ABSTRACT

Title of Dissertation: MASTER THERAPISTS' PERCEPTIONS
            OF SELF-DISCLOSURE USE IN
            INDIVIDUAL PSYCHOTHERAPY:
            A QUALITATIVE STUDY

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            Doctor of Philosophy, 2017

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            Psychology

The majority of psychotherapy practitioners use therapist self-disclosure (TSD; Lane, Farber, & Geller, 2001; Henretty & Levitt, 2010), clients say it is helpful (Hanson, 2005) Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, E., 1988), and a growing body of research and theory suggests that avoiding TSD in all circumstances may have harmful effects on both the client and the therapy (Barnett, 2011). Thus, continued research is called for to provide clinicians with recommendations for how to use the intervention therapeutically, as well as how to avoid using it in ways that might be harmful. However, little is known about how master therapists make decisions about TSD, and researchers have found that studying therapists' use of disclosure, in general, is of limited use (Gallucci, 2002). Accordingly, we interviewed 13 master therapists about their general attitudes about TSDs, examples of actual successful TSDs, examples of

actual unsuccessful TSDs, and instances during which they felt an urge to disclose but chose not

to do so. We analyzed the transcripts using consensual qualitative research. In terms of general

attitudes, therapists believed that some types of TSD can be helpful in some situations if used

sparingly, but had many cautions about using TSDs. In successful TSDs, there were no typical

antecedents; therapists typically intended to provide support, facilitate exploration and insight,

and build and maintain the therapeutic relationship; the content was typically about similarities

between the therapist and client and relevant to the client's issues; and the consequences were

typically positive. In unsuccessful TSDs, the typical antecedents were countertransference

reactions; the typical intentions were to provide support; therapists typically misjudged perceived

similarities; and the consequences were negative. In instances when therapists felt urged to

disclose but did not, the typical antecedent was countertransference; and the content of what was

not disclosed typically seemed relevant to the client's issues. Implications for practice, training,

and research are discussed.

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PSYCHOTHERAPY: A QUALITATIVE STUDY

by

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Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2017

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Acknowledgements

First, I would like to thank the master therapists who agreed to volunteer their invaluable time to be interviewed and allowed themselves to be vulnerable in considering their clinical work. Second, I would like to thank the interviewer-auditors, Drs. Clara Hill, Mary Ann Hoffman, Barbara Thompson, and Pat Spangler, who did a wonderful job in drawing out the interviewees and helping them to clarify and articulate their ideas. And third, I would like to thank the research assistants at the Maryland Psychotherapy Clinic and Research Laboratory for their tireless transcription of the interviews.

Very special thanks go to my core research team members—Monica Kearney, Elissa Sarno, Lizzie Sauber, Jen Brady, Glenn Ireland, and Sydney Baker—who spent many hours coding therapist self-disclosures and providing thoughtful input. Their genuine interest in and enthusiasm for the project helped to sustain my own. My thanks go next to my committee members—Drs. Charlie Gelso, Mary Ann Hoffman, and Ed Lemay, and Bob Lent—whose insightful questions and suggestions helped to improve and refine the initial research idea and the final product.

My heartfelt thanks for wonderful guidance and seemingly unlimited patience go to Clara Hill, my advisor and committee chair. Her expertise and support have been fundamental in too many ways to count throughout my time in the program.

Lastly, I would like to thank two important men in my life. My unending thanks go to my father, David Giddens, for planting the first seeds of intellectual curiosity in my mind decades ago and for tending and nurturing them and, more importantly, me, for my entire life, and to my spouse, Ciro Pinto-Coelho, for his steadfast love, support, and encouragement, without which neither my graduate school career nor this project would ever have come to pass..

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Chapter 1: Introduction

Scholars are converging on the beliefs that avoiding therapist self-disclosure (TSD) in all circumstances may have detrimental effects on the client and the therapy, and that judicial, intentional TSD can have beneficial effects. Indeed, in one examination of therapist response modes in actual therapy (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988), clients rated TSD as the most helpful of all therapist responses. On the other hand, TSD can be harmful to clients in some situations (Audet & Everall, 2011). Skill is required to deliver therapeutically beneficial TSDs, and skill deficits in TSD delivery may lead to premature termination (Hanson, 2005). Given the call in the literature for therapists to be prepared to disclose something, some of the time, and to do so in a therapeutic way, it seems important to be able to provide practitioners with guidelines about how, when, and what to disclose.

Although there are quite a few studies focusing on TSD (see reviews in Henretty & Levitt, 2010; Hill & Knox, 2001), one conspicuous area in which we have limited information is experienced therapists' perspectives about the use of specific disclosures. Such information is important because these therapists have years of accumulated experience with different clients, during which they have repeatedly made decisions about whether, when, and how to disclose. It is also likely that experienced therapists have periodically revisited their philosophical positions about TSD, leading them to either evolve over time or consolidate their original stances, based on practical clinical application of the intervention with a range of clients. Finally, examining actual instances of TSD in therapy is important because researchers have suggested that studying therapists' use of TSD, in general, is of limited use (Gallucci, 2002).

In this study, we used the definition of TSD put forward by Hill and Knox (2002) in their review: "therapist statements that reveal something personal about the therapist" (p. 256), that is

to say, it involves a revelation about the therapist's life or person outside of therapy. For

example, the therapist may disclose to the client, "When I was your age, I experimented with

drugs too." We explicitly excluded nonverbal self-disclosures (such as a family photo on the

desk) and self-involving disclosures that entail the therapist sharing "immediate or past feelings

or experiences in response to the patient's experiences or feelings" (also known as immediacy)

(Gelso & Palma, 2011, p. 343).

Theoretical Perspectives about TSD

Historically, the debate has been whether TSD hinders (Freud, 1958; Greenson, 1967;

Curtis, 1982) or enhances treatment effectiveness (Bugental, 1965; Kaiser, 1965; Jourard, 1971;

Strassberg, Roback, D'Antonio, & Gabel, 1977; Derlega, Hendrick, Winstead, & Berg, 1991).

More current literature, however, indicates that therapists and theorists of various orientations are

converging on the beliefs that TSD can have a variety of beneficial effects if used intentionally

and judiciously and that avoiding disclosure in all circumstances may have detrimental effects on

both the client and the therapy (Eagle, 2011; Farber, 2006; Henretty, Currier, Berman, & Levitt,

2014; Hill et al., 2008; Henretty & Levitt, 2010; McWilliams, 2004). Indeed, in his recent

analysis of the ethical and clinical considerations surrounding TSD, Barnett (2011) suggested

that a policy of rigidly failing to share any personal information with clients could potentially

damage the relationship and clients by engendering "a very sterile psychotherapeutic

environment" (p. 317). In other words, according to the literature, TSD itself is neither a good

nor a bad intervention *by definition*; rather, its effectiveness and appropriateness depends in great

measure on contextual factors (Henretty & Levitt, 2010) and therapist skill (Hanson, 2005).

Empirical Research about TSD

    Analogue Studies. The findings from analogue studies have been mixed (see Appendix A). Researchers have found that: (a) students' previous experience in therapy may or may not affect their ratings of TSD events, "therapist," and "session;" (b) beliefs about the strength of the working alliance prior to TSD may be an important contextual factor that affects students' ratings; (c) TSD (in its varying types) may or may not affect students' perceptions of "therapist" trustworthiness, expertise, empathy, warmth, credibility, attractiveness, professionalism, and ability to inspire hope; students' levels of self-disclosure; students' ratings of "session" smoothness, depth, and positivity; and students' helpfulness ratings for "sessions" (McCarthy & Betz, 1978; Dowd & Boroto, 1982; Hoffman-Graff, 1977; Reynolds & Fischer, 1983; Myers & Hayes, 2006; Yeh & Hayes, 2011).

    Analogue and simulated studies offer the benefit of experimentally controlling variables of interest. However, many of these studies asked participants to respond to recorded or written (analogue) "client" and/or "therapist" stimuli and/or used non-client (student) volunteers in single brief (e.g., 6-, 10- or 12-minute) sessions, neither of which is a close approximation of actual therapy. Hill and Knox (2002) suggested that results of analogue studies might not be generalizable to real therapy. For example, Kushner, Bordin, and Ryan (1979) compared therapist responses to a filmed client (an analogue) with therapist responses to real clients in intake sessions, and found that therapists behaved differently in the two situations. The researchers concluded, "One cannot assume that results obtained in analogues can be extrapolated to real therapy settings," and emphasized, "therapist behavior is highly responsive to situational factors" (Kushner et al., 1979, p. 766). In other words, the complex context of real-life therapeutic dyads cannot be recreated in therapy simulations. It is difficult, if not impossible,

to simulate contextual variables such as client and therapist background, much less the interplay between the two individuals (i.e., the moment-by-moment interactional sequence; Hill, 2009) and among therapist intentions and interventions and client reactions, perceptions, and changing needs and goals.

Non-analogue studies. *Client perspective.* Research from naturally-occurring psychotherapy has provided rich qualitative accounts of clients' views on the positive and negative effects of TSD (see Appendix A). Some of these studies have compared types of disclosure in a nominal way (e.g., self-involving/self-disclosing, reassuring/challenging, helpful/non-helpful) whereas others have examined variables such as the helpfulness, amount, and relevance of TSD, and their relationships to treatment process and outcome variables. The findings have led to several conclusions: (a) TSD can have positive or negative consequences, though positive effects have been more prevalent; (b) TSD occurrence is related to the quality of the therapeutic relationship and client involvement in therapy and is related to treatment progress and treatment outcome; (c) failure to disclose may be detrimental to the therapeutic alliance; (d) consequences of TSD may be affected by contextual factors such as client expectations and preferences about TSD, the strength of the working alliance before the TSD, and the skill level with which TSD is delivered; and (e) clients assess the therapist's intentions for disclosing and evaluate TSDs for relevance to their issues and therapeutic needs (Ain, 2008; Audet, 2011; Audet & Everall, 2010; Barrett & Berman, 2001; Hanson, 2005; Hill et al., 1988; Hill et al., 1989; Knox et al., 1997).

Therapist perspective. In contrast to the rich *qualitative* accounts of clients' views, research on therapists' views of TSD use in naturally-occurring therapy tends to be *quantitative.* Most studies support the idea that therapists do disclose to clients (Ain, 2011; Berg-Cross, 1984;

Edwards & Murdock, 1994; Hill, 1988; Knox & Hill, 2003; Lane et al., 2001; Robitschek & McCarthy, 1991), and that the most frequently shared information pertains to professional issues, whereas the least frequently shared information is related to sexual issues (Berg-Cross, 1984; Edwards & Murdock, 1984). Most findings suggest that therapists disclose primarily to promote universality and provide reality testing (Gallucci, 2002; Mathews, 1988), though some indicate that modeling, increasing similarity between client and therapist, validating the patient's experience of reality, strengthening the therapeutic alliance, or increasing clients' awareness of alternative viewpoints are common rationales for disclosing (Edwards & Murdock, 1994; Lane et al., 2001). The primary reason for *not* disclosing is because therapists do not want to shift the focus away from the client; secondary reasons vary, and include: interfering with the transference, interfering with patients' material, and concerns about creating doubt about the therapist's mental health (Gallucci, 2002; Lane et al., 2001; Mathews, 1988). Several authors (Gallucci, 2002; Hill, 1988; Knox & Hill, 2003) suggested there is some ambivalence on the part of therapists regarding TSD, and one (Gallucci, 2002) specifically found that at least some therapist respondents decried the lack of training they received in this area.

Most of the research on therapist views of TSD has been collected via survey methodology, which limits the response options. Respondents are forced to choose among a finite selection of options, rather than thinking deeply about specific disclosures and then stating their rationales. Several authors (Ain, 2011; Audet & Everall, 2010; Gallucci, 2002; Henretty & Levitt, 2010) asserted that it is difficult to derive general guidelines for practitioners because the context of each disclosure is very specific. Gallucci (2002) may have said it best when she wrote that discussion of TSD in general terms (i.e., therapists responding to questions about disclosing with clients in general, rather than describing the context of a specific disclosure with a specific

client under specific circumstances,) is not useful because of the complicated and context-specific nature of the intervention. Furthermore, in their research-based suggestions for practitioners on how to use TSD, Knox and Hill (2003) theorized that there are 7 types of disclosure. More recently, Pinto-Coelho, Hill, and Kivlighan (2015) found in a study of actual TSD in naturally-occurring psychotherapy that different types (e.g., facts, feelings, insight) were differently associated with client ratings of the therapeutic relationship. Unfortunately, though it provides us with important information about how therapists see TSD, most of the extant research is, in fact, general. This lack of specificity limits our ability to draw conclusions about what kinds of disclosures are beneficial, when, and with whom.

Consensual Qualitative Research Methodology

Consensual Qualitative Research (CQR; Hill, 2012) was designed to use individual participants' experiences to create a comprehensive, richly detailed picture of the phenomenon of interest. The objective is to create a meaningful consolidation of qualitative data that highlights both commonalities and differences among participants. Using an inductive, or bottom-up approach, CQR enables conclusions to be drawn based on what participants have said. Each judge views the world through his/her own filters, and that affects how s/he will interpret the data. Judges have different perspectives and there is a need to discuss the data extensively until the team reaches consensus (i.e., "an unforced unanimous decision," Hill, 2012, p. 10) about the data. In conducting CQR, "We recognize the mutual influence between researcher and participant" (Stahl, Taylor, & Hill, 2012, p. 26). CQR provides a structured process that enables researchers to come as close as they can to representing participants' experience, through the use of multiple perspectives. The process facilitates staying close to the original data. There is also

the use of one or more auditors to avoid groupthink and ensure the trustworthiness of emerging

conclusions.

Purpose of the Present Study

The major purpose of this study was to examine master therapists' perceptions about

disclosures that they have actually used in individual psychotherapy. We wanted to interview

master therapists because they should have thought the most extensively about how and why

they use TSD. For the purposes of this study, my hope is that "master therapists" recruited via

peer nominations are "the best of the best" among psychologists. The intention was that

participants would meet the key requirements Skovholt and Jennings (2005) put forward as

critical signposts on the path from novice to master therapist: (a) a lot of time, (b) extensive

experience with clients, (c) a desire to use that experience in order to develop professionally, (d)

an open attitude that encourages exploration, (e) reflection on the work, (f) comfort with

uncertainty and ambiguity, and (g) a progression through stages of development.

We first wanted to examine what master therapists consider when deciding whether or

not to disclose (e.g., client's presenting issues, strength of the relationship, therapist's comfort

with material, client's anticipated reaction) to begin to parse out when participants believe the

intervention is warranted and when it is contraindicated. Second, we wanted to know more about

how expert therapists evaluate the success/efficacy of their disclosures as well as about their

perceptions of what constitutes successful and unsuccessful disclosure. The third purpose was to

explore how experienced therapists handle challenging situations related to TSD. For example,

how do participants' handle situations in which they felt an internal pull to disclose? Finally,

what advice do experienced therapists give to trainees and early career practitioners about how to

decide whether, when, what, and how to disclose?

Lastly, we wanted to situate our sample in a larger context. Hence, we used participants' responses to questions from an existing measure, the Therapist Self-Disclosure Questionnaire (TSDQ; Gallucci, 2002) to examine the extent to which our participants believed they had disclosed certain types of information, factors that influenced their disclosure, reasons for disclosing or not disclosing, and changes in TSD over time. These data were used to compare this sample to a previous, larger sample.

Chapter 2: Method

Participants

Interviewees. Interviewees were 13 experienced licensed therapists all of whom were psychologists practicing full-time or part-time individual psychotherapy at the time of the study and who had been nominated as master therapists. Participants' demographic data is summarized in Table 3 (located in Appendix I). All 13 participants (100%; 9 female [69%], 4 male [31%]) identified as European American and identified their highest level of education was a Ph.D. in psychology (85% counseling, 8% clinical, and 8% learning theory). The average age of participants at the time of the study was 63.67 ($SD = 8.88$), and the average number of years in practice was 34.69 ($SD = 7.53$). Participants in the current sample rated their belief in and adherence to major theoretical orientations as follows (using a 5-point scale, 1 = *low*, 5 = *high*): psychodynamic ($M = 3.38$, $SD = 1.34$), humanistic/experiential ($M = 3.31$, $SD = 0.95$), feminist/multicultural ($M = 3.15$, $SD = 0.69$), and cognitive/behavioral ($M = 2.69$, $SD = 1.11$).

Interviewers and Auditors. Four female European American licensed psychologists (a 66-year-old faculty member, a 65-year-old faculty member, a 60-year-old private practitioner, and a 57-year-old clinical research psychologist) served as interviewers and auditors. All four interviewers had experience conducting CQR interviews and audits.

Judges. Judges included one 22-year-old post-baccalaureate with a B.S. in Psychology and a B.A. in Criminology/Criminal Justice and six graduate students (6 female, 1 male; 6 European American, 1 African American; M age $= 27.86$ years, $SD = 7.60$) in a counseling psychology Ph.D. program who had completed at least two psychotherapy practica at a large mid-Atlantic state university. All seven had been in therapy in the past and all but one were in therapy at the time of the study.

Measures

Self-disclosure definition. For the purposes of this study, therapist self-disclosure was defined as "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2002, p. 256). In other words, such TSD involves a verbal revelation about the therapist's life or person outside of therapy. This definition intentionally excluded both nonverbal disclosures (e.g., a family photo) and immediacy (i.e., disclosing feelings about the client or the therapy/therapist in the here-and-now).

Semi-structured interview The primary investigator developed the initial set of questions for the interview protocol based on a review of the relevant theoretical and empirical literature. The initial list was then revised based on input from the primary investigator's advisor. Next, the questions were reviewed, discussed, and revised based on feedback from the primary investigator's fellow classmates in a research methods class, a psychotherapy researcher, and two full-time practitioners. The dissertation advisor again reviewed the questions and made suggestions. The interview was then piloted with two advanced doctoral students who were not eligible to participate in the study because they were not experienced therapists. These pilot interviews helped to create a logical flow in terms of question content. The protocol was modified based on feedback from pilot interviewees, in consultation with the primary investigator's advisor. Finally, the interview protocol was reviewed by the dissertation committee and by the interviewers and modified before being considered final. (See Appendix F for interview protocol.)

Therapist Self-Disclosure Questionnaire (TSDQ) (Gallucci, 2002). The TSD survey measure was designed to investigate psychotherapists' intentional use of TSD as a therapeutic intervention. (See Appendix E for the measure and Appendix I for a summary of results.) No

information was available about how the measure was developed. Sample items included:

"Which of the following factors influence your decision to self-disclose? Check all that apply:

(*Type/severity of disorder, Phase of treatment, Quality of alliance, Client gender, Length of*

treatment, Client age)" and "If there has been a change in the frequency of your self-disclosures,

to what do you attribute the change? (*Change in theoretical orientation, Increased comfort with*

self-disclosing, Decreased comfort with self-disclosing, Specific training in self-disclosure").

Where applicable, an open-ended response option was added ("Other [please specify and provide

rating]:") to encourage participants to share additional thoughts not already present in the

questionnaire. No psychometric information was available for these items.

Responses to Gallucci's (2002) TSDQ items were used to situate the present study's

sample in the context larger of a larger ($N = 157$), more diverse sample (including participants

with Ph.D., Psy.D. and Ed.D. degrees and participants who saw children, adolescents, and

couples or families). Gallucci's sample also differed from the current sample in that it was

primarily male (63%; 37% female) and 57% of participants were aged 50-59, which was the

peak of a normal distribution ranging from 30 to 70+ years. Like the current sample, the majority

(all but 1) of Gallucci's participants were European American and endorsed psychodynamic

theory (39%) as their primary orientation, followed by cognitive-behavioral theory (30%),

eclectic theory (18%), and various other theories (13%). The average number of years of

experience for Gallucci's participants was 21.7 ($SD = 7.4$).

Demographics questionnaire. Participants completed a demographics questionnaire (see

Appendix D for the measure and Appendix I for results). Data collected included participants'

age, gender, race/ethnicity, experience of TSD in personal therapy, highest degree and year

completed, licensure, years of experience, theoretical orientation, typical presenting issue(s) of

clients, and typical number of sessions. Participants completed the demographics questionnaire after the interview.

Procedures

       Recruiting participants. Sample selection was conducted using exemplar methodology, whereby individuals who exemplify the construct of interest (i.e., highly developed, experienced psychotherapists) are intentionally identified and invited to participate in order to "view the upper ends of development in practice" (Bronk, 2012, p. 1). Nominations for participants were gathered using snowball sampling, specifically via personal contacts with faculty members, alumni, and current students of the counseling psychology and clinical psychology doctoral programs of local universities (e.g., American University, The George Washington University, Howard University, Catholic University, University of Maryland) as well as staff at these universities' counseling centers, and through local psychoanalytic institutes. This purposeful sampling method of recruiting therapists by peer nomination (Patton, 1990) has been used in past studies of seasoned therapists (Skovholt & Jennings, 1999, 2004; Vivino, Thompson, Hill, & Ladany, 2011).

       An initial email soliciting nominations and stating inclusion criteria for master therapists was sent to identified individuals from an electronic mailbox created specifically for this study (see Appendix C for nomination email). The email asked recipients to respond by nominating up to 5 "master" therapists in the Washington, D.C./Northern Virginia/Maryland metropolitan region to whom they would be likely to refer a dear friend or close family member for psychotherapy services. The purpose of confining the search to a specific geographic region was to limit the possible number of therapists considered in order to enhance the probability that individual therapists would receive multiple nominations. In addition, master therapists had to

work with adult clients, use TSD, and have practiced for at least 15 years. One follow-up email message was sent after two weeks to individuals who did not respond.

This process resulted in 62 therapists being identified as potential study participants. Each of 22 nominees who received at least 2 nominations were contacted via telephone by the primary investigator and also sent an individual email from TSDstudy@umd.edu informing them they were nominated by their colleagues as a master therapist and inviting them to participate in the study. The recruiting email message to potential interviewees (see Appendix C for recruitment email) included: the study's purpose, structure, and inclusion criteria; affirmation that approval for the study has been obtained from the university's Institutional Review Board; assurance of anonymity; risks and benefits of participating; and the time commitment involved. The email requested that the recipient reply to accept or decline the invitation. Of the 22 most-frequently-named nominees contacted, 5 declined (2 because they were not currently seeing many clients and therefore thought others would be better exemplars, 1 without providing a reason, 1 did not use TSD in clinical work, and 1 was too busy to participate) and 4 did not respond to emails or voice-mail messages.

The 13 interviewees who replied by phone or by email that they were willing to participate received an email message (see Appendix C) informing them of the steps for participating (e.g., telephone interview and online measures). The email included a copy of the interview protocol (Appendix F) and a copy of the informed consent form (see Appendix C) as well as a link to a website where the participant could respond to inclusion criteria checklist items and acknowledge informed consent (see Appendix C). The third and final email message (see Appendix C for participant email #2) was sent after interviews had been conducted. It thanked participants for participating in the interview and provided a link for participants to

complete the TSD and demographics questionnaires. These questionnaires were completed after

the interview so as not to influence participants' responses to interview questions.

Biases/expectations. In accordance with Hill's (2012) guidelines for conducting CQR,

research team members (i.e., interviewers/auditors and judges) individually documented in

writing their expectations and personal biases about the research topic. Expectations consist of

"beliefs that researchers have formed based on reading the literature" (Hill, Thompson, &

Williams, 1997, p. 538) whereas biases are "personal issues that make it difficult for researchers

to respond objectively to the data" (Hill, Thompson, & Williams, 1997, p. 539). Research team

members discussed and attempted to "bracket" (i.e., set aside) their biases and expectations when

evaluating the data (Hill et al., 2005). A brief summary of research team biases and expectations

is reported here to enable readers to evaluate the findings in the context of these biases and

expectations.

Interviewers'/auditors' biases and expectations. All 4 of the auditors agreed that TSD

can be helpful at times, assuming they do not create a sense that the client had to take care of the

therapist. All agreed that in the context of long-term treatment and a strong therapeutic

relationship, there may be times when it would be "weird" not to share relevant experiences.

They all also agreed that there are times when it is clear to the client that something is happening

and it may be helpful for the client to have information about exactly what that is, rather than to

"create too much mystery" or in cases when the client's fantasies may be worse than reality, but

that proceeding with caution and considering the client's presenting issues, psychology, and

likely response to the TSD are all important. All agreed that use of TSD depends on the client

and the client's needs. One auditor suggested that clients like when therapists disclose something

clients are struggling with that the therapist has resolved. Another auditor indicated that she only

discloses about resolved issues and that she does so to normalize behaviors and to make herself more human to clients. One auditor emphasized that the therapist's comfort with sharing is a critical factor in deciding to disclose. Two auditors suggested that when not disclosing is sometimes wounding to the client.

Training interviewers. During a training session before conducting interviews, interviewers documented and discussed their expectations and biases. Interviewers also practiced asking interview questions, with one of the interviewers presenting a practice case.

Interviews. Once nominees agreed to participate, confirmed they met inclusion criteria, and completed the online informed consent, one of the interviewers telephoned or emailed the participant to schedule a 60- to 90-minute, semi-structured interview. When scheduling the interview, the interviewer requested that the participant review the interview protocol in advance, reflect on answers to the questions, and select the clinical vignettes they planned to discuss.

Interviews were conducted by telephone and audio recorded. Before beginning the interview, participants were reminded of the purpose of the study, and informed that the interview would be recorded and transcribed, and would be confidential. Interviewers then proceeded with asking questions from the semi-structured interview protocol, along with unscripted probes to gather more in-depth information. At the end of the interview, the interviewer thanked the participant and informed him/her that s/he would receive an email with the interview transcript. Finally, transcripts of interviews were sent to participants for their review via email, and they were given the opportunity to respond with corrections, clarifications, and additional thoughts. None provided feedback or additional input.

Confidentiality and transcription. To ensure participants' confidentiality, interviewees were assigned a code based on the interviewer's name. These codes were used to name the audio

files that were sent for transcription. During transcription any remaining identifying information (e.g., names and references to specific locations) was removed. Research assistants transcribed the interviews verbatim, and interviewers reviewed the transcriptions to check for accuracy.

