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Cultural Considerations in Therapy – A South Asian Perspective

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**Portfolio submitted in fulfilment of the requirements for the
Professional Doctorate in Counselling Psychology (DPsych)**

City University

Department of Psychology

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Glossary

TR – Therapeutic relationship

SA – South Asian

TSD – Therapist self-disclosure

IPA – Interpretative Phenomenological Analysis

NHS – National Health Service

BME – Black Minority Ethnic

GPs – General Practitioners

BPS – British Psychological Society

RET – Relational Emotive Therapy

CBT – Cognitive Behavioural Therapy

CQRM – Consensual Qualitative Research Method

DA – Discourse Analysis

NA – Narrative Analysis

GT – Grounded Theory

BPD – Borderline Personality Disorder

SMT – Schema Mode Therapy

ST – Schema Therapy

EMS – Early Maladaptive Schemas

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Last, but certainly not least, I offer my sincere thanks to the six participants of this study who offered me their valuable time, allowing me a glimpse into their lives and for sharing with me so openly. Their contribution was invaluable and I do hope this research has done their experience justice.

City University Declaration

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Preface

This portfolio represents the culmination of three years of training both as a counselling psychologist and as a researcher. On this journey, an area that has particularly caught my attention and stimulated my passion to practice has been exploring the cultural aspects of the therapeutic relationship (TR) with South Asian (SA) clients. Cultural issues permeate into all areas of our lives and therefore have an important part to play in the therapeutic work we do. Developing this understanding has helped shape me into a reflexive and empathic practitioner.

The portfolio consists of three different pieces of work relating to the topic of cultural considerations when working with SA clients in the practice of counselling psychology. Firstly, there is an exploratory piece of research focussing on SA clients' experiences of therapist self-disclosure (TSD). Secondly, there is a case study illustrating an initial grasp of Schema Mode Therapy undertaken with a SA client diagnosed with Borderline Personality Disorder. Culture is an essential part of who we are is inseparable from the individual. Therefore, this piece of work explores how schema mode therapy might address or account for culture in the work conducted with clients. Finally, there is a journal article that stems from the findings of the research study. There are connections between the research study and the case study as they both address similar issues pertaining to working with SA individuals, and the TR in this specific cultural context. The research and case study both illustrate convergences and divergences of experience. The research highlights the overarching experience of a group of SA participants (via super-ordinate themes) whereas; the case study highlights the individual meaning making process for that specific client. All three components of the portfolio highlight the multi-faceted, complex nature of therapy and TRs and make an attempt to understand various ways of working with SA clients and the meaning ascribed to having therapy. An overview of each piece of work will now be presented explaining more fully the area that it covers and its aims and objectives. The preface will then be concluded with a summary of how the pieces of work are connected by a more personal theme.

Part A: The research

This section consists of an original piece of research that intended to explore SA clients' in-depth subjective experiences of TSD in individual therapy. The study used semi-structured interview data

gathered from a homogenous sample of six participants whose therapists had self-disclosed during the course of therapy. In all cases the participants had terminated therapy. The data were analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). The research focuses particularly on the impact the TSD had on the participants as individuals but also on the TR and the therapy process as a whole. Further attention was given to how the participants understood and conceptualised the TSD. The analysis is discussed in light of theoretical insights gained as well as the extant empirical literature. Implications for the clinical practice of counselling psychology are identified and discussed.

Part B: The case study

This section contains an example of clinical work in the form of a case study. The aim of this piece of work is to demonstrate competence in the chosen therapeutic model through showing an initial grasp of knowledge of theory and its application to practice. The study is a summary of the main aspects of the collaborative work between client and the therapist¹ over the course of 17 sessions of schema mode therapy. The client's difficulties are formulated within the model and evidence of critical reflection on clinical practice is presented. It aims to provide an account of my clinical skills, including the ability to integrate theoretical concepts with practice, and personal and professional self-awareness.

In the case study I present to you a Panjabi female client who has a diagnosis of Borderline Personality Disorder. This particular case was chosen because the role of culture within therapy was very apparent and I believe it highlights the significance of cultural context in the development of a TR. I will demonstrate where at times the client's cultural context enhanced and/or served as a potential obstacle in the TR and how it was important that I was transparent about my lack of knowledge about certain aspects of her culture. In adopting this open and honest stance I was able to encourage the client to educate me about her culture, to ensure that I was alert when cultural differences emerged and when relevant to explore in the therapy. This seemed essential in creating an atmosphere of collaboration and respect in addressing differences constructively and also enabled a strong

¹ The terms "counselling psychologist", "therapist", "psychologist", "practitioner", "counsellor" and "clinician" will be used interchangeably throughout the report.

therapeutic bond to be formed. Lastly, this particular case highlights my own process in terms of my development as a psychologist.

Part C: The journal article

This section contains an abridged version of the Research with the aim of being published in *The Journal of Counselling Psychology*. Formatting of the article remains consistent with the portfolio but will be submitted for publication in accordance with the journal guidelines (Appendix A). This journal was selected as it has a particular interest in publishing work that sets trends and incites fresh thought and innovation in the practice of counselling psychology. There is an emphasis on work with under-represented populations and diversity and empirical findings that can point to new directions which is in keeping with this paper. The publication of the article within this journal would allow its dissemination to practitioners across the globe and from diverse cultural backgrounds and disciplines. The article aims to convey the participants' experiences of TSD and its impact on the TR. Furthermore, it aims to demonstrate the impact of TSD but in particular its ability to foster connection between the therapist and the client thus enhancing the TR.

Thematic connection for the portfolio

Each part of this portfolio is joined by the interrelated themes of cultural considerations and TRs, with varying emphases. The National Health Service (NHS) provides mental health services to those from all areas of society, however it is embedded within a Western model of psychological health. When accessing mental health care in the UK, reports have found that BME populations have received poorer services in comparison to the White British population. A number of factors have been put forward in an attempt to explain the variation in access to and utilisation of mental health services. There has been an increase in the recognition of the importance of psychological therapy as an early intervention in preventing the deterioration of mental health the need to address the low uptake of counselling services by SA communities is imperative. These issues are integral to the discipline of counselling psychology, and are of great interest to me professionally.

A strong TR can play a vital role when facilitating change in our clients. I view TRs as having the power to both damage and repair especially when working with individuals from cultural backgrounds where therapy is seen as taboo and those individuals may be reluctant to fully engage with the therapeutic

process. I have always been intrigued by what we as psychologists can do to improve the experiences of therapy for this particular group of people and how TSD as a tool or intervention, could be one way of positively impacting on the TR and overall experience of therapy.

In the research and journal article, I explore the subjective experience of TSD in a small group of SA Clients. Both pieces of work focus on the impact of TSD on an individual level but also on the TR as a whole. I feel I have been fortunate enough to meet, clinically work with and interview many of who are trying to make sense of their experiences and I am deeply grateful for having been allowed to be part of this. I strive to respect and embrace individuality in all aspects of life and use this to build upon my professional practice.

