clients that they are not 'alone or particularly crazy' (Antaki *et al.*, 2005: 196). Antaki *et al.*, (2005), set out in their article to rectify what they argued was a significant fault in psychology's treatment of self-disclosure; namely, that what most empirical work on self-disclosure had systematically avoided what they considered to be the most interesting thing about self-disclosure: "how the speaker brings it off *as a disclosure*" (p.195). This treatment of self-disclosure as 'a-contextual', risks missing the point that self-disclosure is a phenomenon that takes place within a social interaction and, therefore, has its interactional consequences. With that in mind, they approached real exchanges of talk, which yielded a number of features of the speaker's talk that seemed to be significant in making it work as a self-disclosure. All of them were found to be significant only in the circumstances of their production (i.e., indexical). They found three prominent features of self-disclosure as a performed and situated social action: a) the design of the talk as a report of personal information, b) as significant, and c) as over and above the expectations of the moment. However, Antaki *et al.*, (2005) did not study the consequences that the speaker achieves by choosing to disclose at *just* the moment they chose, nor did they examine self-disclosure's impact on the intersubjective trajectory of the talk. These two crucial points need to be examined further as they are deeply embedded in the development of the counselling relationship.

Regarding the content of the therapist's self-disclosures, Lane, Farber, and Geller (2001), in a paper presented at the annual meeting of the Society for Psychotherapy Research, argued that the most commonly disclosed topics included the therapist's theoretical orientation, training experience, counselling style, beliefs about the therapy's effectiveness and apologies for clinical errors. Some of the least frequently disclosed topics were the therapist's dreams, physical attraction to the client and personal issues. These findings are in accordance with previous research (Knox & Hill, 2003) that has indicated that revelations that are too personal are avoided because they may burden clients, shift the attention away from the client, and therefore compromise the therapeutic relationship. The most common therapists' self-disclosures (Farber, 2006) are those that provide hope to the client, enhance the therapeutic relationship and restore ruptures in the working alliance. These

disclosures can be regarded as self-involving rather than self-revealing per se. While the content areas of self-disclosure by therapists can vary from demographic information, to professional training, to more personal information, therapists with more traditional training generally avoid engaging in self-disclosure on the subjects of sex, money and politics (Simi & Mahalic, 1997). A therapist's choice of whether, what and when to self-disclose is very much idiosyncratic and depends on a number of different factors, such as the therapist's technique and the therapeutic modality he or she applies as well as client diagnosis, treatment length and the exact nature of what is going on in the room at any particular moment. In different therapeutic situations with different clients, different types of self-disclosure may be most appropriate (Farber, 2006).

Nilsson *et al.*, (1979) recruited 120 male and 120 female participants to view a videotaped vignette of a simulated counselling session. The therapist's verbal self-disclosure had been manipulated such that participants were presented with three different conditions: a) no-disclosure, b) interpersonal disclosure (sharing feelings about the client's problems and/or the counselling relationship, e.g., "Sometimes I worry that you may misunderstand me and see me as putting you down"), and c) intrapersonal disclosure (sharing personal information with particular reference to experiences similar to the client's, e.g., "I was always compared to my brother... it always seemed that he could do nothing wrong and I could do nothing right"). The participants were asked to rate the therapists across a variety of professional (e.g., competences) and personal (e.g., likeability) dimensions. The findings supported the hypothesis that self-disclosing therapists were perceived and evaluated more favourably than non-disclosing therapists were. Specifically, they were perceived as being warmer, more sensitive and honest, and as having a better, healthier self-concept. In addition, therapists who revealed personal information (intrapersonal disclosure) were generally evaluated more favourably than those who disclosed feelings about the client and/or the therapeutic relationship (interpersonal disclosure). This last finding is very interesting as it suggests that more intimate self-disclosures about the therapist's feelings can be viewed less positively in the absence of a strong therapeutic relationship as it was the case in this study, whereas the therapist's self-disclosures about personal information can be a way to make the client feel comfortable, especially when they reflect a commonality between therapist and client. Although the findings do suggest that therapists' self-disclosure may result in

positive evaluations of therapists by clients, the analogue nature of this study, the reliance on college graduates as participants, and the specific content of therapists' self-disclosure, limit the generalisability of the results considerably.

Reynolds and Fischer (1983), in an effort to be more specific, separated therapists' self-disclosure into two distinct types of responses: self-involving and self-disclosing statements. They investigated whether clients reacted differentially to self-disclosing versus self-involving statements when these statements also varied from positive to negative self-disclosures and when personal and professional evaluations were considered separately. There were four therapist self-disclosure conditions: a) self-disclosing positive (disclosure of positive personal information), b) self-disclosing negative (disclosure of negative personal information), c) self-involving positive (disclosure of a positive personal reaction to the client), and d) self-involving negative (disclosure of a negative but not critical personal feeling regarding a statement made by the client, e.g., "I am frustrated that I do not understand what you are saying"). Eighty female introductory psychology students participated in the study by listening to taped segments and evaluating the therapist as they thought the client would do. The results indicated that self-involving statements were more effective than self-disclosing statements in enhancing client perceptions of the therapist's expertness and trustworthiness. It was also found that self-disclosing statements directed the subject's attention toward the therapist, whereas self-involving statements kept the focus of counselling on the client. No significant differences were found in positive versus negative disclosures. However, Reynolds and Fischer (1983) acknowledge that the generalisability of their research findings is limited by the analogue nature of their study and by the use of only female participants. They do suggest that replication is needed in a clinical setting and with other client-therapist gender pairings. Also other content variables, such as the intensity and recency of the revealed material (either self-disclosing or self-revealing), need to be re-examined in order to assess their impact on the therapeutic relationship.

Mathews (1988) explored the therapist's perceptions of their own use of self-disclosure by using a questionnaire that asked about the frequency of self-disclosure, the factors that influence the use of self-disclosure and the positive or negative feelings about the results of engaging in self disclosure. The findings revealed that therapists' perceptions on the topic varied and these differences might be attributed

to several dimensions of self-disclosure. Watkins (1990) suggested three basic dimensions of therapist self-disclosure: namely, the amount of self-disclosure, the intimacy of the information revealed and the duration. Mathews' (1988) study focused on the therapist's perceptions regarding self-disclosure with patients and its potential impact on the therapeutic process. The majority of the client population though had a diagnosis of either a neurotic (34.7%) or a personality disorder (30.9%). Also, 65.8% of the interviewees were either psychiatrists or licensed social workers, therefore, their decision to self-disclose or not was very much influenced by the client's diagnosis. Therefore, this study was limited to a specific client group and the respondents were influenced by the rationalistic approach of 'science' that underpins the medical model, instead of having an integrated way of working that emphasises the relevance of meaning, subjectivity, values, feelings, fluidity and multiplicity of selves and mutually constructed realities that underpin the counselling psychology profession (Blair, 2010).

Existing research on the impact of therapists' self disclosure was mostly based on analogue methodology in which simulations of therapy rather than actual therapy were assessed by observers. Early research was largely designed to test Jourard's belief that 'self-disclosure begets self-disclosure' (Jourard, 1964). Bundza and Simonson (1973) examined the relationship between the therapist's self-disclosure and the client's willingness to self-disclose (reciprocity effect), the client's impressions of the therapist's nurturance and intraception (processing the world primarily through their feelings or emotions). It was hypothesised that a self-disclosing therapist would: a) elicit more willingness to self-disclose on the part of the subject "clients" than a non-self-disclosing therapist, and b) be perceived as more nurturing and less intrceptive than a non-self-disclosing therapist. Bundza and Simonson (1973) provided participants with one of three transcripts of simulated counselling sessions. The three conditions were: 'no self-disclosure', 'warm support', and 'warm support plus self-disclosure'. Participants were asked to rate the therapist in the transcript and indicate their own willingness to self-disclose personal information. Results showed that the 'warm support plus self-disclosure' condition elicited the greatest participant willingness to self-disclose. However, the study was an analogue study that utilized college student volunteers rather than clients seeking psychotherapy and the therapist's self-disclosure was always preceded by a warm, accepting statement; was always similar in content to the experience the clients made

reference to; and was always historical in tense. It seems that the concept of the therapist's verbal self-disclosure in this study was reduced into a "simply-categorisable single piece of verbal behaviour" (Antaki *et al.*, 2005: 196) whereas in real psychotherapeutic settings, other types of verbal self-disclosure may take place as well (e.g., challenging the client's stated position); therefore, the results could not be generalised in all dyadic exchanges.

Curtis (1982a), arguing against self-disclosure, examined the relationship between the therapist's self-disclosure and the client's perceptions of the therapist's empathy, competence and trust. He used written dialogues to manipulate the three conditions of high, low and no therapist self-disclosure and used the Barrett-Lennard Relationship Inventory and Sorenson Relationship Questionnaire to measure perceived empathy, competence and trust. His findings confirmed the initial prediction that the greater the use of the therapist's self-disclosure, the lesser was the participant's perceptions and evaluations of the therapist's empathy, competence and trust. Curtis (1982a) concluded that self-disclosure as a psychotherapeutic technique might adversely shape the client's impressions of congruence, empathy and trust and, therefore, might cause more harm than good. However in Curtis's study (1982a), which was a simulation of a psychotherapeutic interaction, the 'dyadic effect' of self-disclosure (Jourard, 1971) was not directly examined. Curtis (1982a: 59) argued that in many of the studies which seemed to support a 'dyadic effect' of self-disclosure, "it is difficult, if not impossible, to determine whether the effect of self-disclosure per se, or some other aspect of the interpersonal communication (e.g., attitude similarity), is responsible for the effects obtained". This view should not be diminished as insignificant, as the development and maintenance of a therapeutic relationship relies far less on the therapist's skills or theoretical knowledge or use of self-disclosure than it does on "a number of *'being-based'* attitudes or qualities which seem to lie at the heart of the therapeutic process and its possibilities" (Spinelli, 1994: 178). Being congruent, self-revealing or 'real' in the encounter can be just one of them.

Myers and Hayes (2006) conducted an analogue study in which participants viewed one of three videos in which the alliance was described either as positive or negative and in which the therapist engaged in general self-disclosure, no disclosure or counter-transference disclosure. The study was designed to investigate how perceptions of the therapist and the sessions are influenced by general therapists' self-disclosures and counter-transference disclosures in comparison to no-

disclosures. The results showed that the impact of self-disclosures (either general or counter-transference) on the participants' perceptions of the session, and the therapist depended on the quality of the working alliance. Sessions were rated as deeper and the therapist was viewed as more expert when he engaged in general self-disclosures than non-disclosure and when the alliance was described as positive. However when the alliance was described as negative, the therapist was rated as less expert and the sessions were seen shallow if the therapist was self-disclosing (either general or counter-transference self-disclosure). The results of the study indicate that therapists should be mindful of whether and what to disclose in the context of the perceived strength of the therapeutic relationship. This suggests that the therapeutic relationship is governed by qualities that should precede the therapist's openness and that self-disclosure of the therapist does not shape the development of the therapeutic relationship, rather the opposite; the therapist's self-disclosure is shaped and coloured by the context in which it takes place. It should be held in mind though that the data of this study were collected following a single observation of a segment of therapy. A sole observation, however, cannot capture the essence of the therapeutic process given its complex and fluid nature. If the working alliance is formed through a rupture and repair cycle as Safran and Muran (1996) argue, then just a sole observation is an insufficient reflection of this process.

Knox *et al.*, (1997), used semi-structured interviews to interview thirteen clients who were in long-term therapy. The study focused on examining and exploring clients' experiences of therapists' self-disclosure, where self-disclosure was defined as 'an interaction in which the therapist reveals personal information about himself/herself and/or reveals reactions and responses to the client as they arise in the session' (Knox *et al.*, 1997: 275). Results indicated that a helpful therapist's self-disclosure a) occurred when the clients were discussing personal information of great significance to them, b) were perceived as an attempt by the therapist to reassure the client and c) consisted of personal (but mostly historical) information. Knox *et al.*, (1997), were interested in examining three potential consequences of therapist self-disclosure for clients who were in long-term therapy. First, self-disclosure's impact on the 'real relationship' between the client and the therapist was studied. Real relationship was defined by Gelso and Carter (1994: 297) as 'that dimension of the total relationship that is essentially non-transference and is thus relatively independent of transference'. A second possible consequence that was explored was

the effect of the therapist's self-disclosure on feelings of universality; that is, feelings that the client is not the only person who deals with problems. A third potential consequence of the therapist's self-disclosure is its impact on modelling. The results of the study showed that self-disclosing statements in long-term therapy can be useful since it helped clients to perceive their therapist as more human, gain insight or change their perspective. While the highest percentage of therapist disclosure was positive, there were some negative reactions as well which were mostly associated with the concern about the boundaries of the therapeutic relationship and the actual purpose of self-disclosure. Knox's *et al.*, (1997) study yielded some very interesting findings, namely that the most helpful self-disclosing statements were personal in nature, and largely historical rather than immediate and reassuring, contradicting previous studies (e.g. Hoffman & Spencer, 1977; Hoffman-Graff, 1977). As Knox *et al.*, (1997: 281) argue: "perhaps the immediate disclosures were perceived as too intimate or threatening and therefore were not viewed as helpful, whereas the more historical or autobiographical statements enabled these clients to learn more about their therapists and thus feel a greater sense of safety and comfort". It is quite intriguing though, the fact that none of the clients referred to a self-involving statement as an example of helpful therapist self-disclosure. Focusing only on helpful instances of the therapist's self-disclosure, this study did not examine at all, all those instances that verbal self-disclosures might have been perceived as neutral or even disruptive for the therapeutic relationship. Had that been the case, it may have shed some light as to whether the self-involving statements had been perceived as unhelpful by the clients, and what their impact was on the therapeutic relationship. As the development and maintenance of the therapeutic relationship is an ongoing process, it could be quite simplistic to reduce it to only those instances where the therapist's verbal self-disclosure is being perceived as facilitating; as sometimes rupture can bring about change as well. A therapist's self-disclosure that is perceived unhelpful could still become an opportunity to acknowledge and develop the real relationship between therapist and client.

A qualitative study conducted by Hanson (2005) indicated that sometimes failure or refusal to self-disclose may be damaging to clients. This is in line with Safran and Muran's (2000) suggestion that withholding self-involving disclosures can hinder the therapeutic progress. In Hanson's (2005) study, eighteen participants were asked to discuss their experiences of the effects of their therapists' disclosures

and non-disclosures in therapy. Grounded theory was used as the method of qualitative analysis, which allowed for the emergence of categories and the relationships between them (McLeod, 2001). Four different categories emerged: helpful disclosures, unhelpful disclosures, helpful non-disclosures and unhelpful non-disclosures. When participants reported disclosure as helpful, their reasons were similar to the therapists' rationales for disclosing. Participants valued self-disclosures as they made them feel that the relationship was more egalitarian and the therapist appeared more human. Unhelpful disclosures had a negative impact on perceptions of trust and safety for the participants. Only a few incidents were perceived as helpful and the most prominent reasons for this was that the participants felt free to imagine what they wanted about the therapist. This is in accordance with the psychoanalytic concept of transference. Finally, unhelpful non-disclosures were more frequent and were experienced as destructive to the therapeutic alliance and trust. An interesting finding that emerged in his study was that of the importance of 'the element of skill' in the few helpful non-disclosure incidents; namely, that the skilled therapist would frame their refusal to answer questions compassionately in a way that clients could understand and accept as beneficial, even if they initially had negative feelings. Hanson (2005) acknowledged the fact that therapists should be aware of the skills involved and the timing when they choose either disclosure or non-disclosure as a technique in therapy, but argued that "simply to avoid disclosure in order to avoid the possibility of exploitation, risks doing a disservice to clients" (p.103).

The study by Barrett and Berman (2001) employed a quasi-experimental design and systematically varied the levels of therapists' self-disclosure to evaluate the effect on the therapeutic outcome. Therapists were doctoral students on a clinical psychology programme and clients were university students, faculty and staff, as well as individuals from the general community. Each therapist conducted four sessions with each of two clients. With one client, the therapist increased the frequency of the reciprocal self-disclosures and with the other client they limited the reciprocal self-disclosures. Reciprocal self-disclosure involved the therapist's self-disclosure in response to client's self-disclosures. Therapists made either reciprocal self-disclosures or provided non-self-disclosure responses to clients' self-disclosure. Blind-observer ratings confirmed that the two conditions differed significantly in terms of frequency. Clients in the condition of a heightened therapist's reciprocal self-disclosure reported lower levels of symptom distress and also liked their

therapist more than those in the condition of a limited therapist reciprocal self-disclosure. Overall, the findings suggest that self-disclosure by the therapist may enhance the therapeutic relationship as well as the outcome of treatment. However, Barrett and Berman (2001) based their study exclusively on reciprocal self-disclosures, on an inexperienced sample and on only a four-session treatment model. It is questionable whether such a brief treatment model could be sufficient for a therapeutic relationship to establish and develop. Besides, although therapy was found to be more helpful when therapists increased rather than limited their self-disclosures, “it is impossible to determine from this design whether the difference occurred because increasing therapist disclosure benefits treatment, restricting therapist disclosure impairs treatment, or both” (p.602).

Bottrill *et al.*, (2009), exploring clinical psychology trainees’ experiences of using or not using therapist self-disclosure, conducted a qualitative study in which fourteen trainees were interviewed and the transcripts obtained were analysed using an interpretative phenomenological analysis. The findings indicated that trainees struggle with uncertainty and doubt about when, whether or how much to self-disclose. The dilemmas with which clinical psychology trainees are faced are very much associated with the fact that they are just developing their professional identity; that is, they are going through the student and novice stages as opposed to the more experienced and senior professional stage (Rønnestad & Skovholt, 2003). Their accounts suggest that finding one’s position in relation to self-disclosure is challenging and requires support to master (Bottrill *et al.*, 2009). The view that self-disclosure was taboo or frowned upon emerged as a theme because the participants had the impression that self-disclosure was disapproved of by certain therapeutic models or/and supervisors and therefore, they felt safer not using it. Also, participants’ accounts indicated that some supervisors themselves were reluctant to discuss self-disclosure or at the very least did not prioritize it. Bottrill’s *et al.*, (2009) study yielded some very interesting findings on how trainees experience the use of self-disclosure in their own client work. However, trainees in clinical psychology are not required to have their own personal therapy as opposed to trainees in counselling psychology and this might be a factor that restricts their opportunity to learn from their own therapists.

Non-therapist clients usually start their therapy without knowing very much about their therapist or what therapy means and therefore do not really know what to

expect (Geller, 2003). A study, by Norcross *et al.*, (2001) using a survey method, sought to give voice to the experience of psychotherapists conducting treatment with fellow mental health professionals. The psychotherapists were asked to rate the extent to which their therapeutic approach with fellow colleagues differed from their approach with other clients of similar intelligence, socioeconomic status, and diagnosis. The results indicated that participants were more flexible in their management of the boundaries, more egalitarian and collaborative throughout the course of psychotherapy and more comfortable and less guarded in treating their colleagues. Additionally, they tended to be more open about sharing personal information and more emotionally expressive with clients who were also therapists (Geller, 2003). Statistical analyses of Geller's study (2003) showed that therapists are likely to reveal information about their own personal therapy and to apologise for mistakes when treating clients who are fellow psychotherapists. Taking into account the different empirical findings and the many different theoretical views on therapists' self-disclosure, there are no hard and fast rules regarding what is and what is not appropriate to reveal to a client (Bottrill *et al.*, 2009).

The analogue nature of many of the studies cannot be realistic and, therefore, these studies have limited applicability to real clients, real therapists and real therapy where the evolving context and relationship are essential. The therapist self-disclosure stimulus used in these studies (e.g., Reynolds & Fischer, 1983; Nilsson *et al.*, 1979; Barrett & Berman, 2001) was often provided with minimal context instead of emerging out of an ongoing interaction between therapist and client. Also, previous research on self-disclosure has mostly focused on the reciprocity effect (Bundza & Simonson, 1973), perceptions and evaluations of therapists' competence, empathy, and trust (Curtis, 1982a), different levels of self-disclosure and the effect on the therapeutic outcome (Barrett & Berman, 2001), and the effect of therapists' willingness or refusal to self-disclose in therapy (Hanson, 2005). However, there has not yet been a study that explores the perceptions and attitudes of developing counselling psychologists regarding self-disclosure, in a real-world setting, in order to gain insight into their experiences in both their personal therapy as well as their client work.

3.6. Present Study

The impact of the therapist's self-disclosure on the therapeutic relationship can be examined from the perspective of clients when they are themselves counselling psychologists. Self-disclosure might be considered by some clients as a sign of malpractice (e.g., Curtis 1982a, 1982b), whereas by some others as a 'facilitative ingredient' of the therapy (e.g., Nilsson *et al.*, 1979). The present study aims to examine the experiences of clients when their therapist engages in verbal self-disclosure. Timing of self-disclosure and the effect of the content will be examined from the client's perspective. As counselling psychologists are required to have a 'dual role' during their training, that of the therapist and that of the client, this study contributes to the ongoing dialogue about the value of therapists' self-disclosure in the field of counselling psychology, by exploring developing counselling psychologists' experiences on self-disclosure from two different perspectives: from the perspective of the client as well as from the perspective of the therapist. Although self-disclosure has been examined from the perspective of clients who are themselves psychotherapists (Geller, 2003), there has not yet been a study that explores the perceptions and attitudes of clients who are counselling psychologists who are either trainees or newly qualified, and thus are still developing their professional identity.

The present study will attempt to discover what the participants believe constitutes self-disclosure and how influential their own therapist's self-disclosure or lack of it has been in the development of their personal and professional stance on self-disclosure in their own work with clients. Bottrill *et al.*, (2009), emphasised the uncertainty and vulnerability evident in trainee clinical psychologists. The choice of intervention is sometimes a difficult decision, let alone the decision to engage in self-disclosure or not.

Most studies on therapists' self-disclosure have used quantitative methodologies (Nilsson *et al.*, 1979; Bundza & Simonson, 1973; Curtis, 1982a; Myers & Hayes, 2006; Barrett & Berman, 2001). However, a case can be made for using a qualitative approach to explore this phenomenon on the grounds that quantitative methods, although they allow for generalisability, they overlook the complex nature of self-disclosure, whereas qualitative methods attempt to give an in-depth phenomenological understanding of the complexity and content of self-disclosure. Although some of the previous studies have relied on qualitative methodology (e.g., Knox *et al.*, 1997; Hanson, 2005; Bottrill *et al.*, 2009), none of them has investigated

the perceptions of counselling psychologists in training regarding verbal self-disclosure.

Qualitative research involves mapping and exploring the meaning of an area of human experience (McLeod, 2001). Therefore the knowledge generated will be holistic and will attempt to provide a more in depth representation of the experience of self-disclosure and whether or not this impacts on the quality of the therapeutic relationship. Interpretative phenomenological analysis (IPA; Smith & Osborn, 2003) will be the approach used for an in-depth exploration of how individuals make sense of their experiences in relation to the phenomenon of verbal self-disclosure.

4. Methodology

4.1. Introduction

This study employed a qualitative research approach based on transcribed interviews of participants, designed to explore their experiences of therapists' verbal self-disclosure. This method of study allowed the researcher to gain insight into the experiences of participants and obtain rich data on the phenomenon of verbal self-disclosure. This chapter begins with a description of qualitative research and the differentiation between qualitative and quantitative approaches. It also refers to the epistemological underpinnings of qualitative methods in a brief historical overview, in order to introduce the reader to the contextual constructionism which is the epistemological position of this research study. The methodological approach that will be used is the Interpretative Phenomenological Analysis (IPA). IPA draws on both phenomenology and hermeneutics, therefore a brief section on each one of them will be presented, so as the reader becomes familiar with the philosophies that underpin IPA. At the end of this chapter, the use of IPA and the role of the researcher in this study will be discussed. Also, a small section on the evaluation of the qualitative research will be presented.