Recruiting judges. Candidates were recruited personally by the primary investigator. Criteria for selection included interest in psychotherapy research and CQR, professionalism, and motivation. All judges had completed an online basic ethics course for those conducting human subjects research.

Training judges. Before coding the qualitative data, judges were required to read the Knox and Hill (2003) and Henretty and Levitt (2010) reviews of the TSD literature to ensure they had a general understanding of the intervention and its use in psychotherapy. In addition, judges read an article by Knox, Hess, Petersen, and Hill (1997) that explains how CQR methodology was used to analyze client perceptions of helpful TSDs in therapy. All judges met together for the first two (3-hour) meetings. During the first meeting, judges discussed assigned readings and the primary investigator summarized key points from the literature review and provided an overview of the CQR process to facilitate discussion and encourage questions. During the second meeting all of the judges worked together to code the first transcript. After the first meeting, judges were split into two teams of 4 judges each. The primary investigator participated as a judge on each of the two teams to ensure consistency in coding across teams. Given the differing ages and education levels of the judges, the primary investigator repeatedly emphasized the importance of ensuring each judge participated equally in the process. In both teams, judges were encouraged to monitor themselves and one another to ensure no one dominated the conversation or failed to have their say.

Judges' biases and expectations. Judges discussed their expectations and biases as a

group during training and were encouraged to share this information openly as biases and

expectations are directly relevant to the data analysis process. After the group discussion, judges

were encouraged to document any new biases and expectations. All 7 of the judges indicated that

TSD can be either helpful of harmful, and that it is important to keep the focus on the client

when disclosing. All also agreed that TSD can facilitate deeper connection and thereby enhance

the therapeutic relationship, with one judge saying TSD "has the potential to help the client feel

more connected to or trusting of the therapist, which can improve the relationship." Three judges

indicated that it is important to use TSD with intention, that TSD can facilitate client exploration

and lead to new insight, that it can help clients see therapists as more human, and that TSD

should not be used for the therapist's needs. Two judges believed it is important to use TSD

sparingly, that it must be relevant to the client's issues, that it is only appropriate with certain

clients, that the therapist should attend to and process the client's reactions to the TSD, and that

TSD can help clients get more in touch with their feelings. Ideas endorsed by only one judge

included: TSD can be used to cultivate transparency, vulnerability, and egalitarian dynamics;

TSD should be used with caution; refusal to disclose can be harmful; refusal to disclose can

make the therapist seem cold and lacking in empathy; TSD should not be strictly avoided; TSD

can be used to normalize the client's experience; some clients may need the therapist to disclose

to model appropriate disclosure of personal information; and the therapist should only disclose

resolved issues. One judge also said, "I do not believe therapists can foster deep emotional

experiencing without [TSD]." Three judges mentioned their therapists' use of TSD and how it

affected them. Three reflected on how they use TSD in their work with clients.

Fostering multiple perspectives. Before coding began and throughout the data analysis, the principal investigator led discussions with the research team about the importance of ensuring that each individual member be given the opportunity to fully participate in the discussion and that no individual or combination of individuals exert undue influence on the final ratings. The primary investigator trained the judges and made a special effort to ensure that each team member expressed his/her perspective fully and listened to others respectfully. Decisions made by consensus have been shown to be higher in quality as a result of diverse views being considered (Michaelsen, Watson, & Black, 1989; Miller, 1989; Sundstrom, Busby, & Bobrow, 1997). Given that final "judgments about the meaning of the data" (Hill et al., 2005, p. 196) were established through consensus among the judges, fostering an environment in which everyone felt comfortable sharing their perspectives hopefully facilitated the data analysis.

Developing domains. The first step of CQR is to create a list of domains, or unique topic areas, into which the qualitative data may be grouped according to content. Judges read through a transcript together and generated domains that fit the data. "Chunks" of information about similar topics from the first two transcripts were used to start the domain list, and additional transcripts were reviewed to revise the domain list until it stabilized (i.e., all data in an interview fit well into existing domains). Working as a team, judges then coded "chunks" of information into the domains.

Constructing and auditing core ideas. Core ideas are summaries of the data that capture the essence of a participant's statement in fewer words, and in clear and understandable language. Working as a team, judges reviewed the transcript data for a specific case and consensually created core ideas. The primary investigator created a consensus version of each transcript including raw data coded into domains and core ideas. Each consensus version was

first audited by the primary investigator, then sent to two external auditors (including the

interviewer for that case) for feedback. The research team then accepted or rejected the auditors'

changes and sent the revised version to them again for final review and another round of

revisions, until consensus was achieved between the research team and the auditors.

   Conducting and auditing cross analysis. The cross analysis enables identification of

common themes across participants. In this step, judges looked at all of the core ideas across

participants for a specific domain and consensually constructed categories reflecting common

themes within that domain. Core ideas were put into these categories. Again, two auditors

reviewed the primary research team's cross analysis and provided feedback on the structure of

the category list (e.g., whether some categories should be combined or were some too broad and

should be divided into smaller groupings) and on how well the data was reflected in the wording

of the categories. The research team then accepted or rejected the auditors' changes and sent the

revised version to them again for final review and another round of revisions, until consensus

had been achieved between the research team and the auditors.

   Reporting findings. Once cross-analysis results had been audited and finalized, the team

used frequency counts to determine how representative categories were of the overall data set.

Frequency was determined based on the number of participants whose core ideas appeared

within each category. Based on recommendations from Hill and colleagues (2005; 2012),

"general" consisted of data from all or all but one participant (12 or 13), "typical" consisted of

data from more than half of participants up to the cutoff for general (7 to 11), and "variant"

consisted of data from at least two participants to up to half of the participants (2 to 6). Data for

just one case was allotted to an "other" category in each domain and was not included.

Chapter 3: Results

Qualitative data presented in this section include detailed descriptions of each domain,

organized by research question. Background information from the quantitative TSD measure is

provided in Appendix I. Frequencies from each category and subcategory for domains (a), (b),

and (f) are included in Table 1 (located in Appendix G). To allow for comparison of the clinical

examples (successful, unsuccessful, and feeling pulled to disclose), frequencies from each

category and subcategory for domains (c), (d), and (e) are included in Table 2 (located in

Appendix H). Based on recommendations for conducting CQR cross-analysis (Ladany,

Thompson, & Hill, 2012), when comparing successful, unsuccessful, and feeling pulled to

disclose subsamples, frequencies had to differ by at least 30% of cases to be considered

meaningfully different. Such differences are indicated in Table 2.

Thoughts on Helpfulness of TSD

Typically, therapists in the sample said they thought TSD can be helpful and powerful.

For example, C2 described TSD as important, crucial to therapy, and a powerful way of being

real with clients. K1 said TSD is an important piece of his repertoire, and that TSD has the

potential to be a critical incident or a turning point in therapy.

General Intentions for Disclosing

Typically, participants said they used TSD to build and maintain the therapeutic

relationship. This category included making the therapist seem more human, helping clients to

feel understood, facilitating a sense of connection, and helping clients to feel comfortable sharing

things with the therapist. For example, B2 said s/he would disclose to strengthen the alliance or

to convey a sense of true understanding of something in the client's experience; B3 said that

TSD can deepen the connection and level of intimacy with the client by establishing mutual trust

and symmetry in an otherwise "asymmetric" relationship; K1 said TSD can be used to make the

therapist more human and real; and M3 indicated that TSD deepens the relationship, helps clients

feel understood, and makes clients feel safe and more comfortable sharing things in the

therapist's presence.

A second typical reason for using TSD was to facilitate exploration and lead to new

insight. Therapists spoke about using TSD to deepen the work in various ways, such as

encouraging clients to open up and explore more deeply, moving clients toward expressing their

emotions, or helping clients gain new insight or a new perspective. For example, B1 used TSD to

suggest something clients might have trouble acknowledging or to "open new avenues" in the

therapy. Similarly, B3 used TSD to "broaden the therapy" when clients are stuck or at a plateau,

and P4 used it to advance therapy or remove a block. P3 found TSD useful to help clients see

that things can change for the better when "dealing with particularly difficult circumstances."

Variantly, participants said they disclose to provide support, primarily in terms of

establishing universality and normalizing clients' experiences. B1 said she might use TSD to

communicate, "We may be crazy, but we're not alone." Likewise, C1 used TSD to share "a sense

of common humanity" with clients. Thus, therapists described using TSD to help clients

understand they are not alone.

Research Question 1: What factors have shaped master therapists' views of TSD?

Factors That Shaped Master Therapists' Views of TSD

Three factors emerged that shaped therapists' TSD use. Each category is described in

detail below.

Training. First, typically, therapists indicated they had training experiences that

encouraged them to be open to using TSD. Therapists said supervisors, co-therapists, and other

colleagues discussed, modeled, and encouraged use of TSD. For example, C1 remembered

learning that the person of the therapist is important in therapy and gives the therapist the ability

to persuade or influence clients. P3 spoke of learning about the importance of viewing the

therapist as a real person. B3's post-doctoral peer supervision caused B3 to see TSD as "one of

the conditions that would allow for a deeper connection between you and the patient." B1 had a

supervisor who said, "the patient is as strong as you are" and that TSD was fine as long as you

"kept track of it."

Second, therapists typically said they were trained not to self-disclose or discouraged

from using TSD. B1 said she was taught that therapy was about the client, that "you didn't reveal

yourself at all," and that the message received was "do not disclose." Similarly, B3 tried some

TSD in his first practicum and said his supervise was "horrified by it, or at least taken aback by

it." The supervisor told B3 TSD was not useful. Likewise, P2 said it was a given that TSD "was

something we didn't do," and P3 emphasized that supervisors encouraged trainees to maintain

"an abstinent and neutral position" with clients.

Third, variantly, therapists did not receive any training. They did not have any memories

of TSD training in graduate school, and had few memories of discussing it in supervision.

Personal therapy. First, typically, participants had positive TSD experiences in their

personal therapy, although many participants had more than one course of therapy and therefore

had more than one experience of TSD. They described therapists disclosing how they were

similar to their clients, which led to new insights and deeper, more trusting relationships. For

example, K1 said he had his therapist "up on a big pedestal" and said "every time the therapist

would disclose that helped humanize" him. K1's client found the therapist's TSD to be

extremely helpful and it made K1 want to help others in the same way. Likewise, P3's therapist

disclosed a past relational challenge that helped "normalize lots of things" going on in P3's life and was "very calming and hope-inspiring" for P3. P3 said this experience made the idea of disclosing less taboo and informed her own approach to using TSD with clients. B2 disclosed most often about loss because one therapist disclosed effectively about loss. Thus, therapists had vivid memories of their therapists' TSDs and their effects, and drew connections between their own experiences of positive TSD in therapy and their current use of TSD with clients.

Second, participants typically said their therapists disclosed minimally, or they wanted more TSD from their therapists. They described struggling to feel close to therapists who did not disclose. For example, B3 thought his therapist's non-disclosure may have been damaging. He felt "deprived a lot," and believed a deeper connection would have resulted had the therapist used more TSD. Similarly, C1 described learning something about her therapist from reading an obituary after the therapist's death. C1 felt deeply wounded that she had not known that she and the therapist had shared a specific struggle the participant had spoken a lot about in therapy. She believed it could have been beneficial for her had her therapist chosen to share. Thus, therapists described non-disclosing therapy as "cold" and found these therapists to be withholding.

Third, variantly, participants indicated that their therapists had disclosed too much. For example, C2 said she had to end the therapy because her therapist spent "the whole session going on about himself." Similarly, C3 said that although his first therapist was very important for him, he disclosed too much and was also a "model of what not to do." Participants described therapists disclosing very personal information, such as an attempted suicide on the therapist's part. Thus, these participants indicated that in some cases their therapists had poor boundaries and failed to keep the focus on their clients.

Family and social environment. Variantly, therapists said their families and social

environments encouraged TSD in two markedly different ways. On one hand, therapists recalled

working to *overcome* experiences from childhood, such as when parents were intrusive, causing

them to set overly tight boundaries on self-disclosure, or when the family norm was extremely

secretive, and this was not a norm therapists valued. For example, K1 spoke of the

destructiveness of keeping secrets. Likewise, P3 spoke of "really dramatic things that had been

hidden" in her family, how these secrets had affected the family, "not for the better," and how

this reinforced her sense that "transparency is typically the best policy." On the other hand,

therapists also spoke about the influence of family and friends who believed in being genuine,

open, and immediate with one another, and how this positively influenced them. P4 said that

being a parent influenced her to move in a more disclosing direction.

Also variantly, therapists were not sure of the influence of their family and social

environment on their TSD. Therapists expressed uncertainty about how and whether their

families and early learning experiences had affected their feelings about TSD. For example, B2

said he was not sure how much influence his personal history had on his feeling that TSD is

"verboten." B3 said her family was fluid in some ways and restrictive in others, and remembers

having confused being open with self-disclosure. M1 had varied experiences, with her family

being perhaps over-sharing whereas she felt she could trust her friends to keep private whatever

she confided in them. Thus, for these therapists, the influence of their family and social

environments on their TSD was mixed or unclear.

Research Question 2: How do master therapists' views of TSD evolve over time?

Changes in Participants' TSD Use over Time and Attributions for These Changes

Typically, therapists indicated that they were currently more comfortable and relaxed using TSD than they were early in their careers, and that they disclose more now than they did before. Therapists said that when they first began practicing they disclosed judiciously because of concerns that TSD might be harmful and take attention away from the client. They spoke of worrying about doing something wrong and of feeling their lack of expertise caused them not to use TSD when they were first starting out as therapists. For example, C2 said she used to worry that TSD would undermine her authority with clients in the same age range, but she no longer worried about that. Therapists described their early efforts at TSD as not very nuanced and more often initiated by the client. Therapists also said they were now less restricted and more flexible in their use of TSD than they were in the past. B3 said TSDs are "almost second nature now," and K1 spoke of gaining experience and learning through having made mistakes. Therapists also spoke about feeling less self-conscious with TSD now than they were earlier in their careers. M1 said she does not plan TSD ahead of time, but trusts those that emerge from what is happening in the session more than she used to do. P4 said that she had become more trusting of his/her ability as a healer to handle it if something goes wrong and was "not afraid to be seen anymore," which made her more real and spontaneous.

Variantly, therapists said they disclose less now than they did early in their careers. These therapists spoke of becoming more conservative in their use of TSD over time. For example, P2 said that she started out not disclosing, began disclosing more over time, and today sees TSD as "self-serving" and therefore tends not to use it.

Research Question 3: What do master therapists consider when deciding whether or not to self-disclose?

Recommendations for What to Consider When Using TSD

Therapists' descriptions of what they consider when deciding whether or not to disclose were very similar to their advice for what trainees should consider. Thus, we combined these two domains.

Be thoughtful and strategic. First, therapists typically indicated that it is important to be thoughtful and strategic about using TSD. They suggested asking oneself, "What is going on?" "Who is this client?" "How much of what you're doing is for you and how much of what you're doing is for them?" and "Will it be useful?" before disclosing. They indicated that it is important to identify the intention behind the disclosure and to consider how the client might respond, as well as what might be missed if TSD is used and the therapist becomes the focus. C1 recommended that, "beginners think of an idea of what they might disclose and think it through before doing it." Therapists cautioned that it is important not to disclose just because it feels good. P4 advised that therapists should make sure the TSD "is not ego-based and that it comes from an authentic place and would help the alliance."

Proceed with caution when feeling an urge to disclose or when the client requests TSD. Second, therapists typically recommended proceeding with caution when feeling pulled to disclose or when the client requests TSD. Therapists noted that one can always come back to a TSD later, recommended sitting with the feeling of wanting to make a TSD before doing so, and said early-stage trainees should not disclose in real time. B3 said to "be careful about disclosing when there is pressure to do so from the client," and P4 said "the stronger a therapist feels

pressure from the client to disclose, the less likely the therapist should disclose." Likewise, B2 said, "When in doubt, sit quietly."

Disclose in the contest of long-term therapy or a strong relationship. Third, typically, therapists recommended disclosing more in the context of long-term therapy or a strong therapeutic relationship than in short-term therapy or in the absence of a strong relationship. They spoke about considering the depth of the relationship, the strength of the therapeutic alliance, and the therapist's emotional connection with the client before disclosing. Therapists said they tend to be more cautious early in treatment and more open over time.

Ensure that the focus is on the client rather than on the therapist's needs. A fourth recommendation therapists typically emphasized was that it is important for TSDs to stay focused on the client, rather than on the needs of the therapist. Therapists spoke about the importance of disclosing in a way that enhances the client's exploration or experiencing. C3 said it is important that TSD come from a "transparent, present space," rather than from "exhibitionistic tendencies." Similarly, C1 noted that she had never disclosed the same thing to two clients because TSD should be highly relevant to the client.

Establish and abide by clear guidelines for how to approach TSD with clients. Fifth, typically, therapists recommended establishing clear guidelines for how to approach TSD and sticking to those guidelines. Examples of such guidelines included: preparing clients at the start of therapy for how one plans to respond to requests for TSD and ensuring one understands what is asked before answering. In addition, therapists emphasized that an important guideline would be that the trainees do not have to disclose if they do not want to or if it does not feel right. In other words, the therapist should consider his/her own sense of safety and comfort before disclosing.

Do not disclose with clients who cannot tolerate knowing about the therapist. Sixth, therapists typically suggested refraining from disclosing with clients who cannot tolerate knowing more about the therapist (e.g., low functioning clients and those with personality disorders or severe pathology). Therapists also said it is important to consider the client's presenting issues and the therapist's experience of the client (e.g., the client's openness to hearing about the therapist). Therapists were not likely to disclose with clients who have loose boundaries, who would have curiosity that goes beyond the TSD, if it might contaminate the therapeutic alliance, and if clients were narcissistic or borderline or bipolar (i.e., whose response might be, "but this isn't about you, it's about me").

Disclose when not disclosing violates the basic social contract. In the first of four variant categories of recommendations, therapists recommended disclosing if not disclosing would violate the basic social contract. For example, therapists spoke about the harm that could be done to the relationship if therapists fail to disclose "obvious" content (e.g., pregnancy or injury). Likewise, therapists recommended disclosing when clients might be affected by something happening in the therapist's life such as cancelling a session for illness, a family emergency, or if the therapist has suffered a personal loss recently that might affect his/her work with clients. Therapists emphasized considering the client's needs when deciding whether or not and how much to disclose about such events based on how much the client would notice or be affected by them.

Do not disclose material that is too personal, emotional, or unresolved. Second, therapists variantly recommended not disclosing material that is too personal, emotional, or unresolved. P3 said it is important to know one's "personal triggers," and to be prepared to

attenuate one's emotions around these triggers. K1 indicated that "inappropriately personal material" should never be disclosed, and B2 said trainees should not disclose things they are still working through or around which they have a lot of emotion. B1 said it is important to consider how disclosures about personal feelings toward the client might be misinterpreted (e.g., In the context of therapy in which both therapist and client are single and around the same age, it would not be appropriate to say, "I really like you and I really want you to continue in therapy.") P3 recommended only disclosing something from the past that has been "weathered" and that one has "gained some wisdom from."

Get training, supervision, and consultation about using TSD. Third, participants variantly recommended not disclosing until one has had training on how to disclose. Participants suggested that trainees be given case examples and asked to come up with things they might disclose as practice. They also recommended discussing potential TSDs and how they may or may not be useful for the client in supervision before proceeding. For more seasoned practitioners, therapists recommended consulting with a trusted colleague before disclosing.

Evaluate the effects of TSD by observing the client's reaction. Finally, variantly, therapists said it is important to evaluate the effects of TSD. Therapists spoke about paying attention to the client's response, being aware of whether TSD was helpful or harmful, and asking clients how the TSD affected them. M3 recommended treating TSD like tasting a new food, and suggested that it would be wise to try a little bit to "test the waters" and see how it goes. Likewise, C2 recommended disclosing a small amount and seeing how the client receives it before disclosing more. P1 recommended not disclosing at the very end of a session in order to allow time and space to process the client's reaction to the TSD.

Research Question 4: What characterizes successful disclosure?

This section begins with a brief demographic summary for the successful vignettes, followed by a successful disclosure exemplar selected from the sample. The categories that emerged from the successful disclosure examples (also summarized in Table 2, found in Appendix H) are then described. All 13 participants shared a successful example of disclosure, so, for successful cases, General = 12 to 13, Typical = 7 to 11, Variant = 2 to 6.

Cases with Successful Disclosure

Demographics. Clients' (9 female; 4 male) presenting issues were typically both intrapersonal (e.g., anxiety, depression) and interpersonal issues (e.g., relationship concerns). Typically, the length of treatment for successful TSD cases was more than one year.

Exemplar. In this case, a middle-aged male client was seeking therapy from P3 for stress and co-parenting issues stemming from concerns about his son who was gifted and had ADHD. The therapist felt the client might have been parenting his son in "pretty rigid and sometimes harmful ways" and also asking his child to act in ways that were not appropriate to the child's developmental level. The therapist and client had a strong therapeutic relationship before the TSD. In terms of intentions for the TSD, P3 wanted the client to feel understood and reassured that he could get through his struggles. The therapist also wanted to inspire hope that things would get better with the client's son, and to give the client a "light at the end of the tunnel." The therapist shared with the client, "My son is also gifted and has ADHD. During adolescence, my partner and I decided to prioritize our son's self-esteem, open communication, and our relationship with him *above* school and homework issues. It had a pretty happy ending. Once my son reached the appropriate neurological maturation, he was able to move forward in college and graduate school."

After the TSD, P3's client expressed gratitude and said he felt hopeful. The therapist felt the client became more attached to her as a result of the TSD. The therapist believed that the TSD gave her more credibility, and also made it clear that she really understood the client's struggle. After the TSD, the client became more committed to the therapy. In addition, the client was more able to let his spouse take the lead with their son in moments when the client felt stuck.

Antecedents. First, variantly, before the TSD, therapists said that their clients were experiencing negative emotions, such as increased anxiety about a situation at work or feelings of regret about the state of an important relationship. For example, B2's client was grappling with feelings of regret about not having repaired a conflictual relationship with a parent before the parent became ill with cancer. M3's client was distraught and "feeling like an inadequate parent."

A second variant antecedent was that the therapist was experiencing personal or professional concerns, including countertransference. For example, B3 was dealing with mental fogginess in sessions due to undergoing chemotherapy treatment for cancer. C1's parents had health issues and were approaching death, and C1 "wanted one last experience with parents before they died." In addition, a number of C1's clients had raised this issue of declining elderly parents, so C1 was reflecting a lot on "the complexity of thoughts and feelings when making end-of-life care decisions" for parents whose health is failing.

Third, variantly, therapists described the therapeutic relationship as strong before the TSD. For example, C3 described himself as being "very honest" in the relationship with the client, for whom he said he had "a lot of regard." C3 said the client was "very tuned into" him and that the two of them were similar in some ways. Similarly, P2 indicated that she and her

client were "very fond of each other" and liked each other quite a bit. P2 also said that the client was good at "reading" her. P3 indicated simply that she had a good alliance with the client.

Fourth, therapists variantly described the therapeutic relationship as weak or said there was a recent rupture. B3 said the client had stated a belief that the therapist could not help. Similarly, K1 had a growing sense that the client was questioning his abilities to help with relationship struggles. C2 described her client as difficult, devaluing, dismissive, and angry. P1 indicated work with the client was "laborious" and "emotionally restrictive," which made it hard to get to know her.

Intentions. First, typically, therapists used TSD to provide support, primarily by establishing universality and normalizing clients' experiences. They wanted to convey that they had had similar experiences and could identify with what their clients were going through emotionally. C1 wanted to communicate that "a good person could feel this way," and M3 wanted to help the client feel less inadequate and understand that she "is an okay person and a good mom," even though she had made some mistakes. M1 wanted to normalize the client's experience of loss and grief.

Second, therapists typically hoped to facilitate exploration and insight, thereby deepening the level of treatment. C1 spoke of wanting to help the client "accept unacceptable feelings" and work through the emotions to be able to live with decisions made and "be at peace." B3 spoke of hopes for the therapy "to take off" by expanding the client's notions of how he handled vulnerabilities. P4 wanted to help the client with reality testing. Therapists also spoke about wanting to calm clients and to help clients realize that they could change and that things would get better. P3 wanted to give the client "a light at the end of the tunnel" to see that his struggles were temporary.

Third, typically, therapists said they wanted to build and maintain the therapeutic

relationship, to help clients feel understood and connected, and to be "human and real" (K1) with

clients. M1 wanted to connect with the client "in a powerful, emotional way," and to give the

client "more than facts" in order to connect in "an emotionally meaningful way." P4 disclosed to

build the working alliance, to convey understanding, and to show support that the client was not

getting outside of therapy. P1 described TSD as a tool to help a resistant client feel more

comfortable opening up.

Fourth, variantly, therapists intended to facilitate action or change on the client's part via

TSD. Or, in the case of grief, they wanted to encourage clients to postpone taking action. M3

wanted to encourage the client "to not stay helpless," and P1 wanted to help the client be more

present both in and outside the therapy room to reduce symptoms. P3 hoped the client would

learn a new strategy for dealing with difficult situations.

Content. Therapists typically disclosed similarities between the therapist and client that

were relevant to clients' issues or content and were accurate (i.e., there was, indeed a similarity,

based on clients' reactions to the TSD). These accurate, relevant TSDs consisted of similarities

in experiences with family. Some disclosed about being caregivers to and decision makers for a

declining parent, their ambivalence about wanting a declining parent to live and yet wishing the

parent's suffering would end, their grief and loss reactions after losing a parent and the related

feelings of loss that their children would not have the opportunity to develop relationships with

the dying/deceased grandparent, and their experiences related to raising children. C3 disclosed an

experience from his own childhood, sharing with his client that it was possible to get past the

effects of having a difficult father.