Finally, in the case study I critically explore the role that culture plays in the development of a good TR. This piece of work represents a therapeutic journey for both client and therapist. The client developed a stronger sense of self by overcoming a difficult challenge and recognising her ability to change. I, on the other hand, gained valuable insight that I also developed a stronger sense of myself as a trainee counselling psychologist. The completion of this portfolio is a momentous stepping stone in my journey and has provided me with the determination to continue working within the field of multi-cultural counselling.

PART A – RESEARCH

To disclose or not to disclose?

**An exploration of South Asian clients' experiences of
therapist self-disclosure in individual therapy.**

Sheetal Patel

City University

Supervised by Dr Lucy Longhurst

Abstract

South Asians' (SA) under-representation in mental health services is well-documented (Bowl, 2007; Greenwood et al., 2000), the reasons for which are many. Therapist self-disclosure (TSD) could be considered as a potentially significant part of a therapeutic encounter when providing effective therapy in a culturally diverse society. This study will attempt to explore SA participants' subjective experiences of TSD in individual therapy. The study will attempt to discover how the participants make meaning of TSD, how they experience it and the impact it has on them and the TR. The majority of studies exploring TSD have been mainly quantitative in nature; however, a case can be made for using a qualitative approach as it provides a more detailed representation of the experience and allows for an in-depth understanding of the complexity and content of self-disclosure. Six SA participants aged between 24-33 years completed semi-structured interviews which were analysed using Interpretative Phenomenological Analysis (IPA). Four super-ordinate themes emerged from the interview data: Understanding of therapist self-disclosure, Experience of therapist self-disclosure, Impact of therapist self-disclosure on self, and Impact of therapist self-disclosure on the therapeutic relationship. A compelling 'connection' dimension permeated throughout the accounts and their experience was found to be fundamentally relational in nature. The findings of this study put forward that TSD is but one way of facilitating client self-disclosure, and fostering and maintaining the TR within a cross-cultural counselling context for SA clients. A rich description of the SA client group experience of TSD in individual therapy is therefore presented. It is argued that the study provides insights into this lived experience that may be useful for counselling psychologists when working with this group, and perhaps other BME groups attending therapy. Limitations of the study and recommendations for future research are discussed.

CHAPTER ONE: INTRODUCTION

In order to situate the present study within a meaningful context, the researcher will begin by discussing service utilisation amongst the SA population, exploring possible reasons for the under-representation in mental health services and the influences of culture on therapeutic work. The concept of TSD will then be introduced as a potential way of enhancing the therapeutic experience of the SA population. Whether TSD is seen as appropriate in therapy is widely debated (Andersen & Anderson, 1985; Barrett & Berman, 2001; Bottrill, Pistrang, Barker & Worrell, 2010; Curtis, 1982; Hanson, 2005; Jourard, 1971; Knox, Hess, Petersen, & Hill, 1997; Watkins, 1990) and therefore, is an area that has received great attention in the literature.

A summary of the different theoretical perspectives of self-disclosure will be offered. This will be followed by a critical appraisal of the available literature and research relevant to TSD and SA clients. In the absence of primary research and literature pertaining to SA clients' experience of TSD, literature and research pertinent to other populations experiencing TSD has been reviewed. The researcher will explore what has been revealed in this area might; it is hoped this will provide a backdrop to the experiences of SA clients. The chapter will end with a summary of the main themes in the literature, what is known and unknown regarding TSD and SA populations, the gap in the literature that justified this study, followed by the study's relevance to the field of counselling psychology. Finally, the researcher will state the aims and the research question of the present study.

1.1 SA population

The SA community is the largest ethnic minority group in the UK. In the 2011 census over 3 million adults or 4.9% of the total population classified themselves as UK Asian: Indian, Pakistani, or Bangladeshi. According to Marshall and Yazdani's (1999) definition, SA means "any individual whose cultural or familial backgrounds originate from the subcontinents of India, Pakistan Bangladesh and Sri Lanka, including people from East Africa" (p. 413). Although research has shown cultural and religious differences between each group they do share many aspects of their cultural heritage, values, and beliefs (Quraishi & Evangeli, 2007).

1.1.1 SA clients' access to mental health services

Existing literature has shown a growing interest in the rates of mental health problems in ethnic minorities, in particular the SA population (Gupta, Johnstone & Gleeson, 2007). Multi-cultural research in the UK has shown that levels of mental disorder have varied among ethnic minority groups. These groups have different needs and requirements from mental health services compared to the White British population (Bhui & Rüdell, 2002). The National Health Service (NHS) provides mental health services to those from all areas of society, however it is embedded within a Western model of psychological health. The UK government has recognised that the uptake of services varies between black and minority ethnic (BME) groups, and this has been a concern for policy makers, clinicians and service users. Furthermore, the Human Rights Act (1998) and the Race Relations Amendment Act (2000) have stated that service providers should be free of discriminatory procedures and practice. When accessing mental health care in the UK, inquiries and reports have found that BME populations have received poorer services and health outcomes in comparison to the White British population (Department of Health, 2008). Furthermore, some BME groups have reported dissatisfaction with mental health services and also reported coercive treatments and adverse experiences (Bhui, Stansfield, Hull, Priebe, Mole, & Feder, 2003; Sainsbury Centre for Mental Health, 2006).

In the UK health system, General Practitioners (GPs) are usually the first point of contact for referral to other services. For this reason, research has examined the role of GPs in assessing mental health disorders/problems amongst the SA population. It is argued cultural values held by GPs and explanatory models of mental illness may influence the detection of mental disorders (Patel, 1999). Research found Asian GPs were less likely to recognise illness among Asian patients compared to non-Asian patients (Odell et al., 1997), whereas other research has found no such differences (Bhui, Bhugra & McKenzie, 2000). However, it has been found some ethnic groups present less often to their GPs with psychological distress, as they hold beliefs their GP will not be able to help them (Sproston & Nazroo, 2002) particularly when social issues are at the centre of their distress (Bhui & Rudell, 2002).

SAs' under-representation in mental health services is well-documented (Bowl, 2007; Greenwood et al., 2000). A possible explanation for this has been institutional racism (Sashidharan, 2003). Although dated, the MacPherson Report (MacPherson, 1999) described institutional racism as an organisation's failure to provide an appropriate service to its users because of their colour, culture or ethnic origin. Discrimination in mental health services can occur in many ways, the main form recognised being poor decisions made about service users' care and treatment by professionals. As a result, service users'

needs from BME populations are not being met (Singh, 2007). Institutional racism has received ongoing attention in the public and political domain through inquiries and reports (Department of Health, 2005; 2008; 2009).

