Experiences of Clinical Psychology Trainees in the use of therapist self-disclosure

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Overview

This thesis consists of three sections. Part one is a review of the literature on the impact of therapist self-disclosure with clients on the therapeutic relationship. Part two is a qualitative empirical investigation, which examines 14 trainee clinical psychologists' experience of using or not using self-disclosure with their clients. Part three is a critical appraisal, which addresses some central issues in carrying out the research. It introduces the background to the study, discuses some key methodological issues encountered, and concludes with implications of the findings for training courses.

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PART ONE: LITERATURE REVIEW

The Influence of Therapist Self-Disclosure on the Therapeutic Alliance

Abstract

The present review examines the empirical evidence concerning the impact of therapist self-disclosure on the therapeutic relationship in individual therapy. Twenty studies were reviewed: 11 investigated therapeutic interactions and nine looked at either clients' or therapists' perceptions of the impact of therapist disclosure. Studies of therapeutic interaction suggest that disclosure can play a positive role in developing and maintaining the alliance, although some studies suggest a negative impact. Studies of clients' and therapists' perceptions emphasise the subtle and often mixed impacts of disclosure, highlighting the importance of therapist skill in delivery and the context in which it occurs. Overall, the findings reflect the inherently complex effects of disclosure and the interactional nature of the alliance. Limitations of the research (such as unclear and inconsistent definitions and the challenge of finding appropriate methodology) and clinical implications are discussed.

Introduction

"The analyst should remain opaque to his patients, like a mirror and show them nothing but what is shown to him" Freud (1912/1958, p.118)

"There is every real reason to reveal yourself to the patient and no good reason for concealment" Yalom (2002, p.83)

The current empirical literature on therapist self-disclosure provides evidence that it is a widely, if sparingly used therapeutic intervention in individual therapy. However, as can be seen from the above quotations, this is in the context of theoretical and clinical controversy over its proper usage. Despite the diverse and often contradictory views expressed by theorists, Knox and Hill (2003) suggest that there is a consensus of "marked respect for the intervention's potential impact" (p. 532).

This paper aims to review the empirical evidence concerning the impact of therapist self-disclosure on the therapeutic relationship in individual therapy. Initially, it will present background information, in particular, definitions and dimensions of disclosure and major theoretical positions within the field, as well as an overview of empirical research and a clarification of the definition and importance of the therapeutic relationship. This will be followed by an outline of the methods employed, an analysis of the studies identified for review, and a discussion of the findings.

Therapist self-disclosure: definitions and dimensions

There is general agreement that therapist self-disclosure (which for simplicity will be referred to herein as disclosure) in its broadest sense refers to statements which convey something personal about the therapist to the client. In this paper we will use the more formal definition provided by Goodman and Dooley (1976); "statements in which the speaker reveals a non-obvious aspect of his condition (feelings, thoughts and experiences) through a distinct self-reference."

Researchers have distinguished subtypes of disclosure along many different dimensions; for example, differentiating between disclosures of negative and positive feelings or reactions towards the client (Andersen & Anderson, 1985), disclosures of reassuring and challenging intent (Hill, Mahalik & Thompson, 1989), or specifying information subgroups such as fact, feeling, insight and strategy (Knox & Hill, 2003). Although the boundary is sometimes hard to define, leading researchers in the field (e.g. Farber, 2006; Knox, Hess, Peterson & Hill, 1997) tend to distinguish between two main categories: *factual disclosures* (also called self-revealing or self-disclosing disclosures) and *self-involving disclosures* (also called immediacy or countertransference disclosures). Factual disclosures involve personal facts or information about the therapist as an individual; they could include statements revealing demographic details such as age or marital status, personal coping strategies (e.g. "when I get anxious I find deep breathing helps"), and previous experience of mental health issues (e.g. "I too have suffered with depression"). Self-involving disclosures involve statements in which the therapist reveals feelings or cognitions regarding the client and/or therapy; these might include "it makes me feel sad when I hear about what you went through" or "it feels to me like we have

become stuck." Unfortunately, in the existing literature it is often unclear which type of disclosure is being studied.

Theoretical positions

Sharply conflicting positions have been expressed within the theoretical literature, a common theme being disclosure's potential impact on the therapy relationship. Historically, the psychoanalytic position has advocated a "blank screen" stance on the part of the therapist. Any form of disclosure has been strongly opposed, with references to its potential to interfere with the unique asymmetry of the therapy relationship and to pollute the development of the transference - both considered crucial to successful treatment. This view has softened in recent years with the predominance of the intersubjective-relational perspective; whilst remaining cautious, some writers suggest a role for 'countertransferential disclosures' (essentially self-involving disclosures) in developing a 'real relationship' within the therapeutic encounter (e.g. Greenberg, 1995; Lomas, 1994, 2004; Palombo, 1987; Renik, 1995, 1999).

Other schools of therapy have actively endorsed disclosure. Humanistic theorists have long extolled the importance of disclosure in the development of a genuine, transparent and equal relationship (Jourard, 1971; Rogers, 1957). Similarly, existential theorists have specifically endorsed self-involving disclosures as a means of creating an authentic "I-Thou" relationship (Buber, 1937/2004; Spinelli, 1994; Yalom, 2002). Feminist therapists (e.g. Mahalik, VanOrmer, & Simi, 2000) have presented an ethical case for disclosing their political and social views to enable clients to make informed choices when selecting a therapist, and stress the role of disclosure in reducing power imbalances in the therapeutic relationship. Cognitive

behavioural therapists have been less vocal on this issue, although more recently, some authors have advocated the use of disclosure as a way of communicating "humanness" in the therapist and thereby developing a therapeutic bond (Goldfried, Burckell & Eubanks-Carter, 2003).

Empirical overview

As one would expect from a topic which generates such theoretical debate, there is a large body of empirical research that bears on this topic. The research can be broadly categorised into analogue studies (wherein therapy simulations are evaluated by non-clinical observers) and studies of actual therapeutic interaction or involving actual therapy participants. Historically, the vast majority of disclosure research has utilised an analogue methodology. These analogue studies have shown mixed results, although reviews suggest participants view therapists more favourably (on measures such as attractiveness, likeability, trustworthiness, empathy and warmth) when they disclose *in moderation*, both in terms of frequency and intimacy (Hill & Knox, 2002; Watkins, 1990). Despite some conflicting results, overall, self-involving statements were found to be more helpful than self-revealing statements (Hill et al., 1989). Furthermore, client expectations and personal preferences appear to moderate the impact of disclosure (Derlega, Lovell & Chaikin, 1976; Peca-Baker & Friedlander, 1987; VandeCreek & Angstadt, 1985).

Whilst these studies provide heuristically useful information, their external validity is clearly questionable (Hill & Knox, 2002). Typically, they involve samples taken from college students and focus on initial session behaviour (often condensed into 5-10 minute sessions). Although this may shed light on initial impression formation in therapy it fails to capture the complexity of the therapy relationship as a

dynamic process built over time. This implies the need to focus on research involving actual therapy relationships or participants in order to investigate the impact of disclosure on the therapeutic relationship. Whilst several good reviews of this type of empirical literature exist, as with much of the literature itself, they have tended to focus on questions of frequency and type, therapist motivations, and the impact of disclosure on distal outcome in therapy (e.g. Farber, 2006; Hill & Knox, 2002). Thus there is a need to identify and synthesise the current empirical literature investigating the impact of disclosure on the therapeutic relationship, with a view to informing clinical practice. However, it is important to clarify first what is meant by the 'therapeutic relationship'.

The therapeutic relationship: definitions

Although there is wide agreement that it is an important part of the therapeutic process, there is currently no consensus on what exactly constitutes the therapeutic relationship. The concept has its origins in psychoanalytic literature (e.g. Freud, 1940, cited in Horvath & Bedi, 2002), which has tended to distinguish between transference and countertransference aspects (i.e., therapist and client distortions based on past experience) and the 'real' relationship or 'alliance' (i.e., the non-distorted connection between therapist and client).

The more recent empirical focus on 'common factors' across therapeutic schools has led to pan-theoretical formulations (Bordin, 1994; Gelso & Carter, 1994; Luborsky, 1976). Bordin's (1994) widely cited model specifically focuses on the active (rather than unconscious) components of the therapeutic relationship, which he refers to as the working alliance. This is formulated as an interactive and collaborative process with three components: tasks (agreement on within-therapy

activities), goals (a consensus on the purpose of the therapy) and interpersonal bonds. The interpersonal bond can be described as a complex network of positive personal attachments between therapist and client, incorporating issues such as mutual trust, personal liking, valuing, caring, acceptance, and confidence (Horvath, 1994). Empirical research has lent support to this tripartite formulation of the alliance (Horvath, 1994). Measures designed to assess the working alliance typically infer its quality from therapists' and clients' individual reporting of their experiences of the relationship (e.g. the Working Alliance Inventory; Horvath & Greenberg, 1986).

In Bordin's formulation the alliance is viewed as the context that interacts with and promotes specific therapeutic interventions, suggesting that positive developments in both of these factors provide a necessary facilitative base for the growth of the other (Horvath & Greenberg, 1994). Hill (2005) extends this picture of the therapy process to include a 'client involvement' variable, referring to the extent to which the client engages in a session or therapy task. In Hill's model, therapist interventions, the therapeutic relationship and client involvement are inextricably intertwined, interacting across four stages of therapy process (initial impression formation, beginning the therapy, the core work of therapy, and termination). Hill suggests that "different therapist techniques are called for based not only on the client type and therapist preference but also in terms of the client's engagement, the strength of the relationship, and the stage of therapy" (2005, p. 440).

This review will focus on the impact of disclosure on the working alliance, using Bordin's pan-theoretical definition.

Method

Relevant studies were identified through a review of abstracts on PsychINFO, limited to peer-reviewed English-language journals published up to December 2007. Search terms were *[self disclosure]* AND *[therapist* or *counselor* or *counsellor]*. Titles and abstracts were read to determine relevance. Studies not directly bearing on the topic were initially excluded; these included reviews of books, non- empirical papers, papers concerned solely with client disclosure, and those focusing on group or vocational counselling, or with child clients. Additionally, a manual search was conducted of the 2005-2007 years of three key journals in the field (*Journal of Counseling Psychology*, *Psychotherapy Research* and *Psychotherapy: Theory, Research, Practice, Training*). Further studies were identified through key books (Farber, 2006; Horvath, 1994; Norcross, 2002), reviews (e.g. Ackerman & Hilsenroth 2001; Hill 1992) and the reference lists of articles which met the inclusion criteria.

Two inclusion criteria were used. The review was restricted to studies of individual therapeutic work with help-seeking adult clients. Articles that made direct reference to the therapeutic relationship, therapeutic alliance, working alliance or aspects of Bordin's trans-theoretical formulation of the alliance (for example including measures of liking or trust) were included.

Results

Twenty studies were identified. They can be broadly categorised into eleven studies examining the therapeutic interaction (summarised in Table 1) and nine

studies looking at either client or therapists' perceptions (summarised in Table 2). The first thing to note is that the research is relatively scarce. Although the issue of self-disclosure in general has attracted plenty of research attention, few studies focus specifically on its impact on the therapeutic alliance. However, also included in this review are studies whose primary focus is the alliance, but which have included self-disclosure as one of several possible factors which could impact on this.

Studies of therapeutic interaction

Five studies examined the relationship between the quantity of disclosures and global ratings of the alliance. Four of these employed a correlational design looking either specifically at disclosure (Kelly & Rodriguez, 2007) or more generally at therapist interventions, including disclosure, (Coady & Marziali, 1994; Luborsky, Crits-Christoph, Alexander, Margolis & Cohen, 1983; Price & Jones, 1998) in relation to global measures of the alliance. In the only study of its type, Barrett and Berman (2001) included an experimental manipulation, systematically varying levels of reciprocal disclosures to assess impact on outcome and the therapeutic alliance. However the research methods employed in these studies lack the sensitivity to address factors such as disclosure timing, appropriateness and the nuances of the therapeutic relationship. The remaining studies examined the immediate impacts on the therapy process. Elliott, James, Reimschuessel, Cislo and Sack (1985) used cluster analysis to develop a framework for rating clients' perceptions of the immediate impact of therapist interventions. Across three studies, Hill and colleagues investigated client and therapist perceived helpfulness of disclosure incidents and their impact on client involvement in therapy (Hill, 1989; Hill, Helms, Tichenor, Spiegel, & O'Grady, 1988; Hill et al., 1989). Two final studies examined

the role of disclosure within the process of therapist-client interaction (Czogalik & Russell, 1995; Safran, Muran & Wallner Samstag, 1994); these differ from other studies in that they focus on both the structure and sequence of therapy interactions.

Studies examining the impact of the quantity of disclosures on global ratings of the alliance have shown mixed results. Two studies found disclosure to be negatively associated with ratings of the alliance (Coady & Marziali, 1994; Price & Jones, 1998). Coady and Marziali (1994) examined the association between specific measures of relationship behaviour and global measures of the alliance at different points in time-limited psychodynamic therapy. The Structural Analysis of Social Behaviours model (SASB; Benjamin, 1974, cited in Coady & Marziali, 1994) was used to capture specific client and therapist behaviours. External judges, clients and therapists rated the alliance using the Therapeutic Alliance Rating System (TARS; Marmar, Horowitz, Weiss & Marziali, 1986, cited in Coady & Marziali, 1994). Nine client-therapist dyads were selected from a larger cohort included in a previous study according to post-treatment scores on three outcome variables assessed at one-year follow-up: five good-outcome cases and four poor-outcome cases were identified using factor analysis. A negative correlation was found between therapists' "disclosing and expressing behaviours" (cluster 2 on the SASB) and ratings of the alliance. Unfortunately, the examples of disclosure are not elaborated upon.

Similar results were reported by Price and Jones (1998). They examined transcripts of sessions 1, 5 and 14 of 30 psychodynamic psychotherapy treatments taken from a previous study. Therapist behaviour was quantified utilising the Psychotherapy Process Q-Set (PQS), a 100 item instrument covering a wide range of therapist, client and interactional elements in the process of therapy. Alliance was measured on the California Psychotherapy Alliance Scales (CALPAS; Marmar,

Gaston, Gallagher, & Thompson, 1989, cited in Price & Jones, 1998). Therapists' disclosure of their own emotional conflicts was found to be negatively correlated with alliance ratings.

However, Kelly and Rodriguez (2007) found no relation between therapists' disclosures and the alliance. Their study aimed to investigate the links between disclosure (as reported by therapists) and clients' initial symptom levels, symptom change and the working alliance. Eighty three outpatient clients and 22 therapists were surveyed from across three mental health hospitals. An adapted version of the Self Disclosure Index (SDI; Miller, Berg & Archer, 1983, cited in Kelly & Rodriguez, 2007) was completed by therapists to indicate the extent to which they disclose certain topics to the clients. The 10 topics ranged from 'personal habits' to 'worst fears' and tended to cover disclosures which would be considered 'factual' according to Farber's (2006) distinction. Scores on the SDI correlated significantly with clients' ratings of the extent of their therapists' disclosing behaviour. Working alliance was assessed from both the client and therapist perspectives using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the WAI short form (Tracey & Kokotovic, 1989) respectively. Reported disclosure was not found to correlate with scores on the WAI.

Unlike the previous studies, Luborsky et al. (1983) suggest a positive role for disclosure in the development of the alliance. Their study focused on the comparison of external ratings on a counting signs measure (Helping Alliance Counting Signs; HA_{CS}) and a global rating measure (Helping Alliance Rating; HA_R) of the alliance in therapy. They examined the treatment of the 10 most improved and 10 least improved outpatients from a sample of 73 involved in a previous study. Global ratings (both early and late in treatment) were compared with the ratings for therapist

behaviours which either facilitate or inhibit alliance growth. Therapist references to common therapy experiences with their clients (i.e. self-involving disclosures) were found to be amongst the therapist facilitating "we" behaviours that facilitated the development of the alliance.

In a well designed experimental study, Barrett and Berman (2001) also suggest a positive role for disclosure. They assessed the impact of high and low disclosure levels on outcome and the therapeutic alliance (as measured at the end of every session by clients' reported liking of their therapist). Trainee therapists in a university counselling centre were instructed to limit the frequency with which they disclosed personal information with one client whilst increasing the frequency with another client, across the first four treatment sessions (the mean number of treatment sessions in the clinic being six). Disclosures could be of the self-involving or self-revealing type but had to be reciprocal (i.e. made in response to a client's disclosure). Although the study used relatively inexperienced therapists, the trainees had a wide range of pre-training therapy experience and no effect of therapist experience was found.

In the high disclosure condition, clients reported greater reduction in symptom distress and reported liking their therapists more. It is worth noting that even in the high disclosure condition disclosures were generally infrequent and brief. This study is therefore not informative about how more drastic increases in disclosure could affect the alliance. Additionally, since therapists were told to increase disclosure in one condition and decrease it in the other it remains unclear whether increasing disclosure benefits treatment or restricting disclosure impairs treatment, or both. Either way the evidence suggests that the occurrence of modest levels of disclosure is not harmful to the therapeutic alliance.

It is perhaps unsurprising that the above studies should show conflicting results since their methods are insensitive to issues such as the timing, quality and appropriateness of disclosures, which one would expect to influence the impact on the alliance (Hill, 1992). Additionally, the measures of the alliance are temporally removed from the disclosure events themselves, and could therefore be confounded by the impact of other therapist interventions. An alternative research paradigm is the examination of immediate effects, employed by the following six studies.

Elliott et al. (1985) looked at the immediate impacts of disclosures, examining clients' subjective experience of therapist interventions in ongoing psychotherapy. To provide the framework for this they developed a therapeutic impact taxonomy and rating system from an initial analogue study of one-off, brief helping interviews with volunteer clients who were asked to focus on actual personal problems. Using Interpersonal Process Recall and cluster analysis they identified four types of impacts involving helpful interpersonal contact between client and therapist: Understanding, Reassurance, Personal Contact and Involvement. Interestingly, Personal Contact impacts ("client describes experiencing a greater sense of the therapist as a person or fellow human being [including the] perception of positive characteristics of the therapist as a person and the experience of mutuality or sharing activities with the therapist") and Involvement impacts ("client describes being cognitively stimulated or working harder or becoming more involved or invested in the tasks of therapy") correspond with Bordin's aforementioned division of the alliance into emotional bonding and task aspects (Bordin, 1994).

In the second part of the study they applied this rating system to significant events in three samples of actual ongoing therapy sessions: (1)16 sessions of ongoing, primarily psychodynamic psychotherapy involving 16 different therapists

and clients; (2) a Dynamic-Experiential case which was considered to be unsuccessful; and (3) a cognitive therapy case which was considered to be successful. Clients were asked to describe in detail the impact of helpful therapist interventions. The definition of disclosure used in this study is unclear; however, in a previous analysis of the same data (Elliot, Barker, Caskey & Pistrang, 1982), disclosure was defined as statements that revealed therapist experiences, characteristics or reactions. It can be assumed that a similar broad definition was utilised in the Elliott et al. (1985) study (i.e. incorporating both self-involving and factual disclosures). Disclosures were correlated with 'reassurance' and 'involvement' impacts in the ongoing treatment samples. In the analogue study some clients reported a negative effect of disclosure, namely feeling attacked or distanced, whereas no negative effects were reported in the ongoing therapy samples. Disclosures were correlated with 'personal contact' impacts in both the analogue study and the ongoing therapy study. The authors suggest that these results indicate the utility of appropriate disclosures in the development of the client therapist bond and in building client trust. The differences in the impact of disclosures between the analogue study and ongoing therapy study suggest that the impact of disclosure could vary within the context of different helping situations. However these results need to be taken in the context of limited evidence for the reliability and validity of Interpersonal Process Recall (Elliot, 1986).

In a series of papers based on the findings from eight cases of brief psychotherapy, Hill and colleagues suggest that disclosures can have a favourable effect on the therapeutic alliance (Hill, 1989; Hill et al., 1988; Hill et al., 1989). The eight client-therapist dyads of anxious or depressed clients and experienced therapists were each videotaped over 12-20 sessions. Both therapist and client

reviewed the tape and rated the helpfulness of therapist interventions. Additionally, client speaking turns were rated for level of involvement in therapy using the Client Experiencing Scale (Klein, Mathieu-Coughlan & Keisler, 1986).

The initial analysis (Hill et al., 1988) found that although disclosure occurred infrequently (accounting for only 1% of therapist responses), it was rated by clients as the most helpful therapist response mode and led to the highest levels of client experiencing. Interestingly therapists were divided as to how helpful they felt their disclosures were; five rated it as one of the least helpful responses, whilst three rated it as the most helpful. In a further analysis of the data, Hill et al. (1989) specifically examined the examples of disclosure. Disclosures were categorised along two dimensions: *involving* ("therapist's feelings or cognitions regarding the client and/or the therapy") versus *disclosing* ("reveal something about the therapist's life that does not directly involve the client or the therapy"), and *reassuring* ("therapist supports, reinforces, or legitimises the client's perspective, way of thinking, feeling, or behaving") versus *challenging* ("confront the client's perspective, way of thinking or behaving"). No differences were found between involving and disclosing disclosures; however, reassuring disclosures were rated as more helpful (and led to greater client experiencing) than challenging disclosures. In a further elaboration, Hill (1989) examined the two dyads in which disclosure occurred the most frequently with the aim of gaining further insight into exactly how the disclosures were used and what were the impacts.

Hill and colleagues (Hill, 1989; Hill et al., 1988; Hill et al., 1989) suggest that the value of disclosure (particularly reassuring disclosure) to clients lies in it making a therapist seem more human and the relationship more equal, thereby helping clients feel more comfortable and less vulnerable within the relationship. They emphasise

that the incidence of disclosures was extremely low and speculate that the value to clients may be in part due to this scarcity. They suggest that the low therapist ratings could be due to therapists feeling threatened by their disclosures; a therapist might feel vulnerable in sharing part of themselves with clients, or be uncomfortable with the shift in power dynamics that their disclosure creates. The authors also note that the disclosures often occurred with other types of interventions (e.g. interpretation) which are likely to mediate the effects.