4.2. What is Qualitative Research?

Qualitative research aims toward the understanding of how the world is constructed (McLeod, 2001) by focusing on the meanings through which people understand and make sense of their realities. According to McLeod (2001) there are two reasons why it is worthwhile to conduct qualitative research; namely, 'knowing' and becoming a knower'. The goal of knowing in research is far from the everyday knowledge based on reason which relies on a fixed set of rules and axioms. Knowing in research strives to go beyond the everyday ordinary understanding by following processes of more thorough and rigorous inquiry into describing phenomena. "It is on such claims that professional status and expertise can be justified" (McLeod, 2001: 3). Qualitative researchers are interested in meaning attributed to events and the quality of the experience rather than the cause and effect relationships (Willig, 2008). In that way, qualitative research provides 'knowledge of the other', 'knowledge of the phenomena' and 'reflexive knowing'. The role of the researcher in qualitative research is very different from that in quantitative research. The researcher has an

impact on the research process as he or she brings into the process his or her own theoretical knowledge and biographical experiences (Lyons, 2007a). The epistemology underlying the methodological approach is the one that best applies to the researcher according to their different backgrounds and the theoretical concepts they hold in order to make sense of their data. Each methodological approach will offer a different perspective of what might constitute ‘data’, and what can be inferred from it, and this is highly dependent on the epistemological position of the researcher (Smith, Flowers, & Larkin, 2009). The researcher both as a person (personal reflexivity), and as a theorist (epistemological reflexivity), shapes the process of the research as he or she is implicated in the research and its findings (Willig, 2008). The researcher immerses himself/ herself in the data, tries to make sense of it and interpret it. However, what the researcher identifies as useful accounts of the data is to a great extent their subjective judgment. Therefore, there is no such thing as a ‘true’ or ‘correct’ interpretation (Lyons, 2007a); our understanding will always be incomplete since we can never really grasp the meaning of how the human world is constructed. All we can do is strive towards a truth that opens up new horizons for understanding; we cannot really put all our experiences and preconceptions to one side and see the phenomenon as if for the first time. This, therefore, suggests a need for a reflexive approach which is very common in phenomenological research, where the researcher attempts to put their assumptions and expectations to one side in order to gain a better insight into the participant’s world but also is aware of the impossibility of this bracketing and so is able to reflect on what it is they (the researcher) bring to the analysis in terms of their own personal experience and background (Langdrige, 2008).

4.3. Qualitative Versus Quantitative Research

Qualitative research is much more different than ‘cause-and-effect’ quantitative research; it is humanistic in nature and is based on the principle that we “individually and collectively create the world we live in, take responsibility for it, and choose to make it different” (McLeod, 2001: 5).

Counsellors and psychotherapists have shown an increasing interest in qualitative methods of inquiry. Research in psychological and social sciences is characterised by an interaction between verification and discovery (McLeod, 2001); namely, a wish to verify already known propositions and discover new propositions

that apply to the world. Even in the most controlled experimental research there are always some findings that challenge the already established conceptual framework. Equally, in even the most discovery orientated qualitative research, there will be some findings confirming the ordinary everyday reality. Qualitative research has been considered as the most appropriate method for “uncovering the meanings embedded within a slice of social life or piece of action” (McLeod, 2001: 178). Therefore, it is seen as contributing to the understanding of a phenomenon rather than adding factual knowledge and providing causal explanations. This can be seen as an obstacle since qualitative research appears to undermine consolidating, legitimating and verifying data. However, Giorgi (1985: 2) argues that qualitative analysis can give psychological insight equally valuable to what quantitative approaches give. As he puts it, “the major difficulty in its acceptance seems to be the fact that it seems to be too straightforward, too facile. A description seems to be such a flimsy thing upon which to base a science. But if one reflects for a moment, it can be seen that descriptions actually pervade science”.

As more and more therapists are being trained to use different theoretical orientations and are exposed to a variety of different research methodologies, the rigidity of the divisions within the different schools of psychotherapy is fading away. Nowadays, many psychotherapists and researchers have embraced the importance of the different research approaches, quantitative as well as qualitative methods (McLeod, 2001). There are many different approaches to qualitative research but most share the assumption that there is no universal truth or reality, instead knowledge is context specific (Lyons, 2007b). Across a range of disciplines including counselling and psychotherapy, there has been an increase in acknowledging the potential of a phenomenological perspective to gain greater understanding of people’s experiences (Langdrige, 2008).

4.4. Epistemological Underpinnings of Qualitative Research

Qualitative research is underlined by sets of philosophical assumptions concerning how psychological knowledge should be produced; this is referred to as epistemology (Coyle, 2007). Epistemology is “is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (Crotty, 1998: 8). There

are many different epistemologies characterising the different methods covered under the term ‘qualitative research’ (Coyle, 2007).

Madill, Jordan and Shirley (2000) see the differences in epistemological underpinnings of qualitative methods as a continuum where on one end is what they call the naïve realist position and on the other is a radical constructionist position, the so-called social constructionism. In the middle of this continuum, the contextual constructionist position lies. Naïve realism strives for the discovery of reality through the use of appropriate methods. Critical realism, another form of realism is closer to the contextual constructionist position which posits that knowledge exists in context and is influenced by the individual’s perspective. On the other hand, radical constructionist epistemologies assume that reality is not discovered; instead, it is constructed through language (Lyons, 2007a).

4.4.1. Constructionism

Wilhelm Dilthey in 1894 (Coyle, 2007) argued that human sciences should strive more towards understanding than causal explanation. The idiographic research approaches which focus on studying individual cases in detail, were gradually gaining ground over the nomothetic approaches which sought to find general laws that explained phenomena. Subsequently the epistemology of constructionism arose which holds that there is no objective truth. Instead, truth and meaning are constructed through our engagement with the world. Thus, different people may hold different truths as they construct meaning in different ways even in relation to the same phenomenon (Crotty, 1998). The person is not seen as a perceiver, but as a conceiver or constructor who is trying to make sense of the world (Smith, 2003). Constructionism is linked with the concept of intentionality which was the key feature of consciousness for Husserl (Langdrige, 2008) and referred to the fact that whenever we are conscious, we are always conscious of something whether that is another individual or an idea. According to intentionality, all mental phenomena are described as having reference to a particular content or as being directed to an object. In that sense, intentionality emphasises an interaction between the subject and the object as it hypothesises an intimate and active relationship between ‘the conscious subject and the object of the subject’s consciousness’ (Crotty, 1998: 44).

Social constructionism argues that knowledge is constructed and not discovered in the world, thus our interpretation of the world does not correspond to

real, objective entities (Coyle, 2007). Our understanding of the world is through social processes and is embedded within cultural and historical contexts, thus research adopting this epistemological position focuses on how social reality is constructed in a particular cultural and historical context, how the ways of constructing are used and what the implications for human experience are (Willig, 2008). As Coyle (2007) argues, context is a key factor in understanding obtained by qualitative research. The main methodological principle involved in contextualism is ‘the construction of intersubjective meaning’ (Lyons, 2007a: 160). In addition, qualitative research with a contextual epistemological underpinning should ‘generate new theory firmly grounded in participants’ own meanings in concrete contexts’. The role of the researcher in the research process is an aspect of context, which qualitative research puts a lot of emphasis on. The researcher in qualitative methods is expected to give an interpretative framework that informs their research questions and analyses and that also reflects upon the research process.

4.5. Phenomenology

The existence of many different phenomenological routes suggests that phenomenology can be best described as a movement, rather than as one single doctrine (Aspers, 2009). Phenomenology studies the phenomena that appear in our consciousness as we interact with the world around us (Willig, 2008). Its main goal is to arrive at the universal essence of the individual experiences of a phenomenon (Creswell, 2007). Husserl (1859-1938), whose name is strongly associated with the phenomenological approach to qualitative research, radically changed the nature of philosophy itself by “seeking to find a method of arriving at ultimate truth” (McLeod, 2001: 36) and “focusing on the perception of the things in their appearing” (Langdridge, 2008: 1127). Before Husserl’s intervention, philosophers held to more dualistic thinking about how the mind communicates with the world. Husserl’s view was that the very questions themselves are the result of such dualistic thinking and pointed out that instead of posing inappropriate questions we must focus on what we can know empirically (Langdridge, 2008). Later many significant philosophers, like Heidegger, Sartre and Merleau-Ponty, expanded on his ideas. Their ideas were still phenomenological in nature but they focused more on human nature and existence than did Husserl (Langdridge, 2008). That led to the acknowledgement that all experience should be understood in the context of ‘the embodied and situated

subject' (p. 1128); that is, of the person who has the experience. The basic idea of phenomenology is that analysis does not start with the objective world out there like it happens in natural sciences. The phenomenological researcher does not hold a fixed set of assumptions but gradually establishes a foothold which will be only temporary and continuously subjected to scrutiny (Aspers, 2009). This means that phenomenology focuses on the collection of detailed information and perceptions through inductive, qualitative methods in order to gain insight into people's subjective experience. In an attempt to understand the conditions that underlie an experience and make sense of them, our only tools are the experience itself and the language we use to describe that experience.

4.5.1. Hermeneutic version of Phenomenology

Many researchers follow the hermeneutic version of phenomenology which was developed by Heidegger; Husserl's student and assistant (Willig, 2008). According to the hermeneutic version of phenomenology, the researcher's interpretation and analysis is an integral part of phenomenological analysis. The key to Heidegger's approach is that the natural attitude, which is what Husserl wished to suspend and put aside, is the main focus of inquiry. Knowledge is obtained by the researcher's engagement with the topic of inquiry (McLeod, 2001). Heidegger was concerned with the ontological question of existence itself, the relationships we form and how we make meaning of the world as it appears to us through these relationships (Smith *et al.*, 2009). In his work, 'Being and Time', Heidegger (1962), refers to Dasein (there-being) as our engagement with the world but he also emphasises that our access to it can be achieved through our interpretations. All our experience is captured in our embodied being-in-the-world and although we might try to step outside our assumptions in the way we see the world, this will always be an impossible process (Langdridge, 2008). For Heidegger, phenomenology is concerned with concealed or hidden meanings as well as evident meanings for us. Willig (2008) is pointing out the significance in differentiating between the phenomenological contemplation of an event by the phenomenological researcher and the phenomenological analysis of a participant's experience. The former requires paying attention to one's own experience whereas the latter requires paying attention to the description of someone else's experience. In the latter case, the description of an experience becomes the phenomenon with which the phenomenological

researcher engages. While Husserl thought it was necessary to bracket off one's natural attitude in order to discern the essence of a phenomenon, existential phenomenologists, like Heidegger, Sartre, and Merleau-Ponty (Langdrige, 2008), argued that the process of stepping outside of our own preconceptions and assumptions was an imperfect one and that Husserl was wrong in believing that 'it is possible to transcend the noetic (the how of experience) –noematic (the what of experience) correlation and take a God's eye view on experience' (p.1129).

In interpretative phenomenology which embraces a hermeneutic version of phenomenology, description and interpretation are strongly intertwined, since all description *is* a form of interpretation. The researcher is moving from presuppositions to interpretations and back again to gain understanding and all presuppositions are tested as meaning evolves. Thus the interpretative phenomenological researcher is using his or her own assumptions to gain understanding, instead of bracketing them off (Willig, 2008). This is a holistic rather than an atomistic approach, where meaning is understood in context and understanding emerges in a process which is circular, and therefore, called a hermeneutical circle. The main idea of the interpretative phenomenological approach is based on a thematic analysis (Langdrige, 2008). The researcher holds a reflexive position looking for patterns and common themes across the experience.

Although interpretative phenomenological approaches seem rather different from descriptive approaches, the philosophical underpinnings that underlie them have a lot in common. They both strive to describe things as they appear through lived experiences (Langdrige, 2008) and they both put emphasis upon descriptions and reasons, instead of explanation and causes.

In phenomenology, the researcher tries to put aside any assumptions about the object of inquiry, and strive towards a thorough and comprehensive description of the phenomenon itself. This usually means an "in-dwelling in the phenomenon until its essential features reveal themselves" (McLeod, 2001: 56). Conversely, hermeneutics acknowledge that researchers always carry with them their assumptions, prejudices and background; therefore, understanding is always a matter of perspective and interpretation. In addition, in phenomenology, knowledge is never put into a social or historical context, it is context-free. Whereas, from a hermeneutic perspective, we are all inextricably contextual and thus a phenomenon is always put into a historical and cultural perspective. A purely hermeneutic approach to making sense of a

phenomenon could be deemed as “lacking a creative edge, because it can only speak of what people have assumed existence to be” (McLeod, 2001: 60). Alternatively, a merely phenomenological approach to studying a phenomenon would not be acknowledging that people are interpreted beings and it is through interpretation that they construct their world.

Before Heidegger, phenomenology was concerned with grasping the essences of abstract phenomena and hermeneutics was primarily concerned with explaining the meaning of special texts. No one had attempted to shed light on the ‘everydayness’, to study and make sense of the everyday world. Heidegger’s work was mainly focused on the fusion of phenomenology and hermeneutics. His approach was inspired by both phenomenology and hermeneutics and went beyond both since he was able to see very well their limitations and strengths so as to easily swing between interpretation and description whenever necessary. As McLeod (2001) puts it, one of the implications of Heidegger’s writings for qualitative researchers in counselling and psychotherapy lies in the acknowledgement that both phenomenology and hermeneutics can provide us with necessary insight into studying the dynamics of the ‘everydayness’.

Drawing on Heidegger’s (1962) ideas, the present study aims to study the in-training experiences of counselling psychologists in relation to the phenomenon of therapists’ verbal self-disclosure in the therapeutic encounter. The effect (if any) of their therapist’s self-disclosure in their own personal therapy, as well as their own self-disclosure in their work with clients, will be explored. The researcher is interested in investigating how trainees experience their therapist’s self-disclosure, or lack of it, in their own personal therapy and whether this experience informs their own client work regarding self-disclosure. Since the researcher is interested in gaining knowledge about how the participants construct and make meaning of the phenomenon being studied, it is inevitable that the role of the researcher will be interpretative. The most appropriate qualitative method for such an endeavour is deemed Interpretative Phenomenological Analysis (IPA). The next section will introduce the concepts and philosophy that underpin IPA and will focus on the role of the researcher both as a detached observer and as a co-participant in the study. Finally, a discussion will follow on how the researcher constructs the research questions, decides on the sample and collects the data when she conducts an Interpretative Phenomenological Analysis.

4.6. Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA), a version of the phenomenological method, accepts that it is impossible to gain direct access to research participants' worlds (Willig, 2008). IPA examines how a phenomenon appears and the researcher is implicated in making sense of the phenomenon (Smith *et al.*, 2009). Drawing on both phenomenological and hermeneutic philosophies (Smith & Eatough, 2007) IPA recognises that in exploring how the participants construct their world and make meaning of it, the researcher has an interpretative role (Lyons, 2007a; Smith *et al.*, 2009). In the present study, my role as a researcher was what Smith *et al.*, (2009) referred as a 'dual role' since I engaged in a double hermeneutic; that is, I was trying to make sense of the accounts of the participants. This was achieved by the use of IPA which is 'the joint product of the researcher and the researched' (Smith, 2003: 15). The participants, as well as myself, both as human beings, employed our mental capacities to reflect on the phenomenon under study. But I was mindful of being more self-conscious of this process and became aware that the participants' access to the phenomenon was only through their own accounts of it. My role involved adopting different ways of interpreting the data and accepting that any account obtained, would be partial since there will never be a final word on the topic (Smith & Eatough, 2007).

IPA (Smith, 2003) was deemed to be the appropriate method for this study as it is an exploratory, qualitative approach that is suited to areas where there has been little previous research (Bottrill *et al.*, 2009). IPA is particularly useful for investigating complexity, process or novelty (Smith & Osborn, 2003). Most previous research studies on self-disclosure (e.g., Knox *et al.*, 1997; Barret & Berman, 2001; Antaki *et al.*, 2005; Myers & Hayes, 2006) used quantitative methods and relied on analogue studies, potentially missing to gain an in-depth understanding of the phenomenon under study. Also, none of the studies has examined the experience of self-disclosure by individuals who have a *dual role*, that of the client and that of the therapist. IPA helps to provide new and differing perspectives on a phenomenon by learning from those who are experiencing it, rather than learning from, or being biased by existing theories or predetermined notions (Shaw, 2001). The idiographic nature of IPA therefore fits with the objective of this research, to investigate in detail the lived experiences of a group of individuals (developing counselling

psychologists), rather than generalising notions for larger populations (Smith & Osborn, 2003). However, as Warnock (1987, as cited in Smith & Eatough, 2007) put it, “delving deeper into the particular also takes us closer to the universal” (p. 39). Thus exploring at a deepest level, the experience of one person can provide us with some significant insight about the general; gaining insight into the individual’s unique life also gives us an insight into humanity (Smith & Eatough, 2007).

IPA’s philosophy is embedded in symbolic interactionism, a concern for how meanings are constructed by individuals within both a social and personal world (Smith & Osborn, 2003). The present study aims to explore how developing counselling psychologists experience the phenomenon of self-disclosure in both their personal therapy, as well as in their own client work, and thus, since IPA views individuals as experts on their own experiences, it can help the researcher to gain an understanding of the participant’s experiences and thoughts. However, access to another person’s experience is partial and complex, so IPA highlights the value of considering a researcher’s role in influencing the process (Smith & Osborn, 2003). As a researcher’s own views, assumptions and beliefs will influence an interpretation of a participant’s account, IPA stresses the importance of reflexivity to facilitate transparency. It recognises that the production of an interpretative account is a function of the relationship between a researcher and participant, constructed and shaped by their encounter (Larkin, Watts & Clifton, 2006).

IPA allows human experiences to be explored within a cultural context, highlighting contextual factors within an individual’s life that directly or indirectly may play a part in the meaning making process (Shaw, 2001). This is in accordance with the scope of this study which is interested in exploring the experiences of a well defined sample (developing counselling psychologists) within a specific cultural context (participants are from the UK and have had the experience of a personal therapist who engaged in self-disclosure).

Furthermore, Thompson, Kent & Smith (2002) advocate the need for further research using IPA to explore *process* rather than *outcome*, fitting with this study’s aim to explore the process of how personal therapy impacts or not, on one’s own client work regarding verbal self-disclosure. Also, an additional benefit to a novice researcher is the clear guidelines provided regarding its application (Smith & Osborn, 2003).

4.6.1. Constructing Research Questions, Deciding on a Sample and Collecting Data in IPA

The method of IPA focuses on the in-depth exploration of how participants perceive and make sense of their lived and personal experiences (Smith & Osborn, 2003; Smith & Eatough, 2007). Although IPA recognises that it is almost impossible to obtain direct access to the participant's internal world, the researcher is required to delve into the individual's accounts so as to gain an 'insider perspective' (Willig, 2008). Research questions in IPA focus on people's understanding of their experiences. Such questions are open and exploratory in nature and they mostly reflect process and not outcome (Smith *et al.*, 2009), focusing on meaning rather than the causes of events (see Data Collection).

From a phenomenological viewpoint, the world and the individual cannot be conceived as separate entities. Therefore, the aim of IPA is to explore "how the world represents itself to people as they engage with it in particular contexts, and with particular intentions" (Willig, 2008: 68). IPA researchers usually have a rather homogenous sample (Smith & Eatough, 2007). The rationale behind that is that it not helpful to think in terms of a random or representative sample but in terms of a purposive sample; a well-defined group sample for which the research question will be significant (see Participants). The sample size in an IPA study is roughly between three and six participants but in general the sample size depends on: a) the degree of commitment to the case study level of analysis, b) the richness of each participant's account and c) the organisational limitations one is operating under (Smith *et al.*, 2009). For this study, nine participants was deemed to be an appropriate number as it provided enough cases to examine similarities and differences between the individuals but not so many that it would generate an overwhelming amount of data (Smith & Eatough, 2007). Besides, the primary focus of IPA is quality and not quantity, thus IPA studies benefit from a thorough and detailed account of a small number of cases.

The method of data collection in IPA studies is usually one-to-one semi-structured interviews. Some of the questions included in the semi-structured interview of the study can be found in the 'Data Collection' section. Reliability is attained by the researcher adhering strictly to the interview schedule and showing as little variation as possible between interviews. The format, therefore, of the

structured interview provides the researcher with maximal control but can have at the same time a negative impact on the encounter between the researcher and the participant (Smith & Eatough, 2007). By deliberately putting limits on what the participant can talk about, the researcher might miss out on a novel aspect of the subject (Smith & Osborn, 2003). For that reason, the semi-structured interviews for this study included a set of questions from a schedule which was used mostly as a guide rather than the prescription for the interview. The rationale behind it was to facilitate rapport with the participants, as well as giving them space to unravel their experiences. My goal was not to stick strictly to the format but to be more flexible and enter the world of the participant. I was, therefore, freer to probe interesting areas that might arise and that I might never have considered. This enabled the interview to go into novel areas and, therefore, produce richer data (Smith & Osborn, 2003; Smith & Eatough, 2007).

Constructing an interview schedule is good practice in conducting interviews since it requires the researcher to think in advance about what they think or hope the interview might cover. Also, it enables them to think of difficulties or sensitive areas that might arise and how these might be addressed. Indeed, one area that was deemed sensitive before the construction of the interviews was the concept of self-disclosure itself. A topic on self-disclosure may be intimidating for many individuals, especially when the participants feel they have to talk about their therapists or their own practice. The idea of maybe exposing their therapist by either giving examples of his or her self-disclosure or exposing their own selves by admitting to engaging in self-disclosure and expressing examples of it, can be particularly challenging and even frightening for a lot of trainees who are still developing their professional identity and yet lack the experience of more competent therapists in the field. This issue was addressed in the study by making explicit to the participants (see Appendix A) that the research was not interested in delving into the content of the self-disclosures per se. Instead, the aim was to explore how these self-disclosures were perceived and experienced by the individuals at the time and whether that experience has informed their own client work in regard to self-disclosure. The researcher, when constructing the interviews, did not include any questions regarding the actual content of self-disclosure; instead, a question was asked about whether the content had had an impact on the therapeutic relationship.

A good interview technique usually involves a gentle nudge from the interviewer and the use of as little prompting as possible, so as to avoid leading the participant by being too explicit. The interviewer starts with a general question and hopes that it will be sufficient to enable the participant to talk about the subject. However, the researcher also prepares more explicit construct prompts to use when the participant has difficulty or does not understand or gives a tangential reply (Smith & Eatough, 2007). Smith and Osborn (2003) provide some tips on good practice for constructing the interview schedule which are: a) questions should be neutral and not loaded or leading, b) the researcher should avoid the use of jargon language or make assumptions of technical proficiency and c) closed questions should be avoided and instead open ended questions should be used as they encourage the participant to open up about their thoughts and feelings. These tips were used as a guide while constructing the interviews for this study.

Semi-structured interviews last approximately one hour and, depending on the topic, can become quite intense. It is necessary, therefore, to put the participant at ease and enable them to feel comfortable about opening up (Smith & Eatough, 2007). The role of the interviewer is to facilitate the process rather than explicitly dictate what will happen during the interview (Smith & Osborn, 2003). The interview does not have to adhere strictly to the interview schedule, whether in the sequence or wording of the questions. Indeed, with some participants some of the questions were asked earlier than they appeared on the schedule because it followed naturally from what the respondent had just said. With one participant, the interview moved away from the questions on the schedule into areas that had not been predicted (e.g., self-disclosure and supervision) but were quite enlightening and important for the overall research question.

With some questions, some participants might feel less comfortable and this might be evident from their non-verbal behaviour or from the way they reply. The interviewer is ethically bound to take into consideration any potential negative effects the interview might have on the participant and act accordingly. Thankfully, no such issue came up with any of the participants during the interviews. For IPA, it is necessary to record and transcribe the interviews. The level of transcription is often at the semantic level (Smith and Osborn, 2003), meaning that the researcher needs to pay attention to all the spoken words including false starts, significant pauses and laughs. During the painstaking work of transcription, I was mindful of paying

attention to every single word of each one of the participants, something that helped me gain a deeper insight than what I had gained during the actual interview. Transcription functioned as a repetition of the interviews and although initially seemed a tedious task, it proved to be very useful.