Other factors that may explain the variation in access to and utilisation of mental health services are cultural health beliefs regarding psychological distress, styles of coping, level of knowledge about services in relation to cultural appropriateness and its referral system, previous dissatisfactory experiences of services, social exclusion, language barriers, lack of trust in the service and their cultural and religious needs not being adequately addressed (Bhui & Bhugra, 2002; Bhui & Rüdell, 2002; Goldberg, 1999; King, Weich, Nazroo, & Blizard, 2006;). Although there has been an increase in the recognition of the importance of psychological therapy as an early intervention strategy in preventing the deterioration of mental health, (Busfield, 1999; McLeod & McLeod, 2001; Mellor-Clark, Simms-Ellis, & Burton, 2001), Netto, Gaag, Thanki, Bondi and Munro (2001) highlight the need to address the low uptake of counselling services by SA communities.

1.1.2 SA clients' culture and psychological therapy

Since the individual is embedded in his/her cultural context, and inseparable from it, it would seem plausible that cultural issues have a significant role to play in therapeutic work, as argued by Eleftheriadou (2003). Thus, therapists' ability to work effectively with culturally diverse clients is increasingly important, particularly in a multicultural society. Adherence to Asian cultural values may act as a barrier to psychological help-seeking (Atkinson & Gim, 1989; Tata & Leong, 1994), possibly because individuals with more traditional values (i.e., concern with socio-economic prosperity and the collective well-being of the community; loyalty and respect towards figures of authority; preference for collectivism) are less likely to recognise the need for psychological help, are more likely to stigmatise those with mental health disorders, and are less open to discussing personal problems with a service provider (Soorkia, Snelgar, & Swami, 2011). Furthermore, within SA culture, the stigma of mental health problems and the concept of shame and being labelled as having "lost it" may make it particularly difficult to seek help (Netto et al., 2007). Research has also demonstrated that SA clients tend to be reluctant to seek out counselling due to a cultural emphasis on keeping family matters private (Almeida, 1996; Segal, 1991; Sharma, 2000).

Asian cultures place great emphasis on collective needs, interdependency and conformity, as opposed to the individualistic orientation of Western societies (Ponterotto, Casas, Suzuki, & Alexander, 1995). The collectivist positioning of SA cultures places importance on the welfare of the family as a whole. There is an expectation that individuals will sacrifice their personal goals to ensure the well-being of the family if their goals conflict with the goals of the family unit (Almeida, 1996; Ibrahim, et al., 1997; Segal, 1991). Additionally, individuals own sense of self may be experienced more overtly in relation to others, and pursuing their own goals that go against those of the family is seen to be selfish (Segal, 1991). SA children are also expected to remain emotionally dependent on their parents well into adulthood (Almeida 1996; Segal, 1991). Elders are seen as wise authority figures and respected highly, and therefore parents have a significant amount of control and influence in all areas of an individual's life. Research found that those who were more acculturated (i.e., the extent to which individuals assimilate to the norms of the dominant culture) than enculturated (i.e., the extent to which individuals adhere to the norms of their indigenous culture) had more positive attitudes toward psychological help (Matthew et al., 2011). Such values are likely to play a role in SA clients' experience of self and identity, how they make sense of their problems, and what they expect from therapy. However, it is also important to recognise that clients will vary in the degree to which they adhere to the values and norms of their indigenous culture.

A quantitative study in the USA by Kim and Omizo (2003) found that Asian American students with high adherence to Asian cultural values were less likely to have a positive attitude toward seeking psychological help. This was due to adherence to cultural values that stress that individuals should restrain from expressing strong emotions, particularly negative ones. These values encourage Asian Americans to suppress their pain, suffering, and anger rather than to express them. Straying from these values and acknowledging psychological problems could be seen as a violation of Asian cultural values, bringing shame to the family (Kim & Omizo, 2003). These results have been replicated in multiple studies (Atkinson, Morten, & Sue, 1998; Leong et al., 1995; Root, 1993; Sue, 1994; Sue & Sue, 1999). However, the study suffers from the limitations inherent in conducting research with college students. The use of these individuals limits the generalisability of findings to this population alone and it would be useful to see if these relationships exist in an adult sample. The participants who took part in the study were also very diverse in terms of ethnicity. The study did not take into account the cultural variability amongst the sub-groups such as differences in languages, dress, traditions, customs and religious sect.

More recently Soorkia et al. (2011) using quantitative methods examined factors influencing attitudes towards seeking professional psychological help among SA students in Britain. The sample was made up of Indian, Pakistani and Bangladeshi students born and raised in the UK. The results showed greater adherence to Asian values was negatively associated with attitudes towards seeking psychological help. The findings of the study are subject to the limitations of any self-report survey and leave little room for exploration of what the attitudes actually were and of the reasons for differences in attitudes between the three cultural groups. Furthermore, as the sample consisted of SA students in Greater London, it may not be possible to generalise the findings to non-student populations or to students in other parts of the country. London is very multicultural whereas other parts of the country are much less so, and therefore this sample may differ considerably, potentially impacting their relationship with therapy. Therefore, it would be useful to see if the results could be replicated in an adult and community sample. The findings of this study are also consistent with previous findings from other quantitative studies on Asian populations (e.g., Tata & Leong, 1994; Zhang & Dixon, 2003; Kuo, Kwantes, Tomson, & Nanson, 2006).

In general, the aforementioned studies have used quantitative methods in order to examine the factors influencing attitudes towards seeking professional psychological help for SAs and the relationship between adherence to cultural values and seeking psychological help. These studies have been highly valuable, but there is a need for research to examine the views of SA individuals who have actually experienced therapy. This requires alternative methodological approaches, which can complement the more tightly controlled experimental designs typically used in the studies described here. A strength of some qualitative approaches is that they allow researchers to study, in depth and detail, the complexity of individuals' experiences within natural settings (Barker, Pistrang, & Elliott, 2002) and allow further, more detailed insight into how adherence to cultural values can impact the therapeutic alliance, which influences the outcome of the therapy itself.

A study using grounded theory (GT) conducted by Netto et al. (2007) examined male and female SA individuals' views and preferences regarding primary care counselling services in the UK. Most of the participants had migrated to the UK, ranged in age from 21 to 75 and half had used counselling services and half had not. The key themes found were: need for formal support, accessing counselling, expectations and preferences of counsellors, and language of counselling. The majority of clients and non-clients felt that formal support from a 'neutral' professionally trained person would be beneficial. Shared understanding of cultural norms and values was also viewed as important by the participants,

with some believing that this would not be found in counselling services. Most participants had low awareness of the counselling service and reported that they faced difficulties in accessing it and in finding counsellors who matched their preferences, particularly concerning ethnicity and language. The majority expressed satisfaction with their counsellor, seeing them as 'caring' and 'professional' and revealed that the qualities of the counsellor they valued most were active engagement in the process, being 'heard' and being treated with respect. As found by other studies, the relationship of the client with the counsellor was crucial in ensuring a positive outcome (Rogers, 1951; Everall & Paulson, 2002). Clients' preferred choice of counsellor was influenced by a complex interplay of individual, cultural and institutional factors, including concerns about confidentiality, adherence to cultural norms, fluency in English and trust in the service to respond sensitively to intimate issues. However, the Asian participants in the present study appeared to face greater difficulties in finding counsellors who matched their preferences, especially in respect of ethnicity and language.