Consequences. Consequences, for the purposes of this study, were defined as what happened after the TSD. In other words, we are not implying causation, only a chronological sequence of events, with consequences coming after, but not necessarily caused by, TSD. Three typical categories and four variant categories of consequences of TSD emerged. First, typically, therapists indicated a deepening of the therapeutic work in terms of exploration and insight following TSD. Thus, clients' negative feelings were alleviated, their hope increased, engagement in therapy increased, clients relaxed or felt less tension, seemed more hopeful, remained present and connected rather than withdrawing, and became more committed and less resistant to the therapy. For example, P1 realized that her binge eating was connected to her family dynamics.

Second, typically, clients' positive reactions included verbally stating that the TSDs were helpful and/or referring back to the TSD in a positive way in future sessions. B3's client said that, including the client's previous three courses of therapy, B3's TSD was "the most helpful thing that was ever said to me" and described it as "a game changer."

Third, therapists typically said the therapeutic relationship improved following successful TSD. They indicated that TSDs allowed clients to see therapists as more human, to idealize them less, and to connect with them more. C2 described the disclosure as an important joining that helped the dyad "build a crucible." C2 believed the TSD satisfied the client's need for a more personal relationship with someone who understood her both experientially and empathically. Likewise, P2 said the TSD had therapeutic value because it "cemented my bond with the client" and made the client feel like she mattered to the therapist. P3 felt the client became more attached to the therapist after the TSD because the therapist understood the struggle.

Fourth, variantly, clients' negative feelings were alleviated or their hope increased. Following TSD, therapists said clients relaxed and seemed less nervous. C3 said that after the TSD the client predicted a less negative future.

Fifth, another variant consequences was that clients made changes in life outside of therapy. These changes included intrapersonal and interpersonal behavior changes that facilitated clients' achieving their goals. For example, when M1's client was anxious, she would remember she did not have to make decisions immediately. P3's client was able to improve his romantic relationship by being more respectful, less critical, and more affirming of his spouse.

Sixth, variantly, therapists had negative or ambivalent feelings about having disclosed. C2 worried that the client might continue to ask follow-up questions after the TSD, or that the client might engage in social comparison that would be uncomfortable for both of them. Although she did not think the outcome of the TSD was negative, P2 expressed regret that it had not been strategically designed to have a therapeutic outcome.

Research Question 5: What characterizes unsuccessful disclosure?

This section begins with a brief demographic summary of the unsuccessful vignettes, followed by an unsuccessful exemplar. The categories that emerged from the unsuccessful disclosure examples (also summarized in Table 2, found in Appendix H) are then described. Two participants could not recall an example of unsuccessful disclosure so $N = 11$. General = 10 to 11, Typical = 6 to 9, Variant = 2 to 5.

Cases with Unsuccessful Disclosure

Demographics. Clients' (8 female; 3 male) presenting issues were typically both intrapersonal and interpersonal issues. Treatment length at the time of the TSD was typically more than 1 year and variantly less than one year.

Exemplar. In this case (B2), a woman in her thirties came to therapy because she struggled with occasionally disliking her two-year-old son. The therapist disclosed to normalize that there are times we do not like our children, "When my child was a toddler, I also sometimes did not like her, and it felt shameful." The client responded to the disclosure with impatience and seemed to want the therapist to stop talking so that they could get back to what the client had been talking about. The therapist knew the disclosure was not successful because there was no deepening or increased emotional awareness. Reflecting on the disclosure, the therapist realized that he had assumed that the client was beating up on herself for not liking her son, and wanted to share another way of feeling about it, but that assumption had been wrong given that the client did not seem to have any feelings about not liking her son. Ultimately, the therapist took the cue from the client that the TSD was not welcome and began to wonder if narcissism made the client feel like "there's only room for one of us in here." The therapist said there were no lasting consequences to the disclosure.

Antecedents. First, typically, before the TSD, the therapist was experiencing personal or professional concerns, including countertransference. For example, B3 spoke of an ethic in his family where "caring was doing" that was triggered by B3's client's deep hurting and "self-repudiating ways." C2 did not agree with her client's apparent sense that the client should be able to have whatever she wanted without having to sacrifice to get it. C2 said that her countertransference around the client's entitlement mentality made it hard to accept the client's choices. P3 spoke of being unsettled because the client, who was very reactive, had blown up at one of her "remaining friends." P3 believed that the client needed more support than once a week therapy and was anxious that the client's isolation would destabilize the client and lead to another episode of major depression. C3 was feeling ill but had dragged himself out of bed to

come to work and said during the session he was "pretty self-absorbed and really caught off balance" when the client commented on it. K1 said his "guard went down" when he learned that he and his new client had a number of acquaintances in common. K1 had ignored the "buzzers" going off in his head and enjoyed talking with the client for a while about their shared acquaintances.

A variant category of antecedent was that clients were experiencing negative emotions, such as being "freaked out" by learning that one's child was gay. Another client was experiencing a lot of pain and guilt, feeling suicidal and describing self as "somebody's hell."

Therapists variantly described the therapeutic relationship as strong before the TSD. They said the relationships with their clients were feeling pretty good, growing, and beginning to feel fruitful in terms of exploring new material, and in the case of B3, "deep stuff."

Variantly, therapists described the therapeutic relationship as weak or said there was a recent rupture. C1 said the client was "cruising for a rupture" so she could yell at and be mad at C1. C2's client had trouble being open in therapy and C2 described the client as difficult to work with as a result. C2 felt that the client did not want to know her and that there was no room for a relationship with this client.

Intentions. First, typically, therapists wanted to provide support, primarily by establishing universality and normalizing clients' experiences. They wanted to communicate that they understood what their clients were going through emotionally, and to validate clients' perceptions. For example, M1 wanted to help the client recognize that other people experience similar feelings and to empathize by sharing that M1 had had similar feelings.

Second, variantly, therapists identified no intention. Therapists said that they did not use TSD "in a strategic way as a therapeutic technique."

Third, therapists variantly hoped to facilitate exploration and insight. C2, for example, wanted to offer the client a different family model for how things could be. Likewise, M1 disclosed to help the client gain a new perspective.

A fourth variant intention was that therapists said they wanted to facilitate action or change on the client's part. Therapists spoke of wanting to encourage clients to try something new that might work more effectively for them. B3, for example, wanted the client to seek support outside of therapy. C2 hoped to give the client permission to take her career more seriously so she could contribute to the family's income.

Fifth, variantly, therapists said they wanted to build and maintain the therapeutic relationship. Therapists spoke of trying to connect with clients, to make clients feel that the therapist cared, and to create "a sense of shared reality."

Content. Therapists typically misjudged and disclosed similarities between the therapist and client (i.e., there was not a similarity, based on clients' reactions to the TSD). Therapists disclosed about family or relationship concerns, such as experiences with parenting their own children, with caregiving for their parents, and with their search for and relationships with romantic partners, or about personal topics, such as about the therapist's professional endeavors outside of therapy. Variantly, therapists disclosed information that affected the client's treatment (e.g., the therapist was feeling unwell, the source of noise dyad could hear from outside the session room).

Consequences. First, generally, clients had negative reactions following the TSD. Therapists spoke of clients' anger, impatience, and withdrawal, and emphasized that there was no deepening of the work or increased emotional awareness on clients' parts. B1's client agreed to the TSD too readily, and B3's client "slipped into this shell of pleasantry" and stopped

disclosing. Although C2's client did not respond to the TSD, C2 believed the client felt criticized and judged. Clients of B2, M1, and P3 responded to the TSDs with impatience and eagerness to get back to what they had been saying. Clients of C1, C3, and P2 responded with anger, and both C3 and P2 terminated therapy.

Second, typically, therapists spoke of regretting having made the TSD. Therapists talked about perhaps having mishandled things as well as about the timing not being right. B1 said perhaps something other than TSD would have been better in the moment, and C1 said she felt that she had misjudged the situation. M1 felt pulled to disclose because the client wanted her to "fix the problem."

Third, variantly, therapists questioned the appropriateness of TSD with this client. Therapists spoke about clients' narcissism and/or disinterest in learning about the person of the therapist, clients misunderstanding therapists' meaning, and therapists not knowing clients well enough to realize TSD would not be welcome. For example, M1 said, in retrospect, that TSD was not what the client needed or wanted at the time.

Research Question 6: How do master therapists handle feeling pulled to disclose?

This section begins with a brief demographic summary for the vignettes of feeling pulled to disclose, followed by an exemplar selected from the sample. The categories that emerged from the unsuccessful disclosure examples (also summarized in Table 2, found in Appendix H) are then described. Two participants could not recall an example of feeling pulled to disclose so: $N = 11$. General = 10 to 11, Typical = 6 to 9, Variant = 2 to 5.

Cases for Feeling Pulled to Disclose

Demographics. Clients' (5 female; 4 male; 2 couples) presenting issues were typically interpersonal issues and variantly intrapersonal issues. Treatment length was generally unspecified.

Exemplar. In this case, therapist had used the same medications as the client had in the past and had experienced severe negative side effects. She cared about the client and "felt pulled to tell the client not to take her meds because of my experience with those meds." However, she chose not to disclose because she was not a physician, it was outside the boundaries of her role as a psychologist, the client might have a different reaction to the medications than the therapist did, and it would not have been helpful. Rather than disclose, the therapist helped the client explore experiences with the medication.

Antecedents. Typically, therapists were experiencing personal or professional concerns, including countertransference. Therapists talked about feeling pulled to disclose about similar medical treatments, shared interests (e.g., certain musicians), or vacation destinations. C1 was familiar with the ups and downs of long-term marriage that might have been relevant for the couple she was seeing, and P2 knew what it was like to wrestle with the choice of inviting an elderly parent to live with you.

Content. Generally, therapists felt pulled to disclose similarities in experiences. Typically, these similarities seemed relevant to client's issues (although that was not confirmed as clients did not have an opportunity to react). Examples include experiences with family, such as parenting, handling conflict in romantic relationships, and caregiving for an elderly parent. Variantly, the similarities were not related to the therapeutic work (e.g., common music interests).

Reasons therapist did not disclose. First, variantly, therapists realized that the TSD would have been more for their own needs than for the clients' needs. Therapists also imagined that if they disclosed, clients would ask questions and the focus would shift to them rather than the client. P3 thought that it was more helpful for the client to focus on his own experience than to learn about the therapist's experience. P3 believed that staying with the client's experience would enable the client to observe his own feelings and thinking about what he might do differently, which would allow the client to readily call on and use those ideas in the future.

A second variant reason therapists gave for not disclosing was that TSD would not have been consistent with maintaining appropriate boundaries in therapy. Therapists also talked about not wanting to disclose because certain information felt too personal to share. B2, for example, did not disclose because he had some shame around being a parent of an acting out child. Though it may have been helpful, C1 had reservations about sharing details of her romantic relationship because it would reveal too much and might make C1 seem self-aggrandizing.

Third, variantly, therapists said TSD did not seem therapeutic or appropriate at the time. Therapists worried that TSD might be dismissing of the client's problem, or that they did not know enough about the situation to be sure TSD would be helpful. Some therapists mentioned the importance of keeping the conversation focused and on task (e.g., C3 did not disclose because doing so would have invited "cheap, easy linkages around commonalities").

Comparison of Subsamples

This section describes meaningful differences (i.e., differences of at least 30% of cases) among subsamples (i.e., general attitudes, successful TSDs, unsuccessful TSDs, and feeling pulled to disclose examples.) See Table 2 in Appendix H for a summary of meaningful differences among subsamples.

Antecedents. In both successful and unsuccessful TSD, an antecedent was that clients were experiencing negative emotions, but not in examples when therapists felt pulled to disclose but chose not to do so. Thus, it seems therapists were more likely to disclose in the context of clients struggling and more likely not to disclose in the absence of negative client emotions.

For examples of unsuccessful TSD, therapists typically indicated they were experiencing personal or professional concerns (countertransference) before the TSD. Likewise, therapists who felt pulled to disclose typically said countertransference was an antecedent. In contrast, therapists in successful TSD described countertransference as a variant antecedent. Thus, therapists seemed most likely to experience countertransference prior to unsuccessful TSD and feeling pulled to disclose than with unsuccessful TSD. However, countertransference was also an antecedent for some successful TSD cases.

Intentions. This section compares general attitudes with successful and unsuccessful TSDs. For general attitudes, building and maintaining the therapeutic relationship and facilitating exploration and leading to new perspectives were typical, whereas providing support was a variant intention. However, for actual instances of successful TSD, all three of these intentions were typical. For actual instances of unsuccessful TSD, therapists typically said they wanted to provide support and variantly they wanted to facilitate exploration and lead to new perspectives as well as to build and maintain the therapeutic relationship.

Of these three intentions, the only one that differed by greater than 30% of cases was to build and maintain the therapeutic relationship. (See Table 2 in Appendix H for a summary of meaningful differences among subsamples.) Building and maintaining the relationship was espoused more frequently by therapists as a general intention than as an intention for successful TSD, and, in turn, more frequently for successful TSD than for unsuccessful TSD. Thus,

therapists were more likely to cite building and maintaining the relationship as a general

recommendation than as an actual intention they had for successful TSD, and in turn, more likely

to cite it as an intention for successful than for unsuccessful TSD.

Facilitating action or change was not included in therapists' general intentions for TSD.

However, therapists variantly mentioned it as an intention for both successful and unsuccessful

TSD. Thus, therapists were more likely to have the intention of facilitating action in actual TSD

(both successful and unsuccessful) than in general recommendations for using TSD.

In unsuccessful TSDs, therapists were variantly unable to identify an intention. This

category did not come up in general recommendations about TSD or in successful examples of

TSD. Thus, therapists were more likely to lack an intention for unsuccessful TSD than in

successful TSD.

Content. Similarities in experiences were what therapists disclosed for successful TSD

when therapists felt pulled to disclose but chose not to, and unsuccessful TSD. More specifically,

in successful TSD, therapists disclosed similarities in experiences with family that were directly

relevant to the client's work and were perceived by clients as accurate (based on clients'

responses to TSD). Therapists were also pulled to disclose similarities, that typically seemed

relevant to clients' issues and variantly did not, but these similarities were less likely to be about

experiences with family. Because pulled to disclose content was never shared, we do not have

clients' responses to indicate whether these would have been perceived as accurate similarities.

In contrast, clients' reactions suggested that unsuccessful TSDs were *not* similarities, although

therapists may have expected that they would be. In unsuccessful TSD, the topics seemed to be

related to clients' work (and were similar to content in successful TSD), but missed the mark

because therapists did not see things quite the way their clients did. For example, C1 shared that

with her parents, once they entered their eighties it was hard for them to recuperate from health issues, but C1's client believed her mother would recover. Thus, successful TSD involved accurate similarities in experience with family that resonated with clients; instances in which therapists felt pulled to disclose involved similarities in experiences that seemed relevant to clients' therapeutic work but that therapists chose not to share; and unsuccessful TSD involved therapist family or personal topics that were not perceived by clients as relevant or in tune with their perspectives.

Consequences. When comparing examples of successful and unsuccessful TSD, all but one consequence differed by subsample. The exception was the client making changes outside of therapy; this came up variantly for succesful TSD cases. For successful TSD, the consequences were primarily, although not exclusively, positive: deepened the therapeutic work, improved the therapeutic relationship, client positive reaction, and client negative feelings alleviated. None of these positive consequences occurred for unsuccessful TSD, for which the consequences were all negative: client negative reaction, therapist regretted disclosing, and (variantly) therapist questioned appropriateness of TSD with this client. Thus, successful TSD tended to have positive consequences whereas unsuccessful TSD tended to have negative consequences. We did not capture consequences for feeling pulled to disclose because TSD did not occur in such instances.

Experience Participating in the Study

Participants typically indicated that preparing for and participating in the interview caused them to think more deeply about TSD, to have new realizations, and to wonder how other experienced therapists use TSD. One therapist indicated the interview enabled her to be more self-observant, and another believed the interview would impact his use of TSD with clients in

the future. Some therapists planned to spend time reflecting on what they said during the

interview. One therapist wondered whether she should be disclosing less. Another determined

that he should process TSD with colleagues or with himself to determine his purpose and

whether the TSD actually served the client's needs.

      Typically, therapists enjoyed the interview and described it as fascinating, thought-

provoking, delightful, stimulating, pleasant, or joyous. On the other hand, therapists variantly

indicated that some of the questions were difficult to answer because of remembering the details

or parsing the results of the TSD from other aspects of therapy.

      Variantly, participants indicated that the interviewer was helpful in terms of restating key

points, making helpful clarifications, and making the interview feel conversational. One therapist

said the interviewer kept her on task, and another said the interviewer put him at ease.

Chapter 4: Discussion

The findings of this qualitative study revealed information about master therapists' general attitudes about using TSDs and specific experiences with successful TSDs, unsuccessful TSDs, and feeling pulled to disclose. In terms of general attitudes, therapists believed that some types of TSD can be helpful in some situations if used sparingly, but had many cautions about using TSDs. In successful TSDs, antecedents variantly included clients experiencing negative emotions and therapists experiencing countertransference; therapists typically intended to provide support, facilitate exploration and insight, and build and maintain the therapeutic relationship; the content was typically about similarities between the therapist and client and relevant to the client's issues; and the consequences were typically positive. In unsuccessful TSDs, the typical antecedents were countertransference reactions; the typical intention was to provide support; the therapist typically misjudged and the content (family/relationship concerns) was not perceived as relevant by the client; and the consequences were negative. In instances when therapists felt pulled to disclose but did not, the typical antecedent was countertransference; and the content of what was not disclosed was similarities in experience that typically seemed relevant to the client's issues. In this section, we compare findings for general attitudes, successful TSD events, unsuccessful TSD events, and events related to feeling pulled to disclose. We also discuss recommendations for disclosure.

Comparison of Subsamples

Differences among general attitudes, successful, unsuccessful, and pulled to disclose examples are discussed in this section (although note that data only exist for intentions for the general attitudes and no consequences are available for pulled to disclose). See Table 2 in Appendix H for a summary.

Antecedents. The client experiencing negative emotions was a variant antecedent for both successful and unsuccessful TSD and did not occur for pulled to disclose. It is not surprising that clients were experiencing negative emotions, given that psychological distress is a primary reason clients seek psychotherapy (Hill, 2014).

For both successful and unsuccessful TSD (but not for pulled to disclose), therapists variantly described a strong relationship as an antecedent. Also variantly for successful and unsuccessful TSD (but not for pulled to disclose), therapists described a weak relationship or a recent rupture. We were somewhat surprised that relationships were not typically strong for successful TSDs, given recommendations in the literature (Gallucci, 2002; Myers & Hayes, 2006; Pinto-Coelho et al., 2015) for disclosing in the context of a strong alliance or positive relationship. Likewise, we were not expecting ruptures to be antecedents for successful TSDs, although ruptures have been described as "inevitable over the course of therapy" (Gelso & Samstag, 2008, p. 269). It seems that some therapists were using TSD to try to strengthen or mend the relationship.

The only antecedent for therapists feeling a pull to disclose (typical for unsuccessful TSDs and feeling pulled; variant for successful TSDs) was therapists experiencing personal or professional concerns or countertransference, which occurred more frequently in both feeling pulled and in unsuccessful TSD than in successful TSD. It is not surprising that some therapists had unresolved issues (Gelso, Nutt Williams, and Fretz , 2014; Hayes, McCracken, McClanahan, Hill, Hargy, & Carozzoni, 1998). It seems likely that in such cases, when therapists were experiencing emotional reactions, they were more likely to experience a strong desire to share, characterized by (Stiles, 1987) as disclosure "fever." In our cases of feeling a pull to disclose,

our master therapists resisted the temptation (although these may have been represented in the unsuccessful disclosures).

It is interesting to note that therapists experiencing personal or professional concerns or countertransference was present as an antecedent even in cases of successful TSD (although only variantly). Perhaps this should be expected, given that most therapists experience some countertransference reactions in most therapy sessions (Gelso and Hayes, 2007; Hayes et al., 1998). Perhaps in cases of successful TSD and feeling a pull to disclose but choosing not to do so, therapists were aware of their emotional reactions and managing them, whereas in the cases of unsuccessful TSD, they were unable to manage their countertransference or were unaware at the time that it was occurring.

Although there is literature that addresses the pros and cons of disclosing countertransference reactions to clients (e.g., Gabbard, 2001; Gelso & Hayes, 2007; Myers & Hayes, 2006), reviews of the literature on TSD (Henretty & Levitt, 2010; Hill & Knox, 2002; Knox & Hill, 2003) did not mention countertransference. In a theory paper about use of TSD by therapists-in-training, Davis (2002) suggested that "countertransference temptation" plays a strong role in influencing beginning therapists' decisions both to disclose and not to disclose. Davis argued that trainees may be particularly prone to "both temptations to make a self-disclosure when it is not indicated, as well as temptations not to self-disclose when to do so would be helpful" (p. 442), particularly in the face of clients' strong transference feelings, in order to avoid their own powerful feelings. He attributed this tendency to beginning therapists not having mastered the myriad abilities (e.g., cognitive processing of large amounts of information, learning to contain clients' and their own emotional reactions) required to practice effective psychotherapy and to their tendency to feel insecure and personally exposed regarding

their nascent clinical abilities. It seems unlikely, given their experience levels and their

descriptions of the events, that our master therapists disclosed to avoid clients' or their own

feelings.

Intentions. We did not collect data on intentions for examples of feeling pulled to

disclose, so this section compares general intentions with those for successful and unsuccessful

TSDs. For the most part, therapists' intentions for general recommendations, successful TSDs,

and unsuccessful TSDs were similar to those presented in the literature (Farber, 2006; Henretty

& Levitt, 2010; Knox & Hill, 2003), although frequency differed by subsample.

First, building and maintaining the therapeutic relationship was espoused as a general

intention more frequently than in successful TSD, and, in turn more frequently in successful than

in unsuccessful TSD. Similarly, strengthening the relationship was consistently one of the top

three reasons therapists cited in surveys (Lane et al., 2001) for disclosing, so it makes sense that

it would be foremost for therapists when thinking generally about TSD. However, in actual

clinical examples, it appears that other concerns are more salient.

Second, although facilitating action or change was not mentioned as a general intention

for TSD, it was mentioned for both successful and unsuccessful TSDs. It is possible that without

a specific client in mind, therapists may be wary of stating that they are trying to get clients to do

something differently. However, Farber (2006) emphasized the importance of sharing disclosures

of strategies to give clients ideas of how to think, feel, and behave differently, as therapists in our

sample appear to have done. Likewise, Hill (2014) recommended disclosures of strategy to

facilitate the change process.

Third, in unsuccessful TSDs, some therapists were not able to identify an intention for the

TSDs, whereas none of the therapists in successful TSDs indicated that they were not able to

identify an intention, and none of the therapists in general said that it was a good idea to not have

an intention. Not having a clear intention for TSD contradicts guidelines in the literature for how

to use TSD successfully in practice. Specifically, Knox and Hill (2003) recommended that

therapists have appropriate reasons for disclosing, and Henretty and Levitt (2010) advocated that

therapists only disclose with a clear rationale. Thus, one reason that some TSDs were

unsuccessful was that therapists did not have an intention. Obviously, there are times that

therapists are grasping for what to do in a difficult situation.

Our findings about differences between therapists' general thoughts about intentions for

TSD and the intentions they had for actual TSDs provide some support for Gallucci's (2002)

assertion that general attitudes when studying TSD are somewhat different from actual instances

of TSD in therapy. It also provides some support for Farber's (2006) suggestion that therapists

are more likely to present their ideal rather than real selves when responding to surveys about

their TSD use, reporting what they wish they did rather than what they actually do. These results

suggest that we should take what we learn from survey data with a grain of salt.

When therapists felt pulled to disclose, their reasons for not disclosing, all variant,

included realizing the TSD would have been more for their own needs than the client's needs,

recognizing that the TSD would not have been consistent with maintaining appropriate

boundaries, and believing that TSD was not therapeutic or appropriate in the moment. Mathews

(1988) found that the most frequent reasons therapists gave for not disclosing were not wanting

to shift the focus away from the client and not wanting to interfere with the transference.

Similarly, Lane, Farber, and Geller (2001) found that survey respondents' most commonly-

endorsed reasons for not disclosing included interfering with the client's material and removing

the focus from the client. Likewise, in Gallucci's (2002) survey, the most frequently cited reason for not disclosing was shifting the focus from the client to the therapist.

Content. Across successful, unsuccessful, and pulled to disclose examples, the content involved a similarity between the therapist and the client. However, an important difference was that in the successful events, therapists seemed to be accurate about the similarity, whereas they seemed to assume that there was similarity when there was not in the unsuccessful events, based on clients' reactions. For the pulled to disclose events, there seemed to be a similarity between clients and therapists, and in these cases, the purported similarities seemed to be related to the client's therapeutic work. However, this was not confirmed by clients' reactions because therapists chose not to disclose.

For successful TSDs, content seemed to consist of benign biographical data and to be tailored to clients' individual needs per practitioner guidelines put forward by Knox and Hill (2003). In other words, these TSDs were therapeutically meaningful to clients as recommended by Audet and Everall (2010) and consistent with Ain and Gelso's (2008) recommendation that therapists disclose only information relevant to their clients. Comparison with the literature is limited because most previous research was done using survey methodology asking about TSD in general, rather than about actual TSDs used in therapy. However, survey responses suggest that sharing personal experiences (Gallucci, 2002), particularly in the area of interpersonal relationships (Edwards & Murdock, 1994), is, perhaps, a relatively common content area for TSD. A number of theorists and researchers have recommended that therapists disclose similarities between the client and the therapist (Audet & Everall, 2003; Berg-Cross, 1984; Hill & Knox, 2001) and relevant struggles from the past that the therapist has successfully resolved (see Henretty & Levitt, 2010 and Knox & Hill, 2003). In her latest book on helping skills, Hill

(2014) suggests that helpers use disclosures of similarities to reveal "personal information about ways in which they are like the client to help the client feel less isolated or alone," (p. 169) citing Yalom's (1995) emphasis on universality as an important change mechanism.