4.6.2. Role of the Researcher/ Reflexivity

The philosophical underpinnings of phenomenological psychology offer a drastic alternative to the more traditional positivistic approaches that attempt to break down phenomena into variables in order to explain and predict. In phenomenological research, the researcher is supposed to frame a question in order to explain an experience or a particular aspect of experience, without holding a hypothesis. However, I do agree with Langdridge (2007) who argues that it is impossible for the researcher to enter the field without having an agenda. Whether or not the researcher collaborates with their participants to frame the research questions, he or she can never actually be completely neutral and free from their assumptions and presuppositions. Like Spinelli (1989), I am quite sceptical as to how it is possible for a phenomenological researcher to suspend all assumptions and biases in one's contemplation of a phenomenon. It seems more realistic that one enters a topic of inquiry, holding a critical stance on their customary way of knowing about a phenomenon rather than attempting to completely bracket it off. The researcher in qualitative research is a central figure who actively constructs the collection and interpretation of data. Research becomes a joint product of the participants, the researcher and their relationship (Finlay, 2003a). The researcher's presence cannot be abolished, "instead the subjectivity in research is transformed from a problem to an opportunity" (Finlay, 2002a: 531). Qualitative researchers acknowledge the significance of being reflexive in how they interpret their data, in their role in the analytic process, and the ideas and assumptions they hold (Mauthner & Doucet, 2003). Reflexivity enhances a critical attitude towards locating the influence of research context and the researcher's subjectivity on research design, data collection, analysis and the presentation of findings (Gough, 2003). Including personal motivations and academic rationales in research reports can contextualise the research further and may even refine the research questions.

Throughout the process of the research the researcher should be conscious and reflective about the ways in which the questions used, the method applied, and

their very own subject position might influence the psychological knowledge produced in a research study (Langdrige, 2007). As a researcher, I will attempt to be cautious and aware of my own assumptions and presuppositions and explore the potential ways in which my involvement in the present study, influences and informs my research. I will attempt to continually examine myself so as not to let my prejudices and assumptions dominate my research findings. My goal is to engage in an ongoing dialogue between my past pre-understandings and the present research process in order to allow new understanding to emerge. I will focus on both personal and epistemological/functional reflexivity (Willig, 2008; Langdrige, 2007), which involves, respectively, reflection upon the ways in which my personal values, experiences, beliefs and interests shape my research, as well as reflecting upon the assumptions about the world and knowledge that I will make in the course of the research and upon the implications of such assumptions for the research and its findings.

In the following sections, I will try to answer some of the questions that encourage a reflexive approach to my research, which will be revisited during the study and once the study has been completed (Langdrige, 2007). I will also attempt to inform the reader of my position as a researcher with regard to the specific topic of investigation. This information will hopefully enable the reader to understand my position and how this has affected the findings. I will need to be conscious of and monitor the effects of my intersubjective reactions and interventions regarding research participants, as well as reflect on the interactions and relationships developed in the research setting and attempt to include these reflections alongside with my data.

As a counselling psychologist in training, I very often face the uncertainty and vulnerability regarding choice of interventions in my client work. Struggling with different techniques and theories, I have frequently found myself attempting to assimilate different and often conflicting perspectives on the 'right' way to conduct therapy. The decision to engage in self-disclosure or not was one of the dilemmas I faced with a considerable number of my clients, as self-disclosure had always been an 'intervention' deemed unsuitable by most supervisors throughout my training. However, being trained to work relationally made me view self-disclosure as an inevitable part of a two-person encounter. I suppose the contradiction between the professional stance I was trained to have and the personal experiences both in my

own therapy and in my own client work have led me to want to investigate this topic further.

During my research I am embracing and, at the same time, struggling with issues around phenomenological methodology. How do I distance myself from the more naïve realism perspective and the logical positivism which holds that no statement is meaningful unless it is capable of being verified (Crotty, 1998)? How is it possible to take off the spectacles of modernism that take for granted that our constructions relate to the real world and that the researcher can elaborate the structure of scientific constructs in a direction that leads closer to the truth of actual reality (Ashworth, 2003)? Besides, as psychology students, we were introduced to quantitative methodologies as the conventional ideals of science because they favour professional distance and objectivity and lead to testable propositions and cause and effect relationships. As an undergraduate psychology student, I was taught that psychology had been based traditionally in positivist epistemology and strived to establish objective and reliable methods of investigation. Now as a PsychD in counselling psychology student, wanting to embrace phenomenological methodology and wanting to challenge my own modernist way of thinking, how is it possible to allow for engagement and subjectivity? How can I reconcile my naïve realism leanings with attending to the accounts that people formulate of *their* reality? How can I put aside my own assumptions and preconceptions as a researcher?

I entered the PsychD in counselling psychology from a positivistic background in experimental psychology. I was very much used to thinking in a very positivistic and modernist way and always saw myself as ‘an observer who can overcome my perceptual biases and know reality in its true form’ (Hansen, 2004: 131). Being introduced to the postmodern movement, my basic assumptions of how meanings are created and discovered were challenged. This ‘complex, multifaceted, philosophical movement’ (p.133) inspired me to want to engage in phenomenological research and attempt to create reality rather than discover it. I was very much attracted by contextualism and the position that all knowledge is “local, provisional and situation dependant” (Madill *et al.*, 2000: 9). However, I still feel intellectually caught sometimes between two paradigms. While my theoretical and methodological position is one that rejects the notion of the neutral and objective researcher, I often feel a positivist pressure to detach myself and my presuppositions from my research.

My journey through self-disclosure and the meaning it has to counselling psychologists when they are at ‘the receiving end’ began when I understood that I was a participant in my own research. As a trainee in counselling psychology in my last year of training, researching other trainees or newly qualified people in counselling psychology, I was trying to explore their meanings while grappling with my own. As Finlay (2003b: 106) puts it: “I am both a subject and an object. Part of myself is reflected in my participants while they – or maybe my understanding of them - becomes part of me”. I was very much drawn to Heidegger (Smith *et al.*, 2009) and his emphasis that we are ‘thrown into this pre-existing world of people, objects, language and culture, and cannot be meaningfully detached from it’ (p. 17). Also Merleau-Ponty’s (Smith *et al.*, 2009) view that our knowing about the world is shaped by our embodied experience of it, was quite appealing to me as it enabled me to view myself as an engaged and active researcher who would need to be reflexive throughout the research process. Furthermore, I was very much influenced by Sartre’s (Smith *et al.*, 2009) idea that our perception of the world is largely shaped by the presence of others and the world in which we inhabit. I guess reading some of the ideas of some great figures in phenomenological philosophy like Husserl, Heidegger and Sartre, I gained an interest in wanting to focus on experience and its perception. Gadamer’s (Smith *et al.*, 2009) idea of the hermeneutic circle seemed to describe the process of interpretation very effectively and gave me an insightful understanding about engaging in a dialogue between my fore-structures and the phenomenon as it is been revealed. I was also influenced by Finlay’s (2003b) version of reflexive phenomenology which she called ‘hermeneutic reflection’. Hermeneutic reflection is shaped by existential phenomenological approaches which argue that (Finlay, 2003b: 107):

- Pre-reflective lived experience can never be fully grasped in its immediate manifestation
- Our assumptions and presuppositions are both our ‘closed-ness’ and openness to the world
- Our access to the world and our perceptions of it are already structured by our interpretations

- Our historicity and situatedness shapes our understanding
- The object of study and our own expectations and cultural traditions will inevitably be informed by any understanding we gain from research
- Reflection that aims towards self awareness - be it in researcher or participant -needs to engage in recovering something of our unreflective experience.

In hermeneutic reflection, Gadamer's (1975) hermeneutic cycle can be understood as a cycle of three stages: 1) the fore-structures which are the researcher's preconceptions, 2) dealing with the 'resistance' when exploring an experience, and 3) re-evaluating the fore-understanding by interpretation. Given that the method of interpretation aims at challenging the fore-structures and presuppositions of the researcher, the process is cyclical and by definition involves a continuous reflexive approach towards an ongoing dialogue between the assumptions and preconceptions and the experience itself (Finlay, 2003a, 2003b; Smith *et al.*, 2009). Our fore-structures and pre-judgments then cannot be completely disentangled from the experience being studied because this is how we have access to the world; it is always through interpretation (Smith *et al.*, 2009), and it is thus, through reflection that we gain a more direct contact with the lived experience.

My first task in the early stages of the research process was to attempt to identify and put aside my own assumptions and predispositions, in order to be as transparent and open as possible to the lived experience of the participant and listen genuinely to their own view. The best way to do that was by making my approach as explicit as possible before immersing myself into my participant's world. My experience of being both a researcher and a counselling psychologist in training in my third year, studying other counselling psychologists who were newly qualified, involved questions around missing points of difference between my participants and myself and colluding with them. It was important to recognise and locate myself socially, emotionally and intellectually so as to retain some boundaries between the participants' accounts and my own interpretations. I tried to be aware of the many variables that might interfere with the fair collection and interpretation of data, including my own emotional involvement with the research topic, my knowledge formed from reading the existing literature on self-disclosure and the various aspects

of interaction with my participants (Morrow, 2005). I am a white, middle-class developing counselling psychologist and all my participants were white (except one), middle-class developing counselling psychologists as well. This made me think that I already ran the risk of entering the interviews feeling quite familiar and comfortable with the fact that we shared a similar professional socialisation and background. This last year's workload, the client work, the different views of supervisors, the personal therapy, juggling with so many different things at the same time, it felt like I was already entering the interviews having the assumption that there would be a mutual feeling of understanding, that we would be able to share the same language and jargon, and that we shared the same dilemmas and tensions about self-disclosure in personal therapy that lay clients could not pick up. Indeed in one interview, I found myself colluding with one female participant who admitted that had she not been a trainee at the time (when her therapist was self-disclosing to her), she would have probably left therapy. Here is the excerpt:

“But if, if I hadn't been in training perhaps as well, I think I probably would have, I may have left the therapy. I may have...I don't know whether being in training made me more critical, or actually being in training made me stay! I don't know, because, you know doing the doctorate and so many demands I didn't want to find another therapist. And we did have a good relationship, but therapeutically I think if I'd have been a client needing to deal with more stuff... if I hadn't felt like I'd dealt with quite a lot of stuff already as well in my first therapy, I don't think I would have found that the space I wanted it to be. So I might have left, I don't know. perhaps in some ways I stayed because I was a trainee, because it was more convenient and I had too much else going on to go through the hassle of finding another therapist and because we were doing good enough therapy, it felt it was okay”.

Entering the field of therapists' self-disclosure, I had the assumption that trainees or counselling psychologists would be more aware when their therapist engaged in self-disclosure and would be more critical of it, whereas lay clients might even not pick up on it. It came as quite a surprise to me to hear that from a participant and I felt that my assumption was confirmed by another individual who was also a counselling psychologist. However, I was quite struck by what this participant revealed later on about the fact that she stayed in therapy because she could not deal with the hassle of finding another therapist in the midst of all the workload. I suppose

during my training I had had a similar experience when although at times I was thinking of changing therapist, I continued with this specific one as it was quite convenient for me in terms of time/ money/distance.

Finlay (2002b) uses the term 'reflexivity as introspection' in an attempt to describe the importance of the researcher's personal introspection which can lead to insights that can form the basis for a more generalised understanding and interpretations. In this study, while conducting one of the interviews, I found myself quite impatient and annoyed with one participant who was constantly hyper-vigilant not to self-disclose any experiences. She was talking about her feelings about self-disclosure but she was very reluctant to put anything in context. I found myself asking more probing questions with this participant. I did not know whether this impatience stemmed from my own unfulfilled curiosity or from my need to make the participant feel safe. Reflecting on my behaviour, I understood that it was more a clash of our perspectives. Her negative experiences of her therapist's self-disclosure made her clearly edgy and upset during the interview, thus making her quite reluctant to self-disclose to me. My need for her to feel open and safe was not met. I constantly had the feeling she was not being transparent due to her own negative experiences. Examining my own feelings of irritation enabled me to better understand how she had experienced her therapist's self-disclosure and the extent to which this experience had shaped her own client work in terms of self-disclosure.

Finlay (2002b) also referred to 'reflexivity as intersubjective reflection' to describe the researcher's attempt to explore the mutual meanings emerging in the research relationship. The researcher ought to focus on the research encounter and on how the unconscious processes shape the relations between the researcher and the participant. Hollway and Jefferson (2000) used reflexivity along with their narrative method to describe their sense of rapport and identification with one of their participants. Similarly, I found that with a few of the respondents, I shared some points of identification, namely the institutional context which seemed to have played a key role in shaping our ontological and epistemological positioning. Likewise along with Hunt (1989), I wondered whether the transferences that were situationally mobilised to our encounter had any effect on the questions I asked, on the answers I heard and on the materials I observed. As a counselling psychologist in training, I have been trained in active listening skills. Therefore, building rapport with my participants came a bit as a natural process. However, in taking on the researcher's

role, I now faced the challenge “to manage the slippery slope on which boundaries between research and therapy may be confused” (Morrow, 2005: 253). I noticed that even these participants, who viewed the therapist’s self-disclosure negatively, prompted me to self-disclose prior to the interview. Most of them wanted to have more information about my coping in terms of being a trainee in my last year. I suppose their asking had to do more with their need to find common ground, since most of them were newly qualified and had been through that experience themselves quite recently. One participant in particular asked me about my cultural background – I suppose because of my name and accent - and very enthusiastically disclosed that she was also coming from a different culture. It felt that my self-disclosure was a way for both parties to feel more comfortable and establish rapport (Haverkamp, 2005), a quality so vital in the researcher-participant relationship. Reflecting on that, I wondered whether my self-disclosure was an attempt to break the ice or an attempt to facilitate the interview process and whether it stemmed from my own need or both parties’ needs. It did seem to play its role though in the establishment of rapport with the respondents and it left me wondering whether this could be the case in the therapeutic relationship as well.

4.7. Evaluating Qualitative Research

One of the biggest challenges in qualitative research is to ensure its quality and trustworthiness. Qualitative research has been criticised from those of the positivist position who view it as “‘merely’ subjective assertion supported by unscientific method” (Ballinger, 2006: 235). Subsequently in IPA, the use of reliability and validity are seen as inappropriate means of evaluating the research, as these evaluative criteria are based on the supposition of scientific objectivity which holds that the researcher and the researched are independent of each other (Madill *et al.*, 2000). The integrity then of the qualitative research process requires evaluation criteria which will allow researchers to “acknowledge that trust and truth are fragile...[while enabling them] to engage with the messiness and complexity of data interpretation in ways that...reflect the lives of...participants” (Savin-Baden & Fisher, 2002: 191). For qualitative research there is no consensus about the best criteria for evaluation (Coyle, 2007), but they should be compatible with the epistemological framework of the research. Consequently, it is of paramount

importance to position the epistemological position of a qualitative study before we evaluate it (Willig, 2008).

Yardley (2000) outlined four criteria that would be more appropriate for the evaluation of qualitative research: ‘sensitivity to context’, ‘commitment and rigour’, ‘transparency and coherence’ and ‘impact and importance’. Sensitivity to context refers to the clarity concerning the socio-cultural setting of the study and the relationship between the researcher and the participants. Commitment refers to the engagement with the research project and rigour should characterise the completeness of data collection and analysis. Transparency involves revealing all aspects of the research process and coherence refers to the relation between the research questions and the epistemology adopted, as well as the methods used and the analysis that was conducted. The impact and importance relates to the theoretical and practical implications of the study. As a whole, there is some degree of consensus or overlap between the different evaluative criteria for qualitative research. Generally it is agreed that qualitative research needs to be ‘*trustworthy*’ in the sense of being able to show both *rigour* (process) and *relevance* (end product) (Finlay, 2003a).

In the present study I was attentive to Yardley’s (2000) four evaluative criteria by being sensitive to context; that is aware that I was interviewing developing counselling psychologists in the UK who most of them had had an integrative training and therefore shared a lot of similarities with me. I have been engaged with the project for the last three years and throughout I have been transparent ‘by presenting excerpts of the textual data in which the readers can themselves discern the patterns identified by the analysis, and/or by making detailed records of the data’ (p.222). The reader of this research is welcomed to be attentive to these criteria when reviewing the analysis. Also the contextual constructionism epistemology that the research adopts is in accordance with the research questions and the qualitative methodological approach used (coherence). Last but not least, the impact of the findings of this study are of considerable value, and are explored in the discussion chapter of this thesis.

The philosophy of science paradigm that informs a given research project determines the appropriate standards for evaluating its rigour and trustworthiness (Haverkamp & Young, 2007; Marrow, 2005). Achieving a match between the research purposes and the researcher’s underlying paradigmatic assumptions

enhances the credibility of research. In order to accomplish a coherent rationale and design, the researcher must consider how the research purpose and philosophy of science paradigm intersect.

I am working within a contextual constructionism epistemology which rejects the straightforward criteria of objectivity and reliability into the evaluation of the work (Madill *et al.*, 2000). I do not assume that there is one reality that can be discovered through the employment of correct methodology; instead, I acknowledge that my findings will vary depending on the context in which the data were collected and analysed. The interpretivist/constructivist paradigm embraces the position of the researcher as co-creator of meaning. In order to deal with biases and assumptions that arise from my own experiences or from the interaction with my participants, I will engage in reflexivity (Morrow, 2005). Pidgeon and Henwood (1997) describe four dimensions that may have an impact on the production of knowledge: '1) the participants' own understanding, 2) my own interpretations, 3) the cultural meaning systems that inform my respondents' as well as my own interpretations, and, 4) 'the act of judging particular interpretations as valid by scientific communities' (p.250). Part of the evaluation involves weighing one account against another since there is the notion that some accounts may be more persuasive or valuable than others or even more relevant to the particular research question (Madill *et al.*, 2000). In their article, Madill *et al.*, (2000) describe triangulation in relation to contextual analysis as 'a possibility of retaining truly novel perspectives which may have been discounted when consensus - and hence probably conventional - understandings are valued' (Madill *et al.*, 2000: 10). In other words, triangulation in contextualist epistemology aims at completeness and not convergence. Also, the researcher's subjectivity in contextual analysis is very important. The researcher needs to make clear how they approach material and that includes details, such as gender, age, ethnicity, and any factors that inform the reader of the positions from which the researcher writes.

5. Method

5.1 Introduction

This section will summarise the method involved in conducting the current research. It includes the demographics of the participants, the ethics, procedure, data collection, data analysis and evaluative criteria. Also, The role of the researcher will also be included in the documentation since it is acknowledged that the research process (Willig, 2008) shapes the purpose of inquiry.

5.2 Participants

The participants in this study were six chartered counselling psychologists (See Table I for participant demographics) and three counselling psychologists in training, nine in total. All the participants had either completed or were in the final year of a BPS accredited course in counselling psychology at the time of the interview and were working in the United Kingdom.

The decision to use either newly qualified counselling psychologists or counselling psychologists in training was informed by the research question (Willig, 2008). And the rationale behind it was to investigate the views and perceptions of self-disclosure from the point of view of the client in a real world setting, when the clients themselves were developing counselling psychologists and could, therefore, shed light on how their therapists' self-disclosure influences (if it does) their developing professional identity. Farber (2006; Botrill *et al.*, 2009) argues that positive emotions linked with self-disclosure can coexist with negative emotions such as vulnerability and uncertainty. These negative emotions may be even more pronounced for the developing therapist who is likely to be facing many dilemmas already regarding the choice of intervention (Botrill *et al.*, 2009). As Polkinghorne (2005: 139) put it: 'Participants and documents for a qualitative study are not selected because they fulfil the representative requirements of statistical inference but because they can provide substantial contributions to filling out the structure and character of the experience under investigation'. Only developing counselling psychologists who had experienced at some point during their therapy (regardless of the approach), their therapist's self-disclosure were included in the final analysis and were representative of the whole sample group. Since IPA is an idiographic approach (Smith *et al.*, 2009), it is conducted on small sample sizes and is concerned with the

detailed case-by-case analysis of individual transcripts. The aim is to examine in depth the perceptions and understandings of these participants. Six to eight participants is considered an appropriate number for participants for an IPA study, as suggested by Smith and Eatough (2007). For the present study, nine cases (Table I. Participant's Demographics) were deemed to provide enough data to examine similarities and differences between participants but not so much that the researcher was in danger of becoming overwhelmed by the amount of data produced.

Demographics:

Number of Participant	Gender	Trainee/ Newly Qualified	Type of Personal therapy	Place of Work
1	F	Newly Qualified	<ul style="list-style-type: none"> • Psychodynamic 	NHS-IAPT
2	M	Newly Qualified	<ul style="list-style-type: none"> • Integrative/Mainly Psychodynamic 	Private Practice
3	F	Newly Qualified	<ul style="list-style-type: none"> • Psychodynamic 	Private Practice & NHS-IAPT
4	F	Newly Qualified	<ul style="list-style-type: none"> • Clinical Psychologist- Unknown approach • Person Centred • Psychodynamic 	NHS
5	M	Newly Qualified	<ul style="list-style-type: none"> • Person Centred • Psychodynamic 	NHS-IAPT
6	F	Newly Qualified	<ul style="list-style-type: none"> • Humanistic • Integrative 	No work at the moment
7	F	Trainee	<ul style="list-style-type: none"> • Person Centred • Psychodynamic • Integrative-Mainly CBT 	NHS Placement
8	M	Trainee	<ul style="list-style-type: none"> • Psychodynamic-Jungian Style 	NHS Placement
9	F	Trainee	<ul style="list-style-type: none"> • Person Centred • Integrative • Psychodynamic 	NHS Placement

Table I. Participant Demographics

5.3 Ethics

Ethics was obtained through the university's Ethics Board before commencing data collection. This process required submitting an ethics application form and reviewing amendments until a satisfactory version had been attained. The study strictly adhered to both the principles of the British Psychological Society (BPS) *Code of Ethics and Conduct* (BPS, 2006a) and Health Professions Council (HPC) to ensure proper ethical conduct. The nature of the inquiry only required the researcher to investigate how the participants perceived the relationship with their therapists when he/she self-disclosed and was not concerned with the content of the sessions or the identity of the therapists. A written consent form (Appendix B) was provided so that the participants were fully aware of the procedure regarding how the data would be used; namely anonymity, exclusion of identifying elements in the text, the assurance that the interviews would be identifiable only by the researcher through a coding system, the assurance that the recordings of the interviews and the transcripts would be safely stored for ten years for verification purposes and then destroyed and their right to withdraw at any time by quoting their ID number which appears on the debriefing form (see Appendix C). Participants were informed that in case they experienced emotional distress during the interview, they had the right to end the interview. Also, contact details of support groups were provided on the debriefing form which was given to the participants at the end of the interview. It was the researcher's intention to navigate the interview process through non-maleficence (Bond, 2007) and ethical attunement (Brinkmann & Kvale, 2008) using the *Division of Counselling Psychology's Professional Practice Guidelines* (BPS, 2006b) and the BPS's *Code of Ethics and Conduct* (BPS, 2006a).

5.4 Procedure

The participants were recruited through word of mouth and the electronic distribution of a recruitment poster. The researcher also approached program directors of universities in south-west London that offered a PsychD in counselling psychology and asked for permission to circulate information about the study to their former students who had completed the PsychD in Counselling Psychology. After the initial contact, participants were informed of the procedure and the approximate length of the interview. Interviews took place in Whitelands College, Roehampton

University, after the researcher had agreed on a convenient date and time with the participant and booked a room for the interview.

5.5 Data Collection

Collecting qualitative data was accomplished using semi-structured interviews as they allowed the researcher and participant to engage in a dialogue where initial questions could be modified according to the participants' responses and the researcher was able to focus on any other interesting areas that arose (Smith *et al.*, 2009). The ultimate research goal was to elucidate the essence of the phenomenon being studied, namely therapists' self-disclosure as it existed in participants' concrete experience (McLeod, 2001). The approach was idiographic (Willig, 2008; Smith *et al.*, 2009; Smith & Eatough, 2007) whereby individual cases were examined for themes and then general categorisations were applied to the whole group. Some of the questions included in the semi-structured interviews were:

“Did at any point in therapy your therapist self-disclose?”