A similar GT study by Netto (2006) interviewed 38 SA clients and non-clients on their perceptions and preferences regarding counselling services in the voluntary sector. The findings showed that the participants generally viewed counselling provision positively. Many non-clients perceived the service to be potentially relevant to them, and most clients found the service to have been helpful in enabling them to cope with psychological distress. The findings also showed that awareness of the existence, nature and purpose of the services was generally low among non-clients. However, once this was explained to them, there was much interest in the service. Netto (2006) suggests that the low uptake of counselling services might be related more to a lack of awareness of the service and its potential usefulness than the existence of alternative sources of informal support. Some participants felt that talking to someone who was of the same cultural background and who shared their values, norms and language was very important. Moreover, they did not think this would be possible within a counselling service. Therefore, making appropriate disclosures in therapy could be one way of psychologists being able to share their values and norms with their clients.

While both studies suggest that there is a potential willingness from SA individuals to engage in therapy if they become aware of services available, there may be cultural barriers to consider which undermine their potential for engaging. However, while the above studies are highly valuable, they both used a diverse sample in terms of age, gender, length of time in the UK, fluency in English, whether they had used a counselling service or not and their ethnic origin. They did not take into consideration cultural variability amongst the sub-groups such as differences in language, dress,

traditions, customs and religious sect. It would be useful to see if the results could be replicated in a more specific sample group as individuals' willingness to seek counselling and psychotherapy could be likely to be mediated by their culturally conditioned beliefs (Schnittker et al., 2000).

1.1.3 Developing culturally competent care

Researchers previously suggested that healthcare had struggled to move away from ethnocentric paradigms and that Asian communities were not well represented in mental health research in the UK (Rugkasa & Canvin, 2011). As a result, the knowledge and training needed to build culturally competent services was scarce, often being poorly evidenced. A series of arguments for and against specialist services for ethnic minorities were put forward by Bhui and Sashidharan (2003). In response to this, the Department of Health (2008) has reportedly made a conscious choice to address these concerns by focusing on cultural diversity in service planning and provision. Researchers have also looked at ways of improving health care for culturally diverse clients (McKenzie, 2008). They have also reviewed mental health professionals' understandings of cultural competence (Bhui, Warfar, Edonya, McKenzie, & Bhugra, 2007) and looked at how to provide effective psychotherapy in a culturally diverse society (Bhui & Morgan, 2007) given that psychological provisions are a vital part of a comprehensive mental health service.

It could be argued that a more culturally competent way of working is to match the client and therapist in terms of ethnicity. Karlsson (2005) proposes that a common question in multicultural counselling is whether clients would rather see therapists of the same ethnicity. However, the literature regarding ethnic matching of clients and therapists is inconclusive. For instance, Takeuchi, Sue, & Yeh (1995) compared the treatment outcomes of ethnic minority clients who received help from ethnic-specific services (defined as a service where more than 50% of clients are from a specific minority group) or mainstream services. The study found that ethnic clients who attended the ethnic-specific services stayed in treatment for longer and had lower dropout rates compared to those who attended mainstream ones. However, treatment outcomes did not show any significant differences.

On the other hand, Erdur, Rude, and Baron (2003) examined the length of treatment and symptom improvement of African American, Hispanic, and Caucasian clients in ethnically matched dyads with therapists in university and college counselling centres. They found that therapist-client ethnicity match did not affect symptom improvement and found inconsistent findings related to length of

treatment. This inconsistency of findings suggests that it is likely that other factors may have an influence on the therapy process besides ethnic matching. Sue (1998) argues that ethnic matching may not be effective for all and it is important to ascertain where it may be effective. It is important to note that the above studies were carried out in America (where much of the research in this area has taken place) and were mostly based on the four main ethnic groups (Native American, African American, Asian-American and Latino). Therefore, these studies do not take into account valuable data from the many other ethnicities (e.g., SA) that constitute British culture (Vontress & Jackson, 2004).

However, it is not only treatment outcomes that may be considered significant. A key consideration for a counselling psychologist concerns the therapeutic bond. The therapeutic bond is key to the underpinning values of counselling psychology and therefore it is imperative that counselling psychologists can identify adjustments in their practice that can meet the needs of ethnically diverse clients (Arredondo, 1999). The issue of cultural matching is therefore of interest, not only with treatment outcomes but also with how it may facilitate or impede the therapeutic bond. Sue and Sue (2003) argue that the TR is the most important factor in determining whether a client engages in therapy, and even more so when the therapist and client are ethnically different. It has been put forward that minority ethnic clients experience greater difficulty in the development of the TR due to perceived or actual cultural differences or biases (Gelso & Mohr, 2001; Helms & Cook, 1999; Taft, Murphy, Elliot, & Keaser, 2001). Farsimadan, Draghi-Lorenz, and Ellis (2007) looked at the effect of ethnic matching on the TR, perceptions of therapist credibility and therapy outcomes. One hundred ethnic minority clients in the UK took part; over half described themselves as SA. The findings showed that ethnic matching had a positive effect on all three aspects of therapy mentioned previously. What should be noted is that the bond with the therapist and therapist credibility were stronger predictors of outcome than ethnic matching. This suggests that other factors also have an impact on therapy outcome and the TR but also supports Sue and Sue's argument that ethnic matching is not necessarily helpful for everyone. The research in this area has produced inconsistent findings and suggests that issues of ethnic difference cannot simply be overcome by client-therapist ethnic matching. However, although it is evident that ethnicity does have some influence on therapy and contributes to a culturally competent service, it remains unclear as to what this may be.

With regard to disclosure Thompson, Worthington, and Atkinson (1994) conducted a study on African American women who were exposed to Black or White female therapists. The effects of counsellor content, counsellor race, and participants' cultural mistrust levels on the frequency and depth of participant self-disclosures and rating of counsellor credibility were examined. The findings suggested that highly mistrustful African American participants were less likely to disclose to Caucasian counsellors. One finding that was not anticipated by the researchers was that participants low in cultural mistrust paired with Black counsellors resulted in the most self-disclosures. One possible explanation for this is that low-mistrustful participants may have been more likely to see Black counsellors as similar to themselves or to their own values and therefore tried to establish some connection with these counsellors. Taking this into consideration, TSD could potentially facilitate a connection between counselling psychologists and establish a connection between them and their clients on something other than ethnicity.