For unsuccessful TSDs, the therapists tended to misjudge, suggesting there was a similarity between therapist and client that did not resonate with clients as relevant or accurate. In our sample, clients evaluated these unsuccessful TSDs as having negative effects. Audet and Everall (2010) found that clients assessed TSDs based on their perceptions of therapists' attentiveness to, understanding of, and attunement with them, their issues, and their therapeutic needs. Furthermore, Audet (2011) found that clients evaluated TSDs as having positive or negative effects in part based on similarity to client's experience (similar preferred); congruence with client's personal values (congruent with client's issues/values preferred); and relevance/responsiveness to client's issues, needs, and the therapeutic context (high relevance preferred).

Consequences. As would be expected from the definition of successful and unsuccessful, consequences of successful TSDs were all positive, whereas consequences of unsuccessful TSDs were all negative (and of course there were no consequences in general attitudes and in pulled but not disclosed). Specifically, positive consequences for successful events typically included a deepening of the therapeutic work, improved therapeutic relationships, positive reactions from clients, and, variantly included alleviation of clients' negative feelings and clients making changes in life outside of therapy. Similarly, Knox, Hess, Petersen, and Hill (1997) found, according to clients, that helpful TSD enhanced the therapeutic connection, fostered the therapeutic work, helped clients feel reassured or normalized, helped clients gain a sense of universality, and led to client insights and change.

Clients' negative reactions to unsuccessful TSD included clients feeling impatient, angry, withdrawn, or judged. Clients in our unsuccessful TSD examples seemed to react in ways that suggested they believed their therapists' TSDs were inappropriate or irrelevant. Similarly, clients in the Audet and Everall (2010) study reported that when TSD was off base it indicated a lack of attunement, hindering the client's confidence in the therapist and the relationship. When clients in that study perceived TSD as irrelevant or inappropriate, they saw therapists as out of touch and unresponsive. Likewise, Derlega, Lovell, and Chaikin (1976) suggested that negative reactions to TSD indicate that therapists failed to meet clients' expectations for appropriate therapist behavior.

In addition, with successful TSD therapists variantly had ambivalent feelings about having disclosed (e.g., indicating it was not harmful but it might not have been helpful), whereas with unsuccessful TSDs, therapists expressed regret at having disclosed. A number of therapists in unsuccessful TSD questioned the timing of the TSD, suggesting it may have been premature. One therapist acknowledged liking the client "perhaps too much" and losing his professional bearing. Another said she disclosed because she wanted to "fix the problem," saying that she should have stepped back "into a stance of being…compassionate and empathic" rather than disclosing. These findings support those of Hanson (2005) that clients identified that unhelpful TSDs involved poor timing, sharing too much information, and lacking in technical neutrality.

Therapists also variantly questioned the appropriateness of TSD with the client with whom they had disclosed unsuccessfully, whereas they never questioned the appropriateness with successful TSDs. Therapists in our sample, when thinking about appropriateness, mentioned clients' narcissism, avoidance, and borderline features that may have rendered clients unable to deal with TSDs. These results are consistent with Henretty and Levitt's (2010) advice against

disclosing with clients who have poor boundaries, those who tend to focus on the needs of others rather than their own needs, those diagnosed with personality disorders, and those with weak ego-strength or self-identity.

Recommendations for TSD Usage

Our data yielded 10 recommendations for using TSD in therapy. Master therapists' descriptions of what they did and their suggestions for trainees were similar, so we developed one common list. As with our findings for intentions, most of the recommendations therapists provided for how to use TSD were consistent with those found in the literature (Henretty & Levitt, 2010; Knox & Hill, 2003). While I join Gallucci (2002) in arguing that the complicated nature and specific context of each TSD make it difficult to develop guidelines for the use of TSD, and concur with Davis (2002, p. 451), who noted, "whether a self-disclosure will further or hinder the development of the treatment process is ultimately determined by the unique qualities of the participants in the therapeutic dyad as well as where they are in the course of treatment," I also assert that continuing to learn more about how to use TSD therapeutically is important. As the following recommendations come from master therapists and were accompanied by a discussion of actual instances of successful and unsuccessful TSD, I hope they will both be helpful to practitioners and add to the body of knowledge on how to use TSD.

Be thoughtful and strategic. Master therapists indicated it was important to think through what is happening in the session, who the client is, and whether or not a TSD would be useful before disclosing. This recommendation is consistent with Knox and Hill's (2003) suggestions that TSD be used judiciously, that it include appropriate content that fits the particular client's needs, and that therapists have appropriate reasons for disclosing.

Proceed with caution when feeling an urge to disclose or when the client requests TSD. Master therapists recommended being cautious when feeling an urge to disclose. If pulled to disclose because of countertransference reactions, participants recommended countertransference management (Gelso & Hayes, 2007; Scheel & Conoley, 2012) rather than TSD.

Furthermore, master therapists suggested that therapists should be cautious about giving TSDs when clients request them. They also emphasized that it is important to understand exactly what clients are asking and why, in order to appropriately respond to their concerns. Similarly, Henretty and Levitt (2003) cited an unwritten rule that therapists should explore clients' reasons for requesting TSD before responding, noting that sometimes requests are actually statements, sometimes they involve boundary testing, and sometimes they are bids for reassurance.

Another note of caution was that participants suggested that early-stage trainees not disclose in the moment. This recommendation is similar to that of Henretty and Levitt (2010) who noted that it is important that therapists feel comfortable with whatever they disclose. As one participant noted, there is a lot for therapist trainees to process during a therapy session, and it would be easy for them to get overwhelmed. In addition, trainees may need help sorting through what is appropriate and therapeutic to disclose and what is not.

Disclose in the context of long-term therapy or a strong relationship. Contrary to Audet and Everall's (2010) findings that clients perceived TSD as contributing to development of the relationship early in the process, master therapists in our sample recommended disclosing more in the context of a longer relationship. This finding highlights both therapists' and clients' differing views regarding TSD and that different types may be used for different reasons in different stages of treatment. Our findings indicated that master therapists believed time is

needed to gain an understanding of the client's issues, to gain an understanding of how the client

is likely to respond to TSD, to establish an emotional connection, and to build a relationship. It is

likely that a positive relationship, developed over time, can serve as a foundation for TSD or as a

buffer for TSD should it go wrong. In addition, in terms of the client's dynamics, McWilliams

(2004) suggested that TSD made in an effort to normalize a client's experience may not have

much "therapeutic power unless it comes after a long period in which the patient realizes how

deeply convinced he or she is that the therapist cannot possibly understand—in fact, any

potential therapeutic power in such a revelation can be lost if it is made too soon," (McWilliams,

2004, p. 189).

Ensure that the focus is on the client rather than on the therapist's needs. Master

therapists emphasized the importance of disclosing for the client's needs rather than for the needs

of the therapist, with a focus on enhancing the client's exploration or experiencing. Likewise,

Knox and Hill (2003) encouraged therapists to be sure about why they are disclosing, suggesting

they should do so only if certain it is in the service of the client's needs, and Henretty and Levitt

(2010) suggested that disclosures should be consistent with the client's therapeutic goals.

Establish and abide by clear guidelines for how to approach TSD with clients.

Master therapists recommended establishing clear guidelines for how to approach TSD and

sticking to those guidelines. To my knowledge, this recommendation has not been included

explicitly in the literature, but the idea that therapists need to be prepared is implicit in

summaries of practical guidelines. For example, Henretty and Levitt (2010) strongly suggested

that therapists give thought to TSD before finding themselves in a position in which they must

make a decision about disclosing.

Do not disclose with clients who cannot tolerate knowing about the therapist.

Variantly, in the unsuccessful TSD examples, therapists questioned the appropriateness of TSD with a specific client. These therapists referred to narcissism, borderline tendencies, and other client characteristics that seemed to make it difficult for the client to hear the TSD. Similarly, it is widely acknowledged in the literature that some clients can handle TSD better than others (Henretty & Levitt, 2010). Knox and Hill (2003), for example, suggested that psychologically-minded clients may be more receptive to TSD than are less psychologically-minded clients. McWilliams (2004) cautioned therapists to consider clients' dynamics before disclosing given that some clients may perceive TSD as a frightening role reversal. She noted, as specific examples, that clients with a very depressed parent, who were parentified as children, or with significant narcissistic tendencies are likely to respond to a TSD with devaluation.

Disclose when not disclosing violates the basic social contract. Master therapists noted that harm might result if the therapist fails to disclose something obvious (e.g., pregnancy, injury) or when clients might be affected by something happening in the therapist's life (e.g., undergoing treatment for illness that affects the therapist's energy and focus during sessions). Similarly, McWilliams (2004) asserted that clients have the right to know things that will affect them and their therapy.

Do not disclose material that is too personal, emotional, or unresolved. In line with Knox and Hill's (2003) recommendation that therapists only disclose issues they have made peace with, our therapists recommended not disclosing material that is too personal, emotional, or unresolved. As Knox and Hill pointed out, it is unlikely that TSD about something the therapist has not resolved will be helpful to the client given that the therapist is likely not able to be objective about it and it is likely to raise countertransference reactions for the therapist.

Get training, supervision, and consultation about using TSD. Master therapists recommended not attempting to use TSD until one has received training, supervision, and/or consultation regarding how to do so effectively. One of the factors to which our participants (and Gallucci's, 2002) attributed their own increased comfort with and use of TSD was having received specific (post-graduate) training. Likewise, the literature highlights a lack of training in TSD (Gallucci, 2002; Henretty & Levitt, 2013; Knox & Hill, 2003). In one study, clinical psychology trainees and their supervisors were reluctant to broach the subject of TSD (Bottrill, Pistrang, Barker, & Worrell, 2010), confirming previous findings that few training programs included discussions about the use of TSD (Burkard, Knox, Groen, Perez, & Hess, 2006). We thus echo Henretty and Levitt (2010) and Pinto-Coelho, Hill, and Kivlighan (2015) in suggesting that both seasoned practitioners and trainees need preparation in order to handle inevitable decisions about when, whether, what, how, and with whom to disclose.

Evaluate the effects of TSD by observing the client's reaction. Master therapists spoke about paying attention to the client's response, being aware of whether TSD was helpful or harmful, and asking clients how the TSD affected them. They suggested that a client's response can provide feedback about whether additional TSD is warranted or to be avoided. This suggestion echoes Knox and Hill's (2003) recommendation to ask clients for their reactions to disclosures.

Conclusion. A general theme that emerges from our findings is that TSD should be used in service of the client's needs to deepen the therapeutic work. Many of our master therapists' recommendations have to do with focusing on the client, and more specifically, on being aware of the client's dynamics and what the client needs in the moment. These recommendations emphasize disclosing in a way that the client can absorb and that will be healing and/or

enhancing of the client's experiencing. Thus, use of TSD requires general attunement to client's dynamics, attunement to the client's readiness and ability to use a specific TSD, and self-awareness related to one's own comfort and skill with using TSD.

Successful use of TSDs also likely means disclosing in different ways at different stages of therapy. As Davis (2002, p. 451) sagely noted, "whether a self-disclosure will further or hinder the development of the treatment process is ultimately determined by the unique qualities of the participants in the therapeutic dyad as well as where they are in the course of treatment." Thus, timing is an extremely important consideration.

Our findings support other researchers' (Audet & Everall, 2010; Hanson, 2005; Pinto-Coelho, Hill, & Kivlighan, 2015) conclusions that TSD is a complex intervention requiring both deep knowledge about the client and a sophisticated perception of what is happening in the moment. TSD has the potential to be more powerful and helpful than other interventions (Hill et al., 1988) but it also may be riskier, because TSD could be unwanted, ill-timed, and/or perceived by the client as a misguided and unwanted bid for intimacy (Derlega, Metts, Petronio, & Margulis, 1993). TSD could also be viewed as an effort to get the client to care for the therapist, thereby highlighting the therapist's potential lack of attunement with the client and lack of attention to appropriate therapeutic boundaries (Knox & Hill, 2003; Pinto-Coelho et al., 2015).

Limitations

All of the therapists were experienced and were nominated by their peers as "master therapists." In addition, all were European American and seeing adult clients in private practice in the DC/MD/VA area. Most of them espoused a psychodynamic, humanistic, or feminist theoretical orientation. Thus, results may not generalize to other therapists, settings, or client populations.

A second limitation is that therapists themselves were the only source of data regarding the TSD events. Using self-reports of participants' perceptions of their experiences is, by definition, limited, as is typically the case with qualitative studies (Polkinghorne, 2005). Given that therapists selected the case examples they used in the interviews, there may have been some bias both in how they chose which clinical examples to share and in how they interpreted the success or lack of success of said TSDs. In addition, our data were dependent on therapists' retrospective recall, so it is possible that time had distorted their memory of the clinical examples they shared. Future researchers would benefit from including other sources of data, such as clients and/or third-party observers, to allow for triangulation of findings (Heppner, Kivlighan, & Wampold, 1999).

A third limitation, always present in CQR, is that the judges themselves played a role in the construction of the findings. Although judges attempted to identify and bracket their biases, CQR is a constructivist process involving subjective ratings, and results obtained from one group's consensual coding may not match those obtained by another group of judges. Further, interviewers and judges shared a bias that TSD can be a helpful intervention.

A fourth limitation is that the TSDQ scale (Gallucci, 2002) used to measure therapists' TSD use was developed for a dissertation and lacks psychometric data. Further research is needed to establish its reliability and validity.

Implications for Practice, Training, and Research

Practice. Implications for practice include therapists being mindful and intentional about using TSDs and paying attention to client reactions. In particular, we note that the importance of therapists resisting the urge to disclose when it might be unhelpful. Therapists may want to revisit their general policy regarding TSD (i.e., ask "Do I use it too often or too seldom?"),

reflect on their use of and comfort with TSD, and consider whether it is accommodating their clients' needs. Similarly, therapists may wish to incorporate into their practice a habit of reflecting on TSD, consulting with colleagues about it, and engaging in continuing education to increase their comfort with it. Therapists may also make a practice of inquiring about clients' previous experience of and expectations for TSD in therapy, as well as informing clients early in therapy of their approach to TSD. In addition, given that participants in our sample typically reported the influence of their own experiences in psychotherapy with their therapists having disclosed or not, practitioners may also want to make efforts to model effective TSD as appropriate for clients who are therapists-in-training.

Training. Given that our therapists reported a lack of formal training in TSD, trainers might review their curricula to ensure that education about TSD is included. In developing such training, trainers should keep in mind that the most compelling training components for our sample involved experiencing successful TSD in supervision or in being paired with more experienced therapists (e.g., group therapy). Likewise, talking about and experimenting with TSD in advanced practica may help trainees understand the complexities involved with disclosing therapeutically. In addition, trainees should be taught to identify the intention behind a TSD, to consider how the client might respond, to observe the client's reactions, to remember to keep the focus on the client, and to consider what might be missed if TSD is used (e.g., perhaps the client was about to come to an important insight or acknowledge a previously denied feeling). Likewise, trainees could be taught not to give in to the impulse to disclose. Perhaps a decision-making tool could be developed to assist trainees in deciding whether or not they should attempt TSD in a specific situation. This tool would address Gallucci's (2002) call for the development of a framework with which clinicians could be trained to make sound clinical

judgments regarding TSD. Similarly, a measure could be developed to assist therapists-in-training in evaluating TSD to determine whether disclosing was a good idea and to learn from instances in which it went wrong. Development of such a measure would fulfill Holmqvist's (2015) suggestion that psychotherapy training include an emphasis on helping trainees reflect on consequences of TSD. It might be helpful for trainees to know that master therapists are cautious about using TSD, have unsuccessful TSDs, and often feel pulled to disclose. Finally, given the role that personal therapy played in our sample's views on TSD, trainers may wish to consider recommending that trainees seek their own psychotherapy to learn about advanced, complex skills such as TSD.

Research. Given the moment-to-moment nature of therapeutic interaction, the context-specific nature of TSD, and the fact that therapists' responses regarding actual instance of TSD differs from their responses regarding TSD usage "in general," it seems important to continue to examine actual instances from real therapy in our research. Qualitative research that encourages respondents to think deeply about specific TSDs would be particularly useful. Areas for investigation include comparing the effects of TSD in long-term vs. short-term therapy; examining how the therapeutic relationship is related to the effects of TSD; examining how clients' presenting issues are related to the occurrence and effects of TSD; and examining how therapist countertransference, countertransference management, and countertransference temptation (Davis, 2002) relate to TSD. A potential fruitful methodology for future research is to use interpersonal process recall (i.e., reviewing tapes of sessions immediately after sessions and inquiring about the participants' reactions and intentions) to allow for immediate reactions to actual events. Using this method, the therapist's and the client's perspectives could be compared to increase understanding of what constitutes helpful and unhelpful TSD, as well as to learn more

about "when and how clinical pairs agree and disagree," as was recommended by Kronner and

Northcut (2015). Another direction for future research would be to examine the question of

whether it is primarily therapists-as-clients who feel withheld from by their therapists or if clients

in general tend to feel this way, and if so, to learn how feeling withheld from by one's therapist

is related to the development of the therapeutic relationship and therapy outcomes.

Appendixes

Appendix A: Review of Literature

This chapter begins with an overview of differing theoretical perspectives on TSD and includes summaries of relevant empirical findings from the literature. I first consider analogue studies, and then investigations of the intervention in naturally-occurring psychotherapy. The section on naturally-occurring psychotherapy begins with the client perspective, then reviews studies that included both client and therapist perspectives, and concludes with examinations of the therapist perspective. The literature review ends with summaries for the client and therapist perspectives and a brief summary of the literature on expertise in therapy.

Therapist Self-Disclosure

Theoretical Perspectives. In the past, psychoanalytic therapists argued that use of self-disclosure shifts the focus away from the client and therefore threatens to interfere with the therapeutic process (Freud, 1912/1958; Greenson, 1967; Curtis, 1982). They maintained that therapist self-disclosure hinders therapists' ability to act as a mirror or "blank screen" onto which clients project their emotional reactions, according to traditional psychoanalytic theory (Freud, 1912/1958, p. 118). In addition to raising concerns about disruption of therapeutic anonymity (Greenson, 1967) and inhibiting clinicians' ability to work with client transference (Goldstein, 1997), traditional psychoanalytic theorists feared that self-disclosure may reveal therapist weaknesses or vulnerabilities, thereby undermining the therapist's credibility in the client's eyes (Curtis, 1981, 1982) and damaging client trust in the therapist. However, contemporary psychoanalysis replaces the "blank screen" conception of the analyst with "a more active and interactional therapeutic role," (Eagle, 2011, p. 196), which for some, includes advocating use of therapist self-disclosure (Bridges, 2001; Davies, 1998; Ehrenberg, 1995; McWilliams, 2004).

Indeed, regarding disclosure of countertransference reactions, McWilliams (2004) describes it as "subtly dishonest to act as if one is 'blank' when one in fact is full of feeling," (p. 185) suggesting that in such cases, a candid reaction often deepens the work further than neutrality would.

Among the first to embrace the use of TSD, according to Henretty and Levitt (2010) and Farber (2006), were the humanistic theorists, who argued that therapist self-disclosure can have a positive impact on treatment, enhancing therapy's effectiveness (Derlega, Hendrick, Winstead, & Berg, 1991; Jourard, 1971; Kaiser, 1965) by encouraging honesty and understanding as a foundation for a stronger therapeutic relationship (Bugental, 1965; Jourard, 1971; Strassberg, Roback, D'Antonio, & Gabel, 1977). Specifically, they postulated that therapists can demonstrate genuineness, authenticity, realness, and mutuality through TSD (Goldstein, 1997; Robitschek & McCarthy, 1991), thus laying the groundwork for client openness, trust, intimacy, gains in self-understanding, and change (Hill & Knox, 2002; Rogers, 1951; Truax & Carkhuff, 1967). Humanists also pointed out that TSD enables therapists to model and encourage openness, vulnerability, strength, and allows for sharing of intense feelings (Knox, Hess, Petersen & Hill, 1997; Kottler, 2003; Rogers, 1951; Truax & Carkhuff, 1967), as well as helps therapists avoid appearing "overly secretive" (Barnett, 2011, p. 316). In his analysis of the ethical and clinical considerations surrounding TSD, Barnett (2011) suggested that a policy of rigidly failing to share any personal information with the client could potentially damage the relationship and the client by engendering "a very sterile psychotherapeutic environment." (p. 317).

Cognitive-behavioral therapists have also espoused the use of TSD. Goldfried, Burckell, and Eubanks (2003) described it as a tool that is useful for "strengthening the therapeutic bond and facilitating client change," (p. 555), providing feedback, reducing client fears, and modeling

effective functioning. Feminist and multicultural therapists use self-disclosure to decrease the power imbalance in the relationship, empower the client, and encourage collaboration in therapy. (Brown, 1994; Brown & Walker, 1990; Mahalik, Van Ormer, & Simi, 2000; Simi & Mahalik, 1997).

In sum, therapists and theorists of various orientations seem to be converging on the belief that TSD can have a variety of beneficial effects if used intentionally and judiciously. Furthermore, there seems to be some consensus that avoiding disclosure in all circumstances may have detrimental effects on both the client and the therapy.

Empirical Findings. In this section I consider analogue studies as well as investigations of TSD in naturally occurring psychotherapy, including surveys of therapists, providing an overview of findings from the literature from the past 4 decades.

Analogue studies. Henretty and Levitt (2010) and Hill and Knox (2002) summarized the extant TSD literature, emphasizing that most research in this area has used analogue data. As described below, definitions of and rating scales for self-involving and self-disclosing statements varied, and results from these studies were mixed (Hill, Mahalik, & Thompson, 1989).

In a study that was described to potential participants as "an investigation of procrastination through an interview with an experienced counselor" (Hoffman-Graff, 1977, p. 185), Hoffman-Graff used an experimental manipulation to examine how use of positive or negative self-disclosures affected interviewee perceptions of the interviewer and of their own behavior. While controlling intimacy, frequency, and duration of disclosures, as well as sex pairing of interviewer and participant, the author manipulated disclosure content (i.e., positive or negative) during 20-minute standardized interviews. Negative disclosures were defined as "interviewer statements revealing personal foibles or negative experiences and personal

characteristics;" positive disclosures were defined as "statements revealing personal strengths or positive experiences and personal characteristics" (p. 184). Results indicated that participants (72 introductory psychology students participating in the study for extra credit; 36 female, 36 male) perceived interviewers (6 counseling psychology doctoral students; 3 female, 3 male) using negative disclosures as more empathic, warm, and credible than those using positive disclosures. In addition, participants' pre-interview and post-interview estimates of how much they procrastinated decreased. However, procrastination estimates by participants in the positive disclosure condition increased following the interview. It is important to note that the content of the "positive" disclosures indicated that the interviewer did not struggle with procrastination, thereby suggesting that they were unlike the participant, whereas those in the "negative" disclosure condition indicated that the interviewer and participant shared a tendency to procrastinate, though in the case of the interviewer, it was a past tendency that had been resolved. The author concluded that admitting to personal weaknesses caused interviewers to be perceived more favorably by participants, perhaps through establishing a more equitable relationship in which the participant's risk of rejection was decreased. She attributed interviewees' changed perceptions of their own levels of procrastination following the interview to social comparison theory. She further suggested based on this change in self-perception that counselor positive or negative self-disclosure could be used in a similar way in therapy to modify clients' perceptions of the severity of their problems.

McCarthy and Betz (1978) investigated the effects of self-involving disclosures (defined as present-tense statements about the therapist's personal response to the client; also known as immediacy) and self-disclosing statements (defined as using past-tense statements regarding the therapist's personal experiences) using audiotaped 11-minute simulated counseling interviews as

stimuli for 107 female undergraduate participants enrolled in an introductory psychology course. The (male) counselor interviewed the (female) "client" about her dissatisfaction with herself, her lack of friends, and difficulties with her parents. There were two conditions, both of which included disclosures that were all positive in nature. One interview included 10 positive *self-disclosing* statements expressing similarity of personal experiences between counselor and "client"; the other contained 10 positive *self-involving* statements expressing positive feelings about or reactions to the "client." After listening to one of the recorded interviews, volunteer participants rated their perceptions of counselor expertness, attractiveness, and trustworthiness, and generated written responses. The authors found that therapists in the self-involving condition were rated as significantly more trustworthy and expert than therapists in the self-disclosing condition, although no difference was found for attractiveness. Volunteer clients in the self-involving condition used more present-tense self-referent statements, less counselor-referents, and less questions about the counselor when responding to the recorded stimulus than those in the self-disclosing condition. The authors concluded that self-involving and self-disclosing statements elicit different (and less desirable) responses from observer-participants (in terms of the written response) and result in different (less favorable) perceptions of the counselor. They emphasized the possible importance of these findings for clinical practice, suggesting that self-involving responses may enhance client exploration and maintain a focus on the client, whereas self-disclosing statements may be a distraction from client exploration and shift the focus of the session to the counselor.

In contrast to the McCarthy and Betz (1978) findings, Dowd and Boroto (1982) used the same definitions and an experimental manipulation but found different results. They did not find differences among the self-involving and self-disclosing conditions in perceived expertness or

trustworthiness of therapists as rated by 217 upper-class undergraduate education majors (75% female; 25% male) after viewing videotaped 20-minute simulated counseling sessions in which a (male) advanced doctoral student in clinical or counseling psychology interviewed a (male undergraduate volunteer) "client" about stress. There were five conditions, with the counselor ending the session in different ways in each video: 1) summarized session, 2) disclosed a past personal problem (that resembled the client's concern), 3) disclosed a present personal problem (that resembled the client's concern), 4) engaged in self-involving statements, or 5) offered dynamic interpretation. Though there were no differences among the present self-disclosure, past self-disclosure, and self-involving conditions in terms of perceived counselor attractiveness, counselors in all three of these conditions were perceived as more attractive than those in the summary and dynamic interpretation conditions. The authors speculated that the gender differences between this study and the McCarthy and Betz (1978) study may have played a role in the difference in findings. In the latter study, female raters observed a male counselor-female "client" dyad, whereas in Dowd and Boroto's (1982) study raters of both genders observed a male-male counselor-"client" dyad. They also noted that in the former study, 10 disclosures occurred throughout each 11-minute recorded session, whereas in their own study, the differences among recording scenarios was only at the very end of a 20-minute recorded interview. Dowd and Boroto concluded that potential clients may prefer a therapist who ends a session by providing an explanation for the client's problems to one who ends by focusing on the relationship or by summarizing the session.