“How did you experience your therapist's self-disclosure?”

“Did the content of self-disclosure have an impact on your relationship with your therapist?”

“When did you find your therapist's self-disclosure more beneficial and when did you find it disruptive?”

“How has your experience with your therapist's verbal self-disclosure or lack of it influenced your developing professional identity?”

The gathered interview material was analysed for themes using these stages as proposed by Smith & Osborn (2003):

Looking for themes in the first case - involves reading the transcript several times to gain new insights, looking for 'similarities and differences, echoes, amplifications and contradictions in what a person is saying' (p.67).

Connecting the themes - involves a more analytical ordering as the researcher is trying to find the connections between the emerging themes. 'Some of the themes will cluster together, and some may emerge as superordinate concepts' (p.70).

Continuing the analysis with other cases - incorporate views from other transcripts, trying to discern repeating patterns but also acknowledge new issues emerging.

Writing up - involves the translation of themes into a narrative account.

At the end of the interview, each participant was asked whether there was anything they wanted to add. The researcher used probes, open ended questions and paraphrasing to facilitate the dialogue and to ensure that a comprehensive understanding of the participants' perspectives was obtained.

Each interview (see Appendix D for a sample of transcript) lasted between 45 minutes and one hour and was preceded by an explanation of the participant consent (Appendix B) and information forms (Appendix A), as well as the debriefing form at the conclusion of the interview (Appendix C).

5.5.1 Reflexive Summary: Data Collection- Conducting the Interviews

In accordance with the *Professional Practice Guidelines* of the *Division of Counselling Psychology* (2006b) section 2.5 *The practitioner as researcher* (p.6), I aimed for congruence between the model of research chosen, its design and implementation and the values expressed in counselling psychology. However, Harper (1999) argues that there is an inherent element of power imbalance in interviews since one person poses the questions and the other provides the answers. One of the biggest concerns as a researcher was to try to conduct the interviews without imposing my own agenda on the participant; however, this appeared almost impossible because of the very nature of collecting the data, namely, interviewing. As Langdridge (2007) argues, the researcher frames the questions based on his or her reading of the existing literature or his or her particular aspect of an experience. Moreover, I had concerns about getting 'relevant material' for analysis and about the suitability of my participants' accounts. To what extent were their accounts suitable material for a phenomenological study and how able were they to convey their experiences in-depth and richness to me? Would language provide my participants with the necessary tools to fully capture their experiences? These were just a few questions I was mindful of during the conduction of the interviews. As a relative novice to IPA, I was comforted to see that "it leaves room for creativity and freedom to explore on the part of the researcher who uses it" (Willig, 2008: 73).

5.6 Data Analysis

The analysis of qualitative data is conducted with the intention of summarising and bringing as much significant meaning as possible to the interviews experienced by the researcher and the participants (Jensen, 2006). It is important to

recognise that qualitative data analysis processes are not entirely distinguishable from the actual data since data collection and analysis processes tend to be concurrent, with new analytic steps informing the process of additional data collection and new data informing the analytic processes (Thorne, 2000). The theoretical background of the researcher, the strategies used for data collection and the understandings that the researcher has about what might constitute relevant or important data in answering the research questions, are all analytic processes that influence the data. The extant literature on analysis in IPA has not dictated one single 'method' for working with data (Smith *et al.*, 2009); instead, there is a lot of flexibility in matters of analytic development, while the analytic task always remains in attempting to make sense of the participants' own experiences.

The process involved transcribing the interviews, including notes of significant non-verbal utterances, pauses and hesitations (Smith *et al.*, 2009) which was then followed by several readings of the transcripts with a view to getting an overall feel for the interview (Storey, 2007) and allowing the researcher's initial encounter with the text (Willig, 2008). Bucholtz (2000: 1440) views the transcription process as a reflective act in itself. He argues that: "The responsible practice of transcription...requires the transcriber's cognizance of her or his own role in the creation of the text and the ideological implications of the resultant product". Therefore, the method the researcher chooses to use and his involvement in applying this method is closely intertwined with his or her epistemological, ontological and theoretical position (Alvesson & Sköldberg, 2009).

The analysis of the data followed the steps outlined by Smith and Osborn (2003). The first step involved within-case analysis. Initially, a transcript was read several times and comments were made in the left-hand margin about the meaning of particular sections of the transcript. These initial notes were shaped into more meaningful emergent patterns (i.e., themes) that were recorded and then listed separately and tentatively arranged into clusters to reflect any shared meaning or references. In line with the iterative nature of IPA, once the initial themes had been identified from each transcript, the transcripts were then reviewed in the light of any new themes that had emerged from the analysis of later transcripts. The second stage involved cross-case analysis, integrating the themes across the transcripts. The researcher attempted to identify common links between themes and to reorder them or cluster them together in order to form higher level themes. Eventually a set of

consolidated super-ordinate themes were established, in order to capture the essence of the participants' experience of self-disclosure. The process was cyclical and iterative, as it involved moving back and forth within the data to check meanings and confirm interpretations (Langdridge, 2007).

A table (see Appendix E in Appendices section) illustrates the category building process of one super-ordinate theme (Super-ordinate Theme 5- Own Client Work). There are six initial emergent themes (cluster of themes) which represent, and fall under the broader super-ordinate theme; namely: 1) Boundaries/ Balance/ Use it tentatively, 2) Depending on the theoretical orientation, 3) Appropriateness: Timing/ Setting/ Relationship, 4) Normalise/ Demystify, 5) Be aware of one's one motives, and 6) Counter-transference disclosure. The first column of the table indicates the number of the participant, and the second column illustrates an example of the participant's accounts that capture most strongly the clusters of the emergent themes. The reader can also refer to the Appendix D which is a sample of transcript that shows the developing emergent themes. In that way the researcher is attempting transparency by detailing the process of data collection and analysis.

5.6.1 Reflexive Summary: Conducting the Analysis

Data was gradually transformed into findings as the study was shaped and reshaped throughout the entire research process (Watt, 2007). The data analysis proved to be one of the most painstaking and longer aspects of the research. As argued by Miles and Huberman (1994: 433), "as each qualitative study is unique, the analytical approach used will be unique". Besides, each researcher brings into the process their own knowledge, strengths, and weaknesses, and "must determine what works best" (Watt, 2007: 95). "Direction can and will be offered, but the final destination remains unique for each inquirer, known only when – and if – arrived at" (Patton, 2002: 432).

Throughout the analysis I was very concerned about capturing the lived experience of the participants and the meanings they make of that experience. Stainton Rogers (1991: 10), however, noted that "in order to weave my story, I must inevitably do violence to the ideas and understandings as they were originally expressed". Appreciating this problem, I was more aware that the end result would always be an account of how I, as a researcher and interpreter think the participants

are thinking. Acknowledging that IPA analysis is tentative and subjective helped to alleviate some of the inevitable tension and adopt a more “fluid description and engagement with the transcript” (Smith *et al.*, 2009: 81).

6. Results

6.1 Introduction

From the process of analysis, five super-ordinate themes emerged that can be grouped under two broad domains (Table II) informed by both the research questions and the responses of the participants; namely, the participant as a client and the participant as a developing counselling psychologist. The participant as a client reflects themes that relate to the experience of having a therapist who self-discloses in therapy and the feelings that this evokes in their own personal therapy as well as the impact of their therapist's self-disclosure on the therapeutic relationship. The second (the participant as a developing counselling psychologist) reflects themes of how the participants use or do not use self-disclosure in their client work and how this decision has been shaped by both their training as well as the experience of their own therapist in personal therapy. These two broad domains are just organizing categories and do not represent distinct entities. Consequently there might be some common elements between themes. The themes and domains presented here are the researcher's interpretations of the participants' accounts of their conscious experiences and, although the researcher assumes they have at least some reality, it is not claimed that they are complete or wholly objective. The researcher's goal in this idiographic phenomenological approach was to gain a more rounded understanding of the effects of therapists' verbal self-disclosure as experienced by the participants. Table II provides a heuristic device to help clarify the researcher's work on the analysis. For reasons of neatness and convenience, in this section the results are presented as falling under those two broad domains. The splitting of analysis in Table II and in the rest of this chapter is a "stepping stone" towards the overall findings that will be outlined in the next chapter. Although in this chapter the participants' responses have been split into two domains; namely the 'participant as a client' and the 'participant as a developing counselling psychologist', the findings were inevitably co-dependent and therefore were treated holistically in a comprehensive discussion of the next chapter. Readers must judge for themselves whether the themes generated and their organisation represent a coherent account or uncover new understandings—two validity criteria often used in qualitative research (Stiles, 1993).

The reader can also refer to Table I (Method section) to view the participants' demographic details. It is worth mentioning that participants had more than one therapist during their training and in their accounts they referred to most of them. Excerpts from the original interviews are used where they indicate the most apt summaries of the emergent theme. In order to protect the anonymity of participants and to clarify individual participants' contributions, each participant was allocated a number from one to nine (see appendix D for a sample transcription).

Table II. Master Table of Themes for the Nine Participants.

1. The Participant as a Client
<i>1.1. Super-ordinate theme 1- Concept of therapist's self-disclosure</i>
Personal details
Counter-transference disclosure
<i>1.2. Super-ordinate theme 2- Feelings around one's own therapist's self-disclosure</i>
Challenging
Surprised
Interest/Curiosity
Closer to the therapist/ Less distance/ Safer/ Understood
Frustration/ Anger/ Annoyance
<i>1.3. Super-ordinate theme 3- Impact on therapeutic relationship</i>
Helped the process
Reversal of Roles/ Client as carer
Confrontation
2. The Participant as a Developing Counselling Psychologist
<i>2.1. Super-ordinate theme 4- Training</i>
Expectations due to training
Taboo in training
<i>2.2. Super-ordinate theme 5- Own Client Work</i>
Boundaries/ Balance/ Use it tentatively
Depending on the theoretical orientation
Appropriateness: Timing/ Setting/ Relationship
Normalise/ Demystify
Be aware of one's own motives
Counter-transference disclosure

6.2 The Participant as a Client

The themes in this broad domain reflect the participants' experiences and perceptions of their therapist's self-disclosure in their own therapy, as well as the impact that this had on the therapeutic relationship. Following a phenomenological position, the researcher asked all of the participants at the beginning of the interview to describe how they understood the concept of therapists' verbal self-disclosure.

Super-ordinate theme 1. Concept of therapist's verbal self-disclosure

Participants described the concept of therapists' verbal self disclosure as the revelation of personal details or experiences, that were either focused on the client and were pertinent to the therapeutic work, or not. Three participants, however, also mentioned the disclosure of counter-transference feelings.

Participant 1:

“My understanding of therapists' self-disclosure is relevant to sharing something about themselves or disclosing something personal about their practice or anything related to themselves which might be relevant to the client's treatment – or irrelevant.

I suppose anything relevant to the therapist's issues or experiences or moods or ... I don't know, professional experiences, but not so much about the client. And at times relevant to the client, perhaps” (p.1, 11-21).

Participant 3:

“My understanding of that is when a therapist shares other feelings or thoughts that they're having with the patient. That can be in terms of how their patient is making them feel, or it can be where they just talk about maybe personal stories about their own life. They may share um yes, just personal experiences that may not be completely focused on the patient” (p.1, 4-13).

Participant 2:

‘Well, I suppose um, the most obvious meaning that springs to mind is when a therapist gives information, something personal about them. Something that the client doesn't already know; something about their personal life or their beliefs.

Facts about themselves, or opinions. I think that's a disclosure. But in another way, another kind of disclosure that I see is when a therapist is talking more about their feelings, like their counter transference feelings. So the things that are going on for them, so more about the process – their process.’ (p.1, 14-30).

Super-ordinate theme 2. Feelings around one’s own therapist’s self-disclosure.

Theme 2.1: Challenging

A common theme that applied to most of the participants was the experience of self-disclosure as challenging in the therapeutic encounter. As participant 2 explains, self-disclosure was experienced as scary and challenging but at the same time ‘upped the ante’ for him since he had to respond as a real person.

Participant 2:

‘It challenged everything that had come so far you see, it changed things because she wasn’t the same person any more, she was someone else. She was, you know, she was more real in a sense – she wasn’t this idea, this very two-dimensional idea of a therapist who just responds. Now she was a real person and I ... and it upped the ante for me because I had to then respond as a real person as well, so um, it pushed me; it was difficult; I had to say things that ... I wanted to say things that were difficult to say so it was quite challenging, you know, scary.’ (p.11, 380-396).

Participant 3 experienced self-disclosure as challenging and at times uncomfortable but felt grateful as she felt more able to see parts of herself that she could not see before.

‘Obviously when I was getting into very deep stuff and he was self-disclosing his experiences of me in that, sometimes it was challenging; I had to come up against parts of myself I didn’t want to come up against. But after a while, I think because he had gained my trust, I really appreciated when he would disclose. Because I felt like he would say things that people wouldn’t say to me and I was so grateful that someone was helping me see these parts of myself that I just couldn’t see, that I wasn’t aware of. So, yes in the beginning it was uncomfortable, but then after a while I was okay, let’s do this; I want to experience more of this. Because I found it very helpful.’ (p.3, 108-126).

Theme 2.2: Surprised by therapist's self-disclosure

For most participants, their own therapist's self-disclosure felt odd or 'uncharacteristic', as they were not anticipating it, either because the therapist was a psychodynamic one and/or they were not used to having him or her self-disclosing to them.

Participant 2:

"And she started getting really ... she started reacting in an uncharacteristic way. She surprised me. Instead of this really calm, quite blank screen person who never gives away anything, she was kind of, um, getting quite upset. Like she seemed anxious" (p.5, 170-177).

"I was very interested I have to say, because it was unusual; we hadn't done anything like this and I was seeing her in a very different light" (p.11, 352-356).

Participant 7:

"When my psychoanalytical therapist told me that she went to ... she lived in Reading and she went to university in the local area, I was a little bit more surprised because ... that stereotype psychoanalytical therapists don't say anything, they don't reveal anything about themselves. But I think that's just more of a myth, you know, you just think that they're going to be quite distant and boundaried in terms of what they reveal, which is nothing. The way you read the literature... and because I was training I was learning a bit more about different theories, so when I did choose to see a psychoanalytical therapist I had an image in my mind, but it turned out to be completely different, because she was more talkative in the therapy. I just assumed they would say nothing for the whole hour and just listen and make the odd comment. But it was much more interactive" (p.5, 222-239).

However, participant 3 reported that her therapist's self-disclosure did not make her feel very uncomfortable as she was used to her supervisor disclosing as well:

"I was just aware of the fact that he was being incredibly honest about his experience with me and at first it was a little uncomfortable. I would pause and think and try to process what was being put in front of me. But also part of my training

previously, during that time, was my supervisor self-disclosing as well. So it wasn't the only place that I was experiencing that" (p.3, 96-105).

Theme 2.3: Interest/Curiosity

Interestingly enough, a theme that emerged from the participants' accounts was the need for more self-disclosure on the part of the therapist out of interest or curiosity. Some of them attributed that to the fact that they were themselves training as counselling psychologists and therefore were 'curious' or 'interested' in their therapist's experiences. However, it was interesting that none of the participants except one asked their therapists any personal questions either because 'they did not have the confidence' or because 'they had reconciled with the idea of retaining the boundaries'.

Participant 7, after her therapist's self-disclosure that she had converted to Islam and had become a Muslim, reported that:

"I think I was curious to know more at the time, but I didn't feel I should or could ask more. Although perhaps, if I think about it, I would have liked to know more, but I didn't feel confident enough to ask her more" (p.3, 146-150).

Participant 8:

"I wanted something ... there was a part of me that really wanted to know about him as well, as a person. I think part of that was because I was training too, and it's like I wanted to know about him as a therapist. I was interested in where his background led him up to being a therapist and ... yes I was very curious" (p.2, 88-94).

Participant 1:

"So in a way it was safe for me that she had her boundaries and I didn't ask her questions, not because I wasn't interested, but because I knew that I wouldn't get an answer and everything was about my fantasies. And I was quite reconciled with this idea of boundaries and I knew what my space and what my place was, and that me and her would never be friends, or ... whatever" (p.5, 226-234).

Participant 1 explains how she struggled with her ambivalence to have some sort of mirroring from her therapist on the one hand, but appreciated the therapeutic space she was given on the other hand:

“And I would die for her to tell me, to give me some sort of mirroring or her point of view on how I looked like. And she wouldn’t; she wanted me to reach that understanding myself without her getting involved, which was really frustrating, on one hand. On the other hand I did appreciate what she did, it was all about me and my perception of myself and work with how I saw myself and perhaps why I would expect her to tell me. Was there something about her opinion being very strong, perhaps her opinion mattered at the time? But she wouldn’t – she was very psychodynamic, she would turn the focus onto me and how I perceived myself” (p.2, 77-91).

However, participant 4 had for a period of a time a purely psychodynamic therapist who adhered to the ‘blank screen’ stance, throughout the course of therapy. Participant 4 found it hard to establish a therapeutic relationship with this particular therapist as she experienced her therapist’s abstinence quite uncomfortable and unhelpful and would have wished for more self-disclosure on her therapist’s part:

“I was trying hard to relate because I suppose for me that is second nature and I couldn’t do it with her. And I found that very frustrating, very hard. And actually I found myself getting tearful a lot in her room because I found myself not, I suppose, not knowing how to deal with it because it was, like, foreign. Because I think it’s second nature to relate to people unless you have something like autism or something. You know, I do think that, and I thrive off that and I pick up cues off people. With her I couldn’t pick up cues” (p.13, 514-530).

It was also quite interesting the fact that four out of nine participants felt ‘pleased’, ‘flattered’, or even ‘honoured’ when their therapist decided to self-disclose. However, two of them, on the one hand felt flattered but on the other hand did not view their therapist’s disclosure positively (participants 1 & 9). Without exception, all of the participants reported that they valued their therapist’s self-disclosure when it occurred later in their therapy, once the therapeutic relationship had been established.

Participant 4:

“And then when she started self-disclosing later it felt like I was being privileged. It felt like I had been loyal and done well, sort of thing, done well enough for her to disclose this small amount of information. It was as if to say... I felt like it was like a present. It felt very precious” (p.8, 323-332).

Participant 7, being Muslim herself, felt pleased by her therapist’s self-disclosure. However, she didn’t think that it made any difference to the process of therapy:

“When my therapist told me she was a Muslim it was useful and I was quite pleased she told me. But I never thought it made any difference to the process of the therapy, me knowing that, in terms of feeling that she understood me. It wouldn’t have made any difference personally, to me, that she was or wasn’t” (p.3, 121-126).

Participant 1 had ambivalent feelings about her therapist’s self-disclosure. Although she felt flattered by her therapist’s self-disclosure, she also viewed it as a sign of weakness:

“In a way that she’s taking me more seriously or that ... it was flattering in a way. Oh, like almost as if she’s surrendering to my needs. But then it was almost ... I know it’s bizarre and pathetic, but I saw it as a weakness on her behalf” (p.5, 210-214).

Participant 9 described how she felt honoured by her therapist’s self-disclosure but felt her therapist should not have engaged in it:

“Although in a strange way I knew that ... because I knew other people she was seeing, quite a few other people she was seeing because there was only two therapists for the whole of the college. So everybody that was seeing a therapist was either seeing her or the other one. So I knew lots of people she had seen and she hadn’t told them anything. So there was a certain amount of feeling kind of honoured and ... that she respected me or had a higher thought about what I knew than the other people that she’d seen. So there was that side to it as well, feeling kind of flattered and honoured, really, that it was me she chose to talk to. But at the same time it shouldn’t have been” (p.8, 420-433).

Theme 2.4: closer to the therapist/less distance/ safer/ understood

Five out of nine participants described feelings of trust and safety when their therapist engaged in self-disclosure. This emergent theme reflected the participants' need for a therapeutic encounter characterised by the notion of 'relationality'. It is worth mentioning that the following participants, except participant 7, were trained at Roehampton University; therefore, the underpinning philosophy of their training was that of intersubjectivity in the therapeutic relationship.

Participant 2:

"But when she started self-disclosing more I felt much better instead, because I understood better. So it helped me understand what was going on. So it was a relief in a sense and I felt warmer in the relationship; I felt closer to her because it was like I was getting to understand her. There was more of a distance between us before then" (p.11, 362-371).

Participant 3:

"But I think it made it a bit more personal. Some of the barriers came down a little bit, and when he would disclose the information about myself, like his experience of me, it made me feel very safe because I felt like he wasn't thinking one thing and saying another. I felt like no matter what I did or what I said he would be honest and I wouldn't have to wonder. Which was very safe for me" (p.4, 165-176).

Participant 8:

"Sometimes it actually made quite a warm feeling, just that he was self-disclosing and that he was quite willing to do it and he trusted me enough to do it. So I think it did help in some ways forming the trust as well, because I think for me that was one of the issues that I needed to work on and he knew that" (p.5, 232-238).

Participant 4 described another form of self-disclosure from her therapist that made her feel 'safe and contained'. All of the participants were prompted to talk about verbal self-disclosure; however a couple of them referred to other types of self-disclosure such as non-verbal cues, the therapist's clothing or the decoration of the therapist's room.

Participant 4:

“One of the things about it was that she always wore one of those nursing type, proper like “doctor tops”, I don't know what they're called! With a little badge that said her name and Clinical Psychologist. And that somehow made me feel quite safe and contained” (p.17, 653-661).

Participant 8 described how his therapist's sharing a similar experience to him, created a safe environment in which he was more able to accept parts of himself that were considered 'embarrassing' before. Also, it formed a trusting relationship, reduced anxiety and offered the basis of a good therapeutic relationship. This is evident in the following excerpts:

Participant 8:

“And I think actually that made me be a lot more open about some of the issues for myself that were a lot more embarrassing that I had never told anybody. They had always been up there in my head as a bit of a no-go area, but also a bit of a mystery as well for me about why a certain thing had happened in my life.

But I actually felt safer talking to him about those things because he did share some of his...

So yeah, I think it made ... it definitely made me trust him a lot more and for me personally, anyway, that is essentially what a lot of therapy is about; it's actually about developing a relationship with somebody which can be used then for ... in a therapeutic way.

And I suppose I come from the school of thought where, yeah it's an artificial situation when you're in therapy, but you're still dealing with human beings, so the everyday things that we do as human beings to develop relationships with people are still important, and part of that is about talking about yourself and sharing that experience. So I'm not one of these people where I'll sit there and have dead silence right from the beginning. If you want to make someone anxious that's the way to do it! That's my philosophy, anyway” (p.6, 294-319).

Participant 8:

“And sometimes he'd talk about some of his physical health experiences which were similar to mine and I think that was quite an important thing for me because some of them I found a bit embarrassing. I know that he talked about certain things just to kind of open me up and to make me feel at ease with them. And it worked; it really worked. And I'm pretty sure he knew what he was up to! I think he knew that if he shared this it would be important” (p.7, 378-387).

Participant 7 also described feeling less anxious knowing that her therapist came from the same cultural background as herself. She felt she did not have to explain herself as they shared similar norms. However, as mentioned earlier, she reported that knowing that her therapist was Muslim did not affect the therapeutic process.

Participant 7:

“Yes it made me feel less anxious to talk about certain issues because I thought ... maybe ... I suppose there was that... sometimes difficulty or fear when you see a therapist who's from a different cultural background if they couldn't understand some of the issues you might bring that might be related to cultural issues. Maybe certain norms that you might grow up with that they might not. Things like that, I suppose you do want them to understand where I'm coming from” (p.4, 176-186).

Theme 2.5 Frustration/Anger/ Annoyance

Annoyance and anger was reported when the therapist was engaging in self-disclosure either too early in therapy or when the therapist was perceived as patronizing. Participant 9 actually used the term *'punishing self-disclosure'* to refer to her therapist's disclosing 'little insights into her (the therapist's) life where she was better than me (the participant)' (p.4, 204-205). The therapist's self-disclosure of private information was perceived as disrespectful when the participant was in a place of exploration and reflection and not in a place of difficulty and need for reassurance.