Typically, psychological practice focuses on the verbal and emotional expression of the client, together with self-disclosure and insight (Sue et al., 1998). Good practice includes use of clinical and cultural formulations and explanatory models. These can help professionals work in a more culturally competent way and allow therapists to gain a greater understanding of their client and the problems with which they present (American Psychiatric Association, 2002; Harper & Moss, 2003; Kleinmann, 1980, as cited in Bhui & Bhugra, 2004). Rather than the client being written off as being reluctant to engage in therapy, it is imperative for the psychologist to be well-vested in a culturally sensitive practice. Therefore, in addition to these forms of good practice, TSD could be considered as one way of providing effective therapy in a culturally diverse society. The therapist could, if appropriate to the context, disclose an experience whereby she/he felt misunderstood or inherently different from others. This could have the potential for making the client feel less isolated or different and even feel that the therapist understands and empathises with the client's difficulty. For these reasons, there is a need to better understand how TSD is experienced by SA clients and whether it could be a useful tool for therapists to use to enhance the therapeutic experience of this population.

1.2 TSD:

1.2.1 Definitions and types of TSD:

Sidney Jourard (1958), a humanistic psychologist, first used the term self-disclosure and referred to it as "the process of making the self known to other persons" (cited in Mathews, 1988, p. 521). Jourard was trained in traditional psychoanalysis, however had difficulty building the TR with clients (Jourard, 1973). As a result, he learnt that if he disclosed some information about himself, the clients were more likely to engage in therapy (Jourard, 1973). Jourard was most interested in the exchange of information between individuals and the impact it had on the TR. His interest led him to conduct a survey to find out how much information he told others about himself (Jourard, 1973). To Jourard's surprise, the results showed he was not nearly as open with others as he thought he was. He continued to research disclosure concentrating on relationships between family and friends and finally concluded "to a shocking extent... real self-disclosure begets real self-disclosure" (Jourard, 1968, p. 64). Jourard concluded individuals only come to know their real selves through the process of disclosure and believed a therapist who self-disclosed was more life-like than one who did not disclose (Jourard, 1964).

Throughout the existing literature, the definition of TSD differs between general and broad to more detailed and distinct ones. Broad definitions include Hill and Knox's (2001) describing TSD as statements that reveal personal information about the therapist to their clients. Weiner (1983) describes TSD to be when the therapist gives more than just professional knowledge or when the therapist is purposely more open and genuine with the client. This could include revealing feelings, attitudes, opinions, associations, fantasies, experiences or history. Hill and Knox (2002) reviewed over 200 studies and put forward these categories of disclosure:

1. Biographical facts about the therapist's life and professional training.
2. Sharing of feelings in the therapist's description of subjective experiences.
3. Insights into past experiences revealing what the therapist has learnt about him/herself.
4. Strategies that the therapist has found helpful.
5. Approval and legitimisation of the patient in the specific therapeutic context.

6. Providing examples from the therapist's life in order to challenge the patient's thoughts and behaviours.
7. Immediate thoughts or feelings toward the patient or the TR.

The definitions of TSD have been refined over the years and more recently research has found that the information therapists reveal about themselves can be grouped into self-disclosing/non-immediate statements or self-involving/immediate statements (e.g. Audet, 2004; Audet & Everall, 2003; Farber, 2006; Knox & Hill, 2003). The first is the disclosure of personal information regarding the therapist's life outside the therapy, for example, life circumstances, past experiences, personal values and beliefs. In contrast, the latter are the internal cognitions and emotions the therapist has in relation to the TR or client (Constantine & Kwan, 2003; Knox & Hill, 2003). It is suggested that immediate disclosure is a more acceptable form of disclosure because of the focus it places on the TR (Myers & Hayes, 2006; Tantillo, 2004).

The categorisation of TSD could help in deciding what is acceptable and what is not when self-disclosing. Wachtel (1993) suggests only reactions within-sessions are acceptable, whereas disclosures about therapist's personal experiences are not. Wachtel states when a therapist brings their own experiences into therapy, they are acting in a selfish way and are neglecting the client's needs. Therefore, it could be suggested outside of session disclosures could be a distraction from the client's experience. Whereas, within session disclosures show attention to the client's experience. It seems a balance should be made between how intimate the therapist disclosures are. Knox and Hill (2003), argue disclosures that are too intimate or personal may frighten or burden the client, but suggest that self-disclosures should contain some degree of intimacy. They state the positive impact of TSD may come from the client's sense of therapists becoming more real and human, feeling as though the therapist trusts the client with the personal information revealed and offering a part of the therapist's life to the client. Various attempts have been made to categorise and define TSD. Some have categorised it based on the similarity or dissimilarity of the therapist experience to the client (Watkins, 1990), whilst others have conceptualised it based on the type of information that is thought to be acceptable to share with a client. This shows little consensus in how to conceptualise TSD.

1.2.2 Ethicality of TSD:

When thinking about whether a specific action is acceptable or helpful for a client, a review of the British Psychological Society's (BPS) Code of Ethics and Conduct (2006a) is imperative. To date there are no concrete guidelines for psychologists regarding the use of self-disclosure. The Code of Ethics and Conduct does make clear that psychologists need to be sensitive to the dynamics of perceived authority or influence over clients (Ethical Principle 1) and to avoid harming clients (Ethical Principle 3.1). However, these principles are quite broad and make general references to the treatment of clients. The Code of Ethics and Conduct does not provide specific principles that address the boundaries mentioned previously to include self-disclosure and provides little guidance to help psychologists who are perhaps grappling with the decision to use specific interventions or actions, like self-disclosure, with their clients. However, with this in mind it might actually be very hard to create rules or boundaries for TSD, since the TR is a complex, dynamic meeting of two unique individuals.

With that being said the possible risks of TSD has been highlighted from an ethics perspective (Peterson, 2002; Zur, 2007). One of the most important factors to consider when thinking about whether TSD is ethical or not is to consider the therapist's motivation for sharing the information they choose to reveal (Peterson, 2002). For instance, by self-disclosing, therapists unconsciously could move the focus toward themselves and their own difficulties to meet their own needs rather than focussing on their client (Hays, 2001). Goldstein (1994) puts forward that therapists need to be very aware of their client's needs and history before using self-disclosure. She suggests it is difficult for a therapist to judge when the choice to disclose is guided by one's own needs and when it is empathetic and helpful for the client. However, increasing attention has been given to TSD which has resulted in self-disclosure becoming a more accepted form in our practice due to the therapeutic benefit for the client (Audet & Overall, 2010; Goldstein, 1997; Knox & Hill, 2003). Although TSD is used because of its impact on the TR, not much is known about the client's view of using this kind of approach and the implications clients feel it has on the therapeutic process.