Reynolds and Fischer (1983) modified the audiotaped simulated counseling session from McCarthy and Betz's (1978) study, using a 6-minute recording. They examined whether 80 female introductory psychology student volunteer participants would respond differently to self-

involving statements (of the counselor's personal reactions to the client during the session) and self-disclosing statements (about the counselors personal experiences or feelings outside the session) provided by a female "interviewer" to a female "client", both of whom were played by graduate students. Disclosures also varied along a positive-negative dimension and by content (personal vs. professional). Negative self-disclosure was defined as the counselor disclosing negative personal information; positive self-disclosure was defined as the counselor disclosing positive personal information. When using positive self-involving statements the counselor expressed a positive personal reaction to the "client." When using negative self-involving statements, the counselor revealed "a negative, but not critical personal feeling regarding a statement made by the client, e.g., 'I'm kind of frustrated that I don't understand what you're saying'" (p. 452). Supporting the McCarthy and Betz (1978) findings, results indicated that a female therapist using self-involving disclosures was rated as more credible than one using self-disclosing statements, and that self-disclosing statements focused the subjects' attention on the counselor, whereas self-involving statements maintained focus on the client. In contrast to Hoffman-Graff's (1977) findings that negative interviewer disclosure increased credibility ratings, Reynolds and Fischer (1983) did not find differences among participants' ratings of therapist credibility based on therapist disclosures of positive versus negative feelings. Reynolds and Fischer (1983) concluded that self-involving statements were more effective than self-disclosing statements because they enhanced observer-participants' perceptions of counselor expertise and trustworthiness.

More recently, Myers and Hayes (2006) examined the effects of general disclosures, countertransference disclosures (defined as disclosure of "internal and overt reactions to clients that are rooted in therapists' unresolved intrapsychic conflicts," p. 173), and no disclosures. They

examined 216 undergraduate psychology and education students' (67% female; 33% male) perceptions of session depth and positivity, and therapist expertise, trustworthiness and attractiveness in the context of either a positive or negative working alliance, using three videotaped scenarios (10-minute simulated therapy sessions with a male counselor and female "client"—one "session" for each disclosure condition). In the positive alliance condition, students rated the session as deeper and the therapist as more expert when the therapist made general disclosures (rather than no disclosures or countertransference disclosures). When students believed the alliance was negative, they rated the session as shallower and the therapist less expert when general or countertransference disclosures were made, and rated expertness and depth higher when no disclosures were made. No differences were found among the disclosure conditions (general, countertransference, none) for students' ratings of therapist trustworthiness or attractiveness. However, Myers and Hayes found that there was a difference in students' ratings of disclosure conditions based on whether the student had prior therapy experience. Specifically, students who had been in therapy before rated sessions deeper and more positive in the countertransference disclosure condition than in the general disclosure condition; students who had not had prior therapy experience rated sessions deeper and more positive in the general self-disclosure condition than in the countertransference disclosure condition. The authors concluded that when the relationship is weak, both general and countertransference disclosures may be problematic, but when the relationship is strong, general disclosure may be beneficial (i.e., perceived as deeper and more positive.) They emphasized the differential pattern of students' ratings based on past therapy experience and the importance of considering the context (i.e., client's prior therapy experience and expectations and the strength of the working alliance) before disclosing.

Yeh and Hayes (2011) investigated the effects of therapist disclosures of more and less resolved countertransference issues on undergraduate students' perceptions of a "therapist" (attractiveness, trustworthiness, expertness, and ability to instill hope) and a "therapy session" (depth, smoothness, and universality between client and therapist). After viewing one of two 12-minute "therapeutic interactions" simulated by two actors (p. 323), 116 undergraduate students (91 females, 25 males) responded to questions about the "therapist" and the "therapy session." Yeh and Hayes found that students perceived a male "therapist" who disclosed relatively resolved countertransference issues to a female "client" as more trustworthy, attractive, and better at providing hope than a therapist who disclosed unresolved countertransference issues. However, type of countertransference disclosure (resolved vs. unresolved) did not affect students' perceptions of: therapist expertise, session depth or smoothness, or universality between client and therapist. Yeh and Hayes also compared students' ratings based on prior therapy experience, and contrary to the findings of Myers and Hayes (2006), they did not find differences on any measured variables as rated by students who had or had not been in therapy previously.

In a meta-analysis of 53 existing studies comparing disclosure to non-disclosure (6% of which examined actual therapy sessions), Henretty et al. (2014) found that overall, TSD had a positive impact on participants/clients (in terms of impressions of counselor and likelihood of disclosing to counselor), and that certain TSDs (those that revealed similarity or were of negative content valence [i.e., either involved negative or uncomfortable thoughts or feelings or included socially undesirable personal information]) compared favorably to non-disclosure in terms of clients/participants' perceptions of the counselor's professional attractiveness. Disclosures of similarity were positively related to participants' willingness to return to see the counselor again.

The authors cautiously concluded that TSD "may be beneficial for building rapport, strengthening alliance, and eliciting client disclosure, with similar [disclosures] being especially beneficial." (Henretty et al., 2014, p. 191). Their caution stemmed, in part, from the fact that only 6% of the sample investigated TSD in actual therapy as well as their finding that type of session (e.g., real session, interview, recording, transcript) was a significant moderator. Henretty at al. (2014) underscored the idea that though we tend to refer to it as a singular entity, TSD includes distinct responses with different effects. They emphasized that the favorable effects of TSD may only occur in certain situations and pointed out that "It may not be enough simply to examine overall effects of self-disclosure." (p. 201).

   Summary of analogue studies. Analogue research has used varying definitions of and rating scales for coding self-disclosure, and varying "doses" or quantities, making it difficult to reach overall conclusions. For example, based on the scenarios used in their manipulations, Hoffman-Graff (1977) and McCarthy and Betz (1978) operationalized "positive self-disclosure" in ways that made their meanings opposite. In the former study, positive self-disclosure was described as a statement revealing personal strengths or positive experience or characteristics of the interviewer. As operationalized, this meant that the interviewer *revealed something dissimilar to the client's experience,* namely, the interviewer did not procrastinate like the interviewee did. However, in the latter study, positive self-disclosure was defined as past-tense statements regarding the therapist's personal experiences that *expressed similarity of experience between the counselor and the client*.

   In addition, experimental manipulations varied significantly across studies. In the closest approximation to actual therapy in the analogue studies reviewed, Hoffman-Graff (1977) used a 20-minute live interview and compared a condition with three *positive* self-disclosures to a

condition with three *negative* self-disclosures. McCarthy and Betz (1978) used an 11-minute simulated audiotaped counselor interview to compare 10 positive *self-involving* disclosures with 10 positive *self-disclosing* disclosures. Dowd and Boroto (1982) manipulated only the ending (last five minutes) of a 20-minute videotaped simulated counseling session, with different five scenarios, one including disclosure of a past personal problem that resembled the client's concern, one including disclosure of a present personal problem that resembled the client's concern, and one including self-involving statements. Reynolds and Fischer (1983) modified the McCarthy and Betz (1978) audiotape so the conditions comparing positive and negative self-involving and self-disclosing statements entailed 6-minute simulated counseling sessions.

The findings of these analogue studies have been informative and intriguing, but mixed, indicating that: 1) students' previous experience in therapy may or may not affect their ratings of TSD types, "therapist", and "session;" 2) beliefs about the strength of the working alliance prior to TSD may be an important contextual factor that affects students' ratings of TSD events, "therapists," and "sessions;" and 3) TSD (in its varying types) may or may not affect: a) students' perceptions of "therapist" trustworthiness, expertise, empathy, warmth, credibility, attractiveness, professionalism, and ability to inspire hope; b) students' levels of self-disclosure; c) students' ratings of "session" smoothness, depth, and positivity; and d) students' helpfulness ratings for "sessions" (Dowd & Boroto, 1982; Hoffman-Graff, 1977; McCarthy & Betz, 1978; Myers & Hayes, 2006; Reynolds & Fischer, 1983; Yeh & Hayes, 2011).

Analogue and simulated studies have provided interesting and provocative perspectives, and offer the benefit of experimentally controlling variables of interest. However, many of these studies used non-client (student) volunteers in single brief (e.g., 6-, 10- or 12-minute) sessions, and/or asked participants to respond to recorded or written (analogue) "client" and/or "therapist"

stimuli, neither of which is a close approximation of actual therapy. Hill and Knox (2002) suggested that results of analogue studies might not be generalizable to real therapy. For example, Kushner, Bordin, and Ryan (1979) compared therapist responses to a filmed client (an analogue) with therapist responses to real clients in intake sessions, and found that therapists behaved differently in the two situations. The researchers concluded, "One cannot assume that results obtained in analogues can be extrapolated to real therapy settings," and emphasized, "therapist behavior is highly responsive to situational factors" (Kushner et al., 1979, p. 766). In other words, the complex context of real-life therapeutic dyads cannot be recreated in therapy simulations. It is difficult, if not impossible, to simulate contextual variables such as client and therapist background, much less the interplay between the two individuals (i.e., the moment-by-moment interactional sequence; Hill, 2009) and among therapist intentions and interventions and client reactions, perceptions, and changing needs and goals.

Naturally-occurring psychotherapy. This section comprises four primary subsections: 1) a review of studies focused on the client perspective on TSD in psychotherapy, 2) a review of studies that included both client and therapist perspectives, 3) a review of studies focused on the therapist perspective, and 4) a summary of one study from the perspective of observers (i.e., judges that were neither clients nor therapists). The section on naturally-occurring psychotherapy concludes with summaries of the client and therapist perspectives.

Client perspective. In a qualitative analysis of client perceptions of the effects of helpful TSD, Knox, Hess, Petersen, and Hill (1997) interviewed 13 adult long-term psychotherapy clients about their experience of helpful TSD. They found that clients characterized helpful therapist disclosures as important, memorable events. Specifically, clients perceived TSD as occurring when they were discussing important personal issues. They felt TSDs were intentional

and that therapists used them to normalize or reassure clients. They also described TSDs as including personal historical information about the therapist. Though the definition of "helpful therapist self-disclosure" used by Knox et al. (1997) to solicit examples from clients included both self-involving and self-disclosing statements, clients only volunteered the latter, differing from suggestions in previous analogue literature that immediate (or self-involving) reassuring revelations were most helpful (e.g., Hoffman & Spencer, 1977; Hoffman-Graff, 1977; McCarthy & Betz, 1978). Knox et al. (1997) found that helpful TSD resulted in both positive (e.g., led to clients perceiving therapists as more real and more human, and that it helped to equalize the power in the relationship, enhance the connection between the two individuals, and foster the therapeutic work) and negative consequences (e.g., one client feared the closeness caused by the TSD and another was uneasy that a therapeutic boundary had been crossed), though the former occurred more frequently. Clients indicated their therapists' disclosures made them feel reassured or normalized, or helped them gain a sense of universality. In addition, TSDs were found to lead to client insights or new ways of seeing, which enabled clients to engage in personal change. However, the authors noted that results were not consistent across cases, with clients differing in their desire for and responses to TSD.

In an experimental study, Barrett and Berman (2001) assessed whether therapist self-disclosures made in response to client disclosures, which they called "reciprocal" disclosures, influenced the outcome of psychotherapy. To assess whether disclosures had a causal influence on therapy outcome, levels of TSD were manipulated during the first four sessions of psychotherapy in 36 cases (15 men, 21 women). Each therapist ($N = 18$) treated two clients during the study. With one client, therapists increased the number of self-disclosures; with the other client, therapists limited the number of self-disclosures. Results from the experiment

indicated that clients receiving psychotherapy under heightened TSD reported lower levels of

symptom distress and higher liking of their therapists when compared to clients receiving limited

TSD. The authors concluded that TSD may improve both the quality of therapeutic relationship

and the outcome of treatment. These findings support previous findings that when therapists self-

disclose, clients are more likely to see the therapist as friendly, open, helpful, and warm (Dies,

1973; Feigenbaum, 1977; May & Thompson, 1973; Murphy & Strong, 1972). The authors

emphasized that in each condition, levels of TSD were modest, with an average of 4.3 self-

disclosures per session in the increased disclosure condition, with each event averaging less than

13 seconds in length, and an average of 2.6 disclosures with a mean of 8.5 seconds in the

decreased disclosure condition. They also emphasized that because there was not a control

group, it was not possible to determine whether increasing disclosure benefits treatment,

restricting therapist disclosure impairs treatment, or both.

Hanson (2005) interviewed 18 people (16 females, 2 males) in therapy about their

perceptions of self-disclosure and non-disclosure. These clients generated and described 157

incidents of disclosure ($N = 131$) and non-disclosure ($N = 26$; defined as "an interaction in which

a therapist chooses not to reveal information about her or himself, in response to a specific

question" the client has asked, J. Hanson, personal communication, October 29, 2012), which

were coded as helpful, unhelpful, neutral, or mixed. Disclosure incidents were also coded as

"self-revealing" or "self-involving." Hanson found that disclosures were more than twice as

likely to be experienced by clients as helpful, while non-disclosures were twice as likely to be

perceived as unhelpful. Self-revealing statements were neither more nor less helpful than self-

involving statements. The participants in this study indicated that TSD contributed to the real

relationship with the therapist (e.g., provided a sense of safety, warmth, intimacy, increased trust,

increased egalitarianism), while non-disclosure was detrimental to the therapeutic alliance (e.g.,

experienced as hurtful, inhibited client disclosure, and decreased trust). Hanson further found

that therapist skill level in delivery affected client perceptions of the event for both disclosure

and non-disclosure. Skillful disclosure was described as reciprocal/directly relevant to client

material (Knox et al., 1997; Barrett & Berman, 2001); designed to emphasize similarities

between the client and therapist; brief with few details; and well timed. Skill deficits identified

with unhelpful disclosures included poor timing; sharing too much information; and lacking in

technical neutrality. The few helpful non-disclosures described in this study were characterized

by compassion and included an explanation of why refusal to answer questions was actually

beneficial to the client (e.g., the therapist refusing to offer an opinion because he trusted the

client to make a decision on her own.) Rigidity was the most-cited skill deficit related to non-

disclosure. One female client felt insulted by a male therapist's policy of not disclosing, because

he did not take her character into account. Hanson found that skillful use of either disclosure or

non-disclosure had a main effect on the therapeutic alliance, either contributing to or hindering

its development. A strong alliance (as described by clients) seemed to buffer the impact of skill

deficits, while a weak alliance combined with skills deficits increased the likelihood of

termination. One finding Hanson described as new was the use of "small talk" self-disclosure as

a kind of transition into and/or out of sessions. Clients said these pre- and post-session transitions

put them at ease and allowed them to refocus their attention inward or outward. Hanson

concluded that avoiding disclosure entirely is a disservice to clients, advocating that therapists

use disclosure deliberately, skillfully, and with therapeutic intent.

Ain and Gelso (2008) examined clients' retrospective perceptions of therapy

relationships, specifically: TSD (amount, relevance, and appropriateness of amount), the real

relationship (strength, realism, genuineness), and therapy outcomes. Participants were 94

volunteer undergraduate and graduate students who had completed a course of at least three

therapy sessions within the past three years. Data regarding clients' recollection of therapy were

collected via hard copy or online measures (Real Relationship Inventory—Client; Therapist Self-

Disclosure Questionnaire – a measure specifically designed for this study to assess client-rated

amount of TSD and appropriateness of that amount; and the Counseling Outcome Measure

[Gelso & Johnson, 1983]). The authors found a positive correlation between clients' ratings of:

1) strength of the real relationship and relevance of TSD, 2) therapy outcomes and relevance of

TSD, 3) overall amount of TSD and relevance of TSD, and 4) real relationship strength and

therapy outcomes. Clients who indicated that therapists disclosed an appropriate amount reported

stronger real relationships and better therapy outcomes than those who reported their therapists

did not disclose enough. The authors noted that only five participants indicated their therapists

disclosed too much, while nine indicated their therapists did not disclose at all. Client ratings of

overall TSD amount were positively correlated with their ratings of real relationship strength,

genuineness, realism, therapy outcome, and overall relevance of TSDs. The authors concluded

that clients' perceptions of TSD relate to their experience of the real relationship, and suggested

that "therapists should self-disclose an appropriate amount of information that is relevant to their

clients" (p. 1).

As part of a larger qualitative study exploring client experience of TSD in therapy, Audet

and Everall (2010) interviewed nine clients (5 males; 4 females) about their experience of the

therapeutic relationship in the context of non-immediate TSD and analyzed the transcripts using

a phenomenological "discovery-oriented" approach. These authors found that clients evaluated

TSD for relevance and therapeutic intentions and perceived disclosure as contributing to

development of the relationship early in the process. Clients perceived TSD as having both

facilitative and hindering effects on the therapeutic relationship. The authors identified three

main themes in clients' descriptions of TSD events: early connection with therapist, therapist

presence, and engagement in therapy. Some clients felt that disclosure made the therapist seem

more human and thereby alleviated the power imbalance in the relationship. Others, for whom

disclosures went outside the bounds of expected and desired therapist behavior, reported that

disclosures derailed the therapy and hindered alliance development. Based on the content,

context, and delivery of TSDs, clients assessed therapists' attentiveness to, understanding of, and

attunement with them, their issues, and their therapeutic needs. Clients reported that therapist

disclosure served as an indicator of the therapist's presence and attunement, and as such, fostered

or hindered confidence in the therapist and the relationship. The perceived relevance/reciprocity

and appropriateness of TSD caused clients to see therapists either as understanding and attentive

on one hand, or out of touch and unresponsive on the other. The authors concluded that TSD has

a bearing on the quality and value of the client-therapist relationship, and suggested that it may

play an important role in enhancing or inhibiting client involvement in therapy.

Audet (2011) examined client perspectives on boundaries and therapist professionalism

in the context of non-immediate TSDs in a further evaluation of the data described above (Audet

& Everall, 2010). Nine clients (5 male, 4 female) reported both positive and negative effects of

TSD on boundaries and professionalism in therapy, with five clients reporting positive

experiences, two clients reporting negative experiences, and two clients reporting both positive

and negative experiences. Disclosures were determined to have positive or negative effects based

on disclosure frequency (infrequent disclosure preferred); intimacy level (low-to-moderate

intimacy preferred); amount of detail (brief preferred); similarity to client's experience (similar

preferred); congruence with client's personal values (congruent with client's issues/values preferred); and relevance/responsiveness to client's issues, needs, and the therapeutic context (high relevance preferred). All participants indicated that it was important for therapists to maintain professional boundaries when disclosing. For clients who had a positive experience of therapist disclosure, perceptions of therapists changed as a result of TSDs early in therapy. These clients said that disclosure helped to humanize the therapist, reduced the power imbalance in the relationship, and made them feel more connected to the therapist. In addition, these clients said TSD helped them to feel less objectified by the therapist and more worthy of trust and respect, while they saw the disclosing therapist as "caring, respectful and non-judgmental," (Audet, 2011, p. 94) and the relationship as more egalitarian and collaborative. However, two clients who reported experiencing negative effects from TSD felt that while disclosure equalized the power balance in the relationship, it also went beyond their preferred boundaries. In one case, it caused the client to consider seeking out another therapist; in another, the client felt the sessions were reduced to friendly chatter because the therapist shared too much too often. Clients who had negative experiences reported that frequent irrelevant TSD shifted the focus to the therapist, restricted the client's exploration and discussion of important issues, resulted in a discomfiting role reversal, and led clients to lose confidence in both the therapist and the therapy. Audet concluded, "clients are cognizant of the importance of therapeutic boundaries and perceive self-disclosure as a plausible therapist behavior in therapy" (Audet, 2011, p. 96). She emphasized that when done well, TSD can have a positive impact on the therapeutic relationship, but cautioned that inappropriate TSD can have negative effects.

Studies involving both client and therapist perspectives. In a naturalistic study, Hill et al. (1988) examined the effects of therapist response modes using the revised Hill Counselor Verbal

Response Modes Category System (Hill, 1985, 1986), as well as their relationships with therapist

intentions and client experiencing, in eight cases of brief psychotherapy. They found that TSD

received the highest client helpfulness ratings of all response modes and were associated with the

highest client experiencing levels. The researchers posited that clients valued TSD because it

made the therapist more human and equalized the power in the relationship. However, therapists

were divided in their reactions, with three rating TSD as the most helpful response mode and five

rating it as the least helpful. Hill et al. (1988) suggested that therapists may have rated TSD

lower because they felt vulnerable while disclosing or uncomfortable with the accompanying

power shift.

In a further analysis of the Hill et al. (1988) data (Hill, Mahalik, and Thompson, 1989),

judges rated two dimensions of TSD (involving/disclosing and reassuring/challenging), and then

looked at these ratings in relation to other process variables. Clients and therapists rated

reassuring disclosures as more helpful than challenging disclosures, and indicated that the former

led to higher levels of client experiencing than did the latter. The researchers concluded that

reassuring disclosures facilitated client progress, equalized the relationship, and increased

clients' feelings of safety, though they noted that the reassuring/challenging scale applied more

readily to self-involving than to self-disclosing revelations by therapists. Contrary to findings in

previous analogue literature (McCarthy & Betz, 1978; Reynolds & Fischer, 1983), Hill et al.

(1989) did not find involving disclosures to be more helpful than disclosing disclosures. On the

basis of these results, Hill et al. (1988) suggested that there were several types of TSD: facts,

similarity between therapist and client, feelings, and strategies. Knox and Hill (2003) later

revised these into seven types: facts, feelings, insight, strategies, reassurance/support, challenge,

and immediacy. They suggested that self-disclosures are not so much one type of intervention,
but rather mimicked the intentions of other types of interventions.

In an examination of how 62 East Asian American college student "clients" (33 men, 29
women) with differing levels of adherence to Asian cultural values perceived counselor
disclosures during 50-minute counseling sessions, Kim et al. (2003) randomly assigned
participants to one of two conditions: 1) high-disclosure (up to four in a 50-minute session) or 2)
low-disclosure (either no disclosure or up to one if deemed it would be clinically harmful not to
respond). Counselors were 17 European American graduate students (12 counseling psychology
doctoral program, 3 clinical psychology doctoral program, 2 master's program in college student
personnel services). Kim et al. found that "clients" rated disclosures of strategies as the most
helpful type of disclosures, followed by disclosures of insight, which were moderately helpful
(as compared to disclosures of approval/reassurance, facts/credentials, and feelings). Disclosures
of strategies (which occurred more frequently in highly-rated sessions than in sessions rated low)
and disclosures of approval/reassurance occurred most frequently. Client- and counselor-rated
self-disclosure intimacy was related to client- and counselor-rated disclosure helpfulness,
respectively. Session outcome was not predicted by client adherence to Asian values or
disclosure condition. Despite the similar research design, the latter finding was contrary to
Barrett & Berman's (2001) findings. Kim et al. suggested that this may have been because
Barrett & Berman examined treatment outcome following four sessions of therapy whereas Kim
et al. examined session outcome following a single session.

Ain (2011) examined clients' and therapists' perceptions of the real relationship, amount
and relevance of TSD, and treatment progress for 61 dyads in ongoing psychotherapy using
online measures (clients: Real Relationship Inventory – Client Form, Therapist Self-Disclosure

Questionnaire – Client Form, the Counseling Outcome Measure; therapists: Real Relationship

Inventory – Therapist Form, Therapist Self-Disclosure Questionnaire – Therapist Form; the

Counseling Outcome Measure, the Global Assessment of Functioning Scale). Therapists' ratings

of overall TSD amount (rated from 1 = not at all to 5 = very much) positively correlated with

their ratings of real relationship strength, genuineness, realism, and treatment progress. Clients'

ratings of TSD amount positively correlated with their ratings of real relationship strength.

Clients' ratings of TSD relevance (rated from 1 = not at all to 5 = very much) positively

correlated with treatment progress. The majority of therapists and clients indicated that the

therapist disclosed "about the right amount;" the average amount of TSD from both perspectives

fell between 1 = not at all and 2 = some. Therapist perceptions of TSD amount were positively

correlated with client perceptions of TSD amount and also with client perceptions of treatment

progress. Client perceptions of TSD relevance were positively related to therapist perceptions of

treatment progress. Both therapists' and clients' perceptions of real relationship strength were

positively correlated with their ratings of treatment progress, and both therapists' and clients'

ratings of TSD amount showed a positive correlation with therapist age. Client perceptions of

real relationship strength were positively correlated with therapist perceptions of TSD amount.

Contrary to previous findings (Ain & Gelso, 2008), TSD relevance was not significantly

associated with real relationship strength (from either the therapist or the client perspective). Ain

concluded that therapists should work to strengthen the real relationship, and that appropriate

TSD use may help them to do this.

Kronner and Northcut (2015) used qualitative methodology to investigate how TSD

affected 8 therapy dyads. Specifically, the authors interviewed gay male clients and surveyed

their gay male clinicians (6 licensed clinical social workers and 2 licensed counselors) to learn

how TSD affects these clinical pairs in terms of whether clients perceive the TSD, whether

clients feel connected to their therapists, whether TSD affects clients' sense of connection to their

therapists, and which types of TSD are most effective at facilitating connection. Clients were

asked how they chose a therapist and how often the therapist disclosed what types of

information. Grounded theory (Strauss & Corbin, 1998) was used to break data down into

discrete parts that were then used to identity similarities and differences among participants (i.e.,

open coding) and then axial coding was used to observe themes and patterns in the data.