Participant 4:

“I noticed with her when I was talking to her that I would hold back a lot. And I ... would come away thinking, ‘Why am I being so defensive?’ Because I’m actually quite a, you know, trusting person. I actually don’t have a problem talking about personal, private stuff [...]so something else was holding me back, and I’m wondering now whether it was a bit about the fact that it made me feel less safe – her self-disclosure being so early, so near the beginning” (p.10, 400-426).

Participant 5:

“Disruptive yeah, it was a bit more when I was being a bit more reflective rather than seeking that kind of reassurance out of it, or whatever ... trying to sort of manage whatever was going on for me. When I was being more reflective, I found it quite irritating!” (p.5, 249-254).

Also, participants felt quite irritated when their therapist was self-disclosing ‘*their own stuff*’ that felt ‘*did not belong in therapy*’ (participant 6) or when their therapist was engaging in irrelevant conversations (e.g., politics) and was not focused on the therapeutic work (participant 3).

Participant 6:

“There were two occasions when it was something really specific when it annoyed me because I felt it was about his own stuff and didn’t belong in the therapy, and wasn’t helpful to me to be saying, because I didn’t need to know it. I don’t think you need to know ... I mean it was nothing really bad! But it was enough to ... I just thought I wouldn’t tell my clients that; I don’t need to know that and that doesn’t show you understand because that’s different for you” (p.6, 265-276).

Participant 3:

“Well I remember there was one particular instance where he was, this was my previous, before this guy, where he was talking about politics – because my family is Iraqi – and he just ended up going on about politics for a while and I felt like he was taking up more time talking about the politics than doing our work” (p.5, 196-204).

Super-ordinate theme 3: Impact on the therapeutic relationship

Theme 3.1 Helped the process

Therapists' self-disclosures of counter-transference feelings or similar experiences to the participants' were considered as key moments in the success of the therapy. Participants referred to these self-disclosures as important agents of change in therapy through fostering the relationship, enhancing reciprocal effect, alleviating imbalance or facilitating a deeper level of work.

Participant 2:

"I feel like we started to know each other a bit better; there was more of a connection, an authentic connection, and I think that the work started to operate on a deeper level since then. And also we were more equal as well. It was a great equaliser, because until then she was more the boss, you know, and I was the student, or the apprentice, you know" (p.10, 324-334).

"So I think it brought us closer and it gave me a chance to express myself more because it actually invited me to respond to her self-disclosure. So in a sense I came into the room more as well, so it was quite empowering for me" (p.11, 371-378).

Participant 9:

"When I'm struggling to talk, if my therapist uses something from herself to highlight that that's okay, that's really helpful. If they can empathise with me and put something real with it, I find that really helpful, that's probably the most helpful scenario for self-disclosure for me" (p.13, 710-715).

Some of the participants' accounts highlighted the importance of the use of therapists' self-disclosure in normalizing their feelings and experiences or in making the expectations in therapy more realistic. Therapists were perceived as more human with similar struggles and difficulties; as human beings instead of these '*all-knowing-creatures*'.

Participant 9:

"Sometimes just to give the impression that you're human. Everybody is human; everyone makes mistakes and everybody has their ... these things going on and

experiences and sometimes it's helpful to give a little bit of that to a client so that they can see you as human instead of some all-knowing creature!" (p.1, 10-17).

Participant 5:

"And I was feeling quite down, I was ... of course with all the other pressure and everything and I brought that into therapy. And there she was really, really good when she did a bit of self-disclosure about her own training; about how hard it is and it's okay, or it's normal to feel like that and she felt that as well" (p.2, 109-115).

Participant 2 referred to his therapist's use of self-disclosure to normalise his fantasy that seemed to not have been working at the time:

"And it's interesting that she gave me her answer quite clearly, actually. I think she didn't want this fantasy to persist and again I think it was a good use of self-disclosure. It was like... it's not helpful... I think she was ... my sense is that she was thinking, 'Okay, okay, fine about the fantasy but anyway let's not go into it in depth, I'll just tell you'. It's a self-disclosure in a sense just to correct, or to normalise the situation" (p.15, 509-520).

However, participant 1 described how her therapist's lack of self-disclosure, had been equally beneficial in helping her stay with her fantasy.

Participant 1:

"Like I had this fantasy that she has only sons, only boys, not daughters or girls. But bearing in mind that she reminds me of my aunt. And she never answered this question, but in fact she made an interpretation, not just about the transference, but she said to me, 'Did you wish that you would be my daughter? That I haven't got any daughters?' Which I thought was fantastic, much better. So much better to stay with my fantasy, my point of view and what it means to me than telling me, 'Yeah you know what, I have two daughters' It would stop the fantasy, wouldn't it? There was nothing for me to imagine any more" (p.5, 254-266).

Theme 3.2. Reversal of roles/ Client as Carer

A quite common type of self-disclosure that created feelings of discomfort in therapy was that of the therapists' disclosure of health issues. The participants would

usually be concerned, *'sorry about the therapist's problems'*, or even take the role of the *'carer'*. The accounts of the participants reflect their concerns about stepping *'outside the role of the client'* and the impact that this may have had on the therapeutic relationship. A couple of the participants mentioned that taking the role of the listener hindered their own disclosure.

Participant 9:

"It really did feel like I was the therapist sometimes, sitting there listening to her. I think what she really needed was someone who understood her conditions properly to sit down and explain them to her, because she really wasn't managing them very well" (p.2, 93-99).

"So it did kind of change the whole focus of therapy because I spent quite a bit of time listening to what was wrong with her and trying to help her with it and stuff like that. And every time she had an attack we'd have a chat about it and stuff. So that, I guess that just left me with the ... I don't know, other than feeling sorry for her, kind of a need to help her and kind of feeling a bit more like a carer than a client really. So that was odd" (p.8, 410-419).

Participant 8:

"I mean I think the only thing is that I sometimes felt that when he did self-disclose about ... especially about his pain, or his back problems, I felt I did feel a bit sorry for him, there was a sort of ... I'm wondering about how that affected me, talking about my problems. Sometimes I thought I shouldn't ... you know. So it was kind of... it did lead on to me taking care of him a little bit, sometimes" (p.2, 95-103).

Participant 4:

"I suppose I became the part of the carer if you want to put it in that role. It feels really like if you're really in the role of a client ...I'm not saying you should be completely inconsiderate to therapists, but you don't normally feel like you have a caring role to play" (p.6, 246-254).

Theme 3.3. Confrontation

Some of the participants confronted their therapists when they engaged in self-disclosure which was perceived as either ‘unfair’, ‘disruptive’ or even ‘unhelpful’.

Participant 2 explained how he confronted his therapist when he perceived her as being unfair and harsh on him after making a counter-transference disclosure.

Participant 2:

“That was more like a self-disclosure that was difficult for me and upsetting and I thought it was very unjust. So for that moment I didn’t like it. I wasn’t sure if that was helpful at all, you know I was like, ‘What’s going on here?’ And if it was left like that I might have not wanted to continue” (p.17, 586-594).

Participant 6 felt quite annoyed by her therapist when he was self-disclosing personal information and confronted him several times, as revealed later on, in her transcript:

“Sometimes it would really annoy me, it would make me feel very angry that he... I felt he wasn’t respecting the frame in the way that I would as a therapist. And then I would have to address that with him and then we would be working on that rather than ... and I felt that that wasn’t my job to be ... so it did cause some problems in the therapy” (p.5, 231-238).

6.3 The Participant as a Developing Counselling Psychologist

All the accounts reflected a development in the participants’ thinking regarding self-disclosure through their own therapy and clinical experiences. The themes that emerged reflected how the participants’ decision to verbally self-disclose or not was shaped by the modality they were using, their own motives and intentions, as well as the timing and the client’s psychopathology.

Super-ordinate theme 4. Training

Theme 4.1 Expectations due to training

Six out of nine participants referred to the impact that training had on how they perceived their therapist's verbal self-disclosure and the expectations they had before going into therapy. There was a common belief that psychodynamic therapists are abstinent, however in reality, as participant 7 explained, that can be a 'myth' (p.5, 241).

Participant 7:

"The way you read the literature... and because I was training I was learning a bit more about different theories, so when I did choose to see a psychoanalytical therapist, I had an image in my mind, but it turned out to be completely different, because she was more talkative in the therapy. I just assumed they would say nothing for the whole hour and just listen and make the odd comment. But it was much more interactive" (p.5, 231-239).

Participant 6:

"I don't know whether being in training made me more critical, or actually being in training made me stay! I don't know, because, you know doing the doctorate and so many demands I didn't want to find another therapist. And we did have a good relationship, but therapeutically I think if I'd have been a client needing to deal with more stuff... if I hadn't felt like I'd dealt with quite a lot of stuff already as well in my first therapy, I don't think I would have found that the space I wanted it to be. So I might have left, I don't know" (p.14, 709-721).

Participant 8:

"Because it's kind of, you know, I suppose there's always that thing where it's talked about being something you shouldn't do, especially when you're training. You must be very, very cautious of it, you know, and I think, to be very honest, we're too cautious of it" (p.3, 140-145).

Theme 4.2. Taboo in training

Quite a few of the participants had become more critical and sceptical about training. What had been learnt throughout their course regarding self-disclosure had been re-examined in the light of their own therapy. Participant 8, referring to his supervision, explained how trainees might engage in self-disclosure but hesitate to talk about it in supervision groups because self-disclosure is regarded as a taboo issue, 'especially in training'.

Participant 8:

"I think people do, do it and they don't talk about it" (p.12, 661).

"I think it's one of those things which is kind of ... the doors are kind of closed on it a little bit" (p.13, 692-694).

"I think there is a taboo. I think it's still a taboo in therapy, especially for trainees anyway. Where they are... most trainees are told they should not be doing it. A lot of books advise against it as well. The books say, 'You can't be doing this.' But I do it; I think it's one of those unhelpful things and ... even though I can feel uncomfortable about it in supervisions I will still talk about it because I think it's an important thing to do. But I think I would like to be able to talk about it more than I do. I think sometimes I do hold back from saying that I said certain things because I worry about what other people might ... not so much my supervisor actually, but what my other ... you know people in the supervision might think of me for doing it" (p.12, 663-678).

"I suppose what happened was because when I was being taught at university it was like I had been told one thing – you shouldn't self-disclose or you should be careful about self-disclosure. And now going to see my therapist, who I trusted, who was self-disclosing, it did set up a little bit of kind of like, well, I suppose what I tended to do was be on the side of my therapist, actually. So I kind of was questioning a lot about what I was being taught at university; I was being quite critical about it actually" (p.9, 468-478).

Participant 9:

“So I think it has changed me because when I was first at the course I was very much, ‘Ooh no self-disclosure is very bad, very bad, very bad. We never do that, never do that’. And I practiced and practiced and practiced avoiding questions. I really did hyper-practice because I had a therapist that was evil and was using it in a totally inappropriate way. But I kind of relaxed a little bit since then! And realised actually it’s not great for my clients to be sat there frustrated and annoyed with me because I won’t show any of myself. Because you can’t be genuine and hide yourself behind a mask – it doesn’t work. So I have relaxed it a bit, but I mean there still are things I won’t go into” (p.17, 966-979).

Super-ordinate theme 5. Own client work

Theme 5.1 Boundaries/ Balance/Use it tentatively

A common theme among the participants was their belief that boundaries should be retained at all times when they self-disclose to their clients. Quite a few of them mentioned that the balance between what one chooses to disclose and what chooses not to, is essential in maintaining a therapeutic relationship. Clients need the space and time to open up and not have a therapist who will ‘impose their own frame on them’; however, some clients will try to blur the boundaries and ask personal questions but participants’ accounts reflect that they attempt to maintain their professional therapist position without becoming ‘*rude*’ or dismissive.

Participant 1:

“Well, some colleagues might say it’s not, but I think they have the right to know, so I’ll tell them where I’m from. Then if they start to get more personal, I wouldn’t be rude, I would try to respond in a containing way which wouldn’t necessarily violate the boundaries. And then perhaps I would sit down and explore it with them” (p.10, 508-514).

Participant 3:

“I’d be very particular about what I disclose with them. Just because I’d know that I’d have to pay extra attention to making sure the boundaries are firm. Because there

are some people that immediately want to blur the boundaries. And that's not helpful” (p.10, 443-449).

Participant 4:

“I think it’s about balance and I think it’s about somehow you being in charge of knowing when it’s enough or too much. Keeping boundaries. I think it’s about keeping the boundaries” (p.29, 1132-1137).

Participant 6:

“Giving the client room and space to explore and open up without you imposing your own frame on them. So it’s something about getting that balance between how you create that relationship I suppose” (p.17, 872-876).

Theme 5.2 Depending on the theoretical orientation

Participants reported that the model they use in their work or placement is the one which leads the way in relation to self-disclosure. Participants who use CBT very often psycho-educate the client or bring similar examples from their own lives. Those who use the psychodynamic model usually provide a rationale for their response or interpretation or disclose counter-transference feelings. However, three out of nine participants mentioned that they do ‘*adapt the model to the client’s needs*’, tailoring the approach to the specific client rather than the other way around meaning that, they might not self-disclose ‘*just to follow the model of being a relational therapist*’.

Participant 1:

“So it was important for me to provide the rationale for why I responded to her the way I did, which is not always in line with the psychodynamic approach, but it’s something about looking after the client, adapting the model to the client’s needs” (p.8, 403-407).

“When it’s relevant to professional and ethical dynamics and requirements, yes, it is appropriate. Yes, I must tell you the qualifications, they must provide a rationale sometimes for the model they’re going to use” (p.9, 448-453).

“Self-disclosure also is depending again on what model and what theoretical orientation you’ve got. It’s very relevant to that as well. For example, it would be

different to ask a person-centred therapist about their future in terms of self-disclosure and psychodynamic as well' (p.10, 527-532).

Participant 4:

"I tend to self-disclose more using CBT, in terms of ... how I might do something; or I'll explain how I might have done it in the past in that way and how it's benefitted me by doing that" (p.24, 969-974).

Participant 5:

"So I would do it. Maybe I should do it more; it's something I need to work on I think. But it's just finding ... making it sort of fit in rather than just forcing it in just to follow the model of being a relational therapist or something. You know what I mean? It has to be a bit attuned doesn't it? I mean just using it willy-nilly I don't think is particularly helpful" (p.9, 471-478).

Theme 5.3 Appropriateness: Timing/setting/relationship

The participants' accounts reflect the recognition of a need to be aware of the appropriateness of when and in what context to self-disclose. Clients are not always ready to use the therapist's self-disclosure, the setting might not be safe for the therapist as well (e.g., in a forensic setting) or the relationship might not be a strong one. Participants reported that when contemplating disclosure, the timing, the setting and the strength of the relationship are good indicators of the appropriateness of self-disclosure.

Participant 6:

"How I experience them if it's right, if that client is in a place where they can make use of that I think" (p.13, 657-659). Participant 7

"If you're working in a forensic setting you wouldn't self-disclose for safety reasons" (p.9, 475-477).

"I think it's about knowing when to and if you need to" (p.6, 292-293).

Participant 8:

“So, but yes, there's always that element of danger around it as well, and I suppose when I've self-disclosed in the past and it's felt dangerous, it's usually the relationship has been relatively strong before I've done it” (p.14, 760-764).

Interestingly enough, a few participants based their decision to self-disclose on their ‘gut feeling’ or ‘intuition’ at the moment with the particular client.

Participant 3:

“I think with that I would go with my feelings. I don't think about a particular diagnosis. I think that it depends on the person and it depends on that moment in the room [...] I know it's a big answer but I usually just...I trust my feelings at the time” (p.9, 424-437).

Participant 4:

“I suppose on the whole if I had to say how I do it at the moment it tends to be partly on gut instinct, which apparently according to all the books I've read, that is all very good because intuition is born out of your experience and your knowledge, so it's not completely off the wall” (p.23, 913-922).

Participant 5 found it more appropriate and comfortable to self-disclose to male clients (being male himself) rather than female clients, whereas participant 7 reported that she was much more cautious with clients who suffer from personality disorders and participant 9 always made the decision on an individual basis. Participant 8 reported self-disclosing more to clients that he ‘likes’ and with whom a good therapeutic relationship had already been established. These accounts reflect the participants’ ‘preferences’ on specific client groups with whom they feel more comfortable or safer.

Participant 5:

“But at the same time of course I work with a few men as well, and they usually come in with problems with a girlfriend or a wife or whatever. And there I tend to self-disclose a little bit more” (p.8, 411-414).

Participant 7:

“For example people who are working with personality disorders need to have more boundaries and some of the clinical issues and risks that can be involved. So perhaps it wouldn’t be recommended to self-disclose too much to that category of patient” (p.9, 469-474).

Participant 9:

‘If I’m going to make a self-disclosure it’s on the basis of the individual client’ (p.19, 1095-1097).

Participant 8:

“I mean I think I self-disclose with clients definitely more with clients that I like, for sure [...] I suppose because it’s more comfortable. I feel like I want to ... I think with clients that I like, that I prefer, it feels like it’s more comfortable to do it. The challenge comes when I feel like I want to self-disclose with clients that I don’t like so much, or the relationship is not as strong. Because ironically enough that probably is some of the most important times to self-disclose! That’s probably why it feels difficult and hard, because you’re trying to make a connection with that person” (p.13, 712-726).

Theme 5.4 Normalise/Demystify

An additional emergent theme was that of normalising and demystifying the process. Participants felt that self-disclosure could be used as a means to show to the client that they are not alone in their experiences. The accounts also reflected a struggle with power dynamics in the room. Quite a few of the participants used self-disclosure to alleviate a power imbalance, to demystify their ‘authoritative roles’ or to foster a sense of connection and commonality.

Participant 2:

“And I will do that sometimes for the purpose of normalising a problem so the client doesn’t feel like they’re completely crazy, or the only one. So to help them understand what they’re experiencing is more normal than they think” (p.25, 855-862).

Participant 5:

“I work with a lot of anxiety and depression at the moment and I use self-disclosure in the sense that of course everybody feels anxious, I feel anxious as well. You know, trying to normalise the symptoms more than anything else” (p.5, 281-286).

Participant 6:

“Sometimes patients can feel quite alone in the experience and sometimes saying that other people have experienced it or you might or I might have felt shy... I mean personally I haven't had that experience of someone saying that to me, but something like that it wouldn't be a bad thing I don't think” (p.6, 303-309).

“I worked with a client once who... for whom it felt important to share – I think it's probably the only time, yeah – I shared that I had been bereaved several years before in a similar way to him and I would never normally disclose something personal, but for him I think it was appropriate at the time because he was much older and for lots of other reasons it felt like he needed something of that connection” (p.13, 637-647).

Participant 9:

“I don't want to ... I don't want to be an enigma; I want to be seen as a person and for that a certain amount of self-disclosure needs to be there. I don't need to disclose every inch of my life, but a certain amount of, ‘I am a human too and I have a life,’ needs to be in the room. Although it's the client's time and it's the client's space, I'm there as well. And if they see me as some kind of authoritative figure then it's just not right, it doesn't sit well with me because I'm not ...” (p.17, 945-955).

“But if you own it as part of your own personality, then they can accept it better as a part of theirs. And I know it sounds silly but it works. And I think sometimes disclosures are helpful just in the fact that clients need to be able to know they can trust you and that you're okay” (p.18, 1049-1055).

Participant 5:

“Clients should understand that you're human, you need a break; you need to go away, whatever, you have a life. I don't believe in all that kind of stuff that therapists tend to feel that they're a lot more important than they actually are” (p.10, 547-551).

Theme 5.5 Be aware of one's own motives

Four out of nine participants emphasised the need to be aware of someone's own motives behind self-disclosure. The accounts reflected their need to grapple with the difficult task of knowing one's own desires and motives regarding self-disclosure and where those originated.

Participant 3:

"I usually ask myself, "Am I disclosing this for them, or would this be for me?" If it's not for them, then I don't say anything and I sit with my own process and see why did I want to say something. That means I'm not being pulled into some kind of a dynamic" (p.10, 428-435).

Participant 5:

"What exactly is it I'm using it for? Is it just a desire to sit and talk about myself, which I don't have when I go into the room to work with a client. I guess if there's a problem, if there's something going on, a difficulty in the relationship or something, then I will use it more. I'd say I'm feeling under attack at the moment and it might be something which is important for us to address, or something like that" (p.6, 314-322).

Participant 6:

"But I would be a million times more guarded about it in terms of thinking about how useful it is to the client. Whether it would be making it about me rather than about us or them" (p.12, 599-603).

"What the purpose of the self-disclosure would be. And needing to question one's motives for doing it and checking out that one isn't sidestepping something or actually whether it's possible to show you're listening or show that you're with someone without making it about yourself" (p.19, 956-962).

Theme 5.6 Counter-transference disclosure

A very common theme (six out of nine participants) was the importance of self-disclosing feelings about the client or the therapeutic relationship. Interestingly enough, counter-transference self-disclosure was linked by two participants to the

concept of authenticity. It seemed that participants viewed counter-transference self-disclosure as having a powerful effect in helping clients. By revealing their felt-responses to the clients, it helped them realise how they might be perceived by others as well.

Participant 8:

“Well you need to tell... I think you should tell your client about how it feels to be with them and what your first impressions were... And again that was one of those things where the client picked up and said, ‘That’s really important; it’s so important to me to acknowledge the fact that I am actually intimidating. Most people would just push it to one side or not want to confront me because they feel intimidated by me!’” (p.15, 825-834).

Participant 5:

“I’d be more likely to self-disclose about how I’m feeling at that time, rather than where I’m going on holiday” (p.7, 343-345).

“I guess if there’s a problem, if there’s something going on, a difficulty in the relationship or something, then I will use it more” (p.6, 317-319).

Participant 6 reported that due to her own negative experiences from her therapist’s self-disclosure, she would never reveal information of a personal nature but would reflect on how she viewed the therapeutic relationship in her attempt to be authentic.

“But I certainly think, and my experience has taught me that as a therapist that there is no way I would describe that level of detail ... definitely not; it’s not my style and I think I would happily endeavour to reflect on what we’re creating together and how the client is, how I experience them if it’s right, if that client is in a place where they can make use of that I think, or, or, again it depends what’s happening in each situation, doesn’t it? But I very much think it’s important to be authentic, whatever that means” (p.13, 651-663).

Participant 2, interestingly enough as did participant 6, linked counter-transference disclosure to the concept of authenticity.

“But in this moment he needed a strong reflection of that, of what he was showing me about himself and how I saw him. So I did, I told him how I felt about him – not so much how I felt, how I saw him. And yes, and also the fact that our relationship was important to me. So that was my self-disclosure in the style of my therapist and I think it was the right thing to do; it brought him back, it kind of contained him and kind of settled him and we explored that later. But it was an example of the kind of authentic relationship that I’d had a bit of experience of” (p.20, 704-719).

7. Discussion

7.1 Introduction

This chapter draws upon theoretical literature to broaden and conceptualise the findings of this study while employing the data found from the qualitative analysis to bring depth to the phenomenon of self-disclosure. Further, the limitations and strengths of the study, the implications for therapeutic practice and training as well as future research are discussed. This section concludes with a reflexive summary into how the present study has shaped the researcher's attitude towards verbal self-disclosure in the therapeutic context, and into how the findings of the study have generated new questions for the researcher.