The complexity of therapist-client interaction and how multiple immediate impacts unfold in therapy were addressed by two studies which examined patterns of communication and identified therapist disclosure as playing a potentially positive role (Czogalik & Russell, 1995; Safran et al., 1994). Czogalik and Russell (1995) used a P-technique methodology[1] to identify the processes of interaction between client and therapist in therapy sessions. Six therapeutic relationships were examined; the four therapists varied in experience and approach (2 senior analysts, 1 beginning behavioural therapist and an experienced clinician of eclectic orientation) and the six clients presented with a range of difficulties (eating disorders, familial difficulties, OCD, BPD, anxiety). Two cases were rated as unsuccessful and the remaining four as successful. In previous studies (Czogalik & Russell, 1994a, 1994b) the authors analysed over 10,000 therapist and client utterances (sampled from the beginning, middle and end of these therapies) according to over 30 language categories. Four therapist factors (including self-involving disclosures) and four patient factors were then derived by applying P technique to the matrix of category correlations. In the current study the authors applied the factor scores to each utterance and calculated

[1] The P-technique involves assessing multiple variables at each measurement time point. Data is analyzed to determine the nature of occasion-to-occasion changes in the variables. The Stuttgart Interactional Category System (SICS) was used (Czogalik, Hettinger & Bechtinger-Czogalik, 1987, cited in Czogalik & Russell, 1995).

cross-sequential correlations for two turns of talk (i.e., therapist–patient–therapist–patient). The resulting interaction correlation matrix was analysed to reveal the structure and sequence of the therapeutic discourse.

Four therapist-client interaction factors were identified, which explained 40% of the variability. The Therapeutic Negotiation factor described a "structure of discourse centred around the deliberate negotiation of the therapeutic relationship and the defining parameters of the treatment." The role of the therapist in this negotiation typically included self-involving disclosures. This factor was found to play a more prominent role in the therapeutic relationships that were considered to be successful rather than unsuccessful. The authors surmise that self-involving disclosures can play an important interactional role in the maintenance of a viable therapeutic alliance and in working through resistances or ruptures.

A similar suggestion is made by Safran and colleagues who aimed to clarify the processes involved in the repairing of alliance strains or ruptures in their task analytic investigation[2] (Safran et al., 1994). A preliminary model was derived from psychodynamic and contemporary interpersonal theory, which was then developed through intensive observation of single cases and then refined in a series of pilot verification studies. The session data for these studies was drawn from a sample of 8 therapists and their 29 clients receiving time-limited cognitive-interpersonal therapy (20 sessions). Incidents of withdrawal ruptures (characterized by client behaviours or statements that distance the client from the therapist, therapy task, and/or their internal experience) were identified by within-session fluctuations on six WAI items as rated by client and therapists after each session. Model components of client and therapist behaviour and experiencing levels were operationalised using the SASB

[2] Task analytic investigations are based on a process of oscillation between theory building and empirical analysis, including discovery and verification-orientated strategies.

(Benjamin, 1974) and the Patient and Therapist Experiencing Scales (P-EXP and T-EXP; Klein et al., 1986) respectively.

Their stage-process model suggests that once a client has indicated (through behaviour suggesting avoidance of exploration) the presence of a rupture, it is critical for resolution that the therapist focuses attention on the experience in the here and now. The authors suggest that a therapist can do this in a number of ways, one of which is to provide feedback on his/her subjective perception of the negative sentiments that the client has expressed (directly or indirectly), i.e. to use self-involving disclosures. The therapist must also have a minimum coding of 4-3 on the T-EXP Scale, "indicating that the therapist is attuning to the patient's experiences in the moment and elaborating on them in an empathically involved manner." The model indicates an additional role for disclosures in the following exploration of the rupture experience; if a client is able to express their negative feelings, it is important for the therapist, where appropriate, to accept responsibility for their role in the interaction i.e. use self-involving disclosure. The authors emphasize that their findings are preliminary; the pilot verification studies, whilst lending support to the model, need to be extended with additional larger samples. However, they indicate that empathic self-involving disclosures that are attuned to the client experience can be important components in resolving ruptures in the alliance.

Summary

In summary, these eleven studies suggest that appropriate disclosure can have a beneficial effect on the alliance. Disclosure in general can aid alliance development through making the therapist more likeable (Barrett & Berman, 2001) and more human, thereby equalizing the relationship and helping to build client trust (Elliott et al., 1985; Hill, 1989; Hill et al., 1988; Hill et al., 1989). In this respect

there does not appear to be any differences between factual and self-involving disclosures; however, reassuring disclosures appear to be more helpful than challenging disclosures (Hill et al., 1989). Self-involving disclosures in particular appear to play a specific role in the development and maintenance of a viable therapeutic alliance and in working through resistances or ruptures (Czogalik & Russell, 1995; Luborsky et al., 1983; Safran et al., 1994). However three of the eleven studies did not support this positive view of disclosure. Therapists' disclosure of their own emotional conflicts (Price & Jones, 1998) and therapists' "disclosing and expressing behaviours" (Coady & Marziali, 1994) were found to be negatively correlated with alliance ratings. Additionally, Kelly and Rodriguez (2007) found no correlation between factual disclosures and alliance ratings. Simply conceptualising disclosure as present or absent rather than considering the content, context, delivery or intention embedded in the event could explain some of the variation in these findings.

Studies of therapists' or clients' perceptions

Therapists' perceptions

Studies of therapist opinion indicate that those who employ disclosure typically do so to meet goals for the immediate therapy process (Hill & Knox, 2002; Matthews, 1988; Simon, 1988); with an oft cited aim being that of strengthening the therapeutic relationship (Farber, 2006). However, only one study was identified as also having asked about therapists' observations of the impact of using disclosure (Burkard, Knox, Groen, Perez & Hess, 2006).

In their qualitative study of disclosure in cross-cultural therapy, Burkard et al. (2006) interviewed 11 European American therapists of varying theoretical

orientations about their experience of using disclosure with racially different clients. Participants typically reported disclosing their feelings and reactions to the client's experience of racism (i.e. self-involving disclosures) with the intention of enhancing or improving the therapeutic relationship and acknowledging the impact of racism. In line with their intention, therapists perceived these disclosures as helping their clients feel understood and enhancing the therapeutic relationship. For example, one therapist noticed his client visibly relax ("not quite as hypervigilant") and felt that a mutual respect seemed to develop ("the client treated me as someone who had something to offer him").

Whilst the authors acknowledge the possibility that these findings could be accounted for by notions of "empathic demeanour" or "multicultural sensitivity", they conclude that such disclosures may be helpful in building an effective cross-cultural therapy alliance. However, these results clearly pertain to a very specific therapy situation: that which involves a cross-cultural therapy dyad, where the therapist is of the dominant cultural group and where experience of racism is an explicit client issue. Therefore, these results cannot be generalised beyond this context. Additionally, the authors do not investigate the clients' perception of these events; research suggests that clients hide negative reactions from their therapists (Hill, Thompson & Corbett, 1992), and that therapists are less accurate at perceiving negative client reactions (Thompson & Hill, 1991). Therefore, it is possible that therapists may have had an overly positive view of the impact of their disclosures.

Clients' perceptions

Four studies looked at how clients perceived therapist behaviours to influence either the therapy alliance or process: two utilised a qualitative methodology to identify critical incidents which clients viewed as positively influencing the

therapeutic alliance (Bedi, Davis & Williams, 2005; Fitzpatrick, Janzen, Chamodraka & Park, 2006), whilst two employed quantitative surveys to rate client perceived effects of therapist interventions (Curtis, Field, Knaan-Kostman, & Mannix, 2004; Ramsdell & Ramsdell, 1993). A further four in-depth qualitative studies specifically investigated clients' perceptions of the impact of disclosure; two incorporated a broad definition of disclosure (Hanson, 2005; Wells, 1994), whilst two focussed solely on factual disclosure (Audet & Everall, 2003; Knox et al., 1997).

Fitzpatrick et al. (2006) and Bedi et al. (2005) identified positive critical events that clients felt influenced the development of the alliance. Both studies included extensive validity checks. Fitzpatrick et al.'s (2006) study focussed on early alliance development. They included twenty participants, self-selected from undergraduate students, who had been offered the option of short term therapy (12 to 15 sessions) as an experiential component of their degree. The therapists were trainee counselling psychologists. Participants were interviewed after their third session; nineteen identified a positive critical incident that contributed to the development of the therapy relationship. Data was analysed using the Consensual Qualitative Research method (Hill, Thompson & Nutt-Williams, 1997), identifying five domains: description of incident, meaning of incident, client contribution to the incident (openness), impact on the relationship, and general outcome of the incident. Participants described seven incidents of disclosure, either of the therapists' positive view of the client or of personal information (i.e. self-involving or factual disclosures). Participants typically noted positive effects of the incidents on the alliance with the most frequently endorsed effect being on trust or confidence in the therapist, or increased comfort in the therapy relationship. The authors developed an organising framework to describe the relationship between the five domains - the

Positive Emotion-Exploration Spiral. This depicts a kind of relationship building process where a therapist intervention is ascribed a positive meaning by the client, increasing client openness and exploration, which in turn engenders positive client emotions towards the therapist resulting in further exploration or positive feelings. This suggests that the impact of disclosure is mediated by client attributions.

In a somewhat larger study, Bedi et al. (2005) interviewed 40 clients to identify therapist behaviours and statements which had significantly helped to form or strengthen the alliance across therapy. The majority of participants were educated, white women in mid-adulthood in non-brief therapy. The Critical Incident Technique was used to identify a total of 376 critical incidents which were then organised into 25 categories. Disclosure incidents were defined as occurring when a therapist shared general factual information, similar experiences, or non-verbally disclosed information. An incident of disclosure was identified as a critical incident positively impacting the alliance by 32% of participants.

Although they did not ask specifically about the impact on the alliance, two further studies found that clients view disclosure as beneficial to therapy in general (Curtis et al., 2004; Ramsdell & Ramsdell, 1993). In a factor analytic study, Curtis et al. (2004) surveyed 75 analysts about what they found to be helpful and hurtful in their personal analyses. Participants were asked to rate the effect of 68 therapist behaviours or qualities, plus specific changes engendered by the treatment. Both self-involving and factual disclosure were rated as having a helpful impact on therapy; however only self-involving disclosure was linked to client psychological change.

Ramsdell and Ramsdell (1993) surveyed 67 former clients of a psychotherapy centre. Participants were asked to rate the frequency and effect ("very detrimental"

to "very beneficial") of a list of 21 therapist behaviours. Almost 60% of the sample indicated that their therapist had shared personal information; however this occurred infrequently, with 43% indicating that this occurred on fewer than 4 occasions across therapy. Of those who had experienced disclosure, the majority (almost 60%) indicated that it had had a beneficial effect on the therapy.

Taken together these four studies suggest that clients consider both factual and self-involving disclosure to play a role in alliance building (Bedi et al., 2005; Fitzpatrick et al., 2006) and to be beneficial to the therapy process in general (Curtis et al., 2004; Ramsdell & Ramsdell, 1993). However, they do not inform understanding about how and why they impact positively on the alliance. A fuller picture is provided by four in-depth qualitative studies which looked specifically at disclosure and found a major theme to be the impact (both positive and negative) on the therapeutic relationship.

In the first study of this type, Wells (1994) conducted semi-structured interviews with eight former clients whose therapy experience ranged from five months to six years, focussing on the participants' experience of disclosure. Responses pertained to one specific incident of therapist disclosure recalled by participants, which were analysed according to emergent themes (although the method of analysis was not specified). The results were mixed. Overwhelmingly negative effects on the therapeutic alliance were reported by half the sample. These participants described a tenuous therapeutic alliance prior to the disclosure and a subsequent significant reduction in trust and confidence in their therapist. Several also questioned their therapist's ability to maintain appropriate therapeutic boundaries. In contrast, half the sample reported a positive overall effect of the disclosure on the therapeutic relationship. These participants also commented on

what they felt to be their therapist's helpful intent behind the disclosure. They described the prior therapeutic relationship in positive terms and felt that their therapist's disclosure "enhanced mutuality and their sense of connection with the therapist" (p.34) and made them feel more understood and accepted. Several also reported an equalising effect on the relationship. However, these changes seemed to introduce aspects of non-therapeutic social relations (for example concern for the therapist as a potentially vulnerable "three dimensional" person rather than an "expert" professional), an effect of which was to inhibit their free exploration of the therapeutic issue or the disclosure. The following quote describes this potential trade-off:

> "My confidence in her as somebody to take me seriously increased but my confidence in her as someone who was going to be incredibly professional and be full of a lot of insights lessened" (Wells, 1994, p.30).

Indeed, the entire sample reported "some degree of disappointment, disillusionment or "surprise"" in response to the disclosure. Despite these negative experiences most of the clients in the study held the view that, in theory, disclosure has the potential to "enrich and strengthen" the therapeutic alliance when used cautiously and professionally, and advised against a strict 'blank slate' policy. Participants emphasised the importance of a therapist maintaining a "professional role" whilst disclosing, through brevity, paucity, and an awareness of maintaining the relevance for and focus on the client. Framing of the disclosure also appeared to be important; participants commented that when their therapist had specified the disclosure as their own information it had greater value and prevented it from feeling burdensome. They also suggested that negative effects could be mitigated by providing a safe

environment for the exploration of client reactions to the disclosure. However, the findings of this study are limited by a lack of reflection on any researcher bias and a lack of auditing in the analysis.

In a more methodologically sophisticated study Hanson (2005) examined the effects of both disclosure and non-disclosure (incidences where the client requested information that was not given or incidents when the client felt that the therapist could have disclosed but did not). Eighteen clients currently in therapy (ranging from 2 months to 10 years) were asked to identify incidents of self-involving and self-revealing disclosures or non-disclosures. This generated 157 incidents of disclosure and non-disclosure, which were coded (by the researcher) as either 'helpful', 'unhelpful', 'neutral', or 'mixed'. The quantitative analysis showed that disclosures were two and a half times more likely to be experienced as helpful and that non-disclosures were twice as likely to be experienced as unhelpful by the participants. The qualitative analysis found the greatest effects of disclosure and non-disclosure (both good and bad) to be on the alliance. 'Helpful' disclosures improved the alliance by increasing the senses of connection, intimacy, trust, and being deeply understood. They also provided the opportunity to identify with the therapist, gave a sense that the therapist would take responsibility for mistakes, and made the relationship feel more egalitarian. 'Unhelpful' disclosures were reported to damage the alliance, making clients feel that they needed to manage the relationship and reducing their felt sense of trust and safety. Of the 10 incidents of 'helpful' non-disclosures half the respondents said that this left them free to imagine what they wanted about the therapist. 'Unhelpful' non-disclosures were experienced as detrimental to the therapeutic alliance, with clients feeling disconnected from and distrustful of their therapists. Similar to the study by Wells (1994), the pre-existing

therapeutic alliance and the therapist skill were identified as influencing how a disclosure or non-disclosure was experienced by participants. Skilled disclosures were identified as brief, well timed and in the context of client material, whilst skilled non-disclosures were framed compassionately and delivered in a way that the client could understand and accept as beneficial. Skilled disclosure or non-disclosure tended to develop the alliance whereas skill deficits damaged its development. Similarly, "a positive pre-existing alliance mitigated the effects of skills deficits; while a negative or nonexistent alliance exacerbated the effects and could tip the scale towards termination" (p.101).

Two further studies looked solely at factual disclosures (Audet & Everall, 2003; Knox et al., 1997) and found similar results, identifying both negative and positive effects on the therapeutic alliance. Audet and Everall (2003) presented the responses of four participants selected from interviews with nine former clients on the basis of the richness of their data and the fact that both positive and negative experiences were described. Knox et al. (1997) interviewed 13 participants currently in long-term psychotherapy and specifically asked about the impacts of a 'helpful' disclosure they had experienced. Whilst the nature of the question makes it unsurprising that the majority of effects identified were positive, it is interesting to note that nonetheless, several hindering effects of disclosure were reported. Across both studies, participants typically reported an enhanced connection, a more equalized relationship, and a view of their therapist as more 'real'. Negative effects on the relationship included reduced trust and confidence in the therapist's ability to help, concern about therapeutic boundaries, discomfort at the closeness that the disclosure engendered with their therapist, and an increased likelihood of critical feelings towards therapist. These studies also suggest that clients actively evaluate

the disclosure content and/or the disclosing behaviour itself for fit with their perception of a therapist's role. The participants in Knox et al.'s (1997) study all perceived their therapists as having a clear positive intention for the disclosure; the authors speculate that this perception could have contributed to their experience of the disclosures as helpful. Audet and Everall (2003) found that participants who had no prior conceptions about disclosure accepted it as an appropriate part of therapy, however one participant who (on the basis of previous therapy experience) was not expecting disclosure, experienced some doubts about the therapist.

In line with Wells (1994) and Hanson (2005), Audet and Everall (2003) identified the importance of brevity, paucity and timing in delivery of disclosures. Additionally, Audet and Everall (2003) identified the intimacy level of a disclosure as important, suggesting that low intimacy disclosures could be useful in building alliance but more intimate disclosures need to be delivered in the context of a more solid alliance. Similarly to both Wells (1994) and Hanson (2005), Audet and Everall (2003) found that, for those participants describing the disclosure as occurring within the context of a tenuous alliance, the disclosure led to a dramatic reduction in trust and confidence in the therapist and possible termination of the therapy. However those participants who described a more established alliance tended to acknowledge any negative impacts but reflected mainly on the positive effects.

It is noteworthy that Knox et al. (1997) invited participants to think of examples according to a very broad definition of disclosure; however they only offered examples of factual disclosures. This appears to be in contrast to suggestions in the theoretical literature that self-involving disclosures are more helpful. The authors speculate on why this would be the case, suggesting that factual disclosures might be more memorable, interesting, or less threatening to clients.

Summary

In summary, the first four studies reviewed in this section suggest that clients identify both factual and self-involving disclosures as having positive effects on the alliance (Bedi et al., 2005; Fitzpatrick et al., 2006) and the therapy process in general (Curtis et al., 2004; Ramsdell & Ramsdell, 1993). The in-depth examination of client experience provided by the second four studies offers a more complex picture, suggesting not only that disclosures can be identified as impacting negatively on the alliance, but that even disclosures that are identified as having a positive overall impact can also have some negative effects. The impact of a disclosure on the therapeutic alliance appears to be influenced by the skill with which it is delivered. These studies emphasize the importance of delivery factors such as framing (Hanson, 2005; Wells, 1994), level of intimacy (Audet & Everall, 2003), frequency, brevity, and relevance to the client context (Audet & Everall, 2003; Hanson, 2005; Wells, 1994). They also highlight the significance of context, such as the strength of the existing therapeutic relationship (Audet & Everall, 2003; Hanson, 2005; Wells, 1994), clients' active evaluation of therapist intention (Knox et al., 1997) and their expectations of a therapists' role (Audet & Everall, 2003). Although these qualitative studies do not provide scientific evidence for generalisable psychological theories (Hoyt & Bhati, 2007), the findings provide interesting subjective experience to inform our understanding of the range of potential impacts of disclosure on the alliance. Taken together the findings of these studies suggest that appropriate and skilfully made disclosure can have a beneficial impact on the alliance. Where negative impacts occur, these can be ameliorated by post-disclosure exploration with the client (Wells, 1994).

However, it is important to note that these studies varied in their attention to methodological rigour. Most of the studies included extensive validity checks (Bedi et al., 2005; Fitzpatrick et al., 2006 Knox et al., 1997) or at least paid some attention to the issue of researcher bias (Hanson, 2005); however it remained unclear whether these issues were specifically addressed by other authors (Audet & Everall, 1997; Wells, 1994). Furthermore, studies of client and therapist perceptions fall foul of the disadvantages of retrospective recall such as recall bias and differing abilities to recall internal experiences (Knox et al., 1997). They can also be criticised for using an overly simplistic model of what therapists and clients say and their reasons for doing so (Priest, 2005). Clients and therapists are necessarily bound by their own awareness, i.e. other factors may have operated outside of their awareness (Bedi et al., 2005). Additionally, both clients and therapists will be influenced by their pre-existing theories or stereotypes about how people relate together generally and specifically within the therapeutic frame, which will influence their interpretations of events and inevitably their feelings.

Discussion

This review has addressed 20 studies employing a wide variety of research methodologies. Although the body of research is relatively small, several broad themes emerge. Before these are addressed it is worth noting some methodological issues which have a bearing on the interpretation of the results.

With a few exceptions (Czogalik & Russell, 1995; Safran et al., 1994), the methodologies employed in the quantitative studies generally do not tap into the dynamic process of the alliance and are based on simplistic present/absent, helpful/unhelpful dichotomies around the use of disclosure. However, this is

unsurprising given that the explicit aims of some studies were not in line with the question being addressed here. Additionally, a lack of consistent or clearly specified definitions makes it hard to draw conclusions across these studies and little reference is made to whether the disclosures were appropriately or skilfully delivered. Finally, sample sizes have been small (70% of studies had 30 or fewer participants). Inevitably both the quantitative and qualitative studies in this review suffer, as do all volunteer studies, from a bias of self-selection; there is no way of knowing whether those who volunteer are in some way different to those who do not. Despite these methodological difficulties there are some clear patterns which can be derived on the basis of the available literature.

Disclosure type

In line with reviews of analogue research (Hill & Knox, 2002; Watkins, 1990), studies of therapeutic interaction using a broad definition of disclosure have generally shown positive effects on the alliance (Barrett & Berman, 2001; Elliott et al., 1985; Hill, 1989; Hill et al., 1988; Hill et al., 1989), thereby lending support to theorists who have suggested that disclosure can strengthen the alliance (e.g. Rogers, 1957). These studies suggest that disclosures can increase clients' perceptions of therapists as real and human, equalise the therapeutic relationship, and increase client trust, thereby strengthening the alliance.