Therapist questionnaires collected data including theoretical orientation, years of experience

practicing with gay men ($M = 10.94$, range = 5-18 years), types of clients treated, awareness of

TSD, types of TSD used, and opinions on whether TSD affected their therapeutic relationships.

Therapists were also asked to rate how often they disclosed and their perceived level of

connection to the client. According to clients, themes in therapists' TSDs included: developing

therapist-client connections, normalizing clients' experiences, and helping clients to feel less

isolated. Clients were able to recall specific disclosures from their therapists, and indicated that

therapists used *implicit* self-disclosures (including philosophical information,

countertransference, emotions, thoughts or feelings about the client experienced by the therapist

both in and outside of sessions, and ideas or fantasies stimulated during interactions with clients)

more frequently than *explicit* self-disclosures (biographical information about the therapist's past

or current life). Therapists likewise indicated that they used implicit disclosures more often than

explicit disclosures, and that they were aware both of disclosing and of their reasons for doing

so, which involved building trust, normalizing experience, and reducing clients' sense of

isolation. Therapists indicated they disclosed explicitly about training, spirituality, relationship

status, family difficulties, and coming out experiences, and indicated they sometimes used TSD

to facilitate connection. Similarly, clients reported their therapists were using TSD to connect

with them. Clients reported that their therapists used more explicit TSD than therapists reported.

Clients' responses indicated that 73% of explicit disclosures were helpful, 24% were neutral, and

3% were negative. Kronner and Northcut concluded that additional research needs to be

conducted to gain an understanding of what makes a TSD positive or negative, as well as "when

and how clinical pairs agree and disagree" on that subject, noting that clients sometimes

perceived TSDs that clinicians would likely see as boundary violations as positive experiences.

 Therapist perspective. Berg-Cross (1984) used survey methodology to examine the

perceptions of 63 male diplomates of the American Board of Professional Psychology on their

use of TSD and immediacy. For TSD, participants responded to 25 items designed for the study

to indicate the number of clients with whom they reveal personal information in four content

areas (demographic information, personal beliefs, personal experiences, and affective

experiences) using a 5-point Likert-type scale (1 = rarely or never shared with clients, 3 = shared

with half of one's clients, 5 = always shared with clients). Two sample items are: "beliefs about

extramarital relations," and "experience as a child." It is important to note that this part of the

survey assessed with how many clients therapists believed they disclosed different kinds of

content, not the frequency with which they actually did so. Berg-Cross found that therapists

believed TSD occurred with statistically equal frequency in all four content areas, with mean

frequencies ranging from 1.49 (sexual experiences) to 2.98 (professional training). The author

noted that the sample was small, highly experienced, and exclusively male, limiting the

generalizability of the findings to broader populations.

 Mathews (1988) investigated the beliefs, attitudes, and perceptions of 342 therapists (60.9

percent males, 29.5 percent females) regarding their use of TSD in psychotherapy (282 via

survey, 60 via personal interview). The 14-item instrument designed for the study included nine

open-ended questions (e.g., "How often do you self-disclose with clients?") and five multiple-

choice items (e.g., "Do you self-disclose more with clients: a) Older than yourself, b) Younger

than yourself, c) Approximately the same age as yourself, d) Age of the client does not affect

your self-disclosures?"). The sample included psychiatrists, licensed psychologists, and social

workers, with various degrees (MD, PhD, PsyD, MA, EdD), and ages ranging from under age 35

to over age 45 with 50.5 percent between these ages. The most frequently cited reasons Mathews

found for self-disclosing were to promote universality and to provide reality testing. The most

frequent reasons for not disclosing were removing focus from the patient and interfering with the

transference. The majority of the results were summarized in a qualitative way, comprising

verbatim responses from participants (e.g., in response to the question, "What types of self-

disclosure do you find are most helpful with your clients?", a male psychiatrist aged 45-49 years

and in practice 16 years responded: "When I share that 'Yes, I've felt that too,' I'm

communicating to the patient that I don't think a particular feeling is crazy…it's a form of

validation…"). For complex issues related to TSD use, such as the client's diagnosis or

transference, Mathews used respondents' quotes to support discussion of the factors therapists

must weigh when using this response mode in these contexts. Mathews concluded by putting

forth opposing views on the use of TSD and posing important questions about when and with

whom the intervention is beneficial.

Robitschek and McCarthy (1991) used a modified version of the Berg-Cross (1984) scale

to investigate counselors' perceptions of their use of self-referent statements in individual

therapy. The survey measured frequency of TSD in three areas: counselor demographics,

personal beliefs, and personal experiences. Participants (91 counselors: 32 men, 59 women) were

asked about the frequency with which they used positive and negative self-referent statements of

two types: self-disclosing and self-involving. The definitions used for self-disclosing responses

("statements of factual information about oneself", p. 218) and self-involving responses

("statements of emotional reactions to one's client", p. 218) were consistent with past research.

The authors' hypotheses were: 1) Male and female counselors would report using more positive

than negative self-referent statements, 2) Female counselors would report using more disclosure

than male counselors, 3) Counselors with low and high experience levels would report more

positive and negative self-disclosure than counselors with moderate experience, and 4)

Experienced counselors would report using more positive and negative self-involving responses

when compared with counselors of low or moderate experience. Hypothesis 1 was supported:

respondents reported using more positive than negative self-reference. Hypotheses 2 and 3 were

not supported: neither counselor gender nor counselor experience level was related to increased

self-disclosure. Hypothesis 4 was not supported: experienced counselors did not report using

more self-involving responses than less experienced counselors. An interaction was found via

post-hoc analyses: for male respondents, as experience increased, self-reference of all types

decreased.

Edwards and Murdock (1994) surveyed 184 (90 males, 94 females) practicing doctoral-

level therapists regarding their use of TSD in therapy. They differentiated self-disclosing from

self-involving statements and explicitly excluded the latter from investigation. The authors

investigated a series of variables they thought, based on previous research, might be predictors of

TSD: counselor gender, ethnicity, and theoretical orientation; reasons for self-disclosure

identified as "appropriate" in the literature ("e.g., increasing expertness, attractiveness,

trustworthiness, or because the client desires it" [p. 387]); and content of self-disclosure. No

difference in frequency of disclosure was found based on counselor gender or ethnicity, but there

was a difference in relation to theoretical orientation. Humanistic therapists ($M = 3.28$, $SD =$

1.38) reported significantly more disclosure than psychoanalytic therapists ($M = 2.45$, $SD =$

0.94). More than half of respondents endorsed modeling self-disclosure and increasing similarity

between counselor and client as reasons for disclosing, though other theory-posited therapeutic

reasons for disclosing were not highly endorsed. Significant differences were found among the

frequency of self-disclosure for the six content areas from Hendrick's (1990) Counselor

Disclosure Scale (CDS), listed here from most to least endorsed: professional issues;

success/failure; interpersonal relations; attitudes; personal feelings; and sexual issues. The CDS

was originally designed to investigate *client preferences* for therapist self-disclosure content. The

authors adapted the instrument creatively, thereby contributing to our understanding of how

therapists perceive their self-disclosures, particularly in the area of reasons for disclosing. The

two most commonly endorsed reasons for self-disclosing were increasing perceived similarity

between counselor and client (55%) and modeling self-disclosure as a desired behavior (52%).

Especially informative and innovative was the presentation of means and standard deviations of

counselors' responses for frequency of disclosure with clients' preferences for such disclosure

(Edwards & Murdock, 1994) in the six content areas from Hendrick's (1990) study. This

comparison places Edwards and Murdock's (1994) findings into a broader context, highlighting

the similarities in clients' stated desires and therapists' self-reported sharing of certain kinds of

information (e.g., clients' most desired information content area, professional issues, was also

the area for which counselors' reported the most disclosure).

Lane, Farber, and Geller (2001) surveyed 68 therapists (62 psychologists, 4 social

workers, and 2 psychiatrists; 43 female, 23 male, 2 did not provide gender) about their use of, the

different impact of, and variability in clients' requests for various kinds of TSD. They also

examined therapists' rationale for disclosing or not disclosing. The survey included 52 self-

referential items representing a broad range of self-disclosing statements clinicians might make

in several subject areas (demographics, professional information, personal preferences, personal

experiences, and self-involving statements). For each item, respondents used 7-point Likert-type

scales to indicate the frequency with which they disclosed (1 = *never disclosed*, 7 = *usually*

disclosed), the degree to which the client requested information (7 = *solicited*, 1 = *not solicited*),

and the extent to which disclosing the information advanced the therapist's treatment aims. In

addition, therapists responded to 18 additional items to indicate reasons they used to justify

disclosure (e.g., "to strengthen the therapeutic alliance," "to validate the patient's experience of

reality"; 1 = *not at all important consideration*, 7 = *extremely important consideration*).

Consistent with findings in previous studies (Berg-Cross, 1984; Edwards & Murdock, 1994;

Mathews, 1988; Robitschek & McCarthy, 1991), Lane et al. (2001) found that when TSD

frequency was averaged across the 52 items (*M* = 2.7, *SD* = 1.1; 1 = *never disclosed*, 4 =

sometimes, 7 = *usually disclosed*), therapists disclosed a moderate amount. Respondents

indicated they disclosed most frequently (with means in parentheses) were: theoretical

orientation (*M* = 5.0), beliefs about therapy efficacy (*M* = 4.8), praise about a patient's artistic

performance (*M* = 4.6), and apologies for mistakes made (*M* = 4.6). Among the least-frequently

disclosed items were therapists' dreams (*M* = 1.2), physical attraction to the patient (*M* = 1.2),

whether a survivor of sexual abuse (*M* = 1.2), and feelings about the patient's previous therapist

(*M* = 1.3). The authors also found that clients "frequently" (p. 30) solicited information (*M* = 4.4,

SD = 0.76 averaged across items; 1 = *nonsolicited*, 7 = *solicited*). Information therapists

indicated patients requested most often included therapist's age, marital status, parental status,

and vacation location; least-requested items included therapist's dreams, reactions to a patient's expressive style, apologies for mistakes, and praise for a patient's creative performance. Therapists indicated that TSD was neutral or slightly helpful ($M = 4.7$, $SD = 0.69$ averaged across items; 1 = *not at all helpful or therapeutic,* 4 = *neutral*, 7 = very helpful and therapeutic). Respondents indicated that feelings of respect for the patient, attitudes toward child-rearing, opinions regarding patient's prognosis, and emotional reactions to the patient were among the most helpful disclosures, whereas the therapist's birthday, political views, vacation destinations, and opinions about people the therapist and patient both know were among the least helpful. The most commonly-endorsed reasons for TSD included validating the patient's experience of reality, strengthening the therapeutic alliance, and normalizing the patient's experience. Most commonly-endorsed reasons for *not* disclosing included interfering with the patient's material and removing the focus from the patient. Lane et al. noted with interest that though "…many authors have warned against the use of self-disclosure for fear it would violate the principles of abstinence or neutrality…these were the least common reasons reported for choosing not to disclose." (p. 31). The authors also noted that in some cases, the least-disclosed items were rated as the most helpful (e.g., disclosing loving feelings toward a patient). They surmised that disclosing personal information too frequently might reduce its helpfulness or remove the focus from the client, concluding that careful, measured disclosure may be particularly beneficial. Lane et al. (2001) concluded that "no conclusive recommendations for practice can be offered" (p. 34) based on their results, and suggested that when evaluating TSD, it is important to remember factors such as the therapist's personal style and theoretical orientation as well as the patient diagnosis, treatment duration, nature of the therapeutic relationship, and type of disclosure.

In an investigation of TSD in individual psychotherapy with adults, Gallucci (2002) used a survey to explore 157 psychologists' (63% male, 37% female) perceptions of the frequency with which they use 7 kinds, or content areas, of TSD (listed in order of frequency: professional information; metaphors, images, and fantasies; personal experiences; opinions and attitudes; affect toward client; personal weaknesses; and personal strengths); their theoretical rationale for and against disclosing; the potential influence of client and therapy characteristics, therapist theoretical orientation, and therapist experience level on decisions for or against disclosure; and therapists' perceptions of their own therapists' TSD. The majority of therapists in the sample reported disclosing at least some of the time, especially when clients' specifically asked for information. Participants were most likely to disclose about subjects that are less therapist-focused and have more therapeutic benefit (e.g., more likely to disclose about metaphors, images, and fantasies about the client than about therapist's personal strengths or weaknesses). Most frequently cited reasons for disclosing included providing modeling and increasing clients' awareness of alternative viewpoints. The most frequently cited reason for *not* disclosing was shifting the focus from the client to the therapist, followed by a concern that TSD may create doubt about the therapist's mental health. Factors most frequently endorsed as influencing participants' disclosure frequency were the quality of the alliance, the client's issues, and the phase of treatment. Experience was positively correlated with disclosure frequency, but the author cited limited range as a potential confound, with 65% of the sample reporting more than 19 years of experience. However, she noted that the majority of the sample (65%) indicated they disclosed more at the time of the survey than they did earlier in their careers, with 61% of these attributing the change to increased comfort with disclosure. (Disclosure frequency remained the same for 26% of the sample and 9% indicated they disclosed less frequently than earlier in their

careers). Gallucci (2002) indicated that the relationship between experience and disclosure frequency was not linear, but seemed to plateau at some point. She also noted that several participants included an open-ended comment that they wish they had received training in appropriate use of self-disclosure. Theoretical orientation did not seem to influence therapists' use of TSD, however, the author noted that there was a limited range in the sample, and the categories used may not have been specific enough to be useful (psychodynamic, cognitive-behavioral therapy, and eclectic). The majority of participants (78%) reported that their own therapist's self-disclosure was beneficial in therapy, but such perceptions were not related to the frequency of therapists' use of disclosure in therapy with clients. Positive correlations were found, however, between the frequency of participants' and their therapists' use of each of the 7 disclosure content areas. Nonetheless, Gallucci (2002) suggested that it may not be disclosure content area that is important when comparing therapists' disclosure frequency with their therapists' disclosure frequency, but rather the occurrence (rather than the content) of disclosure. The author concluded "a discussion of the use of self-disclosure in general terms is not useful." (p. 147) because of its complicated nature and the specific context of each disclosure. Gallucci (2002) indicates that these factors make it difficult to develop specific guidelines for the use of self-disclosure but emphasizes that gaining more information about how to use it therapeutically is important. She emphasized that the lack of training on the subject leaves therapists to look to their own experience to gain information about how to use TSD, and calls for development of a framework with which therapists may be trained to make "sound and sophisticated clinical judgments" (p. 149) about disclosing.

Holmqvist (2015) investigated TSD use by 183 Swedish psychotherapists using a Swedish version of Edwards and Murdock's (1994) (previously-described) adaptation of

Hendrick's (1988) 32-item survey. Holmqvist defined TSD as "the psychotherapist's deliberate and verbal communication to the client about matters that concerned him or her personally," (p. 87) and specifically examined the frequency and type of information shared by participants of differing theoretical orientations (11% psychoanalytic, 34% psychodynamic, 35% CBT, 10% family systems, and 10% other) and years of experience as licensed psychotherapists (40% 5 years or fewer, 37% 6-15 years, 12% 16-25 years, and 9% 26 years or more). Disclosed information that received the highest average ratings (on a *reversed* Likert-type scale, where $1 =$ always and $5 =$ never) included: amount of professional experience ($M = 3.12$, $SD = 1.02$), amount of therapist's professional training ($M = 2.98$, $SD = 1.22$), and diagnosis ($M = 2.60$, $SD = 1.43$). Disclosed information that received the lowest average ratings included: therapist's sex life ($M = 4.97$; $SD = 0.16$), whether or not the therapist was a sexual abuse victim ($M = 4.96$; $SD = 0.22$), therapist attraction to client ($M = 4.92$; $SD = 0.29$), and therapist's experience of suicidal ideation ($M = 4.88$; $SD = 0.43$).

Holmqvist (2015) conducted a principal component analysis and settled on a four-factor varimax rotated orthogonal solution that accounted for 58% of the variance in item scores. The four factors (and respective percentages of variance) were relationships (29%), opinions (11%), training (9%), and private issues (9%). Holmqvist found that younger therapists shared about their training and their relationships more than older therapists did. Likewise, CBT therapists shared more about their training and their relationships than did psychoanalytic and psychodynamic therapists. On training, psychoanalytic therapists disclosed less than family systems therapists, who, in turn, disclosed less than CBT therapists. Holmqvist concluded that CBT therapists were more revealing as both a confirmation that psychodynamic therapists shared less in order to focus on transference and that CBT therapists shared more for the purpose of

modeling, and also attributed this finding to the fact that recent training has had a reduced

emphasis on therapist neutrality and has been influenced by relational theory. He also suggested

that younger therapists may feel a greater need to impress clients with their training. The finding

that younger therapists disclosed more about their relationships was in contrast to earlier findings

that older therapists tended to be more disclosing of personal information (Andersen &

Anderson, 1989; Barrett & Berman, 2001: Skovholt & Rönnestad, 1992). Holmqvist surmised

that younger therapists may feel more free to share personal information with clients based on

both a reduced emphasis on psychodynamic traditions and a general increase, with the rise of

social media, in comfort with sharing personal information.

Holmqvist also suggested that psychotherapy training include an emphasis on helping

trainees reflect on consequences of self-disclosure. He further emphasized that the clinical

context and situation is critical for determining the appropriateness of TSD, and wondered

whether recommendations in the literature for disclosing with moderate frequency, limited detail,

and limited intimacy (Farber, 2006; Henretty & Levitt, 2010; Hill & Knox, 2002; Watkins, 1990)

may be too general. He suggested that future studies should examine the actual occurrence of

TSD in psychotherapy and its antecedents and effects as well as clients' differing expectations

and desires for TSD, with consideration given to theoretical orientation, therapist skill, and

clients' needs.

Observer perspective. Pinto-Coelho, Hill, and Kivlighan (2015) investigated the

occurrence of TSD in 16 cases of psychodynamic psychotherapy. They consensually coded 185

instances of TSD for type, intimacy level, quality, and therapist intention and examined the

associations of these TSD characteristics to clients' ratings of the therapeutic relationship. They

found that taken together, disclosures of insight and disclosures of feeling were judged as higher

in quality than were disclosures of facts. Challenging TSDs and those that both challenged and reassured the client were both judged as higher in quality than were reassuring TSDs. The authors found that intimacy and quality levels differed from one TSD to the next both *across* types of TSD as well as *within* a given type (e.g., one disclosure of feeling may vary greatly from another). Statistically significant associations were found among TSD variables and client-rated real relationship (RR) and working alliance (WA). Specifically, frequency of factual disclosures was negatively related to client-rated RR and WA whereas frequency of feelings disclosures and frequency of challenging disclosures were positively related to client-rated RR. The authors concluded that TSD should be conceptualized as multifaceted, nuanced, and complex for the purposes of practice, training, and research. These results suggest that the tendency to lump all TSD together and conclude that the intervention is either favorable or unfavorable confounds our understanding of what is actually happening, because different types of TSD have different effects.

Summary of client perspective. Research from naturally-occurring psychotherapy has provided rich qualitative accounts of clients' views on the positive and negative effects of TSD, though it must be kept in mind that these accounts are retrospective, in some cases occurring years after termination of therapy. Some of these studies have compared disclosure in a dichotomous way (e.g., self-involving/self-disclosing, reassuring/challenging, helpful/non-helpful) while others have examined variables such as the helpfulness, amount, and relevance of TSD, and their relationships to treatment process and outcome variables. The findings have led to important conclusions: 1) TSD can have positive or negative consequences, though positive effects seem more prevalent; 2) TSD has a bearing on the quality of the therapeutic relationship and client involvement in therapy and is related to treatment progress and treatment outcome; 3)

failure to disclose may be detrimental to the therapeutic alliance; 4) consequences of TSD may

be affected by contextual factors such as client expectations and preferences about TSD, the

strength of the working alliance before the TSD, and the skill level with which TSD is delivered;

and 5) clients assess the therapist's intentions for disclosing and evaluate TSDs for relevance to

their issues and therapeutic needs (Ain, 2008; Audet, 2011; Audet & Everall, 2010; Barrett &

Berman, 2001; Hanson, 2005; Hill et al., 1988; Hill et al., 1989; Knox et al., 1997;).

Summary of therapist perspective. In contrast to the rich *qualitative* accounts of clients'

views, research on therapists' views of TSD use in naturally-occurring therapy tends to be

quantitative. Most studies support the idea that therapists disclose a moderate amount (Ain,

2011; Berg-Cross, 1984; Edwards & Murdock, 1994; Hill, 1988; Knox & Hill, 2003; Lane et al.,

2001; Robitschek & McCarthy, 1991;), and that the most frequently shared information pertains

to professional issues, whereas the least frequently shared information is related to sexual issues

(Berg-Cross, 1984; Edwards & Murdock, 1984). Most findings suggest that therapists disclose

primarily to promote universality and provide reality testing (Gallucci, 2002; Mathews, 1988),

though some indicate that modeling, increasing similarity between client and therapist, validating

the patient's experience of reality, strengthening the therapeutic alliance, or increasing clients'

awareness of alternative viewpoints are common rationales for disclosing (Edwards & Murdock,

1994; Lane et al., 2001). The primary reason for *not* disclosing is because therapists do not want

to shift the focus away from the client; secondary reasons vary, and include: interfering with the

transference, interfering with patients' material, and concerns about creating doubt about the

therapist's mental health (Gallucci, 2002; Lane et al., 2001; Mathews, 1988). Several authors

(Gallucci, 2002; Hill, 1988; Knox & Hill, 2003) suggested there is some ambivalence on the part

of therapists regarding TSD, and one (Gallucci, 2002) specifically found that at least some therapist respondents decried the lack of training they received in this area.

Most of the research on therapist views of TSD had been collected via survey methodology, which limits the response options. Respondents are forced to choose among a finite selection of options, rather than thinking deeply about specific disclosures and then stating their rationales. Several authors (Ain, 2011; Audet & Everall, 2010; Gallucci, 2002; Henretty & Levitt, 2010;) asserted that it is difficult to derive general guidelines for practitioners because the context of each disclosure is very specific. Gallucci (2002) may have said it best when she wrote that discussion of TSD in general terms (i.e., therapists responding to questions about disclosing with clients in general, rather than describing the context of a specific disclosure with a specific client under specific circumstances,) is not useful because of the complicated and context-specific nature of the intervention. Unfortunately, though it provides us with important information about how therapists see TSD, most of this research is, in fact, general. This lack of specificity limits our ability to draw conclusions about what kinds of disclosures are beneficial, when, and with whom.

Expertise in Therapy and Counseling

Defining "master therapist" is a difficult proposition. Ideally, client outcome data could be used to identify such therapists. However, little psychotherapy outcome data exist for clients in actual therapy. Accumulated experience is not sufficient to yield mastery, because one may begin poorly and continue in the same vein. My conceptualization of a master therapist was derived primarily from the work of Jennings and Skovholt (1999), and is described in the following brief summary of the literature on expertise and mastery in therapy.

Jennings and Skovholt (1999) used qualitative interviews to investigate the characteristics

of 10 master therapists (7 female, 3 male; 6 psychologists, 3 social workers, 1 psychiatrist),

"those considered the 'best of the best' among their professional colleagues" (p. 9). The authors'

suggested that more than time and experience are required for one to develop into a master

therapist, and that proactive efforts to improve were common among participants. Furthermore,

the authors identified nine key cognitive, emotional, and relational characteristics shared by

master therapists. They

> (a) are voracious learners; (b) draw heavily on accumulated experiences; (c) value
>
> cognitive complexity and ambiguity; (d) are emotionally receptive; (e) are mentally
>
> healthy and mature and attend to their own emotional well-being; (f) are aware of how
>
> their emotional health impacts their work; (g) possess strong relationship skills; (h)
>
> believe in the working alliance; and (i) are experts at using their exceptional relational
>
> skills in therapy. (Jennings & Skovholt, 1999, p. 3).

These findings were consistent with the literature on competence and expertise,

especially in terms of growing professionally by accepting and reflecting on complexity.

Jennings and Skovholt (1999) emphasized that truly master therapists have developed high levels

of functioning in the cognitive, emotional, and relational domains, and are able to call upon and

integrate these three areas ("the three-legged expertise stool", p. 9) in their clinical work.

Jennings et al. (2003) reviewed the counseling expertise literature, outlining the

challenges of trying to define expertise in counseling and presenting research-based contributors

to its development. The key factors these authors identified as critical to developing expertise

included: experience, personal characteristics, openness to change, cultural competence, and an

ability to accept ambiguity. They posited that with more research, additional factors were likely

to be discovered.

In an introduction to a Journal of Mental Health Counseling special section on master

therapists, Skovholt and Jennings (2005) summarized findings about the path from novice to

master therapist from an earlier study they had conducted (Skovholt and Jennings, 2004) and a

study by Rønnestad and Skovholt (1991) comparing therapist development and stagnation. The

key milestones or requirements they noted were: (a) a lot of time, (b) extensive experience with

clients, (c) a desire to use that experience in order to develop professionally, (d) an open

environment that encourages exploration, (e) reflection on the work, (f) comfort with uncertainty

and ambiguity, and (g) a progression through stages of development.

Jennings, Hanson, Skovholt, and Grier (2005) reviewed the expertise literature and

concluded that for various reasons, concepts from this body of research cannot account for what

comprises experience in counseling. One key difference these authors highlighted that

distinguished counseling expertise was the necessity to focus not only on the master-in-training's

cognitive processing capacity, but also on the ability to engender trust and build relationships

with others. They hearkened back to Jennings and Skovholt's (1999) three-legged stool,

emphasizing the importance of the emotional and relational domains, suggesting that: therapists

must be emotionally mature themselves, must respond receptively to others' emotions, and must

be able to work through repeated ruptures and repairs in the therapeutic relationship.