The power dynamics in therapy also need to be taken into consideration when looking at TSD (Chesler, 1972; Gannon, 1982). Gutheil and Gabbard (1993) argue the patient-therapist role can be reversed by the therapist's revelation of their own personal fantasies, dreams, and sexual or financial information, consequently hindering the TR. Glass (2003) made a distinction between 'boundary violations' and 'boundary crossings'. The first being unethical exploitations of clients such things as gross violations of confidentiality, financial exploitations, dual relationships, and sexual contact between therapist and

client. Glass (2003) defines the latter as a process that takes place when the therapist utilises tools that will foster the therapeutic process and relationship. It is viewed that boundary crossings are not problematic in that they are gentle, discussable deviations from the established therapeutic frame. For example, a therapist allowing a session to run over due to the client being tearful or deeply upset or calling a client who has been anxious before a surgical procedure or after it to enquire how she/he is feeling.

Glass (2003) argues if the sharing by the therapist is of benefit to the patient, it is considered a legitimate boundary crossing. However, if the self-disclosure is of benefit to the therapist, it is considered a boundary violation. Nevertheless, the decision to self-disclose or not is fundamentally determined by the therapist and is guided by their intention. Considering the ethical debate around the use of TSD, Simi and Mahalik (1997) reported 60% of clients indicated their therapist had shared some type of personal information with them. In response, Mahalik, Van Ormer and Sami (2000) proposed guidelines for therapists to consider before disclosing. Firstly, disclosures should be made with the goal to develop the TR. Secondly, therapists should be aware of and ensure that their personal needs do not come before the needs of the client and thirdly, disclosures should be related to the client's issues to make sure the focus remains on the client. Although very helpful, currently there are no concrete ethical guidelines regarding the use of TSD other than the reminder to do no harm to the client and being aware of the possible power dynamic. The ethical guidelines that guide therapists' practice are vague however, this is most likely to be because TSD is multidimensional.

1.3 Theoretical orientations and TSD

Theoretical orientation is one predictor of TSD (Forrest, 2010); however, the various perspectives hold different positions on TSD. This section offers the perspective of multi-cultural psychology, psychoanalysis, humanist, and cognitive behaviourist. The researcher has included more work from the multi-cultural counselling perspective than the others in order to reflect the aim of this research.

1.3.1 Multi-cultural counselling perspective

With the continuous growth of our pluralistic society, there is a demand for mental health services to be culturally sensitive. Multi-cultural counselling is a fairly new paradigm, dating back to the 1970s

(Gerstein, Rountree & Ordonez, 2007). Growing recognition of the differences that exist across clients and how traditional approaches that were effective with Caucasian clients but not beneficial to clients from different cultural backgrounds, encouraged the generation of culturally appropriate theory and practice (Cheek, 1976).

First and foremost, when working in a multicultural context it is important for the therapist to be aware of their own frame of reference, this being how they see the world from a moral, social, ethical, and philosophical perspective (Lonner & Ibrahim, 1996). Furthermore, most professional training in counselling and psychotherapy is based on assumptions drawn from Western models and are therefore culture-bound (Fukuyama, 1990; Pedersen, 1987). The values held by therapists are inherently brought to the therapeutic frame and may not be in line with those of the clients they see. Some of the most frequent cultural biases of counselling were highlighted by Pedersen (1987). These included: an assumption that “normality” is a universal concept; importance placed on individualism and independence; an expectation of openness and “psychological mindedness”; and an expectation of client self-disclosure. Therefore, when working with SA clients, therapists’ awareness of their own frame of reference is particularly important as behaviours such as early disengagement and lack of trust in the therapist, may actually be culturally appropriate.

Therapists working multi-culturally may support the use of TSD to convey their sensitivity to working with cultural and racial issues (Burkard, Knox, Groen, Perez, & Hess, 2006; Goldstein, 1994; Jenkins, 1990; Sue & Sue, 1999). With the NHS embedded within a Western model of psychological health, therapists who do work with culturally different clients may need to use an intervention like self-disclosure to show they can be trusted (Sue & Sue, 1999). It is proposed TSD can be used to show therapist sensitivity to racial and cultural issues, which can help form a strong TR with culturally diverse clients (Helms & Cook, 1999; Sue & Sue, 2003).

In their book, *Counselling the Culturally Different*, Sue and Sue (1990) state that a culturally diverse client is likely to be particularly apprehensive when seeing a therapist for the first time,

‘what makes you any different from all the Whites out there who have oppressed me?’ ‘What makes you immune from inheriting the racial biases of your forebears?’ ‘Before I open up to you (self-disclose), I want to know where you are coming from’... ‘Can you really understand what it’s like to be Asian, Black, Hispanic, American Indian, or the like?’ (p. 71).

Their assumption is that a culturally different client may not self-disclose until the therapist self-discloses first. Consequently, these clients may respond more positively to therapists who reveal his/her thoughts and feelings. However, limited research exists exploring the impact of TSD in multicultural counselling and it seems as though such research is needed to see how it could impact on the development of counselling relationships across different cultures (Burkard et al., 2006).

The use of TSD with clients from diverse backgrounds is an important aspect of multicultural competence (Helms & Cook, 1999; Sue & Sue, 2003). Barnett (2011) suggests that therapists should be aware of the various aspects of diversity of each client and have knowledge about how these can influence their needs in therapy. For example, some cultures may view the therapist as aloof and impersonal if he/she refuses to disclose personal information. However, in other cultures TSD can be seen as intrusive and unprofessional (Barnett, 2011). Therefore, an important feature of a therapist's ability to be able to provide effective and ethical care, should consist of knowledge of each client's background and how the use of self-disclosure would be viewed and received (Barnett, 2011). This is also supported by Goldstein's (1994) argument presented previously in this chapter.

The decision making process involved in disclosing or not is a complex one but actually it is viewed that complete avoidance of self-disclosure could alienate the client. For instance, Vasquez (2009) states rigidly adhering to boundaries such as self-disclosure and not taking the individual's needs and differences into consideration could result in "recreating shaming, oppressive experiences for racially and ethnically diverse clients, most of whom may have histories of discriminatory, shaming, and oppressive experiences" (p. 407). Vasquez also states when careful thought is given to the use of self-disclosure it can reduce the imbalance that can exist in the therapist-client relationship giving the client more power in the relationship. Authenticity and genuineness shown by the therapist are particularly valued by multicultural models of interventions and as Vasquez argues these qualities can enhance the therapeutic alliance. For example, when a client from a diverse background shares with the therapist an experience which results in feelings of shame, failure, and humiliation it could be helpful for the therapist to also share a similar experience with the client to show that they have understood it, that they are not judging the client and that one can survive (Vasquez, 2009). TSD thus could offer a way of increasing support and connection with the client. This argument is further supported by a case study presented by Constantine and Kwan (2003). They highlighted a case whereby, the therapist was able to show a sense of caring and connection with her client (a Black female) through self-disclosure. Furthermore, the therapist created a safe and open space for the

client to share her experiences and feelings with ease. The disclosure enhanced the TR by modelling the importance of speaking about racial, ethnic, or cultural similarities and differences within the therapeutic setting. Constantine and Kwan suggest that TSD can be used to develop and maintain the TR between clients of colour and their therapist, addressing cultural mistrust, showing cultural competence, and exhibiting therapist expertise.