However, the term disclosure covers a vast range of possible therapist statements, which raises the question: do some types of disclosures have relatively greater benefits for the alliance than others? Some theorists have argued for the relative value of self-involving disclosures over factual disclosures (e.g. Spinelli, 1994), and reviews of the analogue literature have provided modest support for this

hypothesis (e.g. Hill et al., 1989). The studies in this review, however, do not support this; studies which directly compared types of disclosure found no differences between self-involving and factual disclosures (Hanson, 2005; Hill et al., 1989). Having said this, it does seem that self-involving disclosures can play a specific role in the maintenance and reparation of the alliance (Czogalik & Russell, 1995; Safran et al., 1994).

Quantity of disclosure

A number of studies in this review examined the relation between quantity of disclosure and the working alliance, finding conflicting results (Coady & Marziali, 1994; Elliott et al., 1985; Kelly & Rodriguez, 2007; Luborsky et al., 1983; Price & Jones, 1998). The lack of consistent or clearly specified definitions makes it hard to draw conclusions across these studies. However, it is perhaps unsurprising that a clear picture has failed to emerge given that there is no convincing reason to presume that the greater the disclosure the greater the positive impact on the alliance. In fact, it may be that disclosure is effective specifically when it is used infrequently (Hill & Knox, 2002). Certainly, reviews of the analogue literature (Farber, 2006; Hill & Knox, 2002; Watkins, 1990) suggest that moderation is the key to disclosure's positive impact on the alliance. On the basis of her research, Hill (1992) postulates that there is an optimal range of disclosure frequency, and suggests that it could be between 1% and 5% of therapist utterances. She suggests that too little disclosure could make a client feel isolated and disregarded; yet too much, especially about past personal events, may distract the focus from the client, overly burden the client, and reduce the therapist's professional status.

A further argument against there being a consistent relationship between disclosure frequency and the alliance is suggested by the notion of "responsiveness" (Stiles, Honos-Webb & Surko, 1998). If a therapist is acting responsively to an individual client's needs at a specific time, they might disclose more or less than to another client; hence it is the appropriateness of a disclosure which is important.

Disclosure appropriateness

A number of authors have asserted the view that there is nothing inherently useful about self-disclosure per se, rather it is the appropriateness of the disclosure which is important (e.g. Weiner, 1983). The qualitative studies in this review clearly support that position (Audet & Everall, 2003; Hanson, 2005; Knox et al., 1997; Wells, 1994).

Skill of delivery

Skill of disclosure or non-disclosure appears to be crucial to its impact on the alliance (Audet & Everall, 2003; Hanson, 2005; Wells, 1984). Skilled disclosures appear to be brief, infrequent, framed as the therapist's information and situated in the context of client material. Intimacy level of a disclosure is also important; low intimacy disclosures could be useful in building alliance but more intimate disclosures need to be delivered in the context of a more solid alliance. Attention to these skill factors seems to enable therapists to disclose whilst maintaining their professional status in the relationship (Wells, 1994).

Contextual and interactive aspects

The alliance is the product of both the client's and the therapist's contributions to the process and therefore inevitably client intrapersonal and interpersonal factors will be relevant. It appears that clients do not passively receive

therapist disclosures but actively evaluate the disclosure content and/or the disclosing behaviour itself for fit with their perception of a therapist's role (Audet & Everall, 2003; Knox et al., 1997). This supports the findings by reviews of analogue studies (Farber, 2006; Hill & Knox, 2002; Watkins, 1990), and is in line with recent research suggesting that a client's assessment of therapy is interactive and not merely responsive to therapist factors, and is influenced by their expectations of therapy (Horvath & Luborsky, 1993). Clients' assessments of disclosures will also be impacted by their preferences for personal interaction style (Knox et al., 1997). It is inevitable, therefore, that disclosure will enhance the alliance for some clients whilst having a detrimental or negligible effect for others (Bachelor & Horvath, 1999). Or as Norcross (2002) puts it, "different folks do require different strokes" (p. 6).

As the alliance literature suggests, interventions such as disclosure and the alliance are intertwined and interact (Hill, 2005). In line with this, the studies in this review suggest that disclosure can strengthen the alliance, and yet the strength of the relationship at the time of a disclosure can influence its impact (Audet & Everall, 2003; Hanson, 2005; Wells, 1994).

Cultural considerations

Constantine and Kwan (2003) have noted that much of the existing literature only concerns the use of disclosure with White or European American individuals, and that there is a dearth of research on disclosure in cross-cultural settings. Certainly this is the case for the studies in this review; where details are provided, the ethnic homogeneity of the studies is apparent, although more often than not details on ethnicity are lacking. In the single study which involved cross-cultural therapy dyads, therapist observations suggest that disclosures which validate clients'

experience of the negative impact of racism may be helpful in building an effective cross-cultural alliance (Burkard et al., 2006). It is also possible that individual client differences in disclosure preferences could be related to cultural values (Fitzpatrick et al., 2006). For example, an analogue study found that Mexican participants were more trusting of a non-disclosing therapist, which could reflect the Hispanic cultural value placed on formalism (Cherbosque, 1987).

Clinical Implications

Whilst these findings do not provide an exact framework, it is hoped that they provide an understanding of how disclosure may impact on the therapeutic alliance. Given the key role of the alliance in treatment success, a deeper understanding of disclosure's potential impact may enable therapists (especially those in training) to better attend to the individual needs of clients (Knox & Hill, 2003).

Disclosure clearly has the potential to be helpful in developing and maintaining the therapeutic alliance (Barrett & Berman, 2001; Bedi et al., 2005; Curtis et al., 2004; Czogalik & Russell, 1995; Elliott et al., 1985; Fitzpatrick et al., 2006; Hill, 1989; Hill et al., 1988; Hill et al., 1989; Luborsky et al., 1983; Ramsdell & Ramsdell, 1993; Safran et al., 1994). However, client studies suggest that disclosure is a double edged sword whose effects can be both subtle and mixed (Audet & Everall, 2003; Hanson, 2005; Knox et al., 1997; Wells, 1994). Clinicians need to be aware that clients will differ in their expectations of, and preferences for, the use of disclosure. It would also be helpful for therapists to be aware of their own and their clients' cultural values, as well as the interaction of these in the therapy relationship (Constantine & Kwan, 2003). Therapists can ameliorate the negative

impact of disclosures by being responsive to client feedback and providing a space for clients to discuss freely the implications for them (Wells, 1994).

Conclusions and future directions for research

In summary, these findings reflect the inherently complex effects of disclosure and the interactional nature of the alliance. Disclosure certainly has an impact on the alliance; studies of therapeutic interaction in general suggest potentially positive effects on the alliance although some studies suggest a negative impact. Simply conceptualising disclosure as present or absent rather than considering the content, context, delivery or intention embedded in the event could explain some of the variation in findings. Qualitative studies of clients' perceptions, although few in number, paint a surprisingly consistent picture; they emphasise the subtle and often mixed impacts of disclosure, highlighting the importance of therapist skill in delivery. The studies also suggest that the effect of disclosure is influenced by the context in which it is delivered: namely client expectations, client preferences and the quality of the existing alliance.

As this review demonstrates, a range of different methodologies have been used to investigate the effects of disclosure on the alliance; however no single method is likely to capture the full complexity of this phenomenon and several areas remain insufficiently explored. For example, it has been suggested that certain groups of clients such as adolescents and people with a diagnosis of psychosis might require higher levels of therapist disclosure (Farber, 2006); however no research has looked specifically at these groups. A clear omission from the existing research is the personal experience of the therapist. Although the therapist's purpose and intent is the promotion of client growth, self-disclosure inevitably impacts on the therapist

as well. Much as clients' expectations and personal preferences shape the meaning that they make from a disclosure incident (Audet & Everall, 2003; Knox et al., 1997), so one might expect therapists' professional and personal preferences to shape their experience of disclosing with clients. Further qualitative research could provide a valuable insight into how therapists make a decision to disclose which would help to inform the novice therapist grappling with this contentious and complex issue.

Table 1. ***Studies of Therapeutic Interaction***

Study	Clients	Therapy	Study design	Disclosure (type and measurement)	Alliance measurement	Findings relevant to this review
Barrett & Berman (2001)	36 outpatient clients (15 male, 21 female)	Approximately 6 sessions of mainly CBT or supportive therapy 18 trainee clinical psychologists	Experimental manipulation: therapists increased disclosure with one client and decreased with another client	Self-involving and self-revealing reciprocal disclosures Observer rated	Client indicated how much they liked their therapists on a 9-point Likert scale at the end of every session Rated over first 4 sessions of therapy	Clients in high disclosure condition reported liking their therapist more
Coady & Marziali (1994)	5 good-outcome clients and 4 poor-outcome clients selected from original sample of 42 outpatient clients (2 male, 7 female)	20 sessions of time-limited psychodynamic psychotherapy Therapists had a minimum of 4 years post-graduate experience	Correlational	Therapist disclosing and expressing behaviours Externally rated using Structural Analysis of Social Behaviours model (SASB; Benjamin, 1974)	Therapeutic Alliance Rating System (TARS; Marmar et al., 1986) Observer rated	Negative correlation between therapist use of disclosing and expressing behaviours and alliance ratings
Czogalik & Russell (1995)	6 clients (3 male, 3 female)	11 – 89 sessions 4 therapists (2 senior analysts, 1 beginner behavioural therapist, 1 experienced eclectic clinician)	Transcripts from 3 randomly selected sessions from each third of therapy analysed using a P technique	Self-involving disclosures Observer rated using Stuttgart Interactional Category System for therapist-client interaction	Observer rated using SICS therapist evaluations of the therapy relationship	Self-involving disclosures identified as playing an important interactional role in maintaining a viable alliance and in working through alliance ruptures

Elliott, James, Reimschuessel, Cislo, & Sack (1985)	18 clients	16 sessions of ongoing psychotherapy (16 different clients and therapists) Plus 2 case studies (10 sessions of psychodynamic therapy, and 12 sessions of CBT)	Correlational therapeutic impacts studied using Interpersonal Process Recall	Definition unclear but presumed to be broad definition incorporating both self-involving and factual disclosure	Therapist response modes rated by client on a 7-point helpfulness rating scale	Disclosures positively correlated with 'personal contact' impacts, suggesting the utility of appropriate disclosure in building client trust
Hill (1989)	8 anxious or depressed clients	Brief psychotherapy (12-20 sessions) 8 experienced therapists (rated themselves as more psychoanalytic than humanist/ behavioural)	Sessions videotaped. Client, therapist and observer watched videos post sessions.	Feelings or personal experiences Identified using the Manual for the Therapist Verbal Response Modes Category System (Hill, 1989)	Helpfulness of disclosure rated by both client and therapist at end of session (The Helpfullness Scale (Elliott, 1985, 1986)) The Client Experiencing Scale (Klein et al., 1986)	In-depth exploration of individual cases. Disclosures seemed to equalise relationship and enhance therapeutic relationship.
Hill, Helms, Tichenor, Spiegel & O'Grady (1988)	8 anxious or depressed clients	Brief psychotherapy (12-20 sessions) 8 experienced therapists (rated themselves as more psychoanalytic than humanist/ behavioural)	Sessions videotaped. Client, therapist and observer watched videos post sessions.	Feelings or personal experiences Identified using the Manual for the Therapist Verbal Response Modes Category System (Hill, 1989)	Helpfulness of disclosure rated by both client and therapist at end of session (The Helpfullness Scale (Elliott, 1985, 1986)) The Client Experiencing Scale (Klein et al., 1986)	Disclosures rated by clients as the most helpful therapist response mode and led to greatest client experiencing levels

Hill, Mahalik &Thompson (1989)	8 anxious or depressed clients	Brief psychotherapy (12-20 sessions) 8 experienced therapists (rated themselves as more psychoanalytic than humanist/ behavioural)	Sessions videotaped. Client, therapist and observer watched videos post sessions.	Feelings or personal experiences Identified using the Manual for the Therapist Verbal Response Modes Category System (Hill, 1989)	Helpfulness of disclosure rated by both client and therapist at end of session (The Helpfullness Scale (Elliott, 1985, 1986)) The Client Experiencing Scale (Klein et al., 1986)	Reassuring disclosures rated as more helpful and led to greater client 'experiencing' levels. No differences between factual and self-involving disclosures
Kelly & Rodriguez (2007)	83 outpatient clients (17 male, 66 female) (92% White, 6% Black, 1% Latino, 1% other)	22 therapists (theoretical orientations mainly CBT or eclectic)	Correlational	Adapted version of the Self Disclosure Index (Miller et al., 1983) administered to therapists Clients rated extent of therapist disclosing behaviour	Client form of Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) Short form of WAI (Tracey & Kokotovic, 1989)	No correlation found between factual disclosures and measures of alliance
Luborsky, Crits-Christoph, Alexander, Margolis & Cohen (1983)	20 outpatient clients (10 most improved, 10 least improved)	18 experienced psychiatrists SE psychoanalytic psychotherapy	Correlational	Therapist reference to common therapy experience with their clients Observer rated on Therapist Facilitating behaviours by the Rating Method	Helping Alliance Rating Method (HARM) Therapist Facilitating behaviours (TFB) Both observer rated	Self-involving disclosures amongst the therapist facilitating "we" behaviours that were positively correlated with alliance measures

Price & Jones (1998)	30 patients (10 male, 20 female)	brief psychodynamic psychotherapy (11-20 sessions) 15 therapists (clinical experience: average = 6 years; range 1-19 years)	Analysed transcripts of sessions 1, 5 and 14	therapists' disclosure of their own emotional conflicts Disclosures identified using Process Q-Set (observer rated)	CALPAS used as alliance measure (California Psychotherapy Alliance Scales) Observer rated	Therapists' disclosure of their own emotional conflicts was negatively correlated with alliance ratings
Safran, Muran & Wallner Samstag, (1994)	29 clients	20 sessions of time-limited integrated cognitive-interpersonal therapy 8 therapists	Task analytic study. Analysed incidents of withdrawal ruptures.	Self-involving disclosures identified using SASB	Six WAI items rated for each third of the therapeutic hour by client and therapists after each session Patient and Therapist Experiencing Scales (observer rated)	Self-involving disclosures useful for the resolution of alliance ruptures

Table 2. ***Studies of Therapists' or Clients' Perceptions***

Study	Participants	Disclosure type	Study design	Findings Relevant to this Review
Audet & Everall (2003)	4 previous clients (2 male, 2 female; all Caucasian)	Disclosures about the therapist's personal life outside therapy	Qualitative interviews Phenomenological analysis	Both positive and negative impacts identified Low intimacy disclosures are a useful tool for building alliance, but more intimate disclosures actually require a solid relationship Impact found to depend on the context (client expectations) and way delivered (frequency, intimacy, similarity and timing)
Bedi, Davis & Williams (2005)	40 clients (9 male, 31 female; 70% White)	Therapists shared general factual information, similar experiences, or non-verbally disclosed information	Clients interviewed using Critical Incident Technique to identify incidents which had strengthened the alliance	32% of participants identified an incident of disclosure as a critical incident positively impacting the alliance.
Burkard, Knox, Groen, Perez & Hess (2006)	11 European American therapists (5 male, 6 female)	Disclosures of reassurance and support (Knox & Hill, 2003)	Qualitative interviews	Results indicated that therapists typically shared their reactions to clients' experiences of racism or oppression and that these self-disclosures typically had positive effects in therapy, often improving the counselling relationship by helping clients feel understood and enabling clients to advance to other important issues
Curtis, Field, Knaan-Kostman & Mannix (2004)	75 psychoanalysts in personal analysis (55% male, 45% female)	Disclosures of feeling / disclosures of aspects of the therapists personal life	Postal Survey Factor analysis	Both types of disclosure perceived as helpful to therapy by client

Fitzpatrick, Janzen, Chamodraka & Park (2006)	20 clients (4 male, 16 female; mainly Canadian)	The therapists' positive view of the client or of personal information	Qualitative interviews Consensual Qualitative Research method	Participants typically noted positive effects of the incidents on the alliance with the most frequently endorsed effect being on trust or confidence in the therapist, or increased comfort in the therapy relationship
Hanson (2005)	18 current clients (16 female, 2 male; mainly Caucasian Canadians)	Therapist reveals personal information and/or reactions to client Non-disclosures also included	Qualitative Interviews Constant Comparison method	Disclosures 2 ½ times more likely to be found helpful. Non-disclosures twice as likely to be found unhelpful. No differences found between factual and self-involving disclosures. Main effect of disclosure and non-disclosure (both good and bad) were on the alliance. Skill in delivery of disclosure important in determining effect.
Knox, Hess, Peterson & Hill (1997)	13 clients in long term therapy (9 female, 4 male European Americans)	Helpful, self-revealing disclosures	Qualitative interviews Consensual qualitative research	Disclosures resulted in an improved or more equalized therapeutic relationship
Ramsdell & Ramsdell (1993)	67 former clients 91% Caucasian, 9 % Black/Hispanic/ Asian	Sharing personal information	Postal survey	Therapist sharing of personal information seen by clients as beneficial to therapy
Wells (1994)	8 former adult clients (1 male and 7 female)	Self-involving and self-revealing	Qualitative interviews	Half of sample described overall experience of disclosure as having positive impact on the alliance, whilst also describing some negative impacts. Half of sample reported overwhelmingly negative effects on the alliance. Highlighted importance of prior alliance and skill in delivery.

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Summary

In summary, the first four studies reviewed in this section suggest that clients identify both factual and self-involving disclosures as having positive effects on the alliance (Bedi et al., 2005; Fitzpatrick et al., 2006) and the therapy process in general (Curtis et al., 2004; Ramsdell & Ramsdell, 1993). The in-depth examination of client experience provided by the second four studies offers a more complex picture, suggesting not only that disclosures can be identified as impacting negatively on the alliance, but that even disclosures that are identified as having a positive overall impact can also have some negative effects. The impact of a disclosure on the therapeutic alliance appears to be influenced by the skill with which it is delivered. These studies emphasize the importance of delivery factors such as framing (Hanson, 2005; Wells, 1994), level of intimacy (Audet & Everall, 2003), frequency, brevity, and relevance to the client context (Audet & Everall, 2003; Hanson, 2005; Wells

However, it is important to note that these studies varied in their attention to methodological rigour. Most of the studies included extensive validity checks (Bedi et al., 2005; Fitzpatrick et al., 2006 Knox et al., 1997) or at least paid some attention to the issue of researcher bias (Hanson, 2005); however it remained unclear whether these issues were specifically addressed by other authors (Audet & Everall, 1997; Wells, 1994). Furthermore, studies of client and therapist perceptions fall foul of the disadvantages of retrospective recall such as recall bias and differing abilities to recall internal experiences (Knox et al., 1997). They can also be criticised for using an overly simplistic model of what therapists and clients say and their reasons for doing so (Priest, 2005). Clients and therapists are necessarily bound by their own awareness, i.e. other factors may have operated outside of their awareness (Bedi et al., 2005). Additionally, both clients and therapists will be influenced by their pre-existing theories or stereotypes about how people relate together generally and specifically within the therapeutic frame, which will influence their interpretations of events and inevitably their feelings.

Discussion

This review has addressed 20 studies employing a wide variety of research methodologies. Although the body of research is relatively small, several broad themes emerge. Before these are addressed it is worth noting some methodological issues which have a bearing on the interpretation of the results.

With a few exceptions (Czogalik & Russell, 1995; Safran et al., 1994), the methodologies employed in the quantitative studies generally do not tap into the dynamic process of the alliance and are based on simplistic present/absent, helpful/unhelpful dichotomies around the use of disclosure. However, this is

unsurprising given that the explicit aims of some studies were not in line with the question being addressed here. Additionally, a lack of consistent or clearly specified definitions makes it hard to draw conclusions across these studies and little reference is made to whether the disclosures were appropriately or skilfully delivered. Finally, sample sizes have been small (70% of studies had 30 or fewer participants). Inevitably both the quantitative and qualitative studies in this review suffer, as do all volunteer studies, from a bias of self-selection; there is no way of knowing whether those who volunteer are in some way different to those who do not. Despite these methodological difficulties there are some clear patterns which can be derived on the basis of the available literature.

Disclosure type

In line with reviews of analogue research (Hill & Knox, 2002; Watkins, 1990), studies of therapeutic interaction using a broad definition of disclosure have generally shown positive effects on the alliance (Barrett & Berman, 2001; Elliott et al., 1985; Hill, 1989; Hill et al., 1988; Hill et al., 1989), thereby lending support to theorists who have suggested that disclosure can strengthen the alliance (e.g. Rogers, 1957). These studies suggest that disclosures can increase clients' perceptions of therapists as real and human, equalise the therapeutic relationship, and increase client trust, thereby strengthening the alliance.

However, the term disclosure covers a vast range of possible therapist statements, which raises the question: do some types of disclosures have relatively greater benefits for the alliance than others? Some theorists have argued for the relative value of self-involving disclosures over factual disclosures (e.g. Spinelli, 1994), and reviews of the analogue literature have provided modest support for this

hypothesis (e.g. Hill et al., 1989). The studies in this review, however, do not support this; studies which directly compared types of disclosure found no differences between self-involving and factual disclosures (Hanson, 2005; Hill et al., 1989). Having said this, it does seem that self-involving disclosures can play a specific role in the maintenance and reparation of the alliance (Czogalik & Russell, 1995; Safran et al., 1994).

Quantity of disclosure

A number of studies in this review examined the relation between quantity of disclosure and the working alliance, finding conflicting results (Coady & Marziali, 1994; Elliott et al., 1985; Kelly & Rodriguez, 2007; Luborsky et al., 1983; Price & Jones, 1998). The lack of consistent or clearly specified definitions makes it hard to draw conclusions across these studies. However, it is perhaps unsurprising that a clear picture has failed to emerge given that there is no convincing reason to presume that the greater the disclosure the greater the positive impact on the alliance. In fact, it may be that disclosure is effective specifically when it is used infrequently (Hill & Knox, 2002). Certainly, reviews of the analogue literature (Farber, 2006; Hill & Knox, 2002; Watkins, 1990) suggest that moderation is the key to disclosure's positive impact on the alliance. On the basis of her research, Hill (1992) postulates that there is an optimal range of disclosure frequency, and suggests that it could be between 1% and 5% of therapist utterances. She suggests that too little disclosure could make a client feel isolated and disregarded; yet too much, especially about past personal events, may distract the focus from the client, overly burden the client, and reduce the therapist's professional status.