Skovholt and Starkey (2010) theorized about the knowledge bases for developing

therapist expertise as a three-legged stool, with practice, research/theory, and personal life

serving as the three legs. These authors suggest that each of these areas "on its own provides rich

data, but each, when used exclusively, is not necessarily sufficient to understand the complex

nature of a client's life." (Skovholt & Starkey, 2010, p. 126). They emphasized the importance of

being open to learning experiences from various areas of life, and to reflecting on all of these

areas and experiences deeply in order to develop a balanced stool that can "provide the

foundation for the confusing and chaotic work in the swampy world of the most complex of all

species." (p. 129).

Appendix B: Statement of the Problem

More than 90% of therapists report that they have used TSD (Lane, Farber, & Geller, 2001; Henretty & Levitt, 2010), and therapists and theorists are converging on the belief that TSD can have beneficial effects if used intentionally, judiciously, and skillfully (Hill et al., 1988; Barrett & Berman, 2001; Hanson, 2005). Furthermore, a growing body of research and theory suggests that avoiding TSD in all circumstances may have harmful effects on both the client and the therapy (Barnett, 2011). Yet little is known about how master therapists make decisions about TSD. My purpose in the present study was to investigate master therapists' attitudes toward and decision-making process for sharing personal information with clients. My intention was to begin to answer the "who, what, when, and where" questions surrounding the intervention, as Gelso and Palma (2011) called for in their guidelines for advancing the study of TSD, as well as the question, "How do master therapists decide whether or not to disclose?"

Surveys have provided glimpses into possible factors that affect how therapists view and use TSD, as well as their rationale for and against its use, but survey methodology limits the answers to the responses researchers provided. I was interested in learning of master therapists' answers to such questions when their answers are neither limited nor influenced by prompts.

Research Question 1: What factors influence master therapists' views of TSD?

Using survey methodology, Gallucci (2002) found that 74% of respondents' indicated their views of TSD changed over time (most increased whereas others decreased usage), and that therapists selected various reasons for this change (e.g., change in theoretical orientation, increased/decreased comfort with self-disclosing, specific training in TSD). However, participants in that study were not necessarily master therapists. Participants in the current study

were licensed psychologists with 15 years of experience working with adult clients who were identified by others in the field as master therapists.

Research Question 2: How do master therapists' views of TSD evolve over time and to what do they attribute these changes?

Although surveys (Lane, Farber, & Geller, 2001; Gallucci, 2002) have given us an idea of some things therapists consider when deciding whether or not to disclose (e.g., type/severity of disorder, phase of treatment, quality of alliance, client gender, length of treatment, client age), participants in these surveys have varied (e.g., psychiatrists, social workers, psychologists), and responses have, for the most part, been limited to answers provided by the researchers. In addition, these questions have been asked and answered in a general way, which Gallucci (2002) suggested was not useful. The interview protocol in the present study asked participants to describe actual instances of TSD in therapy, and to explain the factors they considered in making self-disclosure in real-life clinical situations.

Research Question 3: What factors do master therapists consider when deciding whether or not to self-disclose?

In addition to understanding how participants decide whether or not to self-disclose, of interest is how respondents evaluated their TSDs, and as masters, reflected on them and made course corrections for the future.

Research Question 4: What characterizes successful disclosure?

Research Question 5: What characterizes unsuccessful disclosure?

Therapists of all experience levels face challenging situations. This may involve "disclosure fever" (feeling an urge to share something personal with a particular client; Stiles, 1987). It would be helpful to understand how master therapists handle such situations.

Research Question 6: How do master therapists handle feeling an urge to disclose?

I addressed these questions in the present study by asking participants about their use of TSD, how it has evolved during their careers, and factors that they believed influenced their views of TSD. In addition, I explored instances from therapy of specific TSDs that went well and did not go well, as well as how participants handled feeling an urge to disclose.

Appendix C: Recruitment Emails, Telephone Scripts, Inclusion Criteria Checklist, Informed Consent

Initial Nomination e-mail

Subject: Nominate master therapists in D.C. area

Who are the best therapists in the region? Within each field there are people who stand out above all others. These are the best of the best.

I am writing to ask you to nominate these master therapists as potential participants for my dissertation on master therapists' views on and perceptions of therapist self-disclosure use. Nominating potential participants should take less than 5 minutes of your time and my hope is that the results will contribute to our understanding of how to use therapist self-disclosure in psychotherapy.

How to Help: Two Ways
1. Please **either reply to this email** or (if you prefer) use the link below to nominate at least one, and up to 5, "master" therapists in the Washington, D.C./Northern Virginia/Maryland metropolitan region to whom you would be likely to refer a dear friend or close family member for psychotherapy services.

[INSERT QUALTRICS NOMINATION LINK TO "Qualtrics Page for Submitting Nominations"]

 2. In addition, I would be grateful if you would forward this email to local therapists to invite them to nominate participants as well.

Who Is Eligible to Participate (i.e., Who to Nominate)?
Participants must be licensed psychologists, psychiatrists, or social workers in the Washington, D.C./Northern Virginia/Maryland metropolitan region with at least 15 years of experience seeing adult clients in individual psychotherapy, who excel at developing strong therapeutic relationships.

We hope to recruit the "best of the best" psychotherapists, and, ideally, nominated participants will also meet the following criteria: (a) extensive experience with clients, (b) a desire to use their experiences to develop professionally, (c) open and curious, (d) reflect deeply on the work, (e) comfort with uncertainty and ambiguity, and (f) voracious readers and learners.

What Is the Study About?
The study is a qualitative exploration of master therapists' attitudes toward and perceptions of therapist self-disclosure use, including: factors that influenced their views; how views have evolved over time; factors they consider in deciding whether or not to disclose; an exploration of

specific instances of disclosures that went well and not so well; and how they handle challenging situations, such as a pull to disclose or a client asking for information they would rather not share. This study has been approved by the University of Maryland's Institutional Review Board.

Thank You
Thank you very much for your consideration. If you have any questions or concerns, please feel free to contact me at TSDstudy@umd.edu or 240-447-7754.

Nomination reminder e-mail

Subject: Follow-up: Nominate master therapists in D.C. area

Hello – I am following up on an email I sent to you about a week ago asking you to nominate potential participants for my dissertation on master therapists' perspectives on therapist self-disclosure. If you already nominated one or more therapists for inclusion in the study, or forwarded the email to colleagues, please accept my thanks. If not, responding to this e-mail should take less than 5 minutes of your time and my hope is that the results will contribute to our understanding of how to use therapist self-disclosure in psychotherapy.

How to Help: Two Ways
1. Please **either reply to this email** or (if you prefer) **use the link below** nominate at least one, and up to 5, "master" therapists in the Washington, D.C./Northern Virginia/Maryland metropolitan region to whom you would be likely to refer a dear friend or close family member for psychotherapy services:

 [INSERT QUALTRICS NOMINATION LINK TO "Qualtrics Page for Submitting Nominations"]

2. In addition, I would be grateful if you would forward this email to local therapists to invite them to nominate participants as well.

Who Is Eligible to Participate (i.e., Who to Nominate)?
Participants must be licensed psychologists, psychiatrists, or social workers in the Washington, D.C./Northern Virginia/Maryland metropolitan region with at least 15 years of experience seeing adult clients in individual psychotherapy, who excel at developing strong therapeutic relationships.

We hope to recruit the "best of the best" psychotherapists, and, ideally, nominated participants will also meet the following criteria: (a) extensive experience with clients, (b) a desire to use their experiences to develop professionally, (c) open and curious, (d) reflect deeply on the work, (e) comfort with uncertainty and ambiguity, and (f) voracious readers and learners.

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The study is a qualitative exploration of master therapists' attitudes toward and perceptions of therapist self-disclosure use, including: factors that influenced their views; how views have evolved over time; factors they consider in deciding whether or not to disclose; an exploration of specific instances of disclosures that went well and not so well; and how they handle challenging situations, such as a pull to disclose or a client asking for information they would rather not share. This study has been approved by the University of Maryland's Institutional Review Board.

Thank You

Thank you very much for your consideration. If you have any questions or concerns, please feel free to contact me at TSDstudy@umd.edu or 240-447-7754.

Qualtrics Page for Submitting Nominations

Thank you very much for helping us to identify master therapists to participate in our study.

Please use the fields below to nominate at least one, and up to 5, "master" therapists (i.e., licensed psychologists, psychiatrists, or social workers) in the Washington, D.C./Northern Virginia/Maryland metropolitan region to whom you would be likely to refer a dear friend or close family member for psychotherapy services.

Participants must be licensed psychologists, psychiatrists, or social workers in the Washington, D.C./Northern Virginia/Maryland metropolitan region with at least 15 years of experience seeing adult clients in individual psychotherapy, who excel at developing strong therapeutic relationships.

For each nominee, please include the therapist's full name.

_____

_____

_____

_____

_____

Thank you very much for taking the time to help us identify master therapists to participate in our study!

Recruitment telephone message script #1

Hello Dr. _____. My name is Kristen Pinto-Coelho. I am a counseling psychology doctoral student at the University of Maryland, and I am calling to invite you to participate in a study about master therapists' views and perceptions of therapist self-disclosure use in psychotherapy. Your local colleagues nominated you as a master therapist, and that is why we are hoping you will participate in this study, assuming that you meet our inclusion criteria. That is: 1) you have been practicing with adults in individual psychotherapy for 15 years or more, and 2) you believe therapist self-disclosure can be beneficial and use it as part of your practice. (For the purposes of the study, we are defining therapist self-disclosure as: therapist statements that reveal something personal about the therapist's life or person outside of therapy). If you agree to participate, you would be interviewed by an experienced therapist about your use of self-disclosure in therapy and would be asked to complete some online measures, all of which will take about 90 minutes of your time. Please contact me at 240-447-7754 or TSDstudy@umd.edu to learn more and to let me know whether or not you would be willing to participate. In the meantime, I will send you an email with additional details. Many thanks for your consideration.

(Only if potential participant answers: For the purposes of scheduling the telephone interview, what hours are you generally available? And what is your email address? I will use it to have your interviewer contact you directly.)

Recruitment telephone message script #2 (for non-responders only)

Hello Dr. _____. My name is Kristen Pinto-Coelho. I am a counseling psychology doctoral student at the University of Maryland, and I am calling to follow-up on my earlier voice-mail and e-mail from approximately one week ago. I am inviting you to participate in a study about master therapists' views and perceptions of therapist self-disclosure use in psychotherapy. Your local colleagues nominated you as a master therapist, and that is why we are hoping you will participate in this study, assuming that you meet our inclusion criteria. That is: 1) you have been practicing with adults in individual psychotherapy for 15 years or more, and 2) you believe therapist self-disclosure can be beneficial and use it as part of your practice. (For the purposes of the study, we are defining therapist self-disclosure as: therapist statements that reveal something personal about the therapist's life or person outside of therapy). Even if you would prefer not to participate, please reply to the email or contact me at 240-447-7754 to let me know, so we may remove your name from the list of people to contact. Many thanks for your consideration.

(Only if potential participant answers: For the purposes of scheduling the telephone interview, what hours are you generally available? And what is your email address? I will use it to have your interviewer contact you directly.)

Recruitment e-mail

Subject: Your Peers Have Nominated You as a Master Therapist

Dear _____,

As I mentioned in a voice-mail I left for you [earlier today, yesterday, recently], you have been nominated as a "master therapist" by other local therapists, who have indicated that you are one of a handful of experienced therapists in the area to whom they would be likely to refer a dear friend or close family member for psychotherapy services. As a result, I am writing to invite you to participate in a qualitative study about master therapists' views on and perceptions of therapist self-disclosure use in psychotherapy.

Who Is Eligible to Participate?
To participate, you must: a) be a licensed psychologist, psychiatrist, or social worker in the Washington, D.C./Northern Virginia/Maryland metropolitan region, b) have at least 15 years of experience seeing adult clients in individual psychotherapy, c) believe therapist self-disclosure can be beneficial, and d) use it as part of your practice. (For the purposes of the study, we are defining therapist self-disclosure as: therapist statements that reveal something personal about the therapist's life or person outside of therapy.)

We hope to recruit the "best of the best" in psychotherapists, and, ideally, nominated participants will also meet the following criteria: a) extensive experience with clients, b) a desire to use their experiences to develop professionally, c) open and curious, d) reflect deeply on the work, e) comfort with uncertainty and ambiguity, and f) voracious readers and learners.

What Is the Study About?
The study is a qualitative exploration of master therapists' attitudes toward and perceptions of therapist self-disclosure use, including: how your views have evolved over time; factors you consider in deciding whether or not to disclose; factors that have influenced your views; an exploration of specific instances of disclosures that went well and not so well; and how you handle challenging disclosure-related situations, such as a pull to disclose (disclosure "fever") or a client asking for information you would rather not share.

What Will Be Involved in Participating?
Participating in the study should take about 90 minutes of your time. The first step is to complete the online informed consent and inclusion criteria checklist (5 minutes). Next, an experienced therapist, will call you to schedule a 45-, 50-, or 60-minute telephone interview, based on how you schedule your time. After the interview, we will ask you to complete some brief online self-disclosure and demographic measures (< 25 minutes).

For the interview, we will use the attached questions as well as ask additional questions about things that come up during the interview. The interview will be recorded and transcribed, and you will be given the opportunity to review the transcription and provide any clarification you feel is warranted. The transcript will be assigned a code number so that the transcript will not be connected with your name. In the transcript, identifying information will be removed or modified

as needed to maintain confidentiality. Only members of the research team will have access to the recordings and transcripts, which will be stored in a locked, secure location and destroyed upon completion of the study. If you decide to participate in the study, you have the right to refuse to answer any question(s) and/or to withdraw your participation at any time.

Benefits of Participating
Unfortunately, I cannot offer any monetary compensation for participating in the study, but I hope that participating will provide you with the opportunity to reflect on your practice, your use of therapist self-disclosure, and the evolution of your views and use of this important intervention. My goal is to gain information and clinical vignettes that will assist psychology trainees and early career psychologists in learning how to use therapist self-disclosure most effectively, as well as what factors should be considered in deciding whether and when to disclose.

About Me
My name is Kristen Pinto-Coelho, and I am an advanced doctoral student in the counseling psychology program at the University of Maryland, College Park (UMD). For my master's thesis, I investigated the occurrence of 185 instances of therapist self-disclosure in 16 cases of psychodynamic psychotherapy in a training clinic. I am now turning my attention to how *master therapists* make decisions about disclosing. The current dissertation study has been approved by UMD's Institutional Review Board. My dissertation advisor, Dr. Clara E. Hill, has researched and published extensively in the area of therapist self-disclosure; she also developed the Consensual Qualitative Research (CQR) method I will be using to conduct this study. I have experience using and training others to use CQR.

Thank You and Next Steps
I would be honored and delighted if you would agree to participate in this study. I think we could learn a lot from you about how to disclose therapeutically and how to make decisions about disclosure in psychotherapy, and I hope the interview process will be meaningful for you as well.

Please reply to this message to let me know whether you would be willing to participate. If you are willing, we will email you a link to the informed consent form; if not, we will remove you from our list of individuals with whom we need to follow up.

If we have not heard from you within one week, we will telephone you to inquire about your willingness to participate. We look forward to hearing from you.

Many thanks for your consideration,
Kristen G. Pinto-Coelho
(Attachment: Interview Protocol)

Participant e-mail #1 – inclusion criteria checklist and informed consent (for nominees who agree to participate - with link to Qualtrics)

Subject: Next Steps for Master Therapists/Self-Disclosure Study

Dear Dr. _____,
Thank you so much for agreeing to participate in my dissertation study on master therapists' use and views of therapist self-disclosure. Study participation will involve three steps.

Step One: Inclusion Criteria Checklist and Informed Consent
First, you will complete the inclusion criteria checklist and the informed consent online (also attached here for your records) at the provided link. This should take you 5 minutes or less. (If the link does not work, please copy and paste the url into your web browser. If for some reason it still does not work, please reply to this email to let me know.)

[INSERT QUALTRICS LINK TO INCLUSION CRITERIA CHECKLIST AND INFORMED CONSENT]

Step Two: Interview
Once we have your completed informed consent, [Dr. Clara Hill, Dr. Mary Ann Hoffman, or Dr. Barbara Thompson] will call you to schedule a telephone interview. The interview should take 45-60 minutes. (We will work with you based on how you schedule your time.) Your interviewer will ask you the questions in the attached interview protocol as well as follow-up questions that come up during the interview. It would be extremely helpful if you could review the attached questions in advance, consider your answers, and, especially, select the clinical vignettes you plan to discuss.

Step Three: Measures
Finally, you will complete the therapist self-disclosure and demographic questionnaires online at a link we will provide to you via email. It should take you less than 25 minutes to complete these items.

Again, thank you so much for agreeing to participate in this study. My hope is that it will provide trainees and early career therapists with important information on whether and when to disclose, as well as prompt more seasoned practitioners to think more deeply about their own disclosure decisions.

If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; email: irb@deans.umd.edu; phone: 301-405-0678.

Best,
Kristen G. Pinto-Coelho
Mobile: 240-447-7754
(Attachments: Interview Protocol and Informed Consent Copy for Participant's Records)

Participant e-mail #2 – Measures (for nominees who have completed interview - with link to TSD & demo measures)

Subject: Final Steps for Master Therapists/Self-Disclosure Study

Dear Dr. _____,
Thank you so much for participating in my dissertation study on master therapists' views and perceptions of therapist self-disclosure use. Your interview is currently being transcribed and we will send it to you for your review as soon as possible.

In the meantime, as promised, I am writing to request that you complete the final stage in the process, which involves responding to two brief therapist self-disclosure and demographic questionnaires using the following link:

INSERT QUALTRICS TSD & DEMOGRAPHICS SURVEY LINK HERE.

Again, thank you so much for your participation. My hope is that it will provide trainees and early career therapists with important information on whether and when to disclose, as well as prompt more seasoned practitioners to think more deeply about their own disclosure decisions.

If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; email: irb@deans.umd.edu; phone: 301-405-0678.

Best,
Kristen G. Pinto-Coelho
Mobile: 240-447-7754

Inclusion Criteria Checklist
Thank you for your interest in our study! Please answer the following questions to enable us to determine whether or not you meet inclusion criteria to participate.

1. I am a licensed psychologist, psychiatrist, or social worker in the Washington, D.C./Northern Virginia/Maryland metropolitan region.

__Yes __No

2. I have at least 15 years of experience seeing adult clients in individual psychotherapy.

__Yes __No

3. I am currently seeing adult clients in individual psychotherapy part-time or full-time.

__Yes __No

For the purposes of the following two questions, **therapist self-disclosure** is defined as: therapist statements that reveal something personal about the therapist's life or person outside of therapy.

4. I believe therapist self-disclosure can be beneficial to clients and/or has value therapy.

__Yes __No

5. I use therapist self-disclosure as part of my practice.

__Yes __No

[If participant responds "No" to any of the inclusion criteria, s/he will be directed to a screen that says, "Thank you for your interest but you do not meet our inclusion criteria." If a participant responds yes to all inclusion criteria, s/he will be directed to the informed consent page.]

Informed Consent

Informed consent will be processed via a Qualtrics web form containing the following information and requiring participants to input their name and the date of consent.

Project Title	Master Therapists' Use Of Self-Disclosure In Individual Psychotherapy: A Qualitative Study
Purpose of the Study	This research is being conducted by Kristen G. Pinto-Coelho and Clara E. Hill at the University of Maryland, College Park. We are inviting you to participate in this research project because you are a practicing psychotherapist working with adult clients in individual therapy. The purpose of this research project is to learn about master therapists' perceptions of self-disclosure use in individual psychotherapy.
Procedures	The procedures involve completing a brief inclusion criteria checklist and participating in a 60-minute recorded interview (example question is "What factors influenced your views on self-disclosure when you first began practicing?"); no personal identifiers will be recorded. This will take place via telephone from the Biopsychology Building, Suite 2140, at the University of Maryland or from the private office at 3355 St. Johns Lane Ellicott City MD 21042. You will then complete the Therapist Self-Disclosure Questionnaire (example item: "How often have you verbally disclosed personal information to a client regarding your age?") and a demographic questionnaire, all of which will be completed online and will take 25 minutes or less. The entire process will take about one hour and 30 minutes.

Potential Risks and Discomforts	There may be some risks from participating in this research study. You may experience discomfort if you become aware of certain aspects of yourself or your psychotherapy experiences while completing the measures or taking part in the interview. To mitigate risk, participants are reminded that they do not have to answer any question that makes them uncomfortable, and that they may seek supervision or use the Psychology Today web site (https://therapists.psychologytoday.com/rms/?utm_source=PT_Psych _Today&utm_medium=House_Link&utm_campaign=PT_TopNavF_ Therapist) to find a local therapist with whom they may discuss their concerns.
Potential Benefits	There are no direct benefits from participation in this research. However, possible benefits include learning about yourself, about your own psychotherapy work, and about how to use self-disclosure to help your clients. We hope that, in the future, other people might benefit from this study through improved understanding of therapist self-disclosure.
Confidentiality	We will take precautions to ensure that all data remain confidential. Any potential loss of confidentiality will be minimized by storing data in a locked office. You will be given a code number and your name and identifying information will not appear on any document. As soon as sessions are transcribed, recordings will erased. The only person who will have access to your audiotape is the person who does your interview and the person who completes the transcript; all other members of the team will see only the de-identified transcript.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible. Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities if you or someone else is in danger or if we are required to do so by law. |

Right to Withdraw and Questions	Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits for which you otherwise qualify. If you decide to stop taking part in the study, if you have questions, concerns, or complaints, or if you need to report an injury related to the research, please contact the investigators: **Kristen G. Pinto-Coelho** Department of Psychology, UMD, 240-447-7754, kpinto@umd.edu **Clara E. Hill, Ph.D.,** Department of Psychology, UMD, 301-405-5791, cehill@umd.edu
Participant Rights	If you have questions about your rights as a research participant or wish to report a research-related injury, please contact: **University of Maryland College Park** **Institutional Review Board Office** **1204 Marie Mount Hall** **College Park, Maryland, 20742** **E-mail: irb@umd.edu** **Telephone: 301-405-0678** This research has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.
Statement of Consent	Your inputting your name in the text box indicates that you are at least 18 years of age; you have read this consent form or have had it read to you; your questions have been answered to your satisfaction and you voluntarily agree to participate in this research study. If you agree to participate, please input your name in the text box and input today's date in the date box.

Signature and Date	**NAME OF PARTICIPANT**	
	DATE	

Appendix D: Demographics Questionnaires

Therapist Demographics Questionnaire

Please indicate your highest degree:
__Ph.D.
__Psy.D.
__M.S./M.A.
__n/a

[If n/a, respondent receives notice thanking them for their time but saying they are not eligible to participate in study.]

Year of degree completion: _____

Please indicate program type:
__Counseling   __Clinical   __ Social work   __Other, please specify: _____

Are you licensed to practice? __Yes __No *[If no, respondent receives notice thanking them for their time but saying they are not eligible to participate in study.]*

Do you currently see adult clients in individual psychotherapy? __Yes __No *[If no, respondent receives notice thanking them for their time but saying they are not eligible to participate in study.]*

Please indicate your number of years of experience practicing with adult clients:
[If < 15, respondent receives notice thanking them for their time but saying they are not eligible to participate in study.]
__0-4 years
__5-9 years
__10-14 years
__15-19 years
__20-24 years
__25-29 years
__30-34 years
__35-39 years
__40-44 years
__45-49 years
__50-54 years
__55-59 years
__Other, please explain: _____

Please provide a brief list of your clients' typical presenting issue(s): _____

Please indicate the typical number of sessions: _____

Please select your age range:
__20-24
__25-29
__30-34
__35-39
__40-44
__45-49
__50-54
__55-59
__60-64
__65-69
__70-74
__75-79
__80-84
__85-89
__Other, please specify: _____

Please indicate your gender:
__Male
__Female
__Other, please specify: _____

Please indicate your race/ethnicity (check as many as apply):
__African American
__Asian/Asian American
__American Indian
__Biracial/Multiracial, please specify:___
__Hispanic/Latino
__White (non-Hispanic)
__Other, please specify: _____

Theoretical Orientation

Rate the extent to which you believe in and adhere to the theory and techniques of each of the following theoretical orientations:

	Low				High
Psychoanalytic/psychodynamic	1	2	3	4	5
Humanistic/person-centered	1	2	3	4	5
Cognitive/cognitive-behavioral	1	2	3	4	5
Feminist/multicultural	1	2	3	4	5

Experience as a Client

1. Have you ever been a client is psychotherapy and/or psychoanalysis?

__Yes __No
       (If no, participant will *not* be asked remaining questions in this section.)

2. Are you currently in psychotherapy and/or psychoanalysis?

__Yes __No (If "yes": Participant will not be asked question 2a.)
       2a. If "no": Did you stop therapy/analysis:
       __1-5 years ago? __ 6-10 years ago? __ 11+ years ago

3. What was the primary theoretical orientation of your therapy?

__Cognitive/behavioral
__Humanistic
__Feminist/Multicultural
__Psychodynamic
__Other (please specify)

4. In general, how did you perceive disclosure by your therapist, if applicable?

☐ Detrimental to treatment
☐ Neither beneficial nor detrimental to treatment
☐ Beneficial to treatment

PERCEPTIONS OF SELF-DISCLOSURE

Researcher Demographic Questionnaire

Name: _____

Date: _____

Age: _____

Sex: Male   Female   Other, please specifiy: _____

Race/Ethnicity: (check as many as apply):

    European American
    African American
    Asian American/Pacific Islander
    Hispanic American
    Native American/Alaskan Native
    Middle Eastern
    Multiethnic (please specify:)
    International (please specify:)
    Other (please specify:)

Year in program (Check one):
  FIRST YEAR
  SECOND YEAR
  THIRD YEAR
  FOURTH YEAR
  FIFTH YEAR
  SIXTH YEAR
  SEVENTH YEAR
  NOT STUDENT

Appendix E: Therapist Self-Disclosure Questionnaire

(Items from Gallucci, 2002)

Key to Self-Disclosure Topics Referenced Below
For the purposes of this study, our definition of therapist self-disclosure is "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2002, p. 256), that is to say, it involves a revelation about the therapist's life or person outside of therapy. We explicitly *exclude* nonverbal self-disclosures (such as a family photo on the desk) and self-involving disclosures that entail the therapist sharing "immediate or past feelings or experiences in response to the patient's experiences or feelings" (also known as immediacy) (Gelso & Palma, 2011, p. 343).