7.1.1 Summary of Study Aims and Outcomes

The present study aimed to further our knowledge of the phenomenon of therapists' verbal self-disclosure in the therapeutic encounter. To do this, nine participants who were either newly qualified or trainees in counselling psychology and were willing to discuss their experiences were interviewed. The researcher was interested in capturing their experiences of their therapist's self-disclosure in their personal therapy as well as the experiences of effects of personal therapy on their own practice in relation to self-disclosure. IPA analysis was used, as it is an open-ended qualitative approach and does not impose an *a priori* theory but instead allows the researcher to obtain a detailed knowledge of the participants' perceptions and experiences of self-disclosure in both their personal therapy and their own client work. The in-depth accounts that were obtained revealed two main domains, namely the participant as a client and the participant as a developing counselling psychologist. However, these two domains are inextricably intertwined and co-dependent and were treated holistically. Although each participant's perceptions were coloured by his or her unique history and experiences, the analysis discovered similar themes within each individual's experience of self-disclosure. This suggests the possibility that common feelings and processes underlie the experiences of individuals under certain circumstances in the therapeutic encounter in relation to self-disclosure. Three major findings of the present study might potentially contribute to our understanding of therapists' verbal self-disclosure. Namely, a) trainees in

counselling psychology, or newly qualified counselling psychologists, who were influenced more by their own personal therapy than their training, tended to use counter-transference self-disclosure in their own client work, b) there are no fast and hard rules of when to self-disclose but regarding the appropriateness of self-disclosure- except for the timing, the setting and the psychopathology of the client- participants reported that their decision to self-disclose depended on their intuition or ‘gut feeling’, and c) although training institutions might not encourage self-disclosure, a lot of trainees engaged in it. These three contributions will be discussed at the beginning of the chapter. By understanding in detail how participants experience self-disclosure in their own therapy and how this affects their own client work, the expectation is to gain a more general understanding of the impact of verbal self-disclosure in both personal therapy and in one’s own client work.

7.2 Major Findings of the Study

From the analysis of participants’ accounts, three major findings emerged that contribute to our knowledge and understanding in regard to therapists’ verbal self-disclosure: (a) The use of counter-transference disclosure by counselling psychologists in training (b)The importance of intuition/ gut feeling, and (c) Expectations due to training/ being a trainee in counselling psychology. Of these, (a) and (c), namely *use of counter-transference self-disclosure by counselling psychologists in training* and *the expectations due to training/ being a trainee*, were generated directly through the analysis of transcripts and the identification of themes. Finding (b), the *use of gut feeling or intuition* in the decision to self-disclose or not, although mentioned by a few participants, did not constitute a theme in its own right. However, this finding was generated through further interpretation of the emergent themes. My rationale for including this as a finding is that developing counselling psychologists engage in verbal self-disclosure, but cannot form a theory of what influences their decision-making. This generates questions as to whether this decision-making is based on a “gut feeling”, and whether this “gut feeling” or intuition is the result of accumulated experience (e.g. training and personal therapy) or the result of an apprentice’s mistakes and of a temptation that leads to a random, thoughtless decision at the moment.

I. The Use of Counter-Transference Disclosures by Counselling Psychologists in Training.

Participants' accounts indicated that counter-transference disclosure was found helpful in their own personal therapy as well as in their client work. As Ellis (2001: 1001) argued, counter-transference "can hardly be completely avoided and may deflect from therapy's effectiveness if it is obsessively cultivated or neglectfully minimized". He supported that both the client and therapist could benefit from counter-transference self-disclosure since it enhances rapport-building and learning how to cope with common problems. Similar to counter-transference disclosure is the concept of immediacy; working with the therapeutic relationship in the here-and-now which "involves such therapist actions as inquiring about reactions to the therapy relationship, drawing parallels between other relationships and the therapy relationship, processing ruptures or boundary crossings, and disclosing feelings of closeness to or lack of closeness from others" (Hill and Knox, 2009: 20). The tendency of analysts to see self-disclosure as an unfortunate side effect of analytic work has been partly overcome as the result of the work in relational psychoanalysis encouraging exploration and interpretation of the patient's experience of the analyst's presence (Hoffman, 1983; Renik, 1993). This was supported by the participants' accounts which showed that their psychodynamic therapists were working within a relational model and were quite often engaging in self-disclosure. However, it is worth mentioning that their self-disclosure did not just involve counter-transference feelings and reflections on the therapeutic process but also personal stories or experiences. Eight out of nine participants reported that their therapist's counter-transference self-disclosures made them more aware of their own processes and helped them gain insight; whereas one participant found them destructive, making an argument that the counter-transference feelings of the therapist can easily be skewed by their own shortcomings and issues and, therefore, cannot be a pure reflection of the patient's subjectivity. This was quite an interesting point since it captured the question "what fundamental psychological convictions (emotional organizing principles) guide the content and manner of our revealing and hiding, both witting and unwitting, with a particular patient, and vice versa" (Orange & Stolorow, 1998: 532).

Participants showed a particular preference for counter-transference self-disclosures in comparison to any other kind of self-disclosures from their therapists

and they also reported that they do make counter-transference self-disclosures in their own client work. This is in accordance with Myers and Hayes' (2006) study in which participants with prior therapy experience perceived the sessions as deeper when the therapist made a counter-transference self-disclosure than when he made general self-disclosures. However, participants without prior therapy experience preferred general self-disclosures as opposed to counter-transference or no self-disclosures. Myers and Hayes (2006) concluded that perhaps individuals who are unfamiliar with therapy do not expect and, therefore, have a negative reaction to counter-transference self-disclosures, whereas those who had a prior experience in therapy might have been exposed to therapist self-disclosures of counter-transference feelings. Since the participants of this study were all trainees in counselling psychology or newly qualified practitioners and therefore familiar with therapy, it seemed that they valued counter-transference self-disclosures more. Davis (2002) used the term 'counter-transference temptation' to refer to the therapist's temptation to engage in a counter-transference self-disclosure. He argues that psychotherapists at the beginning of their careers are more susceptible to this temptation and he attributes that to their relative lack of experience in working with transference and counter-transference. Although one participant reported that he was cautious with counter-transference self-disclosures and needed to work more on how to deliver them, most of the participants reported that they did engage in what Davis (2002) called 'counter-transference temptation'. However, the question of what it is about beginner counselling psychologists that makes them especially prone to this temptation still remains and is worth further investigation. The following findings that emerged did not constitute a theme in itself, however, partly provide an answer to this question. Therefore, it is deemed appropriate by the researcher to discuss this in a separate section.

II. The Importance of Intuition/ Gut Feeling

Three participants, when referring to the appropriateness of self-disclosure, apart from the timing, the setting and the client's psychopathology, also reported that their decision to self-disclose or not, depended on their intuition. Although participants did have some principles and thoughts of when to self-disclose and when to avoid it, a few of them followed their 'intuition' and 'gut feeling'. None of the participants who actually self-discloses in their own work could form a theory of

when and under which circumstances they chose to verbally self-disclose. Even though they did mention some circumstances when they would or would not self-disclose; the actual decision, seems to be a product of intuition and gut feeling in the moment. Intuition was described by one participant as born out of experience and knowledge. This notion is akin to the intersubjective principle which includes the subjectivities of two individuals meeting in an intersubjective field which “permits exploration, inquiry, play, and the development of new and/or revised psychological organization” (Orange & Stolorow, 1998: 534). In such an intersubjective field, it is not just clients but both parties that constantly ask themselves if it is safe to share feelings, emotions or thoughts. Therapists express their own sense of personal and intersubjective safety as they decide how or what to articulate to a client. Orange and Stolorow (1998: 534) argue that “if we treat emotional safety as our fundamental criterion, we must ask how particular forms of response affect the safety of the field” and they go on to say that “there is no routine, or default, or procedure” for that decision. If intuition is accumulated knowledge, then it seems that although the training institutions did not encourage this knowledge to the participants (according to their own accounts), then their personal therapy must have. Indeed participants seemed to have been influenced more by their therapist than their training and this can be linked to what was referred earlier about declarative and procedural knowledge (Bennett-Levy, 2006). However, further research on deconstructing the concept of intuition and ‘gut feeling’ would shed light on whether it is accumulated experience, academic knowledge or both.

III. Expectations due to Training/ Being a Trainee in Counselling Psychology

The participants’ position on self-disclosure was very much shaped by their training. Their accounts highlighted that self-disclosure was usually deemed by the training programmes as something that should be avoided. Also, a general sense of avoiding answering client’s questions had been cultivated and a taboo around the use of self-disclosure was evident. One participant very characteristically said that many trainees ‘do it but do not talk about it’, showing that self-disclosure is viewed with disapproval by not just certain therapeutic models but also by training programmes or even supervisors. This is in accordance with Bottrill’s *et al.*, (2009) study in which participants often experienced the use of self-disclosure “as entering uncertain

territory, outside the safe confines of the known 'professional' position" (p.14). Yourman and Farber's (1996) study on supervision showed that although most supervisees present an honest picture of the interaction with their clients, there are times when they consciously distort, conceal or withhold information that they perceive as clinical error. This is quite interesting as it might shed some light onto why trainees may possibly be reluctant to talk about their use of self-disclosure in supervision. One participant talked about feelings of embarrassment in supervision which sometimes made him hold back. Although it did not constitute a theme in itself, it becomes crucial to address at this point, that although for a couple of participants, therapists' self-disclosure was experienced as positive and helpful in their own personal therapy, and consequently they used it themselves in their client work, they were still quite reluctant to talk about it in supervision as they feared potential embarrassment or humiliation. The feeling of embarrassment or shame that might be attributed to the intervention of self-disclosure seems to have outweighed their need to use the supervision session well. This may be due to the fact that in supervision there is always the element of evaluation by the supervisor which impacts on the trainee's professional advancement (Yourman & Farber, 1996; Betcher & Zinberg, 1988; Ward, Friedlander, Schoen, & Klein, 1985). Alonso and Rutan (1988: 577), referring to the feelings of awkwardness and shame with which supervisees grapple in supervision sessions, wrote that "The student is in the midst of a learning dilemma. In order to become expert, the work must be exposed, "dumb" questions must be asked, personal flaws will be illuminated. At the same time, this exposure leaves the trainee sensitive to the gap between the professional ego-ideal, in the form of the supervisor, and his or her own self-image as a professional".

A couple of participants mentioned that they have become more sceptical about their training which retained a more critical stance towards self-disclosure, since they have seen themselves, in practice the beneficial effects of self-disclosure. They grappled with ambivalent feelings caused by the clash between their own experiences and the notion that "such an intervention is inherently ill-advised because it crosses a therapeutic boundary" (Hill & Knox, 2009: 26). It seems that the training environment is accountable to a large extent for the atmosphere that determines whether vulnerability, individuality and potential ignorance is a source of humiliation, or an opportunity for learning, and personal and professional growth. Trainees are exposed to a plethora of different theoretical models, each with different

distinctive elements and positions not just on self-disclosure but also on the role of the therapist and the processing of the therapeutic relationship. The task of training is not just to become competent in these different models but also to help the trainees find their own path and establish their own style of therapy. In a similar vein, Alonso and Rutan (1988) affirm that if supervisors and institutions hold a philosophy of willingness to openness and exposure and allow and foster individuality, then negative critique will be experienced as a constructive feedback and not as a source of shame and embarrassment. Maybe then trainees will be more willing to talk about their use or lack of self-disclosure in therapy, receive feedback and advice and therefore, not compromise their own growth, as well as the therapeutic work with their clients. Although I am reluctant and sceptical to draw any conclusions on whether the experiences of trainees in counselling psychology with their own therapists subvert the theory and principles taught by training institutions, I do believe that this point needs further exploration.

Although it did not constitute a theme in itself, a few participants mentioned that their being therapists or trainees had an impact on how their own therapists treated them in regard to self-disclosure. The fact that self-disclosure is specific to the treatment of clients who are themselves therapists, seems to be consistent with Geller's (2003) view that self-disclosures are context and client specific. Although research (Geller, 2003) has revealed that when therapists treat fellow therapists, they tend to self-disclose information about their own therapy and apologise for mistakes and technical errors; this was not evident in the participants' accounts. A couple of participants felt that just because they were themselves developing professionals, their therapists engaged more in self-disclosure which involved either the therapist's similar experiences around training or health issues. One participant assumed that her therapist tended to self-disclose more to her about her health problems because the participant was 'bound to a certain degree to the ethics of counselling psychology' and, therefore, the therapist's self-disclosure would be held confidential. This contradicts Norcross's *et al.*, (2001) study in which participants who were therapists indicated that their practices with fellow colleagues were in most respects similar to those used with non-colleagues. Also, the participants were advised "not to dilute the therapy of therapists by over-identifying or by overemphasising the collegial aspect of the work" (p.43). It seems though that, in the present study, participants being trainees in some cases might have been seeking from their therapists this 'collegial

aspect of the work' as it can be argued that novice therapists need a role model and are interested in their therapist's professional experiences. Besides, as already mentioned, participants were curious to know about their therapist's background, and what led them up to become therapists. A few participants were quite disappointed by their therapists as they perceived them to be more flexible in their management of the role boundaries and reported a reversal of roles where they had to take the role of the carer. Research (Kelly & Rodriguez, 2007) has shown that therapists tend to reveal more to clients who exhibit lower initial levels of symptomatology. This might partly be an explanation as to why therapists tend to feel more comfortable and less guarded in treating trainees, since trainees seek therapy because it is a training requirement and not because they suffer from severe disturbances. Another possibility is that therapists themselves took on a different role; the role of a mentor or a tutor to pass on their knowledge and experience to their 'trainee-clients'. This distinction, however, and its link to therapy outcome remain to be tested. Norcross *et al.*, (2001) argue that mental health professionals do not receive formal training in treating their fellow colleagues and they wonder whether this is ethically and professionally appropriate. Apparently this is a question that is worth exploring more, as it seems that the knowledge that a client is a fellow mental health professional influences the manner in which he or she will be approached by their therapist and adds a new and different dimension to the therapeutic relationship.

7.3 Current Findings and Previous Literature

Although a lot of research has focused on the phenomenon of therapists' verbal self-disclosure (e.g., Curtis, 1982a; Barrett & Berman, 2001; Geller, 2003; Norcross *et al.*, 2003; Myers & Hayes, 2006; Bottrill *et al.*, 2009), no empirical study has interviewed developing counselling psychologists to explore their experiences as both clients and therapists. The participants were asked about their understanding of the concept of verbal self-disclosure and although most of them defined it as the disclosure of factual or personal information, their accounts revealed that they tended to focus on counter-transference self-disclosures as well. Similarly Bottrill *et al.*, 2009, interviewed clinical psychology trainees and used an IPA analysis to study their experiences in their client work regarding self-disclosure but most of the participants tended to refer more to factual disclosures. Retrospectively, some of the participants in the present study might have been tentatively prompted by the

researcher to think of other types of self-disclosure apart from factual details. Although the interview was open ended and strived to obtain the individuals' accurate accounts, the researcher was also present and inevitably clarified or helped the participants whenever necessary.

The 'interest' or 'curiosity' about their therapists that almost all of the participants mentioned could be emphasised by the fact that the participants were developing therapists themselves and therefore had a need to "consciously or unconsciously imitate or 'echo' techniques, gestures, and behaviours that their own therapist used with them" (Macran, Stiles, & Smith, 1999: 424). However, Streaun (1997: 365) stated that "those of us who have carefully researched the therapeutic process have often learnt that clients whose questions are answered at the beginning of treatment later reveal... that they have more, not less, mistrust of the therapist because she or he could be 'seduced', 'manipulated', or 'easily convinced'". Indeed, although it was evident in only one or two accounts and therefore did not constitute a theme, the therapists succumbing to the temptation of a question or engagement in self-disclosure was viewed as 'unprofessional', as a bad practice, or as a 'weakness' on the part of the therapist.

As Macran *et al.* (1999) argued having the experience of what it is like to be a client, can enhance sensitivity to the needs and concerns of one's own clients when one takes the role of the therapist. Participants were using their therapists either as role models or as anti-role models in relation to self-disclosure. In those cases where the self-disclosure had been perceived beneficial, participants were very enthusiastic to use it in their own clinical work; whereas when self-disclosure had been experienced unhelpful, participants were very reluctant to engage in it with their own clients. All of them however, were heavily influenced by their own personal therapy in that "observing another therapist in action and experiencing clinical methods and interventions firsthand" (Macran *et al.*, 1999: 419) helped them master therapeutic techniques, gain confidence in the power of the therapeutic process, reflect on how they felt when their own therapists did not keep the boundaries and thus became more careful about boundary-related issues. As Norcross *et al.*, (2001: 44) argued, "therapist's therapists unavoidably become role models, powerfully and implicitly influencing how their therapist-patients, especially those who are in training, conduct themselves as practitioners". Indeed, it was quite surprising the fact that eight out of nine participants stated that personal therapy had a greater impact on the

development of their professional identity than supervision or training itself. This might be explained in terms of an information-processing model of the therapist's skill development offered by Bennett-Levy (2006). Grounded in information processing theory, the model provides a comprehensive framework that accounts for a range of phenomena encountered by trainers and trainees. Reflection is identified as fundamental to the therapist's skill development as it enables therapists to build on their conceptual (declarative) knowledge and procedural skills. Declarative knowledge refers to knowing the techniques in therapy and this can be deemed to be acquired through reading or training. Procedural learning, however, refers to the 'how' and 'when' of implementation which can only be learnt through one's own personal lived experiences. "Intentional self-disclosures require interpersonal skills such as tact, timing, patience, humility, perseverance, and sensitivity. These soft skills cannot be learned from a manual" (Geller, 2003: 543). Being a client in a therapeutic relationship, participants had experienced both therapist and client roles and were able, therefore, to "incorporate aspects of their joint experiences with their therapists into their own practice" (Macran *et al.*, 1999: 429). Trainees were engaged in an important experiential learning opportunity where they could experience for themselves the favourable or disruptive effects of self-disclosure and later incorporate that learning into their work with clients. The personal development and this "reciprocal role learning" (p.429), cannot easily be achieved by academic study alone and this is very nicely put by Bottrill *et al.*, (2009: 13) who argued that "a therapist's decision to use an intervention, such as disclosures requires a complex parallel processing of situational information and procedural and declarative knowledge but also reflection on previous experience and how this might be relevant to the current situation". Participants might have been referring to this reflection of their own therapist instead of their training when they were considering their therapist as their role model or anti-role model in their developing professional identity.

In accordance with Myers and Hayes (2006) study, the therapeutic relationship was found to have a great impact on whether the therapist's verbal self-disclosure would be perceived positively or negatively. The quality of the relationship at the time the self-disclosure was made was a powerful and influential factor in how the participants experienced not only their therapist's professional practice but also the warmth and safety in the relationship. Safran, Muran, Samstag

and Winston (2005) found that when the therapeutic relationship is poor, interpretations that drew parallels between the therapy relationship and other relationships in clients' lives were viewed by clients as criticising because these interpretations suggested that the source of such difficulties emerged mainly from the client and not from the therapeutic relationship. In the present study, individuals overall tended to have benefited from therapists' self-disclosures when the relationship had already been sufficiently established and a good therapeutic rapport was present. That could explain why eight out of nine participants stated that their therapist's verbal self-disclosure took place later in the course of therapy. One participant, who mentioned that her therapist's verbal disclosure took place early in therapy, reported feelings of withdrawal and insecurity. This implication is consistent with existing literature (Wells, 1994) that supports that when self-disclosures precede the establishment of a good therapeutic relationship between the client and the therapist, they can lead to overshadow the client's needs (Myers & Hayes, 2006).

Although the researcher expected to find reciprocal effects, namely, that 'self-disclosure begets self-disclosure' (Jourard, 1964; Hendrick, 1987), only few of the participants reported that their therapist's self-disclosure facilitated their own. Interestingly enough, in these cases the self-disclosure of the therapists involved revealing similar issues or difficulties to those of the participant, supporting the notion of a more equal relationship where the therapist appeared more human or fallible (Hanson, 2005). Participants' appreciation was increased when therapists conveyed a more human side in the therapeutic encounter, yet found it more disruptive when their therapist appeared as an 'all-knowing-creature', very experienced and detached from emotions or even authoritative and 'punishing'. This supports Hill, Mahalik and Thompson's (1989) study, which indicated that therapists who are open about their personal weaknesses and vulnerabilities are perceived as empathic, warm and credible and therapists who reveal their professional skills and experiences are not seen as warm and empathic. In a similar vein, Hoffman-Graff (1977) found that therapists who made self-disclosures about their personal vulnerabilities were perceived by clients as more empathic, warm and credible than therapists who made personal disclosures about their clinical experiences. This is also related to research (Knox *et al.*, 1997) which has shown that clients found it beneficial when their therapist felt more like a real person and not a distant experienced professional. However, a closer look at my participants' accounts

reveals that although therapists in many cases were engaging in self-disclosures with similar content, different participants perceived it differently. Presumably, this reflects that the nature of self-disclosure might be of less importance than its delivery; meaning that factors such as warmth, similarity, timing, intimacy and wording might shape an optimal self-disclosure. This is akin to Audet and Everall's (2003) study which emphasised the importance of a responsiveness approach and found that the impact of self-disclosure depends on the context in which it occurs and the way in which it is being delivered.

A theme that emerged from the participants' accounts was that of surprise when their therapist engaged in self-disclosure. VandeCreek and Angstadt (1985) argue that when expectation and the actual amount of therapist self-disclosure differ, the therapist might be perceived in a negative way. Consequently, meeting the client's expectations regarding self-disclosure is considered essential in the use of this technique. Although it has been more than a decade since Macran *et al.*, (1999) argued that despite therapists' tendency to seek therapy from a therapist with a similar orientation, most personal therapy is psychodynamic; it seems that there is some truth in this as eight out of nine participants had had, at some point, a psychodynamic therapist. Although research has shown that psychodynamic/psychoanalytic therapists exhibit less self-disclosure (Edwards & Murdock, 1994; Carew, 2009), participants were quite surprised to experience their own psychodynamic therapist's self-disclosure. Research (Dixon *et al.*, 2009) has shown that a client, who experiences a self-disclosing therapist, after years of more traditional analysis, may feel confused or surprised; whereas an individual who has experienced a long-term exploratory and supportive psychotherapy may feel more at ease with a self-revealing therapist and more upset with a therapist who maintained a more withholding stance. Although this research applies to clients and not to trainees who do have knowledge of the different therapeutic modalities and therefore know what to expect from their therapists, it seems that trainee counselling psychologists do experience similar confusion when their expectations clash with their therapists' self-disclosure or non-disclosure.

Bordin (1979) highlighted the importance of rupture in a therapeutic relationship, suggesting that this phenomenon is a necessary and inevitable part of the therapeutic process. Self-disclosure in a lot of cases caused frustration, anger or annoyance and hindered the therapeutic process; however, those participants who

addressed this and confronted their therapists, seemed to have helped the relationship shift and this enhanced their work to operate on a deeper level. However, an inquiry should be made about whether that should be the participants' role and not the therapists'. Hill and Knox (2009) argue that if therapists and clients address the inevitable problems that arise in therapy in the here-and-now, problems will be resolved and the relationship will be enhanced. This is akin to relational and humanistic theories (Farber 2006; Hill & Knox, 2009; Brigdes, 2001; Roger, 1961; Jourard, 1971) which see the dyadic therapeutic encounter as a two-person system in which both individuals are viewed as co-participants. Safran, Muran, Samstag, and Stevens (2002, as cited in Hill & Knox, 2009) stated that the negotiation of ruptures is the key to therapeutic change. In resolving ruptures that involve confrontation on the client's part, the client initially experiences anger, then disappointment in being let down by their own therapist and finally the client begins to feel vulnerable and expresses the need to be taken care of by the therapist. Indeed, in those cases where the participants felt let down by the therapist's disclosure and did confront the therapist, participants reported that they felt able to explore the dynamics in the relationship more fully, voice their concerns and even experience a shift in the relationship. However, although it did not constitute a theme in itself, interestingly enough a lot of the participants who felt angry or annoyed by their therapist's self-disclosure did not address this annoyance in therapy, either out of 'respect for someone with more experience' or out of 'embarrassment'. This raises concerns as to what extent the trainees in counselling psychology are able to use their personal therapy to the fullest and express negative feelings towards their own therapist.