A further argument against there being a consistent relationship between disclosure frequency and the alliance is suggested by the notion of "responsiveness" (Stiles, Honos-Webb & Surko, 1998). If a therapist is acting responsively to an individual client's needs at a specific time, they might disclose more or less than to another client; hence it is the appropriateness of a disclosure which is important.

Disclosure appropriateness

A number of authors have asserted the view that there is nothing inherently useful about self-disclosure per se, rather it is the appropriateness of the disclosure which is important (e.g. Weiner, 1983). The qualitative studies in this review clearly support that position (Audet & Everall, 2003; Hanson, 2005; Knox et al., 1997; Wells, 1994).

Skill of delivery

Skill of disclosure or non-disclosure appears to be crucial to its impact on the alliance (Audet & Everall, 2003; Hanson, 2005; Wells, 1984). Skilled disclosures appear to be brief, infrequent, framed as the therapist's information and situated in the context of client material. Intimacy level of a disclosure is also important; low intimacy disclosures could be useful in building alliance but more intimate disclosures need to be delivered in the context of a more solid alliance. Attention to these skill factors seems to enable therapists to disclose whilst maintaining their professional status in the relationship (Wells, 1994).

Contextual and interactive aspects

The alliance is the product of both the client's and the therapist's contributions to the process and therefore inevitably client intrapersonal and interpersonal factors will be relevant. It appears that clients do not passively receive

therapist disclosures but actively evaluate the disclosure content and/or the disclosing behaviour itself for fit with their perception of a therapist's role (Audet & Everall, 2003; Knox et al., 1997). This supports the findings by reviews of analogue studies (Farber, 2006; Hill & Knox, 2002; Watkins, 1990), and is in line with recent research suggesting that a client's assessment of therapy is interactive and not merely responsive to therapist factors, and is influenced by their expectations of therapy (Horvath & Luborsky, 1993). Clients' assessments of disclosures will also be impacted by their preferences for personal interaction style (Knox et al., 1997). It is inevitable, therefore, that disclosure will enhance the alliance for some clients whilst having a detrimental or negligible effect for others (Bachelor & Horvath, 1999). Or as Norcross (2002) puts it, "different folks do require different strokes" (p. 6).

As the alliance literature suggests, interventions such as disclosure and the alliance are intertwined and interact (Hill, 2005). In line with this, the studies in this review suggest that disclosure can strengthen the alliance, and yet the strength of the relationship at the time of a disclosure can influence its impact (Audet & Everall, 2003; Hanson, 2005; Wells, 1994).

Cultural considerations

Constantine and Kwan (2003) have noted that much of the existing literature only concerns the use of disclosure with White or European American individuals, and that there is a dearth of research on disclosure in cross-cultural settings. Certainly this is the case for the studies in this review; where details are provided, the ethnic homogeneity of the studies is apparent, although more often than not details on ethnicity are lacking. In the single study which involved cross-cultural therapy dyads, therapist observations suggest that disclosures which validate clients'

experience of the negative impact of racism may be helpful in building an effective cross-cultural alliance (Burkard et al., 2006). It is also possible that individual client differences in disclosure preferences could be related to cultural values (Fitzpatrick et al., 2006). For example, an analogue study found that Mexican participants were more trusting of a non-disclosing therapist, which could reflect the Hispanic cultural value placed on formalism (Cherbosque, 1987).

Clinical Implications

Whilst these findings do not provide an exact framework, it is hoped that they provide an understanding of how disclosure may impact on the therapeutic alliance. Given the key role of the alliance in treatment success, a deeper understanding of disclosure's potential impact may enable therapists (especially those in training) to better attend to the individual needs of clients (Knox & Hill, 2003).

Disclosure clearly has the potential to be helpful in developing and maintaining the therapeutic alliance (Barrett & Berman, 2001; Bedi et al., 2005; Curtis et al., 2004; Czogalik & Russell, 1995; Elliott et al., 1985; Fitzpatrick et al., 2006; Hill, 1989; Hill et al., 1988; Hill et al., 1989; Luborsky et al., 1983; Ramsdell & Ramsdell, 1993; Safran et al., 1994). However, client studies suggest that disclosure is a double edged sword whose effects can be both subtle and mixed (Audet & Everall, 2003; Hanson, 2005; Knox et al., 1997; Wells, 1994). Clinicians need to be aware that clients will differ in their expectations of, and preferences for, the use of disclosure. It would also be helpful for therapists to be aware of their own and their clients' cultural values, as well as the interaction of these in the therapy relationship (Constantine & Kwan, 2003). Therapists can ameliorate the negative

impact of disclosures by being responsive to client feedback and providing a space for clients to discuss freely the implications for them (Wells, 1994).

Conclusions and future directions for research

In summary, these findings reflect the inherently complex effects of disclosure and the interactional nature of the alliance. Disclosure certainly has an impact on the alliance; studies of therapeutic interaction in general suggest potentially positive effects on the alliance although some studies suggest a negative impact. Simply conceptualising disclosure as present or absent rather than considering the content, context, delivery or intention embedded in the event could explain some of the variation in findings. Qualitative studies of clients' perceptions, although few in number, paint a surprisingly consistent picture; they emphasise the subtle and often mixed impacts of disclosure, highlighting the importance of therapist skill in delivery. The studies also suggest that the effect of disclosure is influenced by the context in which it is delivered: namely client expectations, client preferences and the quality of the existing alliance.

As this review demonstrates, a range of different methodologies have been used to investigate the effects of disclosure on the alliance; however no single method is likely to capture the full complexity of this phenomenon and several areas remain insufficiently explored. For example, it has been suggested that certain groups of clients such as adolescents and people with a diagnosis of psychosis might require higher levels of therapist disclosure (Farber, 2006); however no research has looked specifically at these groups. A clear omission from the existing research is the personal experience of the therapist. Although the therapist's purpose and intent is the promotion of client growth, self-disclosure inevitably impacts on the therapist

as well. Much as clients' expectations and personal preferences shape the meaning that they make from a disclosure incident (Audet & Everall, 2003; Knox et al., 1997), so one might expect therapists' professional and personal preferences to shape their experience of disclosing with clients. Further qualitative research could provide a valuable insight into how therapists make a decision to disclose which would help to inform the novice therapist grappling with this contentious and complex issue.

Table 1. ***Studies of Therapeutic Interaction***

Study	Clients	Therapy	Study design	Disclosure (type and measurement)	Alliance measurement	Findings relevant to this review
Barrett & Berman (2001)	36 outpatient clients (15 male, 21 female)	Approximately 6 sessions of mainly CBT or supportive therapy 18 trainee clinical psychologists	Experimental manipulation: therapists increased disclosure with one client and decreased with another client	Self-involving and self-revealing reciprocal disclosures Observer rated	Client indicated how much they liked their therapists on a 9-point Likert scale at the end of every session Rated over first 4 sessions of therapy	Clients in high disclosure condition reported liking their therapist more
Coady & Marziali (1994)	5 good-outcome clients and 4 poor-outcome clients selected from original sample of 42 outpatient clients (2 male, 7 female)	20 sessions of time-limited psychodynamic psychotherapy Therapists had a minimum of 4 years post-graduate experience	Correlational	Therapist disclosing and expressing behaviours Externally rated using Structural Analysis of Social Behaviours model (SASB; Benjamin, 1974)	Therapeutic Alliance Rating System (TARS; Marmar et al., 1986) Observer rated	Negative correlation between therapist use of disclosing and expressing behaviours and alliance ratings
Czogalik & Russell (1995)	6 clients (3 male, 3 female)	11 – 89 sessions 4 therapists (2 senior analysts, 1 beginner behavioural therapist, 1 experienced eclectic clinician)	Transcripts from 3 randomly selected sessions from each third of therapy analysed using a P technique	Self-involving disclosures Observer rated using Stuttgart Interactional Category System for therapist-client interaction	Observer rated using SICS therapist evaluations of the therapy relationship	Self-involving disclosures identified as playing an important interactional role in maintaining a viable alliance and in working through alliance ruptures

Elliott, James, Reimschuessel, Cislo, & Sack (1985)	18 clients	16 sessions of ongoing psychotherapy (16 different clients and therapists) Plus 2 case studies (10 sessions of psychodynamic therapy, and 12 sessions of CBT)	Correlational therapeutic impacts studied using Interpersonal Process Recall	Definition unclear but presumed to be broad definition incorporating both self-involving and factual disclosure	Therapist response modes rated by client on a 7-point helpfulness rating scale	Disclosures positively correlated with 'personal contact' impacts, suggesting the utility of appropriate disclosure in building client trust
Hill (1989)	8 anxious or depressed clients	Brief psychotherapy (12-20 sessions) 8 experienced therapists (rated themselves as more psychoanalytic than humanist/ behavioural)	Sessions videotaped. Client, therapist and observer watched videos post sessions.	Feelings or personal experiences Identified using the Manual for the Therapist Verbal Response Modes Category System (Hill, 1989)	Helpfulness of disclosure rated by both client and therapist at end of session (The Helpfullness Scale (Elliott, 1985, 1986)) The Client Experiencing Scale (Klein et al., 1986)	In-depth exploration of individual cases. Disclosures seemed to equalise relationship and enhance therapeutic relationship.
Hill, Helms, Tichenor, Spiegel & O'Grady (1988)	8 anxious or depressed clients	Brief psychotherapy (12-20 sessions) 8 experienced therapists (rated themselves as more psychoanalytic than humanist/ behavioural)	Sessions videotaped. Client, therapist and observer watched videos post sessions.	Feelings or personal experiences Identified using the Manual for the Therapist Verbal Response Modes Category System (Hill, 1989)	Helpfulness of disclosure rated by both client and therapist at end of session (The Helpfullness Scale (Elliott, 1985, 1986)) The Client Experiencing Scale (Klein et al., 1986)	Disclosures rated by clients as the most helpful therapist response mode and led to greatest client experiencing levels

Hill, Mahalik &Thompson (1989)	8 anxious or depressed clients	Brief psychotherapy (12-20 sessions) 8 experienced therapists (rated themselves as more psychoanalytic than humanist/ behavioural)	Sessions videotaped. Client, therapist and observer watched videos post sessions.	Feelings or personal experiences Identified using the Manual for the Therapist Verbal Response Modes Category System (Hill, 1989)	Helpfulness of disclosure rated by both client and therapist at end of session (The Helpfullness Scale (Elliott, 1985, 1986)) The Client Experiencing Scale (Klein et al., 1986)	Reassuring disclosures rated as more helpful and led to greater client 'experiencing' levels. No differences between factual and self-involving disclosures
Kelly & Rodriguez (2007)	83 outpatient clients (17 male, 66 female) (92% White, 6% Black, 1% Latino, 1% other)	22 therapists (theoretical orientations mainly CBT or eclectic)	Correlational	Adapted version of the Self Disclosure Index (Miller et al., 1983) administered to therapists Clients rated extent of therapist disclosing behaviour	Client form of Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) Short form of WAI (Tracey & Kokotovic, 1989)	No correlation found between factual disclosures and measures of alliance
Luborsky, Crits-Christoph, Alexander, Margolis & Cohen (1983)	20 outpatient clients (10 most improved, 10 least improved)	18 experienced psychiatrists SE psychoanalytic psychotherapy	Correlational	Therapist reference to common therapy experience with their clients Observer rated on Therapist Facilitating behaviours by the Rating Method	Helping Alliance Rating Method (HARM) Therapist Facilitating behaviours (TFB) Both observer rated	Self-involving disclosures amongst the therapist facilitating "we" behaviours that were positively correlated with alliance measures

Price & Jones (1998)	30 patients (10 male, 20 female)	brief psychodynamic psychotherapy (11-20 sessions) 15 therapists (clinical experience: average = 6 years; range 1-19 years)	Analysed transcripts of sessions 1, 5 and 14	therapists' disclosure of their own emotional conflicts Disclosures identified using Process Q-Set (observer rated)	CALPAS used as alliance measure (California Psychotherapy Alliance Scales) Observer rated	Therapists' disclosure of their own emotional conflicts was negatively correlated with alliance ratings
Safran, Muran & Wallner Samstag, (1994)	29 clients	20 sessions of time-limited integrated cognitive-interpersonal therapy 8 therapists	Task analytic study. Analysed incidents of withdrawal ruptures.	Self-involving disclosures identified using SASB	Six WAI items rated for each third of the therapeutic hour by client and therapists after each session Patient and Therapist Experiencing Scales (observer rated)	Self-involving disclosures useful for the resolution of alliance ruptures

Table 2. ***Studies of Therapists' or Clients' Perceptions***

Study	Participants	Disclosure type	Study design	Findings Relevant to this Review
Audet & Everall (2003)	4 previous clients (2 male, 2 female; all Caucasian)	Disclosures about the therapist's personal life outside therapy	Qualitative interviews Phenomenological analysis	Both positive and negative impacts identified Low intimacy disclosures are a useful tool for building alliance, but more intimate disclosures actually require a solid relationship Impact found to depend on the context (client expectations) and way delivered (frequency, intimacy, similarity and timing)
Bedi, Davis & Williams (2005)	40 clients (9 male, 31 female; 70% White)	Therapists shared general factual information, similar experiences, or non-verbally disclosed information	Clients interviewed using Critical Incident Technique to identify incidents which had strengthened the alliance	32% of participants identified an incident of disclosure as a critical incident positively impacting the alliance.
Burkard, Knox, Groen, Perez & Hess (2006)	11 European American therapists (5 male, 6 female)	Disclosures of reassurance and support (Knox & Hill, 2003)	Qualitative interviews	Results indicated that therapists typically shared their reactions to clients' experiences of racism or oppression and that these self-disclosures typically had positive effects in therapy, often improving the counselling relationship by helping clients feel understood and enabling clients to advance to other important issues
Curtis, Field, Knaan-Kostman & Mannix (2004)	75 psychoanalysts in personal analysis (55% male, 45% female)	Disclosures of feeling / disclosures of aspects of the therapists personal life	Postal Survey Factor analysis	Both types of disclosure perceived as helpful to therapy by client

Fitzpatrick, Janzen, Chamodraka & Park (2006)	20 clients (4 male, 16 female; mainly Canadian)	The therapists' positive view of the client or of personal information	Qualitative interviews Consensual Qualitative Research method	Participants typically noted positive effects of the incidents on the alliance with the most frequently endorsed effect being on trust or confidence in the therapist, or increased comfort in the therapy relationship
Hanson (2005)	18 current clients (16 female, 2 male; mainly Caucasian Canadians)	Therapist reveals personal information and/or reactions to client Non-disclosures also included	Qualitative Interviews Constant Comparison method	Disclosures 2 ½ times more likely to be found helpful. Non-disclosures twice as likely to be found unhelpful. No differences found between factual and self-involving disclosures. Main effect of disclosure and non-disclosure (both good and bad) were on the alliance. Skill in delivery of disclosure important in determining effect.
Knox, Hess, Peterson & Hill (1997)	13 clients in long term therapy (9 female, 4 male European Americans)	Helpful, self-revealing disclosures	Qualitative interviews Consensual qualitative research	Disclosures resulted in an improved or more equalized therapeutic relationship
Ramsdell & Ramsdell (1993)	67 former clients 91% Caucasian, 9 % Black/Hispanic/ Asian	Sharing personal information	Postal survey	Therapist sharing of personal information seen by clients as beneficial to therapy
Wells (1994)	8 former adult clients (1 male and 7 female)	Self-involving and self-revealing	Qualitative interviews	Half of sample described overall experience of disclosure as having positive impact on the alliance, whilst also describing some negative impacts. Half of sample reported overwhelmingly negative effects on the alliance. Highlighted importance of prior alliance and skill in delivery.

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PART TWO: EMPIRICAL PAPER

Experiences of clinical psychology trainees in the use of therapist self-disclosure

Abstract

The present study examined clinical psychology trainees' experience of using self-disclosure with their clients. Fourteen clinical psychology trainees were interviewed, using a semi-structured interview protocol, about their experience of using, or not using, self-disclosure and their experiences of training and supervision around this issue. Interpretative Phenomenological analysis yielded nine themes which were organised into two domains: the first ('the decision in the moment') concerns participants' in-the-moment struggle with decision making; the second ('the developing therapist') reflects the development of participants' ideas across training and the wider philosophical issues of therapy. Results are discussed in terms of previous research and implications for training, and suggestions for further research are explored. The results imply that trainees would both value and benefit from open and reflective conversations, facilitated by training courses, across their training experience.

Introduction

The empirical literature suggests that therapist self-disclosure is a widely, if sparingly, used intervention, which has the potential to be beneficial if used judiciously (Farber, 2006; Hill & Knox, 2002). However, it has been said that "more than any other single characteristic, the nature and degree of therapist self-disclosure differentiates the various schools of ... therapy" (Yalom, 1985, p.212). Self-disclosure is generally defined as verbal statements through which therapists communicate information about themselves (Hill & Knox, 2002). However, this clearly covers a broad range of statements, from declarations of one's professional credentials to deeply personal aspects of one's life or experience. The *what*, *when* and *how* of disclosure is the subject of great theoretical, ethical and clinical debate.

The traditional position towards therapist self-disclosure is encapsulated in Freud's statement regarding the ideal "blank screen" therapist posture: "the analyst should remain opaque to his patients, like a mirror and show them nothing but what is shown to him" (1912/1958, p.118). Self-disclosure was considered to be a violation of therapist neutrality and anonymity, thereby contaminating the transference. Strict adherence to this ideal prevailed amongst his followers despite Freud himself revealing many aspects of his personal life to clients (Simon, 1988). In more recent years the predominance of the intersubjective-relational perspective has led to a general shift away from this strict position. Theorists such as Renik (1995, 1999) and Greenberg (1995) have argued convincingly against the "pretense of anonymity" (Renik, 1995, p.476), viewing disclosure of the 'self' as an inevitable part of a two-person enterprise. Whilst remaining cautious, this approach argues for the therapist making his or her thinking available to the client in order to facilitate the

latter's self-exploration and proposes a judicious balance between mutuality and asymmetry.

Other theoretical schools have more consistently and actively endorsed disclosure. For example, theorists from humanist and existential traditions have long extolled the necessity of disclosure in the development of an authentic, transparent, and equalized relationship (e.g. Jourard, 1971; Rogers, 1957; Spinelli, 1994; Yalom, 2002). Similarly, feminist theorists stress the role of disclosure in reducing power imbalances in the therapeutic relationship, as well as presenting an ethical case for therapists disclosing their political and social views to enable clients to make informed choices when selecting a therapist (e.g. Mahalik, VanOrmer & Simi, 2000). Theorists from cognitive schools of therapy have advocated disclosure of concrete examples of personal coping (e.g. Beck, Freeman & Associates, 1990; Dryden, 1990; Goldfried, Burckell & Eubanks-Carter, 2003).

However, despite what Knox and Hill (2003) refer to as an emerging consensus of "marked respect for the intervention's potential impact" (p. 532), authors have commented on the taboo surrounding the use of disclosure and the culture of silence around therapists discussing their usage of it (e.g. Audet & Everall, 2003; Dixon, Adler, Braun, Dulit, Goldman, Siris, et al., 2001; Goldstein, 1994). Dixon et al. (2001) contend that disclosure has become a "don't ask, don't tell" therapeutic practice as a legacy of its historical prohibition.

Relatively little empirical attention has been paid to therapists' experience of using disclosure beyond those studies which elicit the reasons therapists give for disclosing. These motivations vary from a desire to strengthen the therapeutic alliance, introduce alternative ways of thinking, and normalise the client experience (e.g. Mathews 1988; Simon, 1988). The extant empirical literature suggests that this

can indeed be the case. Reviews of analogue studies (therapy simulations with non-clinical populations) suggest that moderate disclosures by therapists (both in terms of frequency and intimacy) lead to their being viewed more favourably by participants (Hill & Knox, 2002; Watkins, 1990). Reviews of research involving actual therapy situations or actual therapy participants suggest that disclosure can have a positive impact on immediate therapy process, with disclosures being viewed as helpful by clients (Farber, 2006; Hill, 1992) and playing an important role in the maintenance and repair of the alliance (Ackerman & Hilsenroth, 2003; Hill & Knox 2002). However, qualitative studies of client experience suggest a more complex picture, highlighting that the impact of disclosure is rarely wholly negative or positive, with clients reporting an array of negative impacts even from those disclosures that they identify as helpful overall (Wells, 1994).

Given the lack of consensus from either theoretical or empirical writings, how can a clinician decide what is and what is not appropriate to disclose in a specific therapeutic encounter? Emerging clinical guidelines on the use of self-disclosure highlight the complex nature of a decision to self-disclose and emphasise the need for therapist reflection on this issue (e.g. Farber, 2006; Goldstein, 1997; Knox & Hill, 2003; Peterson, 2002). Numerous aspects require consideration: Will the disclosure be burdensome for the client? Does this disclosure benefit my client or me? How could this be perceived by my client? Is this relevant to the therapeutic issue? However, not only is it virtually impossible to develop rules which could guide therapists in every situation, but generalized guidance is considered inadvisable if it is privileged over case-specific factors and clinical judgments (Farber, 2006; Renik, 1999). The reality of therapeutic work is that opportunities for disclosure often present themselves spontaneously within sessions, and protracted

contemplation is not always possible. Goldstein (1997) is one of a number of authors who suggest that it is useful for the therapist to consider a general way of handling requests or opportunities for disclosure. Therapists are encouraged to think in advance about the potential consequences of self-disclosures, both in terms of their general views on disclosing personal information about themselves, as well as at the level of each individual client. Ultimately, however, even a well intentioned, carefully considered disclosure can be interpreted by a client as critical or negative, either immediately, or at some time in the future through the lens of a different affective state or altered context (Goldstein, 1994).

The theoretical debate and the lack of clear rules on self-disclosure, combined with a culture of silence, pose a particular problem to the developing therapist. The training period is an important time of growth and experimentation in different techniques and theory. Trainees are in the unique position of absorbing and assimilating many different (often conflicting) voices on the 'right' way to do therapy, within the context of their existing interpersonal style, developing professional identity and the ongoing assessment process. Farber (2006) suggests that a relatively inexperienced therapist may attempt to control their anxieties about the appropriateness of using disclosure by adhering to perceived "rules" and adopting a rigid non-disclosing position. Alternatively, he suggests that some may feel comfortable with "revealing personal aspects of themselves out of a need to establish a non-hierarchical, informal therapeutic relationship while experiencing great difficulty in offering self-involving process orientated disclosures" (Farber, 2006, p.161).