1.3.2 Traditional psychoanalytic perspective

In the original writings of Freud (1912), he states the analyst should be “opaque” to his/her patients, ensuring nothing but what is shown to the patient is revealed. Freud also argued the therapist should take a non-revealing stance in order to increase patient motivation for continuing with therapy and the work of analysis. However, in his own work, Freud did not exercise self-restraint and anonymity. For example, he lent books, gave gifts, provided financial support to his patients and also conducted analysis on his own friends and family (Gay, 1989). Similarly, Melanie Klein as well as other psychoanalysts, have also worked against these boundaries by analysing her own children (Grosskurth, 1986). However, the majority of therapists following the psychodynamic model have worked in accordance with Freud’s original view on self-disclosure.

In traditional psychoanalysis, self-disclosure is considered to be a mistake made by novice therapists when trying to help clients overcome resistance (Freud, 1912/1958). Freud believed self-disclosure to be inappropriate as it contradicted the view that therapists should act as a mirror to clients, reflecting only what is shown by the client (Billow, 2000). The psychoanalytic view further states that a client’s transference reaction to the therapist is evident when the therapist presents themselves as a “blank screen” (Goldfried, Burckell, & Eubanks-Carter, 2003). In order to allow a clear analysis to take place it is believed that therapeutic neutrality is required (Goldfried et al., 2003) therefore avoiding making any self-disclosures.

Within the psychoanalytic model, TSD is thought to be a countertransference, whereby the therapist unconsciously responds to the client’s words or actions (Van den Bos, 2009). It is thought countertransference interferes with the therapeutic process (Maroda, 2003; Wells, 1994) and should therefore be avoided. Goldstein (1994) argues TSD is inappropriate if the disclosure of the therapist’s thoughts, feelings or experiences hinder the therapeutic process. Furthermore, it is thought TSD could have a negative impact on treatment outcomes as it exposes the vulnerabilities of the therapist

consequently affecting the client's trust in the therapist (Curtis, 1982). A strong argument put forward by Epstein (1994) is that TSD can lead to clients presenting with suicidal behaviour due to the client acknowledging their therapist as lacking in integrity or acting in a manipulative way. However, it could be argued that if a therapist was presenting in this way the client would experience it with or without TSD. Considering the importance of the TR and it playing an imperative part of the process, together with the interpretation of the transference provides the therapist with information about the client's inner world. However, the traditional psychoanalytic orientation posits the therapist should stay anonymous in order to avoid disruption and contamination of the transference.

1.3.3 Evolving psychoanalytic/psychodynamic perspective

Over the years the traditional psychoanalytic view has evolved into one where certain types of self-disclosure are deemed more acceptable, for example, disclosing one's reaction during the session. There seems to have been a shift in understanding and accepting the difficulty therapists have of remaining completely anonymous and neutral, as perhaps Freud and Klein recommended (Bernstein, 1999). From the outset, the therapist is revealing him or herself for instance, through their choice of clothes or office décor. Billow (2000), a psychoanalyst, claims genuine analysis is only possible when the client is given the opportunity to feel the analyst's emotion. Therefore, contemporary psychoanalysts have begun to accept it is difficult to maintain complete anonymity with clients and have started to explore ways in which disclosures can be used to manage countertransference (Bridges, 2001; Myers & Hayes, 2006).

Ehrenberg (1995) proposes that revealing affective reactions to the client can help the client become more aware of their own unhelpful behaviours and the impact made on others. Furthermore, Ehrenberg argues using countertransference as self-disclosure can facilitate the TR by allowing the patient to see the therapist has feelings, promoting the experience of empathy and understanding. In support of this view, Bridges (2001, p. 22) stated, "intentional self-disclosure is a valuable tool in a TR that facilitates exploration, introduces new perspectives of the self in the relationship, and conveys to the patient the possibility of creating a new, healing object relationship". Therefore, self-disclosure can be thought of as a helpful intervention to make conscious the unconscious and influence the treatment and TR resulting in the client's development (Bridges, 2001; Cooper, 1998; Maroda, 1991).

1.3.4 Cognitive and behavioural perspective

Goldfried et al. (2003) believe TSD is an effective tool within the therapy session. They believe it can improve the therapeutic bond and facilitate client change. It is suggested by behavioural therapists that self-disclosure provides modelling for clients (Edwards & Murdock, 1994). Bandura (1986) described modelling as a powerful way of communicating thoughts and behaviours and facilitating change. However, this has not gone without questioning. For example, Wolpe (1984) criticised Lazarus' (1971) use of self-disclosure, stating that self-disclosure is not a behaviour therapy technique. Lazarus responded by noting that behaviour therapists are not prohibited from using self-disclosure unlike psychoanalysts. Furthermore, he added "selective self-disclosure often enhances the TR and proves valuable when using modelling and behaviour rehearsal techniques" (p. 1419). This argument was further supported by Weiner (1978) who suggested modelling as an important tool in behavioural techniques as it can reduce negative behaviours and reinforce more helpful ones. In addition, it has been said TSD can also be used to normalise a client's experience (Goldfried, 2001). It is suggested by Goldfried that Teasdale's descriptions of secondary interpretations of client's experience (e.g., depressed about being depressed, ashamed about being anxious) could be effectively addressed by providing self-disclosure of similar feelings.

In Albert Ellis', Rational-Emotive Therapy (RET; Dryden, 1990), the therapist takes an educational role whereby the RET techniques are applied by sharing similar experiences to model ways of coping. In so doing, the therapist builds trust and strengthens the TR and creates a setting in which client and therapist are both seen to be fallible human beings, who struggle with common problems. Therapists who self-disclose their personal reactions to the client can help the client recognise and acknowledge the impact that their behaviour could have on others. By responding differently to the client's helpful and unhelpful behaviours within the session, the therapist is encouraging the clients' adaptive behaviours and discouraging behaviours that are unhelpful. In this case a TSD is consistent with the behavioural principles of reinforcement (Goldfried et al., 2003).

Given that there is growing recognition amongst cognitive theorists of the importance of the TR in facilitating change (Arnkoff, 1983; Goldfried, 1982; McGinn, Young & Sanderson, 1995; Safran, 1990) more emphasis is being placed on the therapist's own feelings and reactions in therapy. Arnkoff (1983) puts forward that focussing on the TR is important as it can give the therapist a greater insight into the client's current level of functioning, as the current problems or difficulties are more likely to be re-enacted in therapy. Therefore, it could be said when therapists self-disclose to the clients about the

impact the client has on them, they are in a sense providing the client feedback on how others could also potentially respond to them (Goldfried et al., 2003; Linehan, 1993; McCulloch, 2000; Safran, 1990).