A theme that emerged from the participants' accounts was that self-disclosure can be helpful in the therapeutic process. Participants referred to 'authentic connection', 'alleviation of imbalance', 'deeper level of work', even a sense of 'reality of the therapeutic relationship'. These qualities seem to have constituted important factors in healing, producing reciprocal effects or offering a sense of empowerment to the clients. This supports Hanson's (2005) study which showed that participants valued self-disclosures that made them feel that the relationship was more egalitarian, balanced or mutual and contributed towards a more real relationship in which the therapist appeared more human and instilled a sense of connection, intimacy and warmth. The idea of authenticity is closely interconnected with the idea of genuineness and empathy in a relationally orientated therapy

approach (Cooper, 2004). The concept of empathy did not emerge as a theme, despite the researcher's anticipation but it was implied implicitly perhaps by participants when they were referring to the previous qualities. It seemed that self-disclosure was more associated with realness and authenticity on the part of the therapist than with the quality of empathy per se. A case could be made though about whether empathy can be separated from the quality of authenticity. If the therapist's empathy is stilted and not genuine, then the quality of authenticity surely can be questioned.

Referring to their own client work, participants reported that the model they used or the placement in which they worked, influenced their decision to self-disclose. This supports Carew's (2009) qualitative study which explored the attitudes of therapists working in four different settings and modalities and showed that the willingness to self-disclose ranged from 'never' for the psychodynamic group, to self-disclosures used carefully as a therapeutic strategy for the cognitive and systemic groups, to a therapy style for the person-centred groups. Likewise in the present study, participants reported that used self-disclosure when working in a CBT way to psycho-educate their clients. However, participants seemed to be more flexible and willing to adapt the model to the client's needs in relation to self-disclosure, even when working psycho-dynamically. Orange and Stolorow (1998: 532), discussing the issue of self-disclosure in analysis, stated that:

"Fidelity to our ancestral legacy of psychoanalytic rules often seems a crucial requirement for maintaining our ties with official psychoanalysis and our personal sense of identity as psychoanalysts. Reading and hearing the history of psychoanalysis, with its many incidents of excommunication and exclusion for the crime of being "unpsychoanalytic," makes such anxieties and conflicts more than understandable. Conformity to the rules of technique, which continue to cast great suspicion on any deliberate self-disclosure beyond one's carefully articulated experience of the patient, assures us, if we also conform to the other rules, that we really are analysts. In other words, the question of self-disclosure continues to be discussed, in part, because the psychoanalytic family requires of its members the suppression of spontaneity and self-expression".

Although, Orange and Storolow (1998) referred to analysts and not counselling psychologists, adhering to certain schools of psychotherapy can have an influence on one's decision to disclose or not. However, the participants' accounts showed that although they might be using a particular framework, their priority

would not be the maintenance of the framework, rather the understanding that would lead to the re-organisation of the client's experiences, whether that means the use of self-disclosure or abstinence from it. It is worth mentioning though that none of the participants worked in a purely psychoanalytic way where self-disclosure is deemed to be an impurity introduced by the analyst's personality (Orange & Storolow, 1998). However, a lot of them worked in a psychodynamic way which also demanded that the therapist maintain a certain therapeutic neutrality or distance. Besides, as the movement towards integration in counselling psychology continues to grow and expand, practitioners are urged to explore many different theoretical approaches (Cutts, 2011). Although research (Cooper, 2008; Lampropoulos, 2000) supports that there is no discernable difference across different psychotherapeutic schools, there is a need for critical scrutiny of models within counselling psychology (Cutts, 2011). In line with the scientist-practitioner model in counselling psychology, practitioners should be able to negotiate multiple perspectives of understanding and embrace an integrative stance instead of being subjugated by one ideology. This integrative position apparently does allow some room for self-disclosure.

Although overall data showed that participants are sensitive to their client's needs and adjust their communication styles accordingly, the accounts also reflected the participants' tendency to self-disclose more with specific client groups with whom they felt more comfortable or safer. The extent to which self-disclosure is deemed appropriate depends on the individual client. Research (Peterson, 2002) has shown that self-disclosure might violate the ethical principle of non-maleficence with some specific clients, like those who have poor boundaries and tend to focus more on the needs of others rather than their own; therefore, these clients might have a tendency to take care of the therapist. Indeed, participants mentioned that they would avoid self-disclosing to clients with personality disorders, who might want to blur the boundaries. Interestingly enough, data also revealed that a few participants grappled with their own anxieties around self-disclosure and seemed to be concerned about feeling uncomfortable or challenged when they either 'do not like' the client, feel unsafe because of the setting or work with a client of the opposite gender. Orange and Stolorow (1998: 534) argued that different clients have different needs and, therefore, "we cannot conclude that any particular intervention is better or worse without exploring its particular meaning for this particular person in the context of this particular treatment". Although this was evident in the participants' accounts, it

would be worth exploring the difficulties or uncomfortable feelings that the therapists experience further with specific client groups regarding self-disclosure. Then the question follows of whether these difficulties are triggered more by the client or can be attributed to the therapist's idiosyncrasy or maybe are a combination of both parties' inter-subjectivities.

In their own personal practice, participants stated that they should always be aware of their own motives before they engage in any kind of self-disclosure. Participants were concerned that their self-disclosure could move the focus away from the client, burden the client or even blur the boundaries (Audet & Everall, 2003), therefore, they reported being quite cautious when using it and were always aware of their own intentions. Those adhering more to the psychodynamic model argued that they are more willing to reveal information about their professional qualifications or ethical issues around the work than perhaps answer any other questions of a more personal nature. Those encompassing the humanistic models were more than willing to answer questions provided that it would be for the client's benefit. However, this might require more study since an argument can be made regarding what benefits and what does not benefit clients and who should make this decision. In a similar vein, Edwards and Murdock (1994) found that the content of therapists' self-disclosure might differ from what clients desire. Specifically clients, apart from the therapist's professional background and experience, are also interested in knowing about the therapist's feelings, strategies for coping with problems, ways of handling interpersonal relationships and successes and failures, suggesting a discrepancy between what therapists and clients view as acceptable topics for disclosure (Audet & Everall, 2003). In general, the participants' accounts supported the 'proposed guidelines for therapists to consider before disclosing' (Anderson & Mandell, 1989; Mahalik, Van Ormer, & Simi, 2000 as cited in Myers & Hayes, 2006) which state that self-disclosures should be made with the goal of strengthening the therapeutic relationship, therapists should always be cautious and aware of their motives behind self-disclosure and finally, self-disclosures should be related to the clients' issues in order to ensure that the main focus remains on the client. As far as the therapists' intentions for self-disclosure are concerned, the participants' accounts supported existing research (Simon, 1988; Hill, Mahalik, & Thompson, 1989; Myers & Hayes, 2006) which suggests that therapists self-disclose to provide modelling, to

build rapport, to demystify the therapeutic process or normalise clients' symptoms, and to provide reassurance.

7.4 Conclusions

In this section the limitations of the current study will be addressed and with regard to areas on self-disclosure, that need further empirical examination, future research will be suggested. Also, the implications on theory, practice and training will be discussed.

7.4.1 Limitations & Future Research

The following limitations of the present study should be noted and imply the direction for future research:

Qualitative methodology facilitated the generation of very rich data which also included a contextual element that is often missing from quantitative data (Hanson, 2005). In addition to that, since the concept of verbal self-disclosure was not defined by the researcher but by the participants themselves, it allowed for new ideas and perspectives to emerge. However, the participants' accounts were reflections of their recall of events and, therefore, are subject to the shortcomings of retrospective recall such as memory lapses and distortions (Giorgi & Giorgi, 2003). Readers should be mindful that the participants' reports should not be deemed as objective reports but as subjectively dependent ones and "that within the phenomenological reduction, strong epistemological claims are made only for how things presented themselves to the experiencers, not for how they actually were" (p. 47). Also, the retrospective self-report nature of the data may be just a reflection of what the participants were willing to disclose since a couple of them were concerned that by giving too many details, their therapist would be identified. In future research, videotape-assisted reviews could be used to arrive at more accurate and thorough data. The use of videotape-assisted reviews to collect and process data has been viewed as a major methodological breakthrough as it supports the validity of this method as a means of studying in-session experiences (Hill, O'Grady, Balenger, Busse, Falk, Hill *et al.*, 1994).

The small size of the sample used in this qualitative study does not allow for the generalisability of the results. However, the researcher's goal was not to strive for

generalisability but for the generation of ideas and exploration of subjective experiences (Willig, 2008). Therefore, the reader must be aware that the small sample size leaves open the question of representativeness of these participants (Schnellbacher & Leijssen, 2009). Furthermore, it is possible that the participants who volunteered to be interviewed for this study differed from those who did not in regard to their attitudes and experiences to self-disclosure. Maybe for those individuals who agreed to participate, the topic of self-disclosure was of particular significance to them and triggered their anxieties and personal interest on the topic, whereas for those who refused to participate, possibly the topic of therapists' verbal self-disclosure did not stir up any thoughts, feelings or conflicts. It is also worth mentioning that eight out of nine participants were white; it is possible that culturally diverse participants have different attitudes and experiences in relation to their therapist's self-disclosure as cultural and racial issues also arise (Burkard, Knox, Groen, Perez, & Hill, 2006). Future research should include larger and more diverse samples in order to allow for generalisability of the results and to explore culturally diverse clients' experiences about self-disclosure.

The possibility of the researcher's bias and subjectivity is a concern, especially in qualitative approaches. The researcher's attitudes to therapists' verbal self-disclosure were closer to the humanistic theoretical approach. Being aware of this, I was mindful to ask for experiences that reflected both positive and negative effects on the therapeutic relationship. Also, coming from a contextual constructionism position, I did not assume that there was one reality that could be discovered through the employment of correct methodology; instead, I acknowledged that my findings would vary depending on the context in which the data were collected and analysed. In addition, I engaged in reflexivity as an attempt to deal with biases and presuppositions that arose from my own assumptions (Morrow, 2005). However, as Harper (2003) argued, there is always an inherent difficulty in attempting a balance between seeming to be too interested and appearing to be completely biased when presenting and developing a research idea. Besides, even when researchers attempt to be reflexive, they still cannot detach themselves from the research project. As noted by Mauthner and Doucet (2003), reflexivity may clash with the aims and time limits posed by the institutional organizations that fund research projects, so usually researchers become more reflexive after having distanced themselves from their own doctoral projects: "Can reflexivity be

encouraged and enhanced by building it into our research methods and processes, and by creating appropriate times, spaces and contexts to be reflexive? At the same time, is there a limit to how reflexive we can be, and how far we can know and understand what shapes our research *at the time of conducting it*, given that these influences may only become apparent once we have left the research behind and moved on in our personal and academic lives?" (Mauthner & Doucet, 2003: 415).

7.4.2 Implications for Theory, Practice & Training

Changes in society in regard to the 'therapy business' have brought about changes in attitudes regarding therapists' self-disclosure. Market forces and technology have altered the traditional therapist-client model, launching and empowering a lot more the provider-consumer model in which the client can obtain information about the therapist, which sometimes extends beyond the technical aspects of therapy into the personal realm. In that sense, clients have become 'consumers' and practitioners have become 'providers' (Dixon *et al.*, 2001). This impacts on the regulation issues that if all therapists are state-registered, then clients do not necessarily have to ask about the therapist's qualifications. Also, nowadays many therapists have web-sites or even Facebook profiles with personal information. Thus, self-disclosure has become an inevitable part of therapy even before it begins, as most of the clients, especially trainees, enter therapy already knowing a lot about their therapist. Self-disclosure, however, cannot just be reduced to the mere knowledge of information about one's therapist. The delivery, the process and the timing seem to be of more importance than the actual self-revelation of the therapist. The decision to self-disclose is similar to that of selecting a therapeutic intervention: it should be done thoughtfully, be in accordance with client needs and always be adjusted to the emerging context (Audet & Overall, 2003).

Arriving at the decision of the nature, timing and extent of self-disclosure might be something worth investigating since counselling psychologists - and especially trainees or newly qualified who lack the experience - seem to be caught at times between two conflicting ideas: the idea of avoiding risky interventions such as self-disclosure on the one hand and the idea of making a genuine connection with another human being, on the other hand, in order to facilitate that individual's healing. I am not implying that the two ideas are always contradictory but they can

be at times and these are the times that need special attention. The fact that therapists' verbal self-disclosure already has a place in the therapeutic repertoire is known (Hanson, 2005; Myers & Hayes, 2006; Schnellbacher & Leijssen, 2009; Knox *et al.*, 1997; Geller, 2003; Hill & Knox, 2001). What has not received too much attention though is how, by crossing the threshold of anonymity by self-disclosing, the therapist can have an effect on the client and when that client feels most benefited by this self-disclosure and when less so. Quoting Greenberg (1995: 197), I agree with his position that "talking about how we arrive at decisions strikes me as more interesting than the particular conclusions we reach, especially when those conclusions are idealized as the only ones that are acceptable". Taking it a step further, I am even more struck when this complex skill of decision-making is expected by trainees or newly qualified counselling psychologists who receive little or no training on self-disclosure (Bottrill *et al.*, 2009).

It is hoped that this research has enriched our knowledge and understanding in relation to therapists' verbal self-disclosure, by asking questions about how trainees and newly qualified counselling psychologists view and experience self-disclosure in their own therapy, how these experiences shape their own client work, and their developing sense of professional identity and philosophy of therapy. It was beyond the scope of this study to give a comprehensive view of this topic; however, what this research aimed to do was to shed some light on the phenomenon of therapist's verbal self-disclosure from the point of view of a trainee in counselling psychology; that is, someone who sits both in the chair of the client and the therapist, grapples with anxieties that sometimes stem from receiving conflicting messages between their training and experiences and in the midst of all that, is expected to proceed to a decision-making that will enhance and maintain a strong relationship with clients. Since deciding what, when, and how to self-disclose is an ongoing process and not something that we can get once and for all (Geller, 2003), it is crucial that the counselling psychologist should be trained and educated regarding the repercussions, both positive and negative of such an endeavour while he or she is still in training. And if indeed, the intuition is what urges trainees to self-disclose or to abstain from it, more attention and emphasis in the training of counselling psychologists should be given to it.

7.5 Reflexive Summary

The odyssey of this research began, with my personal quest about therapists' verbal self-disclosure, in the therapeutic context, about three years ago when as a first year trainee in counselling psychology I began seeing a Jungian analyst. My therapist, at the time, engaged a lot in verbal self-disclosure and, although I knew that such an intervention could be viewed with disapproval from academic institutions, or even from the profession as a whole, I did not perceive her verbal self-disclosure as a violation of boundaries. On the contrary, it proved to be quite helpful as it facilitated my own process and added a new dimension to my concept and experience of therapy.

As a training counselling psychologist I was interested in exploring how other developing counselling psychologists experience their therapist's self-disclosure, or lack of it, and whether that experience had informed their own practice. I wished to gain insight into a topic that was considered a taboo as it was not very much discussed during my training. Yet I felt it would often come up in my client work, as a lot of my clients urged me to self-disclose. Therefore, I was interested in investigating how other developing counselling psychologists grappled with this decision. Now, three years later and after the completion and writing up of my research thesis, a lot of my preliminary thoughts and assumptions have been formed into a more comprehensive understanding in relation to therapists' verbal self-disclosure, its merits and pitfalls. I found that, as developing counselling psychologists, we all grappled with similar anxieties and uncertainties regarding the use of self-disclosure in the therapeutic context, and that the practice of it is the result of gradually finding one's own path in developing one's professional identity. However, this study raised new questions for me in relation to the role of supervisors and training institutions regarding therapists' self-disclosure and the extent to which trainees in counselling psychology felt safe to admit and discuss their engagement in verbal self-disclosure.

My epistemological position, as an integrative counselling psychologist, is very much informed by a relational counselling psychology model which regards the fostering and maintenance of a therapeutic relationship as the primary element of good practice (British Psychological Society, 2006a). With that as an overarching principle, my decision to engage in self-disclosure is always informed by the needs of the relationship at the specific time with the specific client. Completing this

research thesis on therapists' verbal self-disclosure has not made me self-disclose either more or less with my clients. What I have gained, though, is a deeper insight into how trainees grapple with this decision and the extent to which our own personal therapist's self-disclosure, or lack of it, contributes to that decision.

Appendix A: Participant Information Sheet



SCHOOL OF HUMAN & LIFE SCIENCES

Roehampton University

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PARTICIPANT INFORMATION SHEET

Research Title:

An Investigation into the Experiences and Attitudes regarding Therapists' Verbal Self-Disclosure from the Developing Counselling Psychologists' Perspective: A Phenomenological Study.

You are being invited to take part in a research study conducted by a Trainee Counselling Psychologist as part of a PsychD in Counselling Psychology, which will explore the notion of the therapist's verbal self disclosure in the therapeutic encounter from the client's point of view. In counselling, it is not uncommon for the therapist to disclose material of personal nature. If and when this happened, you might have found that it had an impact on you, the client. This impact might have been beneficial or not during the course of your therapy. The purpose of this research is to investigate how you perceived this impact, and how this has informed your own client work.

What can you gain from your participation?

It is intended that the results of this research will help us better understand what makes counselling more or less effective. By agreeing to participate, you will be potentially contributing to this endeavour. From a personal point of view, you will be given the opportunity to further explore your own reactions in respect to your counselling and this might provide you with further insights into what was therapeutic for you as a result of your counselling.

What will my participation actually involve?

You will be invited to attend a one-to-one interview with the researcher. This will take approximately one hour (no more than an hour and a half). During this time you

will be asked a series of questions about your counselling with a particular focus on your therapist's personal disclosure. You will *not* be expected to talk about the content of your therapist's self disclosure per se, instead about your own perception and experience of your therapist's disclosure. The interview will be audio-recorded. Following the interview the recordings will be transcribed into writing by the researcher and those transcripts will form the basic material for the research.

How will confidentiality be maintained?

Both on the actual audio-recordings and subsequent transcribed notes, your actual name or any other detail that may identify you will **not** be used. Instead each participant will be given an identity number (ID) and only that number will be used in any material from the interviews. In

other words, everything will be done to protect your personal identity. Following the research, the recordings, notes and any documents will be kept by the University securely locked for ten years before it will be destroyed. In the final dissertation or any other publication of the research, only the ID number will be used so as to protect your anonymity.

What are the limits of the confidentiality agreement?

It is important to be aware that although all attempts will be made to maintain confidentiality, it might need to be mitigated if you disclose a danger of harm coming to yourself or others, or if you reveal details of practice, which might be considered ethically questionable, according to the BPS Code of Conduct & Ethics (2006).

Essential information to consider before participating

Your participation is voluntary and you have the right to withdraw at any time without giving an explanation or incurring a penalty. If for any reason you decide to withdraw, you will contact the researcher and quote your ID number which appears on the Debriefing Form. However, you should be aware that the data in an aggregate form may still be used/ published, meaning that a transcript can be removed but the impact that this transcript had on the formulation of subordinate themes in the mind of the researcher cannot.

You will not be obliged to complete the one-hour interview if you feel uncomfortable for any reason. Participating in this research could lead you to reflect on how you experience your therapist's self-disclosure. If you are concerned that you may be affected in any way it is advised that you do not take part in this study.

How will you be debriefed?

A debriefing sheet will be handed to you after the completion of the interview.

Who is carrying out this research study?

Trainee counselling psychologist Aikaterini Vasileiadou is carrying out this study. It has been reviewed by, and has received clearance from, the University Ethics Board.

If you are happy to participate in the above study then please email the researcher, Aikaterini Vasileiadou at ekaterini.vassiliadou@gmail.com.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

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Thank you for taking the time to read this information form.

Appendix B: Participant Consent Form



SCHOOL OF HUMAN & LIFE SCIENCES

Roehampton University

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ETHICS BOARD

PARTICIPANT CONSENT FORM

Title of Research Project:

An Investigation into the Experiences and Attitudes regarding Therapists' Verbal Self-Disclosure from the Developing Counselling Psychologists' Perspective: A Phenomenological Study.

Brief Description of Research Project:

This study will investigate the phenomenon of Counselling Psychologist's verbal self-disclosure in the therapeutic encounter. The purpose is to examine the clients' experiences and attitudes on therapists' verbal self disclosure. The study will explore the notion of the therapist's verbal self disclosure in the therapeutic encounter from the client's point of view in a real world setting, attempting to address the implications of timing and content of therapist's verbal self-disclosure on the therapeutic relationship (see also the attached Participant Information Sheet). In counselling, it is not uncommon for the therapist to disclose material of personal nature. If and when this happened, you might have found that it had an impact on you, the client. This impact might have been beneficial or not during the course of your therapy. The purpose of this research is to investigate how you perceived this impact.

The researcher is aiming to recruit six to ten participants for this study. The participants will be asked to read and sign the information sheet and participant consent form by which they will be agreeing to participate in a one-to-one interview

(lasting approximately one hour) which will be audio-recorded and subsequently transcribed.

Investigator Contact Details:

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Tel: 07531785944

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any time without giving an explanation or incurring a penalty. In case I decide to withdraw, I contact the researcher quoting my ID number which appears on the debriefing form. I am also aware of the implications of withdrawal, namely that data in an aggregate form may still be used/ published, meaning that my transcript can be removed but the impact that this transcript had on the formulation of subordinate themes in the mind of the researcher cannot.

I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

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Appendix C: Debriefing Form

SCHOOL OF HUMAN & LIFE SCIENCES



Roehampton University
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DEBRIEFING FORM

Title of Research Project:

An Investigation into the Experiences and Attitudes regarding Therapists' Verbal Self-Disclosure from the Developing Counselling Psychologists' Perspective: A Phenomenological Study.

Brief Description of Research Project:

The study endeavours to investigate the phenomenon of Counselling Psychologist's verbal self-disclosure in the therapeutic encounter. The purpose was to examine the clients' experiences and attitudes on therapists' verbal self disclosure by exploring the views and perceptions of self-disclosure from the point of view of the client in a real world setting, attempting to address the implications of timing and content of therapist's verbal self-disclosure on the therapeutic relationship (see also the attached Participant Information Sheet). The ideal number of participants for this study is six to ten. You were asked to read and sign the information sheet and participant consent form by which you would be agreeing to participate in a one-to-one interview (lasting approximately one hour) which was audio-recorded and subsequently transcribed.

Investigator Contact Details:

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Thank you for your participation in this research project. The details you have provided are very important to us and hopefully will help in a better understanding of how counselling can be effective and helpful to others.

The researcher provided you with some time post interview, to discuss any issues that might have arisen. If you still have any questions or complaints regarding the interview do not hesitate to raise them.