The experience of the trainee and how they grapple with this issue is not a topic that has attracted much research. Yet an understanding of this has the potential

to inform clinical training by identifying existing and potential supportive educational and supervision strategies. The current study therefore set out to explore trainees' experiences of using, or not using, self-disclosure in their therapeutic work, and their experience of training and supervision around this issue, with the aim of identifying aspects of the phenomenon that could inform training courses. An exploratory, qualitative approach was chosen as this type of approach is well suited to areas where there has been little previous research. In particular Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003) was selected because it is a psychologically orientated approach which provides an in-depth exploration of how individuals make sense of their experiences, focussing on cognitions and emotions.

Method

Ethical approval

This study was approved by the University College London research ethics committee (see Appendix 1).

Participants

Recruitment

Participants were recruited from four London training courses. Course directors were approached for permission to contact their students; all granted permission. To ensure that participants had a minimum of one year clinical experience, only second and third year trainees were contacted. Trainees were emailed a request for participation with the information sheet (Appendix 2) and invited to contact the researcher to discuss the study further or to arrange an

interview date. Nineteen expressed an interest in participating; however only the first 14 were interviewed as data saturation was considered to have been reached.

Description of sample

Participants were 14 clinical psychology trainees from four training courses in the London region (see Table 1 for a summary of basic demographic information). The sample was composed of four male and ten female trainees, eight of whom were in their third year of training and six of whom in their second. Participants ranged in age from 26 years to 32 years with the mean being 28. Twelve described their ethnicity as white, one participant identified as mixed race and another as Asian British. The participants had had teaching and placement experience in a range of theoretical orientations (primarily cognitive, systemic and psychodynamic); they did not indicate any strong preferences for a particular orientation.

Semi-structured interview

Interviews were designed and conducted according to IPA (Smith & Osborn, 2003) guidelines. The semi-structured interview schedule was constructed to examine trainees' experience of using self-disclosure with their clients within the context of their training experience (see Appendix 3). Given the somewhat controversial nature of the research topic, interviews were introduced by a declaration of researcher interest (as a 3rd year trainee who had been grappling with this issue during training and who was interested in the experience of other trainees). It was felt that highlighting the researcher's own struggle could make it easier for participants to speak freely. However, this declaration was kept sufficiently vague so as not to unduly influence participant responses.

Table 1. *Participant information*

Participant	Gender	Year of training	College
P1	Male	3rd	1
P2	Female	3rd	2
P3	Female	3rd	2
P4	Female	2nd	2
P5	Female	2nd	1
P6	Female	3rd	3
P7	Male	3rd	1
P8	Female	2nd	4
P9	Female	2nd	1
P10	Female	3rd	4
P11	Female	3rd	3
P12	Female	3rd	3
P13	Male	2nd	3
P14	Male	2nd	1

Note: identifying details have been kept to a minimum (e.g. age and ethnicity are not shown here, and colleges are denoted by a number) in order to protect anonymity.

At the start of the interview, participants were provided with the following definition of disclosure: statements through which a therapist consciously and purposefully communicates information about themselves and/or reveals reactions/responses to client as they arise in session. The interview focused on specific examples where the participant had used such disclosure or non-disclosure

with clients. Participants were asked to consider both instances that they perceived as helpful and those that they felt were unhelpful or had uncertain effects. Participants were then asked to describe their felt experience, observations, decision making process, and post-hoc reflections. Their experience of course teaching and clinical supervision around disclosure was also discussed, as were their general attitudes towards the use of disclosure and how these had been influenced.

The style of the interview was conversational and relaxed to encourage participants' to feel comfortable with discussing their full range of experiences, including possible clinical errors. The interview schedule comprised a standard set of questions and used additional probes to clarify or to encourage expansion; however, these were worded in an informal style and used flexibly to fit the flow of conversation.

All interviews were conducted by the author and lasted 60-100 minutes. They took place either in the Sub-Department of Clinical Psychology at UCL, the participant's educational institution, or the participant's home. At the beginning of the interview the information sheet and consent form (Appendix 3) were reviewed, and procedures for ensuring anonymity discussed. Informed written consent was gained from each participant before the interview began.

Qualitative data analysis

The interviews were transcribed verbatim (except for silences, minimal encouragers and other non-language utterances). To protect confidentiality, identifying information was removed and each participant ascribed a code. Given the relatively small population from which this sample was taken and the context of assessment in which trainees are operating, interviewees were given the option of

reviewing their transcript to remove any further information that they felt could identify them from their peers, before analysis. One participant accepted this offer and removed a number of sections.

IPA (Smith & Osborn, 2003) was chosen as the method of analysis because it is consonant with the aims of this study. This approach also has the advantage of a clearly defined set of procedures for systematically analysing data. Interview transcripts were analysed following the stages outlined by Smith and Osborn (2003). The first stage involved within-case analyses (see worked example in Appendix 5). Initially a transcript was read and re-read and overall impressions recorded. Notes were made in the left hand margin concerning processes and issues communicated by the participant). From these notes tentative themes were identified and recorded in the right hand margin. These themes were then listed in an individual summary and tentatively arranged into clusters to reflect any shared meaning or references. In order not to lose the connection with the meaning of the primary source material, themes were illustrated by participant quotations from which themes were derived. This documentation also facilitated credibility checks (see below). In keeping with the iterative nature of IPA, once all the transcripts had undergone this process they were then reviewed in the light of any new themes which had emerged from the analysis of later transcripts.

The second stage of analysis involved an integration of the themes across the transcripts. The clusters of ideas identified in stage one were examined across participants and similar ideas grouped together in order to form higher level themes. The evidence for each of these themes was gathered to provide systematic verification of the analysis process (see Appendix 6 for an example theme). A final set of consolidated themes were arrived at, which aimed to capture the essence of the

participants' experience of self-disclosure. Themes that were mentioned by a minority were not included unless particularly salient to that person's account or particularly instructive at shedding light on the phenomenology of trainee's experience. Particular emphasis was given in the analysis to those aspects of the participants' accounts which were felt to be particular to their position as trainees. These themes were then organised into two domains. Again, this process was an iterative one, involving constant checking against the original transcripts to ensure that they accurately reflected the accounts.

Credibility checks

In line with guidelines for good practice within qualitative research (Elliott, Fischer & Rennie, 1999; Smith, 2003; Willig, 2001), credibility checks were utilised at various points in the analysis process. Two supervisors were involved in a verification check of the data analysis. In the early stages of analysis, supervisors independently analyzed sections of the data and reviewed worked examples at each level of abstraction from the data from transcript notations through to clustered themes. In later stages of the analysis, detailed discussions were held in order to reach a consensus on the accuracy of the emergent final set of themes, and the appropriateness of the organising domains.

Researcher's perspective

My interest in this study stemmed from my own experience as a clinical psychology trainee. I had experimented with using disclosure in my clinical work; sometimes I had perceived the impact of this to be positive but other times I was left feeling uncertain about its utility and the competing rationales behind the use of

disclosure. My experience of supervision was that there was not always the space for reflection on such issues. I also felt there to be a taboo around the topic and felt hindered in opening up discussion either in supervision or at college. I therefore began the research with some preconceived ideas based on my own experience, but also a genuine curiosity to find out how others had managed this issue, if indeed they even saw it as an issue. I attempted to 'bracket' my personal perspective (Giorgi & Giorgi, 2003) as far as possible throughout the research and focus on my genuine curiosity to hear the experience of other trainees.

Results

The participants identified a range of experiences with respect to their use of disclosure and their experience of training in relation to this. Most participants easily recalled incidents where they had used, or contemplated using, disclosure in their therapeutic work. Examples varied widely; factual information ranged from more mundane demographic details (e.g. their age or their marital status) or future plans (e.g. where they were going on holiday), to highly personal disclosures of past experiences (e.g. relationship difficulties, experience of mental health difficulties) or current life style (e.g. interpretations of faith). Disclosures of participants' in-session thoughts or feelings in reaction to the client were less frequent and tended to be more challenging in nature (e.g. disclosing frustration at lack of progress). Initially, some participants tended to focus on just one type of disclosure that was most salient for them (for example, only recalling incidents of factual disclosures); however, they were able to come up with alternative examples when prompted.

The analysis generated nine key themes reflecting common anxieties, conflicts and developmental processes which appeared across individuals. These were grouped into two broad domains (see Table 2) informed by both the research questions and the participants' responses. The first (The decision in the moment) pertains to themes concerning the in-the-moment struggle with decision making, whereas the second (The developing therapist) reflects the development of ideas across training and the wider philosophical issues of therapy. These domains are organising categories and do not represent discrete entities; the struggle to decide is embedded within professional development issues and therefore there are inevitably some shared features between themes. The themes are described in detail below, illustrated by quotations from participants (indicated by their identifying number). Ellipses (...) indicate sections which have been edited for the benefit of clarity and brevity.

Table 2. *Summary of themes*

Domain	**Theme**
1. The decision in the moment	1.1 Caught off guard
	1.2 Is this against the rules?
	1.3 Entering an unknown zone
	1.4 Protecting oneself
2. The developing therapist	2.1 Learning by doing
	2.2 Learning through supervision
	2.3 No space for reflection
	2.4 Finding a balance
	2.5 Finding my own path

Domain 1: The decision in the moment

The themes in this domain reflect the participants' struggle to decide in the immediate moment whether or not to use disclosure. All of the participants experienced some feelings of anxiety, discomfort, conflict or tension around the decision "should I, shouldn't I?"

1.1 Caught off guard

Almost all participants described feeling some degree of discomfort or anxiety when faced with a direct personal question from their client. This was especially daunting early in training or a particular placement. Participants had been asked for personal details (such as their age, marital status, whether they had children and their sexual preferences), questions about their lifestyle (whether they attended a gym or how they were spending annual leave or a national holiday period such as Christmas) or asked to give their opinion on a client issue (such as whether or not they should have plastic surgery).

> *I was feeling a bit sort of oh what do I do now? A bit what's the word, a feeling word? Uncomfortable would be a very good word and I was thinking what do I say now? [P3]*

> *I remember like a surge of adrenalin when she asked me and I think I remember it because it was the first time I'd been asked a ... personal question within that placement. [P11]*

Several participants described feeling caught "off guard", "flustered", "taken aback" or "put on the spot" by a question that was unexpected or which felt out of context. For one participant the fact that the topic asked about was particularly current in his personal life added to this.

> *It was right at the end of the session and it was a bit removed from what we had been talking about before ... and what with it being very current for me at the time it felt like I wasn't expecting it and hadn't quite thought it through as much as I would. [P13]*

A common feeling was that of discomfort with not answering a direct question. A refusal to answer tended to be viewed as a "rude" or "unacceptable" response. This was especially the case when the question was judged to be "normal", appropriate or understandable in some way, or when it was felt that the answering the question would be unlikely to have any adverse consequence.

> *Their [college's] main answer to that is to throw it back to the client and say "why is this important to you?"... I don't think that is an acceptable response to somebody asking you a perfectly normal question. [P8]*

A common concern was that by not answering the question the therapeutic relationship might be in some way "jeopardised" or "damaged": the client might be offended and feel negatively towards the therapist.

> *I suppose that is just my worry that somebody might feel rejected or that they had behaved inappropriately or whatever. [P6]*

> *If it was me in her shoes, I would probably feel snubbed and I'd probably feel a bit patronised actually. [P11]*

Most participants struggled with finding a comfortable way of not answering questions and did not always feel that the suggestions provided by supervisors or lecturers fitted for them.

> *...[A lecturer] said if a client asks me anything personal I just say "why is it important for you to know that?" Obviously that works for her, but for me I always felt I wouldn't be able to say that without sounding confrontational. [P10]*

Participants described a range of different responses to direct questions, but all conveyed a pressure to respond quickly. Some answered "automatically" or "accidentally" in these situations, being driven by the client's request for information. Others talked about answering questions very briefly and then moving on quickly to give the implicit message that further questions weren't welcome.

> *I just answered it really automatically and then thought, oh god what did I just do? [P5]*

I think I did just say things like yes I do have a boyfriend and change the subject and I think she got the message enough. She kind of took it as a kind of that's nice and realised that I wasn't there to talk about me I was there to talk about her. [P6]

Two participants talked about using a standard reply to client questions, suggested to them by supervisors or lecturers, as an emergency response in a way that jarred with the client or felt unhelpful to the participant.

I said to him "why would that be important for you to know?" which really didn't fit at all ... it was ridiculous. It was an emergency thing to say. [P1]

I think once I said to him "I don't mind answering the question but I would be really interested to know why you asked me." [I] said it without really thinking, it was like a reflex and then while he was explaining why I was then thinking to myself is there any way I can get out of this and not actually tell him because I am not quite sure whether I should do or not. [P13]

One participant who was very keen not to disclose talked about how she might go about avoiding disclosing information either by framing her responses in an impersonal way or avoiding answering at all.

I think that my general tendency would be "that's a kind thing to do" rather than use that personal 'I'. I'm not sure if I did use the 'I' or not but definitely my tendency would be to say "that's kind." [P2]

1.2 Is this against the rules?

A feeling that disclosure was "taboo" or frowned upon permeated many of the participants' accounts. Some participants commented directly on implicit negative messages that they felt that they had been given.

I think the messages that I've really have picked up from everywhere is that disclosure is a bad thing in therapy. [P1]

When I had a psychoanalytic supervisor, I really got the undercurrent that perhaps it wasn't that professional to say to clients how they were making you feel in the room. And I guess my feeling is that it isn't really part of that model and it would be probably heavily criticised. [P12]

Participants experienced anxiety or discomfort arising from a concern that they could break "the rules" or be doing something wrong by disclosing.

I don't think it [discomfort] came from concerns about the relationship or concerns about me or concerns about her or effects on the therapeutic relationship or effects on the therapy. I think it did come from concerns about me, screwing up, breaking the rules, which is a bit silly. [P11]

Several participants specifically referred to being concerned as to whether they had behaved unprofessionally, "violated" codes of conduct, or not made a "therapeutically sound" decision.

Because ... of the beliefs that I had at that point about being a clinical psychologist and what that meant and about neutrality, I think I found myself blushing a bit and feeling a bit like it was taking a bit of a risk to do that because it felt a bit against the rules, even though I made a clinical judgment to say it. So I suppose it felt slightly uncomfortable for me. [P4]

I had some anxiety about whether what I was doing was professional. Should I be talking about myself? Should I be bringing myself into therapy? Am I a facilitator for her thoughts and experiences? ... What was the theory underpinning it? [P14]

Participants were keenly aware of the assessment context and anxious to do the "right thing" according to the particular supervisor or model with which they were working. This tension was heightened when their own instinct to disclose was perceived to be in conflict with the opinions of supervisors or training courses.

I think I probably felt anxious because it was quite near the beginning of the new placement, a new model, as a trainee you're being assessed, and because I think I had this idea that self-disclosure was a real 'no no' within that placement, or within that model maybe. [the participant continued later in the interview] I think self-disclosure can be used in a way which is really, really helpful, so ... the discomfort came from ... feeling dictated to by a view towards self-disclosure that wasn't perhaps my own. [P11]

One participant specifically referred to feeling "the guilt of the course": a feeling that she was going against what the lecturers would think that she "should" or "shouldn't" be doing. Although her response was often to disclose where she personally felt appropriate, this conflict caused tension for her in the moment and left her with a lingering sense that she might be reprimanded.

The guilt of the course sits on you, weighs on you. For the rest of my life there will be all these lecturers going "you should do that" and "you shouldn't do

that" and "make sure that that's evidence based". It's training but also I do feel there's some sort of brainwashing because you are being trained to think in a certain way and not think in other ways. [P3]

1.3 Entering an unknown zone

Disclosure was perceived as stepping into an "unknown zone" with uncertain implications for the client or the therapeutic relationship. Several participants commented on the use of disclosure feeling like venturing out of the relatively safe confines of a clear, neutral, professional role (with the implicit assumption that this is how a therapist "should" be) and into "murky waters". The concern was that disclosing might "blur" the boundaries or alter the client's expectations of the relationship. This was often perceived as an uncomfortable, "messy" or potentially damaging thing to do.

Well I felt like the boundary might be becoming a little bit blurred in terms of how matey we might have been being and I was particularly aware about how much I should be trying to relate to her. [P14]

One participant described being wary of answering personal questions when working with a client with learning disabilities.

I always wondered does he see this as a social relationship or a therapeutic relationship and that's why it was very important in my mind not to disclose very much because I didn't want him to think that I was coming round for a chat. [P2]

Although expressing concern about "stepping outside the role of psychologist", some participants perceived potential benefits for the therapeutic alliance. One participant gave the example of disclosing a liking of chocolate and football to a young girl who had presented to a Child and Adolescent Mental Health Service following the death of her older brother.

I was a bit concerned in our sessions whether I was crossing over a bit too much into being a friend, maybe a substitute brother rather than being a psychologist, but then I guess I felt that kind of crossing over slightly more

towards a friend kind of area was then helping some of the work I was doing as a psychologist. I think it is a bit difficult to separate the two sometimes. [P13]

Most participants voiced a concern that disclosure could open the "floodgates" to further disclosures, and were conscious of maintaining the focus of the session on the client. Some voiced a concern that by answering a question they might encourage the client to ask more questions, which they would then find difficult not to answer.

It felt quite awkward because ... once you have disclosed one piece of information in that kind of area for me personally it feels a bit difficult then to say "oh no I am not going to say anymore." I don't know whether in some ways that then makes it more difficult for the client or not because you kind of give them a bit of information but you are not giving them the full story. [P13]

The use of challenging, self-involving disclosures (e.g. giving clients feedback on how they experienced them in a session, that might be perceived as critical) and highly personal factual disclosures were experienced as particularly risky and uncertain in their outcome, but also potentially powerful. For example, one participant gave a client the feedback that she felt pushed away and criticised by her client and wondered if this might be how others experienced her.

I was really anxious about, yeah, using myself more. It felt very powerful like I could damage her. [P9]

Additionally, some participants commented on their uncertainty and anxiety over how to manage a conversation around this sort of disclosure in order to make full use of the opportunities that it afforded.

It's like the elephant in the room thing. I was wondering then what I would do with it once it was out, and how would I be able to handle it for the best. And will she still like me as a therapist, will she start thinking he's you know, and the relationship will start breaking down. That is what I was worried about. [P7]

In one example of a highly personal factual disclosure, a participant talked about having shared his own previous experience of OCD with a client who was presenting with OCD and who was reluctant to embark on exposure therapy. He described the

moment after disclosure as a period of "limbo" where the therapeutic relationship was in "renegotiation." However in contrast with some other participants this change in the relationship was not experienced negatively; he described the greater sense of collaboration that resulted.

> *... the feeling that we are both in it together now, ok we are both on a journey now, it's not me telling you where to go, it's sort of both of us walking down a road and sort of finding our way. [P1]*

1.4 Protecting oneself

All the participants referred to a need to protect their own privacy in their use of disclosure.

> *I suppose I am pro self-disclosure but then I also do have an awareness that I want to protect my own privacy. [P8]*

For some this awareness concerned issues of risk and personal physical safety. This was guided by an awareness and assessment of the potential risk of allowing personal information such as their address to be known to clients. This meant an assessment concerning the motives behind the client's question, the severity of their presenting mental illness as well as the sensitivity of the information involved.

> *... if I was in more acute kind of placements I might be a bit more cautious of my personal information ... I was quite private when I was on inpatient units. [P8]*

In addition, some participants were aware of their personal boundaries in terms of how emotionally vulnerable they were willing to be and the consequences of intimacy with clients. Participants spoke about having the sense of a personal "line" – information beyond this line (such as sexual preferences or religious beliefs) were felt to be too intimate to share in a professional setting.

> *I think I was aware ... this is just too much to share with somebody who is a client and it felt like it was just a bit too intimate. The information was too much for me to discuss with someone that I had a professional relationship. [P13]*

Some participants talked about non-disclosure as "protective" and expressed a fear of being "exposed" and "known" to the client and therefore vulnerable to their judgment.

> *I would be exposed as someone with thoughts and feelings. [P9]*

> *A feeling of insecurity that someone out there knows something about me and I don't really know who they are and I don't really want them to be knowing anything about me. I come here as a psychologist, I don't come here as the individual that I am necessarily. [P14]*

Several participants talked about self-disclosure potentially leading to blurred boundaries and a closer, more personal relationship. They feared that this could result in their becoming less able to "leave work at work" and ultimately therefore more emotionally drained.

> *... [self-disclosure] potentially opening you up to becoming emotionally involved on different levels that might not be helpful, that might be draining or stressful and just can make things more murky and confusing maybe, and more difficult to sort out. [P10]*

> *Maybe it's also about protecting me, because I've thought about it so far with you in terms of protecting the client, closing them down in what they're thinking about, but actually when you put more of you in then someone steps closer don't they? [P9]*

In contrast two participants spoke about their relative comfort with being "known" by clients.

> *I think disclosure can be painful, especially when it's your own stuff. And I think that's normal, and I think that it's a shame if that's a reason for never using it. ... Personally I don't mind people knowing the ins and outs of my life as it is, as it was, as it's going to be ... I don't mind that, so it means that I can disclose. [P1]*

Domain 2: The developing therapist

All the accounts reflected a development in participants' thinking about disclosure over time. The themes in this domain relate to this development of ideas through clinical experience, reflection, supervision and training. Additionally, these

themes reflect how participants' thinking around disclosure relates to wider philosophical issues such as the role of the therapist, the essence of a therapeutic relationship, and the agent of change in therapy.

2.1 Learning by doing

All participants had experimented with using disclosure and had learned from these experiences. The majority of participants referred to experiences either before or during training where they felt that they had disclosed too much. Incidents such as these made them feel uncomfortable and become more "careful", "cautious" or "aware" of disclosing and the possible implications. One participant referred to an incident pre-training in which she had told a client at a residential home where she was going that evening and he followed her there.