Demographic/professional identity: Your marital status, age, degrees held, years of experience, etc.
Opinions/attitudes/views: Your personal views on religion, relationships, political issues, world affairs, etc.
Metaphors/images/fantasies: That come to mind as they relate to the client and/or the client's situation.
Personal strengths: Your positive attributes such as intelligence, courage, kindness, successfulness, etc.
Personal weaknesses: Your negative attributes such as cognitive limitations, prejudices held, selfishness, etc.

1. How often do you *spontaneously* disclose the following types of information to your clients?

	Never	Rarely	Occasionally	Frequently	Routinely
Demographic/professional identity					
Opinions/attitudes/views					
Metaphors/images/fantasies					
Affect toward client					
Personal strengths					
Personal weaknesses					
Personal experiences					

2. When a client requests the following types of information, do you usually:

	Answer question	Answer question then explore	Explore then answer question	Explore without answering question
Demographic/professional identity				
Opinions/attitudes/views				
Metaphors/images/fantasies				
Affect toward client				
Personal strengths				
Personal weaknesses				
Personal experiences				

3. Which of the following factors influence your decision to self-disclose? (Check all that apply.)

□ Type/severity of disorder/presenting issue(s)
□ Phase of treatment
□ Quality of alliance
□ Client gender
□ Length of treatment
□ Client age
□ Other (please specify and provide rating): _____

4. Which of the following do you believe are appropriate reasons for the use of self-disclosure? (Rank order top five by inserting numbers 1 through 5 in the appropriate boxes)

□ Increase client awareness of alternative viewpoints/options
□ Provide modeling
□ Increase client involvement in relationship
□ Increase client perception of therapist empathy
□ Increase client self-disclosure through reinforcement
□ Decrease client anxiety
□ Decrease therapist anxiety

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☐ Decrease client resistance
☐ Decrease transference reactions
☐ Demonstrate therapist availability
☐ Empower the client
☐ Promote feelings of universality
☐ Balance asymmetry of relationship
☐ Decrease inhibition
☐ Provide therapist background
☐ Provide reality testing
☐ Other (please specify and provide number rating): _____

5. Which of the following do you believe are appropriate reasons for limiting or prohibiting the use of self-disclosure? (Rank top three by inserting numbers 1 through 3 in the appropriate boxes)

☐ Shifts focus from client to therapist
☐ Interferes with transference
☐ Creates role confusion
☐ Personally uncomfortable
☐ Creates discomfort in client
☐ Inappropriately influences or burdens client
☐ Creates doubt about the mental health of the therapist
☐ Decreases time available for client disclosure
☐ Deviates from client expectations of a professional
☐ Indicates a countertransference enactment
☐ Other (please specify and provide number rating): _____

6. Compared to when you first began as a psychotherapist, do you currently self-disclose:

☐ More frequently
☐ With the same frequency
☐ Less frequently

7. If there has been a change in the frequency of your self-disclosures, to what do you attribute the change?

☐ Change in theoretical orientation
☐ Increased comfort with self-disclosing
☐ Decreased comfort with self-disclosing
☐ Specific training in self-disclosure
☐ Other (please specify): _____

Thank you very much for your time in completing this questionnaire and for your participation in our study. Please email TSDstudy@umd.edu to let us know you have completed the measures so we may schedule a telephone interview.

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Appendix F: Interview Protocol

Introduction: Thank you for agreeing to participate in this qualitative study exploring master therapists use and views of therapist self-disclosure. We are looking for important disclosures, not disclosures of trivial things (e.g., "I saw that movie too.")

For the purposes of this study, our definition of therapist self-disclosure is "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2002, p. 256), that is to say, it involves a revelation about the therapist's life or person outside of therapy. We explicitly *exclude* nonverbal self-disclosures (such as a family photo on the desk) and self-involving disclosures that entail the therapist sharing "immediate or past feelings or experiences in response to the patient's experiences or feelings" (also known as immediacy) (Gelso & Palma, 2011, p. 343).

I wanted to remind you that I will be recording this interview, and that the interviews will be transcribed for data analysis. Your name and any other identifying information will be removed from the transcripts. Only members of the research team will have access to the recording of this interview, which will be stored in a locked, secure location and will be destroyed upon completion of the study. Your participation in this study is completely voluntary, and you have the right to refuse to answer any question(s) asked of you and/or withdraw from this study at any time.

Do you have any questions before we begin?

Please say whatever comes to your mind in response to each question.

Initial Questions
1. How would you describe your use of therapist self-disclosure?
2. What **training** did you receive in self-disclosure?

Changes over time
3. What **factors influenced your views** on self-disclosure when you first began practicing (post PhD)?
    a. Anything else? (ask this a couple of times, then, if nothing, probe with the following prompts)
    b. Theoretical orientation?
    c. Personal therapy? What memories (if any) of therapist self-disclosure do you have from your own therapy? (of therapist disclosing? of therapist refusing to disclose?)
    d. Supervision? What memories (if any) do you have of supervisor disclosing? of supervisor refusing to disclose? of supervisor advising you about disclosing to your clients?
    e. Childhood?
    f. Other factors?
4. How have you **evolved during your time** as a practitioner in terms of thinking about and using self-disclosure?

Clinical vignettes – these should be relatively recent
5. Please think of a specific client with whom **a disclosure that went well**.
    a. Please briefly explain the case. *[Interviewer: be sure to get client's demographics (age, race/ethnicity, presenting issues, DSM diagnosis, etc.]*
    b. What was happening in therapy when you decided to disclose?
    c. Please describe the disclosure. (Please choose a specific disclosure.) *[Then, if needed, used prompts below.]*
        i.   Who initiated the disclosure?
        ii. What were your intentions?
        iii. What were the consequences? (Be explicit.)
        iv. How did you know it was a successful disclosure?

6. Every therapist has experienced a self-disclosure that did NOT have the intended effect. Please think of a specific client with whom **you regretted a disclosure**.
    a. Please briefly explain the case. *[Interviewer: be sure to get client's demographics (age, race/ethnicity, presenting issues, DSM diagnosis, etc.]*
    b. What was happening in therapy when you decided to disclose?
    c. Please describe the disclosure. (Please choose a specific disclosure.) *[Then, if needed, used prompts below.]*
        i.   Who initiated the disclosure?
        ii. What were your intentions?
        iii. What were the consequences? (Be explicit.)
        iv. How did you know it was not a successful disclosure?

[Be aware of time here and ask if they have time to answer now (15-20 minute) or would prefer to reschedule for another time.]

Feeling pulled to disclose
7. Please provide a (different) example of a specific instance when you **felt a strong urge** to disclose that wasn't initiated by a specific request from the client **and you chose not to**. (An example might be that a client is talking about a specific situation you had also experienced.)
    a. What made you decide not to share?

Final questions
8. What **advice** would you give to trainees or early career practitioners about how to decide
    a. What and when to disclose?
    b. What and when not to disclose?
9. What is your general comfort-level or "set point" with disclosure in your personal life/among people that you know?
10. What was it like to participate in this interview?

At the end of the interview, please:
*   Remind the participant that s/he will be receiving an email from me with a link to measures for them to complete as the last step in participating in the study.

Appendix G: Table 1—List of Domains, Categories, Subcategories, and Frequencies

Domain/Category/Subcategories	Frequency
Attitudes about using TSD in therapy	
Thoughts about TSD's helpfulness	
Thinks TSDs can be helpful	Typical (9)
Does not think TSDs are helpful	Variant (2)
Changes in TSD use over time	
Increased comfort and discloses more now than early in career	Typical (11)
Discloses less now than early in career	Variant (2)
Factors that shaped therapists' TSD use	
Training	
Trained to be open to TSD as a tool/TSD was encouraged	Typical (11)
Trained not to disclose/TSD was discouraged	Typical (8)
No training received	Variant (6)
Personal therapy	
Positive TSD experience	Typical (9)
Wanted more TSD from therapist /Therapist disclosed minimally	Typical (7)
Therapist disclosed too much/had poor boundaries	Variant (3)
Family/social influences	
Encouraged TSD	Variant (6)
Unsure	Variant (6)

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Table 1 continued

Frequency

Recommendations for using TSD in therapy
(What to consider when deciding whether or not to disclose, etc.)

Be thoughtful and strategic about using disclosure	Typical (11)
Proceed with caution when feeling pulled or client requests	Typical (9)
Disclose more in context of long-term therapy or strong relationship	Typical (8)
Focus needs to stay on the client (rather than on needs of the therapist)	Typical (8)
Establish clear guidelines for how you will approach TSD with all clients and stick to them	Typical (8)
Do not disclose with clients who cannot tolerate knowing more about the therapist	Typical (8)
Disclose when not disclosing violates basic social contract	Variant (6)
Do not disclose material that is too personal, emotional, or unresolved	Variant (6)
Get training, supervision, consultation about using TSD	Variant (5)
Evaluate the effects of TSD by seeing how clients respond	Variant (6)

Experience participating in the study

Helpful in reflecting on self as a therapist and clinical work	Typical (10)
Enjoyed the interview	Typical (9)
Interviewer was helpful	Variant (5)
Some questions were difficult	Variant (3)

Note. General = 12 to 13, Typical = 7 to 11, Variant = 2 to 6.

Appendix H: Table 2—Comparison of Subsamples on Antecedents, Intentions, Content and Consequences

| | General Attitudes ($N = 13$) | Frequency | | | Meaningful Differences |
		Successful ($N = 13$)	Unsuccessful ($N = 11$)	Pulled ($N = 11$)	
Antecedents					
Client experiencing negative emotions in life	n/a	V (5; 39%)	V (5; 45%)		s > p; u > p
Therapist personal or professional concerns/Countertransference	n/a	V (5; 39%)	T (9; 82%)	T (8; 73%)	u > s; p > s
Strong therapeutic relationship	n/a	V (4; 31%)	V (2; 18%)	n/a	
Weak therapeutic relationship or Recent rupture	n/a	V (4; 31%)	V (2; 18%)	n/a	
Intentions					
Provide support (universality/ normalize/reassurance)	V (6; 46%)	T (8; 62%)	T (6; 55%)	n/a	
Facilitate exploration and lead to new perspective	T (7; 54%)	T (7; 54%)	V (3; 27%)	n/a	
Build and maintain the therapeutic relationship	T (10; 78%)	T (6; 46%)	V (2; 18%)	n/a	g > s > u

Table 2 continues on next page.

Table 2 continued.

	General Attitudes (N = 13)	Frequency			Meaningful Differences
		Successful (N = 13)	Unsuccessful (N = 11)	Pulled (N = 11)	
Intentions continued					
Facilitate action or change		V (5; 39%)	V (3; 27%)	n/a	s > g
Therapist identified no intention			V (4; 36%)	n/a	u > g; u > s
Reasons not to disclose					
Realized TSD would have been more for therapist's needs than client's needs	n/a	n/a	n/a	V (5; 46%)	
TSD would not have been consistent with maintaining appropriate boundaries/ too personal	n/a	n/a	n/a	V (5; 46%)	
TSD did not seem therapeutic/ appropriate	n/a	n/a	n/a	V (5; 46%)	

Table 2 continued.

| Content | General Attitudes (N = 13) | Frequency | | | Meaningful Differences |
		Successful (N = 13)	Unsuccessful (N = 11)	Pulled (N = 11)	
Content					
Similarities in experiences	n/a	T (10; 77%)		G (11; 100%)	s > u; p > u
Accurate (based on client reaction)	n/a	T (9; 69%)		n/a	s > u
Misjudged (based on client reaction)	n/a		T (8; 73%)	n/a	u > s
Not relevant to client's issues/content	n/a			V (3; 27%)	
Relevant to client's issues/content	n/a	T (11; 85%)		T (8; 73%)	s > u; p > u
Therapist issues affecting treatment	n/a		V (2; 18%)	T (8; 73%)	s > u; p > u

PERCEPTIONS OF SELF-DISCLOSURE

Table 2 continued.

| Consequences | General Attitudes (N = 13) | Frequency | | | Meaningful Differences |
		Successful (N = 13)	Unsuccessful (N = 11)	Pulled (N = 11)	
Deepened the therapeutic work (exploration/insight)	n/a	T (10; 77%)	n/a		s > u
Improved the therapeutic relationship	n/a	T (8; 62%)	n/a		s > u
Client positive reaction	n/a	T (8; 62%)	n/a		s > u
Alleviated client negative feelings/ increased client hope	n/a	V (5; 38%)	n/a		s > u
Client made changes in life outside of therapy	n/a	V (3; 23%)	n/a		
Therapist had ambivalent feelings about disclosing	n/a	V (3; 23%)	n/a		
Client negative reaction	n/a		G (11; 100%)	n/a	u > s
Therapist had regret about disclosing	n/a		T (7; 64%)	n/a	u > s
Therapist questioned appropriateness of TSD with this C	n/a		V (4; 36%)	n/a	u > s

Note. For successful cases and general attitudes: General = 12 to 13, Typical = 7 to 11, Variant = 2 to 6. For unsuccessful cases and for pulled to disclose examples: General = 10 to 11, Typical = 6 to 9, Variant = 2 to 5. G = general. T = typical. V = variant. Meaningful differences are those in which frequencies differ by 30% of cases or more among subsamples. n/a = not applicable because data were not collected.

Appendix I: Table 3—Demographic and Professional Information

Participant's Age Range	N	Percentage
40-44 years	1	8%
55-59 years	3	23%
65-69 years	5	38%
70-74 years	3	23%
Other (1 participant misunderstood the question and provided clients' typical ages)	1	8%
Gender	N	Percentage
Female	9	69%
Male	4	31%
Race/Ethnicity	N	Percentage
White (non-Hispanic)	13	100%
Highest Degree	N	Percentage
Ph.D.	13	100%
Year of Degree Completion	N	Percentage*
1990s	3	23%
1980s	2	15%
1970s	8	62%
Program Type	N	Percentage*
Counseling	11	85%
Clinical	1	8%
Learning Theory	1	8%
Number of Years Practicing with Adult Clients	N	Percentage*
15-19 years	1	8%
20-24 years	1	8%
30-34 years	2	15%
35-39 years	6	46%
40-44 years	3	23%

Table 3 continues on next page.

Table 3 continued.

Clients' Typical Presenting Issues**		
Relationship issues (parenting, difficulty with emotional expression, attachment difficulties, anger management, family or origin issues, marital issues, interpersonal ineffectiveness, co-dependence, inability to connect with others)	13	100%
Mood disorders (anxiety/panic attacks, depression, bipolar, mood lability, poor affect regulation)	11	85%
Overall well-being and existential issues (life meaning, changes in life situation for self or significant others, adjustment to a life issue, loss/bereavement)	4	31%
Health and wellness of self or significant others (physical illness, self-care)	3	23%
Low self-esteem, shame, character pathology	3	23%
Work/career concerns	3	23%
Addiction	2	15%
Identity/identity confusion	2	15%
Sexual issues	2	15%
Trauma, post-traumatic stress	2	15%
Eating disorders	1	7%
Financial issues	1	7%
Typical Number of Sessions	N	Percentage
More than 100	4	31%
50-100	4	31%
Less than 50	2	15%
Very variable: a few sessions to several years	2	15%
Note: Only 12 participants responded.		

PERCEPTIONS OF SELF-DISCLOSURE

Table 3 continued.

Is there anything else you would like us to know about your thoughts regarding therapist self-disclosure and/or your participation in this study?
This was an interesting opportunity to reflect on my experience with/use of self-disclosure. The interview was both fun and thought provoking. Thank you for this opportunity and good luck with the research.
I really struggled with this last set as it is so long ago. I do not remember what or how the therapist self disclosed. I also felt fairly uncertain answering the questions about some of my own use of self disclosure. It felt like I was guessing a lot.
My previous therapist(s) likely treated me differently because I was a therapist at the time as well. I think this influenced their self-disclosure behavior with me. Especially my most recent therapist.
the study has made me very curious about other therapists answers to these questions. so i imagine the results of the study will disclose this eventually. however i would like impressions still from the interviewer or others about the use of self disclosure among the various demographics of therapist if at all possible as a follow up to me.
I think it certainly can be taught - as in how to handle direct questions about ourselves, when to disclose, when not to, how to reflect these issues and dilemmas. However, I think that ultimately, an effective knowledge and awareness about self disclosure comes from years of supervision, training, personal therapy, and experience. Perhaps this is part of the art involved in psychotherapy, an intuition if you will, born out of years of self reflection and self examination.
I believe appropriate self-disclosure in treatment can be highly facilitative, and even transformative in some cases.
NO

* Percentages have been rounded to the nearest whole number so they may not total 100%.
** Participants could indicate more than one response for this item so the percentages may exceed 100%.

PERCEPTIONS OF SELF-DISCLOSURE

Appendix J: Table 4—Scores on TSD Questionnaire and Comparison with Gallucci Sample

Frequency of spontaneous disclosure of the following types of information *5-point scale (Never = 1; Routinely = 5)*			
	Current Sample (N = 13) Mean (SD)	Gallucci Sample (N = 153) Mean (SD)	Effect Size (Cohen's d)
Demographic/professional	3.46 (1.05)	3.24 (1.19)	0.21 (small)
Metaphors/images/fantasies	3.46 (1.05)	3.30 (1.09)	0.15 (n/s)
Affect toward client	3.15 (0.38)	2.62 (0.94)	0.74 (medium)
Personal experiences	2.77 (0.44)	2.71 (0.90)	0.09 (n/s)
Opinions/attitudes/views	2.62 (1.04)	2.35 (0.86)	0.28 (small)
Personal weaknesses	2.46 (0.66)	2.11 (0.82)	0.46 (small)
Personal strengths	2.23 (0.73)	1.93 (0.89)	0.37 (small)
Notes: Lower mean denotes lower frequency of disclosure.			

Factors Influencing Self-Disclosure		
	Current Sample (N = 13)	Gallucci Sample (N = 157)
Type/severity of disorder/presenting issue(s)	100%	77%
Quality of alliance	100%	85%
Phase of treatment	92%	71%
Length of treatment	62%	42%
Other*	62%	3%
Client age	46%	38%
Client gender	23%	17%

*Other responses from current sample:
- Any client demographics
- My own comfort/vulnerability
- Whether it feels like the self disclosure would be useful/helpful for the client
- motivation of the client for asking
- how disclosure has worked (e.g., been effective) in the past with this client
- assessment if a self disclosure will be received well and used to foster the relationship/alliance.
- The extent to which I assess that the disclosure will aid in progressing and/or deepening the therapy
- When client is stuck and/or emotionally entrenched it sometimes helps in perspective

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Table 4 continued.

Appropriate Reasons for Use of Self-Disclosure (Top 5)

	Current Total Sample $N = 13$			Gallucci Total Sample $N = 140$			Effect size
	n	M	SD	n	M	SD	d
Empower the C	11	2.64	1.50	51	2.75	1.51	0.07
Increase C perception of T empathy	9	3.44	1.42	31	3.03	1.47	0.28
Provide modeling	9	2.11	1.05	80	2.84	1.33	0.61
Increase C involvement in relationship	8	4.13	1.25	50	2.68	1.32	1.13
Decrease C anxiety	8	3.38	1.30	66	3.27	1.18	0.09
Increase C awareness of alt. viewpoints	8	2.88	1.55	73	2.56	1.51	0.21
Decrease C resistance	3	3.33	0.58	6	3.83	1.47	0.45
Demonstrate therapist availability	3	2.33	1.53	24	3.33	1.49	0.66
Increase C self-disclosure through reinforcement	1	1.00	0.00	38	3.21	1.30	0.41
Decrease T anxiety	0	0.00	0.00	6	3.83	0.98	5.53
Decrease transference reactions	0	0.00	0.00	3	3.33	0.58	8.12

Note: Larger means indicate higher rankings

Appropriate Reasons for Limiting or Prohibiting Use of Self-Disclosure (Top 3)

	Current Total Sample $N = 13$			Gallucci Total Sample $N = 140$			Effect size
	n	M	SD	n	M	SD	d
Shifts focus from C to T	11	2.55	0.82	120	1.56	0.76	1.25
Inappropriately influences or burdens C	8	2.00	0.53	34	2.38	0.70	0.61
Indicates a countertransference enactment	6	2.00	1.10	17	2.47	0.62	0.50
Creates discomfort in C	3	1.33	0.58	12	2.17	0.83	1.17
Decreases time available for C disclosure	2	2.50	0.71	5	2.00	0.71	1.19
Other*	2	2.00	0.00	n/a	n/a	n/a	n/a
Interferes with transference	2	1.50	0.71	46	2.26	0.68	1.09
Creates role confusion	2	1.00	0.00	32	2.31	0.78	2.38
Personally uncomfortable	1	1.00	0.00	21	1.95	0.86	1.56
Creates doubt about mental health of T	1	2.00	0.00	91	1.84	0.78	0.29
Deviates from C expectations of a professional	0	1.50	0.71	30	2.37	0.61	1.31

*Other: when therapist feels a need to disclose to receive self care from client

Note: Larger means indicate higher rankings

Present Frequency of Self-Disclosure Compared to When First Began as a Psychotherapist (post-PhD)

	Current Sample (N = 13)	Gallucci Sample (N = 152)
More frequently	77%	65%
With the same frequency	15%	26%
Less frequently	8%	9%

Table 4 continues on next page.

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Table 4 continued.

Reasons for Change in Frequency of Self-disclosure *(participants selected all that applied)*		
	Current Sample (N = 13)	Gallucci Sample (N = 152)
Change in theoretical orientation	9%	23%
Increased comfort with self-disclosing	73%	61%
Decreased comfort with self-disclosing	0%	15%
Specific training in self-disclosure	9%	7%
Other*	9%	27%
*Other for current sample: personal lived experience		

Quantitative Data Comparing Master Therapists' Use of TSD to a Survey Sample

The Therapist Self-Disclosure Questionnaire (TSDQ; Gallucci, 2002) was used to assess

participants' overall use of TSD. The purpose of using this measure was not to run statistical

analyses on such a small sample, but rather, to situate the current sample in the context of a

larger sample (Gallucci, 2002; N = 157). Gallucci's sample included psychologists with Ph.D.,

Psy.D., and Ed.D. degrees whose clients were children, whereas the current sample consisted

exclusively of psychologists with Ph.D. degrees who only saw adult clients. Participants' TSDQ

scores and those from Gallucci's larger survey are provided in Table 4 (located in Appendix J).

Frequency of disclosure. Mean frequencies for seven types of disclosure (listed here in

order from most to least frequently disclosed by the current sample, rated on a 5-point scale

[routinely = 5, never = 1]: demographic/professional, metaphors/images/fantasies, affect toward

client, personal experiences, opinions/attitudes/views, personal weaknesses, personal strengths)

are included in Table 4, along with effect sizes of the differences ($d = M_1 - M_2 / s_{pooled}$ where

$s_{pooled} = \sqrt{[(s_1^2 + s_2^2) / 2}$; Cohen, 1988) between the two samples. The current sample disclosed

more than did the Gallucci sample, with small or medium effect sizes in most categories.

Factors influencing self-disclosure. Participants were asked to select all relevant factors that influenced their decisions to self-disclose. Table 4 shows that the current sample endorsed all items higher than Gallucci's sample did. In an "other" category, the current sample wrote in: any client demographics, my own comfort/vulnerability, whether it feels like the disclosure would be helpful for the client, motivation of the client asking, how disclosure has worked in the past for this client, assessment of whether the disclosure would be well received and used to foster the alliance, assessment of whether the disclosure will aid in deepening the therapy, and whether the client is stuck and a TSD might help gain perspective.

Appropriate reasons for using TSD. Participants were provided with a list of 16 reasons for appropriate use of TSD and asked to rank the top five reasons (*1* = most important, *5* = least important). Table 4 shows the comparison between the samples for the top 11 reasons. The three most-endorsed reasons for using TSD (in order for the current sample) were: empower the client (85%), increase client perception of therapist empathy (69%), and provide modeling (69%). In comparison, the Gallucci sample most endorsed: provide modeling (57%), increase client awareness of alternative viewpoints/options (52%), and decrease client anxiety (47%). Current participants were provided the opportunity to input additional reasons but did not do so.

Appropriate reasons for limiting use of TSD. Participants were provided with a list of 11 reasons for limiting or prohibiting use of TSD and asked to select the top three reasons (*1* = most important, *3* = least important). Table 4 shows that the three most-endorsed reasons for limiting use of TSD (in order for the current sample) were: shifts focus from client to therapist (85%), inappropriately influences or burdens the client (62%), and indicates a countertransference enactment (46%). In comparison, the Gallucci sample's three most-endorsed reasons for limiting use of TSD were: shifts focus from client to therapist (86%), creates doubt

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about mental health of therapist (65%), and interferes with transference (33%). Current

participants were provided the opportunity to input additional reasons, and one participant

responded: "When therapist feels a need to disclose to receive self care from client."

Frequency of TSD now compared to early in career. Table 4 shows that the majority

of both samples indicated they disclosed more frequently now (current sample: 77%; Gallucci

sample: 65%). In contrast, some disclosed the same frequency (current sample: 15%; Gallucci

sample: 26%), and less frequently (current sample: 8%; Gallucci sample: 9%).

Reasons for change in frequency of TSD use. Participants who indicated a change in

TSD usage were asked to attribute their reasons for the change. Responses (summarized in Table

4) indicate that the majority of participants attributed the change in their TSD use to increased

comfort with self-disclosing (current sample: 73%; Gallucci sample: 61%). In contrast, change in

TSD usage was attributed to a change in theoretical orientation (current sample: 9%, Gallucci

sample: 23%), specific training in TSD (current sample: 9%; Gallucci sample: 7%), and

"personal lived experience" (current sample: 9%; Gallucci sample: 0%).

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