You may also consider contacting support groups in case you experienced emotional distress. Some agencies providing lower cost, no-cost or specialist counselling are:

-The Samaritans: www.samaritans.org

Tel: 08457 90 9090

-Balham Community Counselling Service: www.balhamcommunitycentre.org

Tel: 0208 673 4422

-The Wimbledon Guild: www.wimbledonguild.co.uk

Tel: 0208 296 0030

-Guild of psychotherapists: www.guildofpsychotherapists.org.uk

Tel: 0207 401 3260

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

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Appendix D: Sample of Transcript (Developing Emergent Themes)

Original Transcript	Emergent themes
<p>Q: Okay, so first of all how do you understand the concept of therapist's verbal self-disclosure?</p> <p>A: My understanding of that is when a therapist shares other feelings or thoughts that they're having with the patient. That can be in terms of how their patient is making them feel, or it can be where they just talk about maybe personal stories about their own life. They may share umm yes, just personal experiences that may not be completely focused on the patient.</p> <p>Q: Okay. You've been in ... you've had your own personal therapy, right?</p> <p>A: Yes. For two and a half years.</p> <p>Q: For two and a half years. And the modality of your therapist?</p> <p>A: The modality was psychodynamic.</p> <p>Q: Psychodynamic. Was it ... it was long term therapy, two and a half years?</p> <p>A: <i>Agrees</i>. It was twice a week.</p> <p>Q: Did at any point in therapy your therapist verbally self-disclosed?</p> <p>A: Yes. He also worked in a way that was also relational. So the ... one of the philosophies in relational psychotherapy in addition to psychodynamics, psychotherapy is to disclose your personal feelings of the patient because it helps to facilitate change within the moment. So he would often discl... verbally disclose to me reactions he was having to my process, or if I was ... if my defensiveness was in a particular way he would disclose his experience of me. So in that sense he did disclose with me.</p> <p>Q: Mmm. So how long were you in therapy when he self-disclosed for the first time?</p> <p>A: When he began? That's a good question. It wasn't right away. I would say it was three months into it when he began to self-</p>	<p>Concept of therapist's verbal self-disclosure:</p> <ul style="list-style-type: none"> -feelings or thoughts that they are having with the patient-counter-transference feelings -personal stories about their own life <p>Timing of self-disclosure: not in the beginning of therapy</p> <p>Feelings around her therapist's self-disclosure:</p> <ul style="list-style-type: none"> -grateful: see parts of myself that I was not aware of -safe: he was honest -closer: barriers came down a bit, less distant

<p>disclose. In the way that I described. It later, like maybe after the second year he might share maybe a personal story that related to what I was experiencing.</p> <p>Q: A personal story?</p> <p>A: A personal story like something about his dog, something about that. Something like that. So it was never really... it never felt like it was distracting from the work, it always felt related to my work.</p> <p>Q: So the nature of the self-disclosure would be... how would you describe it?</p> <p>A: The nature of the self-disclosure was him using his experiences of me to help me... to help mirror back parts of me. So it was used in a way where it was in the context of trying to show me, reveal to me what I was triggering in him, or bringing out in him. So it felt more in the relational piece.</p> <p>Q: Okay. How did you ... can you elaborate a little bit more on how you experienced the self disclosure. How did you feel? How did you react? How did you perceive it?</p> <p>A: Well at first you feel put on the spot, if you know what I mean. So I would feel, like in that moment, what he was experiencing of me. I felt like I had to almost absorb and process in the moment. So it felt very much being put on the spot; so I wasn't able to get away from my stuff.</p> <p>Q: It's quite interesting what you're saying, because usually when the therapist self-discloses it feels like he's on the spot.</p> <p>A: I think it's because of this nature of the self-disclosure. Maybe he was actually; I don't really know how he felt. He may have felt put on the spot; he may have felt vulnerable, I don't know. I mean as a therapist I can say, you know, we can go on with that later, but ... so he may have. I wasn't aware of that though. I was just aware of the fact that he was being incredibly honest about his experience with me and at first it was a little uncomfortable. I would pause and think and try to process what was</p>	<p>-challenging: put on the spot</p> <p>-vulnerable: could not escape from my own stuff</p> <p>-uncomfortable (in the beginning)</p> <p>Impact on the therapeutic relationship:</p> <p>-fast-forwarded therapy: accelerated how much I learnt about myself.</p> <p>-mirroring</p> <p>-facilitated change in the moment</p> <p>-helpful: how he perceived me might be how others perceive me.</p> <p>- more conscious of my processes</p>
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being put in front of me. But also part of my training previously, during that time, was my supervisor self-disclosing as well. So it wasn't the only place that I was experiencing that.

Q: So it didn't feel weird or...?

A: It didn't feel unfamiliar. No, I knew this was coming. Obviously when I was getting into very deep stuff and he was self-disclosing his experiences of me in that, sometimes it was challenging; I had to come up against parts of myself I didn't want to come up against. But after a while, I think because **he had gained my trust, I really appreciated when he would disclose.** Because I felt like he would say things that people wouldn't say to me and I **was so grateful that someone was helping me see these parts of myself that I just couldn't see, that I wasn't aware of.** So, yes in the beginning it was uncomfortable, but then after a while I was okay, let's do this; I want to experience more of this. Because I found it very helpful.

Q: In what way did you find it helpful?

A: I found it helpful because it made my ... it made me **conscious of my process.** So for example let's just say there was a certain way in which I spoke, a certain tone or a certain ... umm mannerism which I would speak with a particular whatever. And he would disclose to me that, "**When you speak this way, you really come across this way,** or it makes me feel like this..." I would find that when I would notice myself behaving that way in situations socially, that I would pick it, I would pick it up right away. Instead of it being like this mystery, "Oh I wonder why I felt that shift in energy." Or, "I wonder why people reacted that way?" Actually it was like, "Oh my God, this is why!" And he hadn't shared that with me it would have taken me a lot longer to figure that out, or I would have had to ... maybe somebody else would have been honest about it. So it's very helpful with my personal life.

Q: Okay. Did the content of the self-disclosure have an impact on your

Counter-transference disclosure:

-using his experiences of me to help mirror back parts of me.

-reveal to me what I was triggering in him

relationship with the therapist?

A: Umm, yes. I think that when he would disclose... when disclosed like later, maybe a story about his dog passing away or something like that, I did **feel closer to him. And it made him a bit less distant.** I mean he was very big on boundaries, so I was always very respectful of that. That is within the frame of psychodynamic therapy is the boundaries are very important. But I think it made it a bit more personal. **Some of the barriers came down a little bit,** and when he would disclose the information about myself, like his experience of me, it made me feel very **safe** because I felt like he wasn't thinking one thing and saying another. I felt like no matter what I did or what I said he would be honest and I wouldn't have to wonder. Which was very safe for me. So I just felt like I didn't have to worry about that.

Q: So was there any time that you found your therapist's self-disclosure disruptive? Because you were describing quite beneficial...?

A: Honestly, no.

Q: So it's been always beneficial?

A: In all honesty, yes. I mean I had a therapist before him, like years before him, for one year that I did. But with this one, no. And the nice thing about our work is that I was also able to talk about my process. You know, like if I was feeling uncomfortable, it was a very open relationship. So ... I'm trying to think if there was any...

Q: You said that there was your previous therapist, he or she self-disclosed and you found it destructive?

A: Well I remember there was one particular instance where he was, this was my previous, before this guy, where he was talking **about politics** – because my family is Iraqi – and he just ended up going on about politics for a while and I felt like he was taking up more time talking about the politics than doing our work. Whereas with this other therapist, the one for two and a half years, **I was always the focus, we never really**

Self-disclosure → Honesty → Authenticity?

Negative experience of therapist's verbal self-disclosure (with another therapist)

-talking about politics-focus not on me

<p>distracted from that. I never felt like it was like he's just kind of going off now and like, wait, wait, wait, come back. So in that sense...</p> <p>Q: So it was beneficial because as I understood it, it was focusing on your processes really.</p> <p>A: Yes. Yes.</p> <p>Q: Okay, that's why you found it beneficial. Whereas when your therapist before him was actually talking about other things, you didn't find it beneficial; you found it disruptive?</p> <p>A: I found like it was like an interruption.</p> <p>Q: Okay. Okay. So it has to do a lot with the content, the nature of self-disclosure really?</p> <p>A: And the process of it. You know if he was just kind of going off and I couldn't get a word in. But this felt very focused. It felt like there was a purpose behind it.</p> <p>Q: Okay. And the purpose was?</p> <p>A: Was for me to be aware of my process.</p> <p>Q: Okay. Now has your experience with your therapist's verbal self-disclosure influenced, or lack of it at some point maybe, influenced your developing professional identity?</p> <p>A: Very much so. I mean one, I think just being more conscious of your stuff is extremely helpful and I think that the self-disclosure was very helpful in me becoming aware of the process that I trigger in other people. Or just my impact on other people and the way that I express myself. With patients it's very helpful to be able to pick up on these things so I'm not... it doesn't feel like a mystery. And also it's helped me gain understanding of what I put my patients through, because that's how I work, relationally. And I self-disclose in the way that I've described, with my other therapist. So, it was very helpful. I feel like I have an experiential view of how to do this kind of</p>	<p>-interrupted my process</p> <p>-could not get a word in edgewise</p> <p>-interruption</p> <p>Own client work</p> <p>-relational work</p> <p>-experiential view of how to do the work/experienced it myself through my personal therapy</p> <p>-use of counter-transference self-disclosure/ use my experience of them to reflect</p>
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work because I experienced it myself.

Q: So you work psychodynamically?

A: Well, to be honest right now I'm working with the NHS so I do Cognitive behavioural work. But the way that my mind, my conceptual vision and my mind frame works is psychodynamically. And if there are moments that are appropriate, that's not distracting from the CBT work, I do do some relational work because it's extremely useful with people that I feel like in moments need to be aware of a specific process that's happening, or some unconscious process that's coming into the room.

Q: And you do use self-disclosure?

A: Yes. I do it very cautiously, not in a way where I disclose too much, **but I try to use my experience of them to reflect.**

Q: It sounds more like a counter transference disclosure.

A: Exactly.

Q: This is what you do...

A: Yes. And in my private practice I do pretty much purely that. More the relational psychodynamic, that and counter transference.

Q: So do you consider that your experience of having your therapist self-disclose makes you more likely or less likely to consider self-disclosure has a legitimate place as a therapeutic intervention? I'm asking this question because psychodynamic approach is quite against self-disclosure.

A: The classic.

Q: The classic, yes. But you said you work relationally. So could you say a bit more about working relationally and integrating self-disclosure as well?

A: Yes, no of course. I think that number one, at least from my experience, is that psychodynamic psychotherapy has shifted quite a bit from classic analysis. Classic analysis the therapist doesn't really disclose

-ask yourself: am I doing this for me or my client?

Role of training

-be very well trained

-‘learn the book before you throw it out’

-be aware of your own processes

-go through a training programme or supervision where you get to

at all. It's more the free association of the patient. But more and more psychodynamic psychotherapists prefer the self-disclosure. But that said, **I think that the therapist needs to be very well trained. It's almost like you need to learn the book, in a sense, before you throw it out.** Does that make sense? So I think that the therapist needs to one, **be very aware of their own process**, and two, **having gone through a training programme or supervision where they get to practice that... the relational piece or the self-disclosure.** Because I think it's very, very **easy to go down a route where the therapist just blurs boundaries** and it's not helpful to the patient. So I think that in that way it's very tricky.

With my own personal experience I was very lucky because I was in a two-year internship programme where I did have the skill taught to me in a way, and I had to go through it. That was very specialised. And I think that my therapist self-disclosing the way that I described was extremely helpful. It almost fast-forwarded the therapy; it almost accelerated how much I learnt. So in that way I think it's extremely beneficial. I think people oftentimes come to a therapist because they just really want to figure out what they're doing in their life that's not working. If the therapist is having all these experiences and they're just going to hold onto them because they don't want to say anything to the patient, then that therapist isn't doing their job. I think that it's extremely beneficial, but again **the therapist needs to be trained** and hopefully if they decide to disclose, that they should **discuss this with a supervisor** on a very regular basis to make sure that they're not over-disclosing or inappropriately disclosing.

Q: What would you consider inappropriate disclosure?

A: Personal stories. Like in a sense of, "Yeah my boyfriend used to do that." Or, "Yeah when my parents got a divorce I experienced that too." Things like that are a no-no.

Q: Okay, so examples of things that are

practice the relational piece or the self-disclosure

-it can be quite tricky-easy to go down the route where you blur the boundaries

-always be in therapy

-be aware of your own transferences

-discuss in supervision

appropriate?

A: Would be... okay I'll give you an example: I had a patient the other day come in and she's explaining to me why she was in treatment for an entire hour, talk, talk, talk. And the second session she came in and my experience of the session was very draining and I was getting lost in the details. So I shared that with her, that I'm finding it difficult to connect with you because I'm getting lost in the details of your story. What is that like for you? And we just focused on that and **I shared with her my feelings of my mind wandering or feeling bored or distracted because I've a hunch that's how other people feel when she's doing this.**

And she ... we went into this whole process where she had this experience with other people and no one had ever really said that to her before, and that she... so it ended up really facilitating a piece of the work very early on, that was extremely beneficial. But I had limited it to that exact experience. I didn't start going into my own life and getting lost in that. So I guess to summarise, so when I self-disclose I leave my personal self out of it. I don't... because I don't think that that's helpful.

Q: So the only self-disclosure that you think is helpful is when it completely focuses on how you experience the client in the room. And you said before you're working with NHS which is CBT work. Do you self-disclose there when you're doing CBT work?

A: *Affirms*

Q: in the same nature of self-disclosure is that?

A: Only when I think it's appropriate. I have some patients that I haven't self-disclosed at all with. I don't feel the need to; we do purely CBT work and it's extremely effective. But with this woman for example, it was just so in the room; there was this huge elephant in the room that I just... this is too important not to point out because I think she will benefit tremendously. And her presenting problem related actually to this dynamic and I so I think it's going to be a

Counter-transference disclosure in her own client work:

e.g.: **'I shared with her my feelings of my mind wandering or feeling bored or distracted because I've a hunch that's how other people feel when she's doing this'**

very important part of the work for our limited time together. I usually try to think of **how can I be the most effective** and I think with her particular instance by processing this dynamic I think will be very beneficial to her.

Q: So to which clients do you usually self-disclose and to which clients to you usually prefer not to self-disclose. When will you choose to self disclose and when not, really?

A: I think with that I would go with my feelings. I don't think about a particular diagnosis. I think that it **depends on the person and it depends on that moment in the room**. Like I usually ask myself, "**Am I disclosing this for them, or would this be for me?**" If it's not for them, then I don't say anything and I sit with my own process and see why did I want to say something. That means I'm not being pulled into some kind of a dynamic. But ... **I know it's a big answer but I usually just... I trust my feelings at the time**. Maybe if there is someone who very early on I can tell really wants to blur the boundaries, I probably would not self-disclose with them. Or if I would, it would be extremely limited to the exact content. I'd be very particular about what I disclose with them. Just because I'd know that I'd have to pay extra attention to making sure the boundaries are firm. Because there are some people that immediately want to blur the boundaries. And that's not helpful.

Q: Do you think that by disclosing how you experience the client in the room it could be dangerous to kind of blur the boundaries? With some clients?

A: With some clients, yes.

Q: What kind of clients...?

A: Again, I'm really careful with diagnosis because I don't like generalising. But a couple, maybe one or two **borderline patients**. And again I don't put them all in the same category. I think that there's a spectrum of the borderline disorder. But there were one or two where I felt like my self-disclosure would be interpreted as an opening of the boundaries and **so when I would self-disclose there would need to be**

When to self-disclose?/
appropriateness

-depends on the client

Depends on the moment in the room

-“Am I disclosing this for them or for me?”

-I go with my feelings/ I trust my feelings at the time

Personality disorders/ Borderline patients

-uncontained/ relational problems

-clarification of the boundaries shortly after the disclosure

-use of counter-transference disclosure

-relational work but also hold the frame

a clarification of the boundaries shortly after. And that's just something that I'm prepared to do because at those moments I felt that, especially with people with personality disorders, the disclosure is very helpful for them; extremely helpful.

Q: In what sense?

A: Because they're so uncontained, and they have so many relational problems that trying to very gently and very cautiously reflect back to them other people's experience of them and digesting it with them, if they're open, is very helpful. And then being able to see themselves and to also have someone reflect back to them what they experience, which usually is extreme anger or volatility, or whatever. And that person still stick around and not leave. So in that sense I think that **that relational work is very important. But the therapist needs to also continue to hold the frame.** So it's a little extra work and that's okay.

Q: Okay. I don't have any more questions. If you want to add something? Do you have anything to add?

A: I think I've said it all. I think just that what I said before about how I think it's really important that the therapist is very... I think the **crux of all of this is the therapist being aware of themselves and continuing to do work.** I'm planning to go back into therapy very soon and I think it's important that the therapist doesn't just think, "Oh because now I figured out *how to* work relationally that there's not just going to be stuff coming up. **I think that as a therapist we have a responsibility to consistently keep an eye and make sure that there is a third party therapist or supervisor to make us aware of our process.** Because I think it's very delicate work that we do and there's a responsibility, especially when self-disclosing. So I think in that sense I think that the therapist should make sure that they are in therapy.

Q: Okay, thank you very much.

A: You're welcome! Thank you.

Role of ongoing supervision/
therapy

-Essential that a third party makes
us aware of our processes.

Appendix E: Category Building Process of Super-ordinate Theme 5-Own Client Work

Boundaries/ Balance/Use it tentatively	
Participant 1	Then if they start to get more personal, I wouldn't be rude, I would try to respond in a containing way which wouldn't necessarily violate the boundaries.
Participant 2	So it's not a kind of off the cuff thing, it's very much in line with what I think they need and something that has to be treated with a lot of care because in general it's not something that I think is appropriate if you wanted to make a blanket answer, yes or no... And it has to be bounded.
Participant 3	I'd be very particular about what I disclose with them. Just because I'd know that I'd have to pay extra attention to making sure the boundaries are firm. Because there are some people that immediately want to blur the boundaries.
Participant 4	I think it's about balance and I think it's about somehow you being in charge of knowing when it's enough or too much. Keeping boundaries. I think it's about keeping the boundaries.
Participant 5	I do think it's quite an important thing to do sometimes. But I think it has to be done really, really carefully because I could have seen how my therapist could have just gone overboard with it, you know what I mean?
Participant 6	Sometimes. It depends on the client. It depends on how long I've been working with them. It depends on what's going

	<p>on. If we've been working for a while I feel a bit more comfortable doing it. Maybe I've modelled that after my therapist, because she took her time, she didn't do it immediately.</p>
Participant 7	<i>Did not contribute to this theme.</i>
Participant 8	<i>Did not contribute to this theme.</i>
Participant 9	<i>Did not contribute to this theme.</i>
Depending on the theoretical orientation	
Participant 1	<p>“Self-disclosure also is depending again on what model and what theoretical orientation you've got. It's very relevant to that as well. For example, it would be different to ask a person-centred therapist about their future in terms of self-disclosure and psychodynamic as well”.</p>
Participant 2	<p>CBT type work actually now that I think about it, the therapist does self-disclose quite a lot in terms of giving psycho-education. Do you know what I mean? Like they're saying, “Well I ...” Okay, a therapist might state it as fact, but the truth is it's their belief is that people with anxiety often have du du du.... So you're giving information so again it's a type of self-disclosure. And I will do that sometimes for the purpose of normalising a problem so the client doesn't feel like they're completely crazy, or the only one. So to help them understand what they're experiencing is more normal than they think. And that demystifies it a bit and reduces some of the anxiety. So it's one way again of helping them in line with the model that I'm using.</p>

Participant 3	<i>Did not contribute to this theme</i>
Participant 4	I tend to self-disclose more using CBT, in terms of ... how I might do something.
Participant 5	I mean it depends on the model as well; I mean, currently I work in CBT, and when I finish it ... I want to work psychodynamically, which I really, really enjoy. In CBT I don't sort of feel ... It doesn't feel like ... you don't have the same ... it's almost taboo to have that kind of self-disclosure. But in psychodynamic I'm a lot more cautious in how I self-disclose. In psychodynamic I'd be more likely to self-disclose about how I'm feeling at that time, rather than where I'm going on holiday.
Participant 6	<i>Did not contribute to this theme.</i>
Participant 7	<i>Did not contribute to this theme.</i>
Participant 8	<i>Did not contribute to this theme.</i>
Participant 9	<i>Did not contribute to this theme.</i>
Appropriateness: Timing/ Setting/ Relationship	
Participant 1	<i>Did not contribute to this theme.</i>
Participant 2	And it felt like at that moment what he really needed was a real genuine moment between us and for me to be authentic. And in a sense self-disclose how I felt about him and what my sense was of him – because I had quite a strong sense of who he was.

Participant 3	I think with that I would go with my feelings. I don't think about a particular diagnosis. I think that it depends on the person and it depends on that moment in the room.
Participant 4	<i>Did not contribute to this theme.</i>
Participant 5	Sometimes. It depends on the client. It depends on how long I've been working with them. It depends on what's going on. If we've been working for a while I feel a bit more comfortable doing it. Maybe I've modelled that after my therapist, because she took her time, she didn't do it immediately.
Participant 6	So I'm not saying it's not ever appropriate, in my opinion from what I've experience, to disclose something of a personal detail about your life. But I certainly think, and my experience has taught me that as a therapist that there is no way I would describe that level of detail ... definitely not; it's not my style and I think I would happily endeavour to reflect on what we're creating together and how the client is, how I experience them if it's right, if that client is in a place where they can make use of that I think, or, or, again it depends what's happening in each situation, doesn't it? But I very much think it's important to be authentic, whatever that means.
Participant 7	I think it depends on the context. I think that rather than it being a general rule, it's more for individual choice depending on what context you work in. I mean different kind of therapeutic issues you might deal with, for example

	<p>people who are working with personality disorders need to have more boundaries and some of the clinical issues and risks that can be involved. So perhaps it wouldn't be recommended to self-disclose too much to that category of patient or ... and it depends on what setting. If you're working in a forensic setting you wouldn't self-disclose for safety reasons.</p> <p>So I think it's very situational.</p>
Participant 8	it's usually the relationship has been relatively strong before I've done it.
Participant 9	I am hugely careful with my self-disclosures. Hugely careful. I run them through my head before I even think about saying anything and try and look at whether it's ... whether a) it's going to do any harm.
Normalise/ Demystify	
Participant 1	<i>Did not contribute to this theme.</i>
Participant 2	So to help them understand what they're experiencing is more normal than they think. And that demystifies it a bit and reduces some of the anxiety.
Participant 3	<i>Did not contribute to this theme.</i>
Participant 4	<i>Did not contribute to this theme.</i>
Participant 5	I work with a lot of anxiety and depression at the moment and I use self-disclosure in the sense that of course everybody feels anxious, I feel anxious as well. You know, trying to normalise the symptoms more than anything else.

Participant 6	<i>Did not contribute to this theme.</i>
Participant 7	Sometimes patients can feel quite alone in the experience and sometimes saying that other people have experienced it or you might or I might have felt shy...
Participant 8	Because actually if you're completely a professional all the time, working in that kind of scenario people would end up disliking you and not getting on with you. Because they need to see that you're actually a real person as well.
Participant 9	But if you own it as part of your own personality, then they can accept it better as a part of theirs. And I know it sounds silly but it works. And I think sometimes disclosures are helpful just in the fact that clients need to be able to know they can trust you and that you're okay.
Be aware of one's own motives	
Participant 1	Besides, we shouldn't forget our clients also represent things and themes for us, and we can have transference as well. So if I don't like one of my clients because they remind me of someone from my past, would it be fair to share it with them?
Participant 2	<i>Did not contribute to this theme.</i>
Participant 3	Like I usually ask myself, "Am I disclosing this for them, or would this be for me?" If it's not for them, then I don't say anything and I sit with my own process and see why did I want to say something? That means I'm not being pulled into some kind of a dynamic.

Participant 4	I'm not saying I haven't self-disclosed, because I have, but I think quite carefully about it before I do, in terms of who the person is, whether it... what the benefits are.
Participant 5	What exactly is it I'm using it for? Is it just a desire to sit and talk about myself, which I don't have when I go into the room to work with a client.
Participant 6	I guess talking it through with you I think for me it's about thinking about what the purpose of the self-disclosure would be. And needing to question one's motives for doing it and checking out that one isn't sidestepping something or actually whether it's possible to show you're listening or show that you're with someone without making it about yourself.
Participant 7	<i>Did not contribute to this theme.</i>
Participant 8	<i>Did not contribute to this theme.</i>
Participant 9	I am hugely careful with my self-disclosures. Hugely careful. I run them through my head before I even think about saying anything and try and look at whether it's ... whether it's going to do any harm.
Counter-transference disclosure	
Participant 1	<i>Did not contribute to this theme.</i>
Participant 2	<i>Did not contribute to this theme.</i>
Participant 3	I do it very cautiously, not in a way where I disclose too much, but I try to use my experience of them to reflect.

Participant 4	<i>Did not contribute to this theme.</i>
Participant 5	I guess if there's a problem, if there's something going on, a difficulty in the relationship or something, then I will use it more. I'd say I'm feeling under attack at the moment and it might be something which is important for us to address, or something like that.
Participant 6	<i>Did not contribute to this theme.</i>
Participant 7	I suppose from my experience, the bit I've done is kind of taken from what the patient has said and maybe from how they were coming across physically in terms of how they generally present.
Participant 8	And again that was one of those things where the client picked up and said, "That's really important; it's so important to me to acknowledge the fact that I am actually intimidating. Most people would just push it to one side or not want to confront me because they feel intimidated by me!"
Participant 9	<i>Did not contribute to this theme.</i>

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