> *Since that example that I told you about I thought "right ok boundaries here" and we talked about it in supervision and then since then I think I've been quite careful, I'm quite sure that what I disclose I can cope with any implications of it. So if I disclose something I feel I have thought about what the possible outcomes could be. [P3]*

Another participant commented on earlier disclosures "coming back" at her later on in the therapy by affecting the boundaries of the therapeutic relationship; clients then felt more able to ask her questions about herself, which she felt uncomfortable with.

> *It wasn't till later on in the first year that it would come back at me like the person giving me the French CD or somebody coming and saying "was your holiday nice, where did you go?" that I began to think oh maybe I shouldn't have said about going on holiday, maybe I shouldn't have said that I liked French, because now it is making it tricky for me to re-establish firm boundaries. [P6]*

The experience of discomfort that participants felt as a result of these disclosures informed their thinking that they had disclosed too much and influenced their future decision making.

I think it was edging on perhaps being too over friendly because I wasn't quite comfortable at times. ... it is nice to feel as a therapist that you are comfortable with the amount you are disclosing ... perhaps I did give it a tad too much but that is just something I have learnt and taken with me. [P6]

Participants' experience of using disclosure with positive effects also informed their thinking. Conversations involving minor disclosures (such as those concerning holidays) were often perceived as "natural" and "comfortable" and seen to help with the "flow" of therapy or the development of the therapeutic alliance. More significant disclosures of personal history or challenging self-involving disclosures were often identified (either by client or participant) as "pivotal" events in the success of the therapy.

It worked. By the end of that session we had agreed that in the next session we would come up with a hierarchy, that we'd pursue the exposure treatment. [P1]

It shifted our relationship in a positive way, it shifted her thinking about things outside that she never knew. [P9]

The transcripts highlighted the importance of post-session reflection in the development of participants' learning from their experiences. Reflection took many forms; it could involve privately mulling over the session, talking with peers, or discussing in supervision.

Actually where I got the most of my resolution from it I guess was private reflection that was informed by the good supervision that I had. [P1]

Reflection enabled participants to become more attuned to and aware of disclosure and its effects. Early in training some participants didn't register some of their disclosures as such, and it was only later that they conceptualised the intervention as a disclosure.

At the time I didn't really think anything of them. It's more been sort of thinking back that I've sort of thought, oh I might do that differently. [P10]

Post-session reflection also seemed to help participants to better understand their decision-making. One participant commented on becoming aware that he sometimes might use disclosure impulsively or without thinking in order to fill silences. Another became aware that she used disclosure when she was at a loss for where to go next in therapy.

> *I realised through my own process of reflection and supervision that sometimes I find silence is difficult and so I try and say something which maybe is an impulsive part of me which means I might sometimes say things without thinking them through as best as I could. [P14]*

> *So I think I am just more wary of it now that it can be a useful tool but that sometimes it is not a tool that I plan to use its more a tool which I end up using because I am like "sugar I need to use something here." [P6]*

One participant, who had disclosed having experienced OCD, felt that he had made a carefully considered decision to do so; however, through a lengthy period of reflection he became aware of other personal motivations for disclosing, namely to heal himself through helping his client.

> *I thought that I was completely aware of all of the reasons that I was disclosing, and I really wasn't. ... I don't feel like I could think quickly enough in the moment, to answer all these questions. It's impossible, it took me weeks, months, to get the answers for myself. [P1]*

Through experience, participants seemed to become more comfortable with handling client questions and more familiar with the process of making a decision regarding whether to disclose information.

> *I was thinking should I do this but I guess I wasn't experiencing as much anxiety about whether I was doing something wrong professionally because I think that I had been through that the time before and it worked out fine and maybe that influenced my view on whether it was acceptable professionally or not. [P14]*

2.2 Learning through Supervision

All participants commented on experiences of supervision that had facilitated their thinking about disclosure and/or developed their practical skills. Most

expressed some anxiety about raising the topic with their supervisors due to uncertainty about their views and fear of judgement; however, open discussions removed the uncertainty around supervisors' views, and made disclosure a legitimate topic for discussion. One participant described having been part of a reflecting team and post-session discussion where the lead clinician had used disclosure with a family.

> *So there was a big discussion about this and I was like "oh that is self-disclosure and that is appropriate" and that made it feel a bit better. It was probably the first time I'd had a discussion with a supervisor about it because like I said it is something that feels a bit tricky bringing to supervision because you don't want to show your supervisor you are getting stuff wrong or miss the point of therapy. [P6]*

Participants also found it useful when supervisors were explicit about their own practice on disclosure, thus providing a valuable model of what level of disclosure might be appropriate either generally or specifically within a certain theoretical approach or client group. One participant commented on the utility of a supervisor providing an alternative to her having disclosed going on holiday to a client.

> *I said I was going on holiday and he said all I need to say is my next available time will be this time and I was like I have never thought of saying it like that I just kind of thought be transparent with your client. [P6]*

Participants also valued supervisors who encouraged them to think about disclosure within the context of wider issues regarding the essential ingredients of therapy, the therapeutic relationship and the therapist role.

> *I had a psychodynamic supervisor in the first year and I think she probably encouraged that, to think about revealing or not revealing responses to the client in terms of whether that can be helpful or not, and whether it is ever possible to stay entirely neutral. [P4]*

> *He wasn't saying "you shouldn't have done this" that wouldn't have been helpful, what was helpful was that he was opening up the right areas for me to think about myself... It was quite conceptual, epistemological things; what do I think therapy is about, what do I think the client is there for, what do I think I am there for, what do I think the relationship actually is in its essence, what do*

I think is the helpful thing, the agent of change in therapy? You know, all of those big questions that scare the shit out of first years. [P1]

Observing supervisors in their interactions with clients played an important role in shaping participants' views. For some it was helpful to see how supervisors handled being asked questions by clients in a way that preserved the therapeutic relationship. Others were reassured by seeing their supervisors use disclosure as it made it less taboo.

I got to see really inappropriate questions and how to cope with them and I just thought [the supervisor] coped with them brilliantly. So that was a nice learning experience. [P3]

On the other hand participants also described "seeing other people doing it and not liking it." Watching a supervisor disclose and feeling uncomfortable with it informed participants about where their personal limits on disclosure were and how they would not like to use disclosure.

I hate the way in which she discloses stuff right left and centre so that pushes me away from disclosing. [P9]

In addition, participants often commented on their experience of their supervisor disclosing, or not disclosing, to them in supervision; this helped to inform their understanding of their clients' experience and shaped their own disclosure practice.

I definitely think that is actually interesting how the level of disclosure in supervision can affect how comfortable and what your views are about disclosure in therapy. [P14]

2.3 No space for reflection

Participants commented on experiences of not having sufficient space for reflection on disclosure either in supervision or on the clinical training course. For many this left them feeling that they had to figure things out for themselves without sufficient support.

All the participants described at least one supervision experience in which the opportunities to reflect on disclosure were limited. In some cases this arose from "time pressures" in supervision, which meant that the conversation was not as helpful as it could be, or that discussions of disclosure got "sidelined". Others had an expectation that a conversation with their supervisor would not be fruitful on the basis that they had not found their supervisor's style to have been very reflective.

> *Our supervisions are quite fraught with trying to fit all the information in at the time. There is not much room for reflection. [P8]*

> *She's not the kind of supervisor where I'd think that we could open up a really reflective conversation. [P9]*

There was also a reticence from participants to take the topic to supervision due to the context of evaluation. There was a sense from a number of the accounts that participants were uncertain about what a supervisor's attitudes to disclosure might be, but assumed they would disapprove. This fear of their supervisor's disapproval or negative evaluation stopped several participants from discussing either an incident in which they had disclosed or one in which they were contemplating disclosing.

> *It wasn't really something I had a huge amount of support around in supervision either. It was something more that I did off my own bat. I had a psychoanalytic supervisor but I was on a CBT placement. ... It felt difficult to talk about things that may be viewed as not okay in the psychoanalytic framework. [P12]*

> *I suppose my fear was that especially as being a new first year he would think it was a ridiculous idea and that you know what was I thinking. So that is what stopped me. [P6]*

For one participant contemplating disclosing a history of similar eating difficulties to a client, the discomfort was around both seeming foolish for contemplating disclosure and also the necessity of sharing personal information about herself with her supervisor.

> *It was tricky because at that time I had [a supervisor] who was a fifty year old man and it just didn't feel like I was able to bring it up in supervision. I think I*

just thought he would look at me and said what are you thinking, why would you want to disclose that kind of thing. [P6]

Others found that even when they did open up a discussion the conversation wasn't useful to them. In one example a participant disclosed feelings of frustration that their client wasn't completing agreed homework and the sense that a teacher-pupil dynamic had developed.

I think it was a good idea but my supervisor wasn't much able to support what I did in terms of what can you do now, because she was rubbish. So I think if I had had some better support or been more experienced myself I think I could have made more of it. I think in the end it [the relationship] changed and I didn't know really what to do with it then. [P7]

Most participants commented on a lack of discussion about disclosure on their training courses. Participants recalled some cursory teaching in the first few weeks of the training course; the message tended to be perceived as one of caution - if in any doubt don't disclose.

I think they [the course] jumped all the hoops in the sense of I'm sure we had some sort of an exercise where we talked about disclosure, but I got the message quite strongly that if you are not sure don't do it ... I felt that the message was err on the side of caution rather than let's really discuss it openly. [P3]

A number of participants questioned this strong stance and struggled with understanding why the course prescription was one of caution.

It was saying "while you can do what you want, you should really do what we want you to do which is to not disclose if at all unsure" ... I found that quite odd because I didn't really understand why. [P3]

The rule of thumb that we were given was just not to ... which is probably safer for a trainee but I don't know. [P8]

Most participants expressed a need for more open discussion and training on the issue.

There needs to be some type of really coherent process training in order to use disclosure and I don't think we've got that on the course. [P1]

2.4 Finding a balance

The accounts reflected participants' struggle with the broader issues of therapy and the essence of the therapeutic relationship: they grappled with the balance between a personal relationship and a professional one. There was recognition by many participants of the inherently "weird" or "odd" nature of the asymmetrical exchange that characterises the therapy dyad. Some participants referred to a desire to give enough of themselves (through disclosures) to reduce client discomfort, gain client trust and encourage client disclosure, but not so much as to set up an expectation of a two-way relationship and remove the focus from the client.

> *I think it is a really difficult balance that we try and tread ...you are trying to get people to feel comfortable enough with you to trust you with things and in normal life that would mean a kind of two way relationship you know a very secure foundation and I suppose mimicking that a little bit is important because you need to give them the message that they can trust you and self-disclosure may be quite helpful with that sort of thing. But then you do also have to be quite careful that its boundried, partly because it is not a normal relationship that you are establishing, it's not a two way relationship and it shouldn't be. [P8]*

> *You are expecting them to tell you everything about them and that in any kind of relationship there is a degree of exchange of information so to not give any information back ever would make for an odd relationship. [P13]*

Participants struggled with the balance between showing their "humanity" and experience to their clients in order to foster a sense of connection and commonality, whilst maintaining their professional therapist position.

> *I think some degree of disclosure is important just at a very not even a psychological more kind of human level. It is quite helpful in terms of I suppose it is to do with the relationship as well but I think sometimes people finding some similarities with you or things like that can be quite helpful as well just to think that they have got something in common with this person. [P13]*

> *I think it is harder when you have lots of similarities ... you have got to remember that it is a therapeutic relationship, that it is not somebody who you are having a nice chat with about your experiences. I suppose especially when*

you are a first year and you are kind of grappling with what am I doing and what is therapy and all of this. [P6]

A further issue was that of equality in the therapy relationship; the transcripts reflected a struggle with power dynamics in the therapeutic relationship. Many participants gave the impression of being uncomfortable with their relative position of power and were keen to use some disclosure to make the relationship more equal.

And it's something I guess I feel quite strongly about, ... really thinking about the impact of the power differential and my role as a therapist really and how actually I can help that person or work with that person to the best of my ability rather than feel like I'm doing things to someone. [P12]

I struggle with ... the power differential in the room and I think self-disclosure can be a way of kind of breaking down some of those barriers. [P11]

In contrast, one participant felt that his use of disclosure was a mark of the power imbalance in the relationship; as the professional in the room he was free from the stigma of a diagnosis, and hence able to disclose without risk of judgment by the client.

It felt very powerful to disclose to him, it felt like 'I'm telling you this, it's my choice', and he has less choice about what he tells me because I am the one who asks the questions in that model ... once I had done it I was very aware of a power imbalance in the room. [P1]

2.5 Finding my own path

Participants' accounts demonstrated the development of their ideas through training, as they established their own style and addressed the question "where am I with all this?" It was clear from the accounts that many of the participants began the training course with a range of different experiences which had informed their views and practice around disclosure. For example, some participants had worked in settings in which disclosure had been overtly frowned upon, whilst others had been positively encouraged to use disclosure. Some had had personal experience of mental health services, and some had family members who were also therapists.

Throughout training, participants were then exposed to a range of different settings, supervisors and models. The accounts suggested that participants were actively assimilating all of these experiences and ideas with their own clinical experience and were gradually finding their own path.

> *I guess I have seen it from all angles, I've seen from being told that you should say if you have ever taken drugs [pre-training experience] to not saying anything and I think I have found a path ... I have got lessons to learn and I'm sure at some point I'll disclose something that I shouldn't have and I won't disclose something that I should have, but I hope that I have got quite a good idea through learning through my own mistakes as well as through other ways. [P3]*

Through this process participants' ideas regarding disclosure often became more flexible and sophisticated: those who initially occupied a very pro-disclosure stance gradually became more aware of the potentially negative impacts; those who were initially very anti-disclosure became more open to and comfortable with the use of certain types; and those who had initially thought very little about disclosure became more aware of it as an issue. The accounts often reflected a growing awareness and comfort with the inevitable uncertainty of disclosure and the lack of a "right or wrong way".

> *When I first started training I don't think I really thought about it massively except times when a question was put to me I just thought I must fend this off somehow and quite often failed and just disclosed ... I suppose just clinical experience made me more aware. [P6]*

> *It's like there are so many different ideas and that's kind of something I'm getting my head round a bit more towards the end of training ... some things are obviously completely inappropriate, but there's so often not a really right or wrong way. [P11]*

The accounts reflected participants' developing their own sense of style and identity as a therapist. Several commented on how their own personality or preferences in interpersonal interaction influenced their use of disclosure and the development of their "therapist-self."

I am first and foremost a person who responds to things in the environment and that doesn't go away when you are in this slightly artificial relationship with somebody in this kind of clinical environment. [P8]

I think just generally my personality influences it ... I don't see therapy as a different kind of closed-me kind of thing. It is just another conversation. [P6]

Several participants felt that their ideas regarding disclosure weren't "fully formed". These participants felt that they hadn't been able to think sufficiently about disclosure as the challenges of the training process and assessment context meant that they hadn't had the "time and the space to breathe and think".

It doesn't feel like my ideas are kind of fully formed about it and I think, to some extent I think that's ... about having the space as well to think about your own identity as a therapist, which I hope is going to come more as I feel less restricted by assessment. [P11]

Several participants had clear ideas as to how they would like to develop in their use of disclosure. These participants identified that they tended to use disclosure as a default or by mistake, and aimed to become more strategic in their use of disclosure.

Ideally I would feel like in a few years when I have mastered it that I would be using disclosure as a therapist, so be taking maybe pieces of information about me and using them a bit more strategically. Whereas I guess I feel like its more of a kind of almost inexperience kind of, my sort of normal responding comes out. [P8]

Discussion

The present study explored the experience of using, or not using, self-disclosure from the perspective of clinical psychology trainees. The 14 participants recounted a range of experiences with respect to their use of disclosure in their therapeutic work and their experience of training and supervision in relation to these. Interpretative phenomenological analysis generated nine key themes reflecting the common anxieties, conflicts and developmental processes that appeared across accounts.

The decision in the moment

The accounts in this study highlight the in-the-moment struggle which trainees can experience when faced with the decision to disclose. Direct client questions posed a particular dilemma for many participants, who expressed a concern that they might damage the therapeutic alliance by not answering the client's question. This focus on the alliance is in line with previous research suggesting that trainees are likely to be concerned about their skills in alliance development: Simone, McCarthy and Skay (1998) found that novice therapists were more likely than experienced therapists to endorse "building rapport" as a reason to disclose. Participants felt a pressure to respond quickly to client questions, often answering briefly and then returning the focus to the client. Ways of reflecting back a question (e.g. "why is that important for you to know"), suggested by supervisors or lecturers, were often felt to be incongruent with participants' interpersonal style or inappropriate in the context of "understandable" client questions. However, participants' concern with the way in which they responded to client questions can be understood in the light of findings from the empirical literature. Qualitative studies of client experience emphasize the importance of therapist delivery technique and suggest that skilled disclosure or non-disclosure tends to develop the alliance whereas skill deficits damage its development (Audet & Everall, 2003; Hanson, 2005; Wells, 1994).

Maintaining the therapeutic alliance was not the only cause of tension in the moment; the feeling that disclosure was "taboo" or frowned upon by their supervisors or the training courses permeated many of the participants' accounts, resulting in anxiety when faced with a decision to disclose. Participants referred to an impression that disclosure was against the rules of certain therapeutic models,

supervisors, or the profession as a whole, and they often experienced its use as entering uncertain territory, outside the safe confines of the known 'professional' position. Given the assessment context, therefore, it was not just participants' relationship with their client that was at stake, but also their relationship with their supervisor, their training course and their developing sense of their professional self. Even in the absence of an assessment context, clinicians may be reluctant to discuss their use of disclosure (Dixon et al., 2001). Therapist disclosures tend to fall on the boundary between what are considered personal and professional behaviours (Farber, 2006) and can lead therapists to feel vulnerable to questioning regarding their professionalism. Given a culture of taboo around disclosure Knox and Hill (2003) suggest that therapists may experience marked internal struggle around their decision which may be helped by knowing the empirical research literature concerning the effects of disclosure and the circumstances under which it may be considered an appropriate intervention. This could be said to be especially true for trainees who already experience much anxiety as to the appropriateness of their interventions (Farber, 2006).

In considering the use of disclosures, participants also felt a need to protect themselves. For some this concerned issues of risk and personal physical safety, whereas for others it involved an awareness of their personal boundaries in terms of how emotionally vulnerable they were willing to be and the consequences of intimacy with clients. Some participants were concerned that disclosures would open them up to potential judgement by clients, and some felt that closer relationships with clients would render them less able to compartmentalise their professional life and therefore, ultimately, less effective therapists. This experience of vulnerability has been suggested in previous empirical research (Hill, Helms,

Tichenor, Spiegel & O'Grady, 1988) and can also be understood with reference to the client self-disclosure literature. Farber (2006), in his comprehensive review of both client and therapist disclosure, suggests that therapists are not immune to the complex and conflicting emotions that clients experience when disclosing aspects of themselves, and that positive emotions associated with disclosure can coexist with negative emotions such as vulnerability and uncertainty. The therapist position of the anonymous professional is a relatively protected one, free from the scrutiny of clients (Davis, 2002), whereas through disclosing, therapists potentially open the door to a greater level of intimacy with their client which may steer the therapy process into unchartered regions. The participants' accounts reflect that therapists, as individuals rather than a homogenous group, vary in their comfort with such intimacy and the uncertainties involved, which will inevitably affect their willingness to be known by their clients (Farber, 2006).

The developing therapist

Participants' ideas about disclosure developed throughout training. They learnt by using disclosure in their therapeutic work, and most crucially by reflecting on these experiences. Supervision played an important facilitating role in this reflection process. This can be understood using an information processing model of trainee skill development; Bennett-Levy (2006) distinguishes between declarative knowledge (the 'what' of therapy, i.e. techniques and knowledge), procedural knowledge (the 'how' and 'when' of implementation) and the process of reflection. Reflection is defined as "a metacognitive skill, which encompasses the observation, interpretation and evaluation of one's own thoughts, emotions and actions, and their outcomes" (Bennett-Levy, 2006, p.60). A therapist's decision to use an intervention,

such as disclosure, requires a complex parallel processing of situational information, procedural and declarative knowledge, but also, reflection on previous experience and how this might be relevant to the current situation. For the trainee therapist this process is understandably "clunky" at first; however, through the process of reflection-on-action (reflecting *after* a session) a therapist gradually becomes more able to reflect-in-action (reflect *during* a session), to assess all sources of information and arrive at a decision for action in real-time. Therefore, within this model reflection is identified as a key element in the development of expertise, and its facilitation the primary aim of training (be it through supervision or teaching).

However, participants' supervision experiences varied widely, and were inconsistent across training in terms of how much time was made available, or how well supervisors were able to support participants in thinking about this issue. Accounts also highlighted a lack of open discussion regarding disclosure on the participants' training courses. These findings are in line with previous research which found that therapists had received inconsistent training with regards to their use of disclosure (Burkard, Knox, Groen, Perez & Hess, 2006). Additionally, participants were often reticent to approach supervisors whom they felt might disapprove of the use of disclosure. Again, this is in line with empirical research that suggests it is common for supervisees to conceal aspects of their work from their supervisors (Yourman & Farber, 1996), especially those that might be considered mistakes or errors of judgement.

A further interesting aspect of the accounts in this study was how participants' position on disclosure was linked to broader issues in therapy, such as the role of the therapist, the essence and balance of a therapeutic relationship, and the agent of change in therapy. Clearly self-disclosure is not simply an overt behaviour

but reflects the crystallisation of these wider issues and an individual's personal philosophy of therapy.

Methodological issues

There are a number of methodological issues to consider when interpreting the findings from this research. Firstly, given the voluntary nature of the study there is the potential for a sampling bias. All second and third year trainees from across four courses in the London region were invited to participate and it is possible that the volunteers were those for whom self-disclosure was a particularly salient topic; this may reflect a personal interest or anxiety around disclosure, and therefore it may be a topic which they had thought relatively more about. Those who declined to volunteer may have done so either because they did not use disclosure in their clinical work or they did not feel any conflict around its usage. Additionally, given that the participants came from across just four training courses, their experiences with respect to training may not be representative of all training courses.

Secondly, this study relied on the participants' recall of events and therefore is subject to the shortcomings of retrospective recall in general (Giorgi & Giorgi, 2003). This type of research depends on participants not only being able to accurately remember events, but is also restricted to what participants are aware of and willing to reveal about their experiences. Some of the accounts in this study may reflect a degree of socially acceptable responding. Interviews varied across participants; some appeared more candid, whilst others seemed anxious and slightly reticent to discuss clinical mistakes. It is possible that, given the controversy surrounding this topic and the wider context of assessment, some participants may

have found revealing mistakes to be challenging to their sense of their professional self.

Thirdly, given the exploratory nature of this study, the definition of disclosure used was intentionally broad, incorporating both statements that revealed factual information and those that included personal reactions or responses to clients in the therapy session. However, in the theoretical and the empirical literature distinctions have been made along various lines, for example: on the basis of content, i.e. distinguishing between personal facts about the therapist as an individual and therapists' feelings or cognitions regarding the client and/or therapy; on the basis of tone, i.e. distinguishing between disclosures of negative and positive feelings or reactions towards the client (Andersen & Anderson, 1985); or on the basis of intent, i.e. distinguishing between disclosures of reassuring and challenging intent (Hill, Mahalik & Thompson, 1989). Although efforts were made to elicit examples of different types of disclosure in the interviews, the broad definition used limits the specificity of the findings and may overlook differences in the experience of disclosure subtypes.

Finally, whilst several validity checks were carried out, respondent validity (Barker, Pistrang & Elliott, 2002) was not able to be conducted due to time constraints. It would have been useful to have received feedback from participants that the findings were an accurate reflection of their experience.

Implications for future research and training

This study focuses on relatively inexperienced therapists and on issues regarding the training process. However, there is in fact very little research on qualified therapists' experience of using disclosure except for studies investigating

the frequency or type of disclosures and therapists' motivations for these (e.g. Mathews 1988; Simon, 1988). Clearly more research is required; future studies could compare these findings with the experience of qualified therapists. The definition of disclosure in this study was deliberately broad and future studies could look at specific types of disclosure. Additionally, further understanding might be gained from looking more broadly at the experience of trainees across a greater number of training courses to identify experiences of helpful teaching and support on this topic. Such research has the potential to inform the training of therapists around this important issue.

The present study sheds light on the experience of the trainee, and suggests that self-disclosure is an issue with which they struggle. The accounts demonstrate that trainees will undoubtedly be confronted with personal questions from clients and are likely to encounter opportunities for the use of disclosure. As some participants in the present study commented, caution against disclosure may be appropriate early in training; however, it is unwise to treat self-disclosure simply as an advanced issue and for it to be neglected across training. Trainees' reticence to discuss disclosure with those evaluating them means that this issue needs to be explicitly addressed. These findings suggest that trainees would both value and benefit from reflective conversations facilitated by training courses and supervisors across their training experience. Training courses could incorporate disclosure explicitly into the lecture programme, providing empirical literature (concerning the effects of disclosure and the circumstances under which it may be considered an appropriate intervention) and clarification of different theoretical perspectives on disclosure. Courses and supervisors could also facilitate open discussion about the dilemmas around the use

of disclosure and role plays to develop skills in disclosing or not disclosing, especially in response to direct client questions.

The accounts reported in this study highlight that self-disclosure is a complex issue that creates anxiety and tension for trainees as well as relating to trainees' developing sense of their professional identity and philosophy of therapy. The theoretical and clinical literature suggests that it is also an issue that continues to have relevance throughout a therapist's career; as Geller comments "deciding what, when and how to reveal one's self to patients is not something we can get straight once and for all, but an ongoing task of reaching towards ever more exact formulations in an ever-changing field" (2003, p.553). As such it is an issue which deserves explicit attention during training.

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PART THREE: CRITICAL APPRAISAL

Critical Appraisal

Introduction

This appraisal addresses some central issues in carrying out this research. Firstly it introduces the background to this project, including my reasons for choosing disclosure as a research topic as well as my particular focus on the trainee perspective. Secondly, it discuses some key methodological issues encountered in the research process. Finally it elaborates on the implications of the research findings for training courses.

Background to the research

My personal interest in the issue of self-disclosure was initially piqued by my own experience as a client when my therapist disclosed a similar significant past experience. This event stands out in my mind as possibly the most useful aspect of the therapy. However, as a trainee the implicit messages and explicit teaching that I received was that non-disclosure was the rule and any form of disclosure was generally to be avoided. I found this message hard to reconcile with my very helpful experience of disclosure.

I was aware that I was relatively uninformed about the potential risks of disclosure beyond stock cautions of diluting the transference and removing the focus from the clients. However, these responses meant relatively little to me as a new trainee, and failed to adequately explain the cautious stance adopted. Given my lack of knowledge a personal aim of this thesis was to provide the impetus to read widely, and to learn about theoretical positions which might not naturally appeal to me. Through this reading, the interviews themselves, and the conversations with peers

and colleagues which my research generated, I developed a greater sense of the complexity of the issues.

Methodological issues

I encountered a number of methodological dilemmas in the process of conducting this research, with respect to the definition of disclosure, sampling, interviewing and analysis.

Definition of disclosure

The definition of disclosure used in this study was intentionally broad in order to meet the exploratory aims of the research. Whilst some previous studies have used a similarly broad definition, others have distinguished between types of disclosure along various dimensions, such as content, tone or intention. Leading researchers tend to distinguish between two main content categories: factual disclosures (personal facts or information about the therapist as an individual) and self-involving disclosures (statements in which the therapist reveals feelings or cognitions regarding the client and/or therapy). However, some researchers have differentiated on the basis of tone, e.g. between disclosures of negative and positive feelings or reactions towards the client (Andersen & Anderson, 1985), or on the basis of reassuring and challenging intent (Hill, Mahalik & Thompson, 1989).

Many of the participants in the study expressed surprise at the broad definition of disclosure used, which incorporated both factual and self-involving disclosures, commenting that they had not previously thought about the latter as disclosure. In general, participants tended to place emphasis on discussing examples of factual disclosures. It is possible that factual disclosures are more memorable for participants, perhaps because they are more likely to feel against the "rules".

Alternatively, it is possible that trainees might find it more difficult to make self-involving process orientated disclosures and therefore use them relatively less frequently (Farber, 2006). Although I did attempt to elicit a range of examples from participants, I did not systematically elicit each type of disclosure. Intuitively, it makes sense that a very intimate factual disclosure (such as previous sexual abuse) would be experienced differently by a therapist than a less intimate factual disclosure of plans for annual leave. Similarly, a disclosure of negative feelings regarding the client or therapy (e.g. "when you react like that to my comments like that I feel criticised and belittled") might be more anxiety provoking to a therapist than a disclosure of positive feelings (e.g. "I have really enjoyed working with you and will miss our sessions"). The broad definition of disclosure employed therefore limits the specificity of the findings. Future research could look more specifically at types of disclosure in order to explore any differences in therapist experiences between these.

Sample

As noted in the empirical paper, the voluntary nature of this research meant that there was the potential for a sampling bias. My supervisors and I discussed the possibility of alternative recruitment strategies that might have addressed this, for example specifically contacting randomly selected trainees from training course lists and inviting them to participate. However, it was felt that these methods would not have had a significant impact on this issue, as ultimately participants would be self-selected. Any difference between the participants in the study and the population of trainees from which they were sampled can only be speculation; however it is likely that participants were trainees for whom self-disclosure was a particularly salient topic. Volunteers might have been those most interested in disclosure or those biased towards its usage. It is also possible that respondents reflect those who are at

a particular point of resolution regarding their own use of disclosure and therefore comfortable in discussing their views. Although it is difficult to confirm or disprove these hypotheses, my impression from the participants' accounts was that they reflected a range of preferences in terms of types and frequency of disclosure usage. The participants also seemed to vary in terms of their resolution with the issue, with some appearing quite certain and confident in their stance whilst others reporting feeling that they hadn't had enough time to reflect on the issue or that ideas were not fully formed.

Interviews

Qualitative guidelines emphasise the importance of the researcher reflecting on their role in the interviewing processes (e.g. Barker & Pistrang, 2005; Mays & Pope, 2000). Being a clinical trainee myself, conducting interviews with other clinical psychology trainees, this was obviously a topic that held personal relevance. There are both advantages and disadvantages to a researcher investigating a phenomenon with which they are familiar. On the one hand it put me in a position of 'epistemological privilege' (Stanley & Wise, 1993, cited in Shah, 2006), whereby I potentially had access to greater understanding of the participants' experience. It has been suggested that an interviewer with similar experiences encourages the generation of richer data (e.g. Shah, 2006). I did feel that I was able to use my similar position to quickly build up rapport with participants. However, interviews are not neutral methods of data collection but a collaborative enterprise between participant and researcher (Rapley, 2001; Yardley, 2000). There was therefore the potential problem with my similar position to that of the participants; I recognized that my own interest (and therefore the direction of the conversation) could lend a focus on areas of similarity which resonated with my own experience, resulting in

the interview becoming an intersubjective exchange. Additionally, this shared experience meant that I could end up assuming an understanding of an aspect of a participant's experience and therefore not fully explore areas. To counter this, my supervisors and I spent time reading carefully through the initial interview transcripts, attending to my interview technique and the overall direction of the interview.

Furthermore, there is the question of how my position as a fellow trainee impacted on the participants and ultimately the accounts that they provided. Previous research has questioned the assumption that the interviewer's identity is without implications for a participant and directed researcher attention to the issue (Abell, Locke, Condor, Gibson & Stevenson, 2006). It is possible that some participants might have perceived a similarity between us and therefore felt able to be more candid as a result; however, it is also possible that other participants might have perceived my role as researcher as elevating me to a relative position of expert on the issue thereby suppressing their free expression of their ideas.

An additional issue was that of my familiarity with some of the participants. I made an effort to recruit from a range of courses other than UCL. However, given that the London training courses provide a relatively small community of trainees it was inevitable that I would have had some prior contact with at least a few of the participants prior to conducting the research. A surprising finding for me was that it was more difficult for me to interview those who I knew already. I had expected that those with whom I was familiar would be easier to build up rapport with and therefore interview. However, I found that in these cases I was more conscious of myself and my role as the interviewer.

There were some additional, more general, methodological issues with this research. For example the use of retrospective descriptions opens up the possibility of error or withholding on the part of the participant (Giorgi & Giorgi, 2003). Errors in recall are less problematic when the aim of the research is an exploration of subjective experience rather than objective reporting. However, the ability of individuals to recall past event did seem to vary. Over the course of the interviews I experimented and found it useful to have a discussion at the outset of the issues I wished to cover so that participants were tuned in to the particular topics in which I was interested. As part of this I gave participants a copy of the schedule; however I found that some participants were daunted by the prospect of recalling examples of their use of disclosure. With these participants, I prompted with suggestions such as "perhaps think of a client who often stayed in your mind, elicited intense emotions from you or whom you discussed at length in supervision". Participants were all then able to arrive at examples; however this led me to wonder about the possibility of sending participants the interview schedule in advance. On reflection this could also have had some disadvantages, such as leading to more socially acceptable responding, or putting some off taking part.

Withholding, however, is potentially more problematic. I was aware that some participants seemed somewhat anxious at the prospect of discussing examples of occasions where they had used disclosure. Although some of this anxiety was related to remembering sufficient details of events, some also expressed embarrassment or discomfort in discussing certain examples. I found it difficult to encourage these participants to focus specifically on their experience of using disclosure, and at times they would veer off onto arguably 'safer', more general descriptions of events. Their anxiety made me reluctant to pursue questions.

Therefore, some of the accounts in this study provided less rich data and may have reflected a degree of socially acceptable responding.

In an interesting parallel to that of the research topic, an additional tension that I experienced in conducting the interviews was that of my own level of disclosure. Given the controversial nature of the topic I felt it wise to précis the interview with a very brief comment on my own interest. The question was, therefore, how to convey a sense of my own struggle without stepping too far from the neutral interviewer position. I settled on introducing myself as a third year trainee who had been grappling with this issue during training and who was interested in the experience of other trainees. I felt that highlighting my own struggle could make it easier for participants to speak freely; however, this declaration was sufficiently vague so as not to unduly influence participant responses.

Data analysis

A fundamental assumption underlying qualitative research methods, such as IPA, is that there is no single truth or version of reality. Qualitative analysis involves an interpretation of the data, a process which is inevitably influenced by the person of the researcher. Multiple possible "readings" of the data are therefore expected (Barker & Pistrang, 2005). Although this makes the use of traditional research quality criteria inappropriate, some authors have advocated flexible guidelines which emphasise the systematic and rigorous analysis of the data (e.g. Barker & Pistrang, 2005; Elliott, Fischer & Rennie, 1999; Mays & Pope, 2000; Yardley, 2000). Such guidelines stress researcher reflection on how their experiences and assumptions have shaped the analysis process and suggest the importance of a range of validity checks. I was aware that the focus of the analysis and therefore the themes yielded could be drawn to aspects of participants' accounts which resonated with my own

experiences. In order to ensure that my interpretations addressed the variation and complexity of the accounts, I paid particular attention to negative case examples for developing themes and held extensive discussions with my supervisors. Additionally, two supervisors conducted verification checks (Elliott et al., 1999) of the analysis process; the supervisors independently analyzed sections of the data and reviewed worked examples at each level of abstraction from the data. Due to time constraints, testimonial validity checks (checking the accuracy of themes with individual participants) were not carried out. This research would have been strengthened had I met briefly with participants for a follow-up interview.

Implications for training courses

There is clearly no one right way to use self-disclosure; there will always be a range of views, influenced by personal preferences, experiences and theoretical orientation. The role of training courses is therefore not to teach a particular way or opinion but rather to open up discussions around the issues and to support trainees in their personal development. As demonstrated in the empirical paper, trainees learn by experimenting with using disclosure, and crucially by reflecting on these experiences (Bennett-Levy, 2006). Whilst reflection by oneself or with peers is of value, it is obviously helpful for trainees to have an experienced therapist to guide this process. The participants in the present study identified numerous helpful experiences of supervision, including open discussion and clarification of supervisors' views, observation of supervisors, and facilitation of a non-judgemental space for trainees' to develop their thinking and their personal stance and style. These findings could be incorporated into guidance for supervisors which could be provided by training courses.

The current study was limited to therapists' use of intentional verbal self-disclosure; however, the issue of self-disclosure is a much broader one. Authors have challenged the notion that disclosure is a choice and argue that as therapists we reveal ourselves in everything that we say and do (e.g. Greenberg, 1995). Aspects of a therapists' physical presence alone convey information to clients; from more obvious characteristics such as clothes, age, gender and race, to subtle facial movements and postural changes (Farber, 2006). As Greenberg states "self-disclosure is inevitable; our only choice is how we accommodate to this fact of our professional lives" (1995, p.194). Trainees would benefit from open, facilitated discussions around not just their intentional verbal disclosures but also the wider issues of how the person of the therapist inevitably influences the therapeutic endeavour.

Reference List

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PART THREE: CRITICAL APPRAISAL

Critical Appraisal

Introduction

This appraisal addresses some central issues in carrying out this research. Firstly it introduces the background to this project, including my reasons for choosing disclosure as a research topic as well as my particular focus on the trainee perspective. Secondly, it discuses some key methodological issues encountered in the research process. Finally it elaborates on the implications of the research findings for training courses.

Background to the research

My personal interest in the issue of self-disclosure was initially piqued by my own experience as a client when my therapist disclosed a similar significant past experience. This event stands out in my mind as possibly the most useful aspect of the therapy. However, as a trainee the implicit messages and explicit teaching that I received was that non-disclosure was the rule and any form of disclosure was generally to be avoided. I found this message hard to reconcile with my very helpful experience of disclosure.

I was aware that I was relatively uninformed about the potential risks of disclosure beyond stock cautions of diluting the transference and removing the focus from the clients. However, these responses meant relatively little to me as a new trainee, and failed to adequately explain the cautious stance adopted. Given my lack of knowledge a personal aim of this thesis was to provide the impetus to read widely, and to learn about theoretical positions which might not naturally appeal to me. Through this reading, the interviews themselves, and the conversations with peers

and colleagues which my research generated, I developed a greater sense of the complexity of the issues.

Methodological issues

I encountered a number of methodological dilemmas in the process of conducting this research, with respect to the definition of disclosure, sampling, interviewing and analysis.

Definition of disclosure

The definition of disclosure used in this study was intentionally broad in order to meet the exploratory aims of the research. Whilst some previous studies have used a similarly broad definition, others have distinguished between types of disclosure along various dimensions, such as content, tone or intention. Leading researchers tend to distinguish between two main content categories: factual disclosures (personal facts or information about the therapist as an individual) and self-involving disclosures (statements in which the therapist reveals feelings or cognitions regarding the client and/or therapy). However, some researchers have differentiated on the basis of tone, e.g. between disclosures of negative and positive feelings or reactions towards the client (Andersen & Anderson, 1985), or on the basis of reassuring and challenging intent (Hill, Mahalik & Thompson, 1989).

Many of the participants in the study expressed surprise at the broad definition of disclosure used, which incorporated both factual and self-involving disclosures, commenting that they had not previously thought about the latter as disclosure. In general, participants tended to place emphasis on discussing examples of factual disclosures. It is possible that factual disclosures are more memorable for participants, perhaps because they are more likely to feel against the "rules".

Alternatively, it is possible that trainees might find it more difficult to make self-involving process orientated disclosures and therefore use them relatively less frequently (Farber, 2006). Although I did attempt to elicit a range of examples from participants, I did not systematically elicit each type of disclosure. Intuitively, it makes sense that a very intimate factual disclosure (such as previous sexual abuse) would be experienced differently by a therapist than a less intimate factual disclosure of plans for annual leave. Similarly, a disclosure of negative feelings regarding the client or therapy (e.g. "when you react like that to my comments like that I feel criticised and belittled") might be more anxiety provoking to a therapist than a disclosure of positive feelings (e.g. "I have really enjoyed working with you and will miss our sessions"). The broad definition of disclosure employed therefore limits the specificity of the findings. Future research could look more specifically at types of disclosure in order to explore any differences in therapist experiences between these.

Sample

As noted in the empirical paper, the voluntary nature of this research meant that there was the potential for a sampling bias. My supervisors and I discussed the possibility of alternative recruitment strategies that might have addressed this, for example specifically contacting randomly selected trainees from training course lists and inviting them to participate. However, it was felt that these methods would not have had a significant impact on this issue, as ultimately participants would be self-selected. Any difference between the participants in the study and the population of trainees from which they were sampled can only be speculation; however it is likely that participants were trainees for whom self-disclosure was a particularly salient topic. Volunteers might have been those most interested in disclosure or those biased towards its usage. It is also possible that respondents reflect those who are at

a particular point of resolution regarding their own use of disclosure and therefore comfortable in discussing their views. Although it is difficult to confirm or disprove these hypotheses, my impression from the participants' accounts was that they reflected a range of preferences in terms of types and frequency of disclosure usage. The participants also seemed to vary in terms of their resolution with the issue, with some appearing quite certain and confident in their stance whilst others reporting feeling that they hadn't had enough time to reflect on the issue or that ideas were not fully formed.

Interviews

Qualitative guidelines emphasise the importance of the researcher reflecting on their role in the interviewing processes (e.g. Barker & Pistrang, 2005; Mays & Pope, 2000). Being a clinical trainee myself, conducting interviews with other clinical psychology trainees, this was obviously a topic that held personal relevance. There are both advantages and disadvantages to a researcher investigating a phenomenon with which they are familiar. On the one hand it put me in a position of 'epistemological privilege' (Stanley & Wise, 1993, cited in Shah, 2006), whereby I potentially had access to greater understanding of the participants' experience. It has been suggested that an interviewer with similar experiences encourages the generation of richer data (e.g. Shah, 2006). I did feel that I was able to use my similar position to quickly build up rapport with participants. However, interviews are not neutral methods of data collection but a collaborative enterprise between participant and researcher (Rapley, 2001; Yardley, 2000). There was therefore the potential problem with my similar position to that of the participants; I recognized that my own interest (and therefore the direction of the conversation) could lend a focus on areas of similarity which resonated with my own experience, resulting in

the interview becoming an intersubjective exchange. Additionally, this shared experience meant that I could end up assuming an understanding of an aspect of a participant's experience and therefore not fully explore areas. To counter this, my supervisors and I spent time reading carefully through the initial interview transcripts, attending to my interview technique and the overall direction of the interview.

Furthermore, there is the question of how my position as a fellow trainee impacted on the participants and ultimately the accounts that they provided. Previous research has questioned the assumption that the interviewer's identity is without implications for a participant and directed researcher attention to the issue (Abell, Locke, Condor, Gibson & Stevenson, 2006). It is possible that some participants might have perceived a similarity between us and therefore felt able to be more candid as a result; however, it is also possible that other participants might have perceived my role as researcher as elevating me to a relative position of expert on the issue thereby suppressing their free expression of their ideas.

An additional issue was that of my familiarity with some of the participants. I made an effort to recruit from a range of courses other than UCL. However, given that the London training courses provide a relatively small community of trainees it was inevitable that I would have had some prior contact with at least a few of the participants prior to conducting the research. A surprising finding for me was that it was more difficult for me to interview those who I knew already. I had expected that those with whom I was familiar would be easier to build up rapport with and therefore interview. However, I found that in these cases I was more conscious of myself and my role as the interviewer.

There were some additional, more general, methodological issues with this research. For example the use of retrospective descriptions opens up the possibility of error or withholding on the part of the participant (Giorgi & Giorgi, 2003). Errors in recall are less problematic when the aim of the research is an exploration of subjective experience rather than objective reporting. However, the ability of individuals to recall past event did seem to vary. Over the course of the interviews I experimented and found it useful to have a discussion at the outset of the issues I wished to cover so that participants were tuned in to the particular topics in which I was interested. As part of this I gave participants a copy of the schedule; however I found that some participants were daunted by the prospect of recalling examples of their use of disclosure. With these participants, I prompted with suggestions such as "perhaps think of a client who often stayed in your mind, elicited intense emotions from you or whom you discussed at length in supervision". Participants were all then able to arrive at examples; however this led me to wonder about the possibility of sending participants the interview schedule in advance. On reflection this could also have had some disadvantages, such as leading to more socially acceptable responding, or putting some off taking part.

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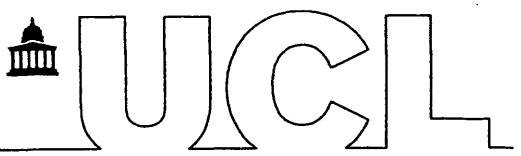
APPENDIX 1: Copy of ethics approval

UCL GRADUATE SCHOOL
UCL RESEARCH ETHICS COMMITTEE



Dr Nancy Pistrang
Sub-Department of Clinical Health Psychology
UCL, Gower Street

26 July 2007

Dear Dr Pistrang

Notification of Ethical Approval

Project ID/Title: 0957/001: Clinical psychology trainees' perceptions of therapist self-disclosure

I am pleased to confirm that the UCL Research Ethics Committee has approved your research proposal for the duration of the study subject to the receipt of your Data Protection Registration Number.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Responsibilities Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

   Reporting Non-Serious Adverse Events.
   For non-serious adverse events you will need to inform Ms Helen Dougal, Ethics Committee Administrator (h.dougal@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

   Reporting Serious Adverse Events
   The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

Yours sincerely

Chair of the UCL Research Ethics Committee

APPENDIX 2: Participant information sheet

SUB-DEPARTMENT OF CLINICAL HEALTH PSYCHOLOGY
UCL PSYCHOLOGY

Participant Information Sheet

Title of Project: Clinical psychology trainees' perceptions of therapist self-disclosure

Samantha Bottrill
Trainee Clinical Psychologist

Dr Nancy Pistrang
Senior Lecturer in Clinical Psychology

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the research about?
Existing research literature suggests that therapist self-disclosure to clients is a widely, if sparingly, used intervention. This study will examine the attitudes of trainee clinical psychologists towards self-disclosure and how these have come about. This study is also interested in exploring trainees' experiences of using and/or not using self-disclosure with their clients.

Am I eligible to take part?
Participants are being invited from several clinical psychology doctoral courses. All 2nd and 3rd year trainees are eligible to take part.

What will I have to do if I take part?
If you agree to take part, I (Samantha Bottrill) will meet with you for an interview. The interview will focus on your attitudes towards self-disclosure in general, how these have come about, and any experiences you may have had using and/or not using self-disclosure in therapy. There are no right or wrong answers – we just want to hear about your opinions and experiences.

The interview will take no more than an hour and a half and will take place either at UCL, your college or your home; whichever you prefer.

Do I have to take part?
Taking part is voluntary. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to change your mind. You can withdraw from the project at any time. If you choose not to participate, or to discontinue participation, this will not lead to any penalty of any kind.

What are the risks and benefits of taking part?
The kinds of topics you will be asked to discuss will be similar to those covered in routine supervision on clinical placement. It is unlikely that this will be upsetting, although it is possible that you could feel uncomfortable discussing aspects of your clinical work if you feel that you have made mistakes. Having said this, we think that taking part is likely to be enjoyable and provide an interesting opportunity to reflect on aspects of your clinical work.

What happens to my information?
All the information you give us will be confidential, anonymous and used for the purposes of the study only. However, if during the course of the interview you tell us information that causes serious concern regarding unprofessional behaviour or risk of harm, then confidentiality will need to be broken.

The digital interview files will be transcribed and then erased. All identifying information will be removed from the interview transcripts so that you cannot be identified individually. Any reports or publications resulting from the study will not reveal the identity of anyone who took part. In accordance with the Data Protection Act 1998 transcripts and questionnaires will be stored securely in a locked filing cabinet. In line with normal scientific procedures the transcripts will be held for 5 years after publication and then destroyed.

What do I do now?
If you would like more information about this study or have any questions, or if you think you would like to participate in the study, please contact Samantha Bottrill (phone number and email address at the top of the information sheet). Prior to taking part in the research, you will be given a copy of this information sheet to keep and a consent form to sign and keep.

For your information
The researchers have undergone satisfactory Criminal Records Bureau checks. This research has been approved by University College London's research ethics committee

Thank you very much for considering taking part in this study

This research has been approved by University College London's research ethics committee

SUB-DEPARTMENT OF CLINICAL HEALTH PSYCHOLOGY
UCL PSYCHOLOGY

UCL

Informed Consent Form for Participants in Research Studies

(This form is to be completed independently by the participant after reading the Information Sheet and/or having listened to an explanation about the research.)

Title of Project: **Clinical Psychology Trainees' perceptions of therapist self-disclosure**

This study has been approved by the UCL Research Ethics Committee [Project ID Number]: 0957/001

Participant's Statement

I ..... agree that I

- have read the information sheet and the project has been explained to me orally;
- have had the opportunity to ask questions and discuss the study;
- have received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant.
- understand that the interview will be taped recorded and I am aware of and consent to, any use you intend to make of the recording after the end of the project.
- understand that the information I have submitted will be published in a research journal. Confidentiality and anonymity will be maintained and it will not be possible to identify me from any publications.
- I understand that I am free to withdraw from the study without penalty if I so wish and I consent to the processing of my personal information for the purposes of this study only and that it will not be used for any other purpose. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Comments or Concerns During the Study
If you have any concerns about this study at any point you should discuss these with one of the researchers, either Samantha Bottrill (Trainee Clinical Psychologist, ----, telephone: ----) or Nancy Pistrang (Senior Lecturer in Clinical Psychology, ----).

Signed: Date:

Investigator's Statement

I .....

confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed: Date:

APPENDIX 3: Consent form

APPENDIX 4: Interview schedule

Clinical Psychology Trainees' Perceptions of Therapist Self-Disclosure

Semi-Structured Interview Schedule

`I am interviewing clinical psychology trainees about their experience of using and their attitudes towards self disclosure. The study is looking at verbal self-disclosure by therapists to clients i.e. the statements through which therapists communicate personal information about themselves and/or reveal their reactions/responses to clients as the arise in session.

I am a clinical psychology trainee at UCL. I am interested in the issue of therapist self-disclosure from the perspective of my own clinical work; it is an issue that I have been grappling with during my training so far. I was therefore interested in the experience of other trainees.

Recap consent and confidentiality [go through a copy of consent form with participant and check if have any questions]

A. Warm-up Question

1) I would be really interested to hear a little about your views in general before I launch into some more specific questions. Is self-disclosure something you have thought much about?

B. Experience of Therapist Self-Disclosure

1) Have there been times when you have used self-disclosure or when you have thought about using it but haven't?

Use example given and ask following sub-questions

a) Could you tell me a bit about what happened? (e.g. was it requested by the client, what was disclosed)
b) How did you experience it – what was it like for you – what did you think in that moment?
c) How did your client respond?
d) How did you make the decision to disclose?
e) How did you reflect on it afterwards?
f) What was your supervisor's reaction?
g) How do you imagine your university would view it?

Dependent on initial example given ask [each followed by sub-questions a - g] :

2) Have there been any occasions when you have used self-disclosure and you feel that it was helpful to your client?
3) I am also interested in hearing about occasions when therapists self-disclose and feel that it wasn't helpful to the client, or that there were some mixed effects. Have you ever experienced something like this?
4) Have you ever experienced an occasion where you thought about self-disclosing and decided not to?

C. Attitudes towards Therapist Self-Disclosure

1) What are your general thoughts and attitudes about using self-disclosure in therapy?
2) What do you feel are the helpful aspects (if any) of using therapist self-disclosure?
3) What do you feel are the problematic aspects (if any) of using therapist self-disclosure?
4) How do you think your course view therapist self-disclosure? Is it a topic covered in your syllabus?
5) To what extent have you discussed the topic with any of your clinical supervisors? What have been their views?
6) What else has informed your understanding of self-disclosure? (Prompts: reading, research evidence, personal experience as a client)

D. Training Experience

1) Please talk me through your placements to date
2) What models have you used on placements? Pre-training?
3) Do you have preferences?

APPENDIX 5

IPA stage one: Within-case analysis

IPA Analysis Stage 1: Initial annotations of text

Extract from participant 8

▪ Open person when not a therapist	I am quite an open person in my non therapist self I don't sort of censor myself too much. My general kind of way of being is to be relatively open about things and to assume that people will be interested. I hope not to a fault and so to come into a therapy context as a new trainee that is quite a big change because even in research you can be quite relatively free about these things and so I found that quite uncomfortable actually and it probably comes under a different question but the course in the first week or so one of the first things that they teach you is how they deal with it with sort of telling people that you are a trainee and what happens if people ask how old you are and how to handle that situation. Their main answer to that is to throw it back to the client and say "why is this important to you? Is it because you think that because we are different I am not going to understand you?" That sort of thing. I don't think that is an acceptable response to somebody asking you a perfectly normal question. A client who hasn't had therapy before is in a you know you are not a doctor you are not a GP where they know the scenario that its all about spending the time talking about themselves and you don't ask. But you are being much more intimate than that in many ways as a therapist and so they are perhaps intimate with you in a way that they are not with other people, well they are but only with their really good friends. In which case a question about where you are going on holiday is completely normal and I think it is actually probably quite damaging almost for somebody to be brushed off with a sort of you know something that is quite obviously don't go there. Obviously you can be a bit more subtle about it and there are good reasons not to spend therapy time talking about yourself but I think my sense is that I will probably be a qualified therapist who does self-disclose
▪ Trainee context a big change from freedom of previous research experience	
▪ Change as uncomfortable adjustment	
▪ Course teaching in first week on managing client questions	
▪ Course suggestion to reflect question back at client	
▪ Doesn't feel reflecting back question is an acceptable response to a normal question	
▪ Unusual nature of therapy relationship – one way intimacy	
▪ Client question about holiday normal in context of intimate relationship	
▪ Brushing off client question could be damaging	
▪ Good reasons not to self-disclose	
▪ Expectation that will be a qualified therapist who does use self-disclosure	

IPA Analysis Stage 1: Tentative themes

Extract from participant 8

I am quite an open person in my non therapist self I don't sort of censor myself too much. My general kind of way of being is to be relatively open about things and to assume that people will be interested. I hope not to a fault and so to come into a therapy context as a new trainee that is quite a big change because even in research you can be quite relatively free about these things and so I found that quite uncomfortable actually and it probably comes under a different question but the course in the first week or so one of the first things that they teach you is how they deal with it with sort of telling people that you are a trainee and what happens if people ask how old you are and how to handle that situation. Their main answer to that is to throw it back to the client and say "why is this important to you? Is it because you think that because we are different I am not going to understand you?" That sort of thing. I don't think that is an acceptable response to somebody asking you a perfectly normal question. A client who hasn't had therapy before is in a you know you are not a doctor you are not a GP where they know the scenario that its all about spending the time talking about themselves and you don't ask. But you are being much more intimate than that in many ways as a therapist and so they are perhaps intimate with you in a way that they are not with other people, well they are but only with their really good friends. In which case a question about where you are going on holiday is completely normal and I think it is actually probably quite damaging almost for somebody to be brushed off with a sort of you know something that is quite obviously don't go there. Obviously you can be a bit more subtle about it and there are good reasons not to spend therapy time talking about yourself but I think my sense is that I will probably be a qualified therapist who does self-disclose

- Naturally open style of non-therapist self
- Adjustment from previous experience
- Course suggestion not acceptable
- Client questions as understandable
- Potentially damaging not to answer client question
- Expectation of future stance on disclosure

IPA Analysis Stage 1: Initial themes for participant 8

Client questions

Course message regarding reflecting back client questions not acceptable when is a normal question

"the course in the first week or so one of the first things that they teach you is how they deal with it.... Their main answer to that is to throw it back to the client and say "why is this important to you? Is it because you think that because we are different I am not going to understand you?" that sort of thing. I don't think that is an acceptable response to somebody asking you a perfectly normal question." [10]

Client questions as understandable

"A client who hasn't had therapy before is in a you know you are not a doctor you are not a GP where they know the scenario that its all about spending the time talking about themselves and you don't ask. But you are being much more intimate than that in many ways as a therapist and so they are perhaps intimate with you in a way that they are not with other people, well they are but only with their really good friends. In which case a question about where you are going on holiday is completely normal" [15]

Potentially damaging not to answer client questions

"probably quite damaging almost for somebody to be brushed off with a sort of you know something that is quite obviously don't go there" [20]

Difficulty with client questions – pressure to respond

"There are situations where it is very difficult to not, like when someone asks you a direct question what are you supposed to do. I tend to answer quickly and move on rather than do what the course tells me to do" [31]

"that is quite an intimate question in some ways but what do you say? I don't talk about that stuff here sort of thing? and I had been working with him long enough that I didn't feel too uncomfortable about it until afterwards I thought I guess that was a bit weird." [38]

Protecting own privacy

What do I want to share?

"I think I wouldn't have wanted the clients to know that I live on the same street but I have actually mentioned to a couple of clients that I used to live on that road but don't anymore" [79]

"I was giving a piece of information about myself that was quite safe to give" [137]

"I suppose I am pro self disclosure but then I also do have an awareness that I want to protect my own privacy" [139]

"if I was in more acute kind of placements I might be a bit more cautious of my personal information" [161]

"I was quite private when I was on inpatient units" [166]

Comfort with answering some questions
"I suppose if I am giving pieces of information out about myself or how I am feeling then that implies that I trust them and it just happens that I am a trusting individual about those sort of things and other people might not be" [463]

Learning through experience
Reflecting on discomfort of having disclosed
"Felt kind of uncomfortable afterwards. I was cycling to work at that point and I remember kind of replaying the conversation a few times in my head after that because I guess you know whether or not I had been pregnant is quite an intimate question" [366]

Positive experience of using disclosure
"She had a relatively similar background to me so I guess that probably for her it just re-enforced sameness which I think can be quite beneficial with a therapeutic relationship understanding" [102]

Decision to disclose based on sense of comfort
"I don't think I kind of thought about it in a structured way in order to come up with an answer about whether I would or not disclose but perhaps that's because my answer was if it seems appropriate or you know feels comfortable then I would" [158]
"made it very natural for me to say" [130]
"It seemed completely natural....and it wasn't uncomfortable information for somebody else to know" [625]

Supervision
No space for reflection with some supervisors
"there is not much room for reflection" [234]

Observing supervisors using disclosure
"I have seen supervisors use self disclosure quite helpfully" [248]

Finding a balance in the relationship
Finding a balance between a personal and professional relationship
"I guess its not my explicit intention but I guess it does slip into a less cut and dried therapist patient dialogue" [307]
"in a psychoanalytic relationship well you just get nothing from the therapist at all so if you are seeing that as the therapeutic way then giving information about your husband is straying down the dimension isn't it but I don't know I think making people feel comfortable is part of it" [312]
"I guess there is two bits to that, one is you are normal just like me, I am just like you. It's a really difficult thing you are going through its quite understandable that you should react in this way. But on the other hand I guess you kind of want to believe that your therapist is has coping skills that maybe you don't have" [339]
"I think it is a really difficult balance that we try and tread because you are trying to get people to feel comfortable enough with you to trust you with things and in normal life that would mean a kind of two way relationship you know a very secure foundation and I suppose mimicking that a little bit is important because you need to give them the

message that they can trust you and self disclosure may be quite helpful with that sort of thing but then you do also have to be quite careful that its boundaried partly because of that because it is not a normal relationship that you are establishing. Its not a two way relationship and it shouldn't be." [483]
"I think the ideal would be to use self disclosure in a strategic therapeutic way so that you are giving them the message that they can trust you and that you are a normal person somewhere under that mask but you are not setting up an expectation that your relationship is anything other than a quite weird one basically. And I think there is an inherent weirdness in what we do really" [496]

Finding own path amongst different messages
Naturally open style of non-therapist self
"I am quite an open person, in my non-therapist self I don't sort of censor myself too much" [5]

Developing therapist-self
"that is the me and you know I am first and foremost a person who responds to things in the environment and that doesn't go away when you are in this slightly artificial relationship with somebody in this kind of clinic environment and yeah I suppose that ideally I would feel like in a few years when I have mastered it that I would be using disclosure as a therapist so be taking maybe pieces of information about me and using them a bit more strategically. Whereas I guess I feel like its more of a kind of almost inexperience kind of, my sort of normal responding comes out" [408]
"things that you might do in your private life but wouldn't do as a clinician and I guess they can pop out and you would ideally feel that you were choosing to use them or not use them so you would be more strategic about it. I suppose that is why the course give you that quite firm ground rule because they know that therapists, new therapists have to kind of develop that, me as therapist" [421]

Adjustment from previous experience
"and so to come into a therapy context as a new trainee that is quite a big change because even in research you can be quite relatively free about these things and so I found that quite uncomfortable actually" [7]

Unsure about cautious course message
"the rule of thumb that we were given was just not to but also to sort of nip it in the bud which is probably safer for a trainee but I don't know" [24]

Expectation of future post-qualification stance on disclosure
"my sense is that I will probably be a qualified therapist who does self-disclose" [23]

Lack of knowledge - Unsure of potential pitfalls of disclosure
"I might be being a bit naïve about what can actually happen if you give too much information away" [316]

Experience as client shaping view

"when I was an under graduate I went to counselling and it was a really useful experience from the point of view of understanding what it is like to be the client I suppose and it was well before I came a trainee but you sit in the waiting room and it is rather like being in a GP waiting room. Nobody looks at each other but you are all kind of, its all normal life and then you get called and you go in the room and then there is this weird bit where you kind of have to shift because you are not in normal life anymore" [501]

APPENDIX 6

IPA stage two: Integration of themes across participants

IPA analysis stage two: Integration of themes across participants

Example theme 1.1: Caught off Guard

P1
I said to him "why would that be important for you to know?" which really didn't fit at all ... it was ridiculous. It was an emergency thing to say. [P1:901]

P2
I think that my general tendency would be "that's a kind thing to do" rather than use that personal 'I'. I'm not sure if I did use the 'I' or not but definitely my tendency would be to say "that's kind". [P2:439]

I remember feeling very uncomfortable, very nervous, probably quite reluctant to answer. I think my tact was "I know if I just avoid saying anything then I'm not right or wrong in any direction". [P2:138]

that did take me back a bit because I think, if you're in a child setting you are used to the ideas of parenting questions to come up and especially as it was my first adult placement and I was like hmmm ... is that her way of asking me if I am a parent? [P2:374]

P3
I would probably try and move the conversation on but I'd just say something like, I might pretend not to hear it or I might say getting back to that question and just probably say no. I have to admit I might say no, depending on where it was and what I thought at the time [P3:304]

I struggle sometimes if someone asks something. I do want to disclose because I want to keep that [therapeutic relationship]. I don't want to make them feel like this person's really cold [P3:346]

I was feeling a bit sort of oh what do I do now? A bit what's the word, a feeling word? Uncomfortable would be a very good word and I was thinking what do I say now? [P3:487]

P4
I just got a bit flustered ... It really caught me off guard and I just told him. [P5:442]

P5
I just answered it really automatically and then thought, oh god what did I just do? [P5:535]

P6
I think I did just say things like yes I do have a boyfriend and change the subject and I think she got the message enough. She kind of took it as a kind of that's nice and realised that I wasn't there to talk about me I was there to talk about her. [P6:261]

I feel like that one of my weaknesses perhaps is being able to work out how to not answer those questions in a polite way that feels comfortable with the therapeutic relationship that I have got going. [P6:399]

I suppose that is just my worry that somebody might feel rejected or that they had behaved inappropriately or whatever [P6:449]

P8

Their [college] main answer to that is to throw it back to the client and say "why is this important to you?"... I don't think that is an acceptable response to somebody asking you a perfectly normal question. [P8:14]

Probably quite damaging almost for somebody to be brushed off with something that is quite obviously 'don't go there' [P8:20]

There are situations where it is very difficult to not, like when someone asks you a direct question what are you supposed to do? I tend to answer quickly and move on rather than do what the course tells me to do [P8:31]

P10

I have accidentally told people things I didn't mean to or want to when I was caught off guard but nothing very significant [P10:37]

[Lecturer] said if a client asks me anything personal I just say "why is it important for you to know that?" Obviously that works for her, but for me I always felt I wouldn't be able to say that without sounding confrontational. [P10:632]

P11

I remember like a surge of adrenalin when she asked me and I think I remember it because it was the first time I'd been asked a ... personal question within that placement. [P11: 110]

I still don't think that I would feel comfortable just dissing any kind of question which doesn't feel inappropriate or that wouldn't affect the therapeutic relationship in an adverse way, because I think it's rude. I think it can come across as unkind and I think one of the key things is expressing warmth and empathy, and I think culturally it's something people do [P11:230]

But it very much came from her I guess, the self-disclosure was driven from her rather than, you know it felt it was useful by default, it didn't feel like it was something that I was using in a particularly skilled, skilful way, it felt like it was something that she was driving and I kind of muddled along with it because I was feeling kind of, you know, how does this fit with the kind of theoretical framework? But yeah, so I think it was driven by her. [P11:299]

If it was me in her shoes, I would probably feel snubbed and I'd probably feel a bit patronised actually [P11:325]

P13

It was something that I had been talking a lot with people outside of work and generally it felt like I had been caught a bit off guard. ... I wasn't really expecting the question at all and it was right at the end of the session and it was a bit removed from what we had been talking about before. ... So it was kind of I guess not expecting it and not really feeling prepared and feeling as well like I wanted to kind of maintain the therapeutic relationship and what with it being very current for me at the time it felt like yeah I wasn't expecting it and hadn't quite thought it through as much as I would. [P13:100]

I felt a bit bad as well because ... I can imagine if I asked someone that and if they knock you back it might make me feel a bit dejected or a bit 'have I said something wrong?' [P13:406]

I think once I said to him "I don't mind answering the question but I would be really interested to know why you asked me." [I] said it without really thinking, it was like a reflex and then while he was explaining why I was then thinking to myself is there any way I can get out of this and not actually tell him because I am not quite sure whether I should do or not. [P13:122]