Within the emerging CBT literature, we can see more emphasis being placed on the use of self-disclosure, not only as an intervention but as a tool to facilitate the TR. It has been stated that self-disclosure can strengthen the TR by allowing the client to see the humaneness of the therapist and to see that the therapist has faced similar problems (Fay, 2002; Goldfried, 2001).

1.3.5 Humanistic perspective

The use of self-disclosure within the humanistic framework is vaguer than those discussed above (Goldfried et al., 2003). Similar to Freud's (1912) way of working, Rogers' (1951) humanistic approach favoured the "mirror" position, whereby the therapist stays neutral. However, Rogers (1961) who adopted a client-centred approach later moved away from this view of therapist neutrality and started to support the use of self-disclosure in therapy. He described a therapist who self-discloses as balanced or congruent and stated the authenticity of the therapist is imperative in supporting the client's journey, and encouraging them to be open, intimate, trusting and self-understanding.

Those who adopt a client-centred approach have illustrated that by thoughtfully modelling openness, strength, vulnerability, and sharing strong feelings, the therapist who makes use of appropriate self-disclosures encourages the client to do the same, encouraging trust, empathic understanding and credibility, and helps to develop a sense of similarity (Knox et al., 1997; Kottler, 2003). Furthermore, Robitschek and McCarthy (1991) suggest self-disclosure demonstrates a therapist's genuineness and positive regard for clients and results in the therapeutic process being viewed as less mysterious (Kaslow, Cooper, & Linsenber, 1979). Therefore, overall, those who espouse a humanistic orientation generally support the use of TSD with the aim of encouraging authentic disclosure from the client (Gelso & Hayes, 1998; Greenberg, 1990; Peterson, 2002).

The different therapeutic modalities presented here have various outlooks on TSD. Therapists who work multi-culturally support the use of TSD, particularly with clients from different sociocultural backgrounds (Jenkins, 1990; Sue & Sue, 1999), whereas traditional psychodynamic therapists are

taught to be neutral, anonymous and discouraged to self-disclose in therapy. However, there has been a change regarding TSD among many therapists in the psychodynamic field who are now more open to its use (Knox & Hill, 2003). The therapists that take on a humanistic stance suggest that TSD shows therapists' genuineness and positive regard for clients (Robitschek & McCarthy, 1991). Similarly, cognitive behavioural therapists also see TSD as an intervention that could improve the TR and facilitate client change (Knox & Hill, 2003). As we can see, there is a wide range of theoretical opinions regarding the use of TSD however, support of the use of TSD for one reason or another.

1.4 Research body on TSD

Self-disclosure is now a familiar technique within therapy, however therapists differ in the way they use or accept it as a helpful technique. Research has focussed on the impact of the therapist's theoretical orientation on whether they choose to self-disclose or not (Edwards & Murdock, 1994; Simi & Mahalik, 1997; Simon, 1990), on the content of the disclosures (Davies, 1994; Edwards & Murdock, 1994; Glue & O'Neill, 2010; Lane et al., 2001), and on its impact (Burkard et al., 2006). This section will present a critical review of the existing literature on TSD focusing on these three areas. The aim is to provide the reader with a full review of the existing research on TSD, discuss the limitations and gaps in the literature and conclude by making a case for this present research study.

1.4.1 Multi-cultural perspective

Theories of counselling Asian clients propose that TSD can facilitate the TR by building clients' trust in therapy and encouraging clients to share information about them, especially when the therapist is from a non-Asian background (Helms & Cook, 1999; Kim et al., 2003; Sue & Sue, 1999). However, there are very few research studies in which race and ethnicity have been considered as independent variables, and those studies that have been conducted have provided mixed results (Ponterotto, Casas, Suzuki, & Alexander, 1995).

When reviewing the current TSD literature on multi-cultural counselling more conceptual work was found than empirical studies. Regardless of the limited research in this area, there appears to be theoretical agreement on its usefulness when working with clients from diverse backgrounds. Constantine and Kwan (2003) argue that TSD could facilitate the development of the TR, address

cultural mistrust, and enhance cultural competence. TSD could prove to be a useful intervention with clients from diverse backgrounds, particularly regarding the development of the therapeutic alliance and forming a relationship based around trust. However, it would be helpful for researchers to examine its use cross-culturally.

Cherbosque (1987) quantitative study used a sample of Mexican and American students, who watched simulated therapy sessions, where the therapist engaged in one of three forms of self-disclosure (similarity or dissimilarity of personal experience either from the past or present, self-involving SD indicating approval or disapproval of the client or no self-disclosure). The participants were then interviewed for 15 minutes and asked to comment on what they thought about the therapist's intervention. The findings revealed that Mexican participants viewed high disclosing therapists as having less expertise and being less trustworthy, and viewed them to be behaving unprofessionally. Both groups of participants reported that they were more willing to self-disclose to a therapist who did not self-disclose. These findings are in accordance with multicultural literature that suggests that cultural values enforce professional boundaries between therapist and client and for this group of clients it seems as though the boundary has been crossed with the use of TSD.

Wetzel and Wright-Buckley's (1988) quantitative study studied the reciprocity effect (whereby self-disclosure from Person 1 to Person 2 results in further self-disclosure from Person 2 to Person 1) in another cultural group. Thirty-three Black American female students were recruited to take part in the study whereby they were interviewed by a female therapist whom they could not see and only communicate through an intercom. Participants were told that their therapist was either White or Black and were exposed to either high or low levels of self-disclosure. The findings showed that African American therapists who exhibited high levels of self-disclosure were more likely to receive high levels of disclosure from their African-American client. Furthermore, African-American clients reported feeling safe and more likely to trust their African-American therapist. However, there was a reciprocity breakdown (no increase in client disclosure) when an African-American client received either high or low self-disclosures from a Caucasian therapist. Interestingly, African-American clients preferred more personal disclosures from their Caucasian therapist, possibly to enhance trust within the early stages of the therapeutic alliance. Furthermore, perhaps the perceived cultural differences required more 'work' or TSD to build such trust and understanding because mutual understanding could not be assumed in the way they might be when therapist and client are culturally similar. The use of a qualitative approach may be helpful to further explore this idea. Due to the analogue design of the

study where only females participated who were not presenting themselves for therapy, generalisability of the findings needs to be addressed with caution.

Burkard et al. (2006) explored Caucasian American therapists' use of self-disclosure in cross-cultural counselling, using CQRM (an inductive analytic process, whereby decisions are made by team consensus). Eleven American therapists took part in the study and indicated that 5-50% of their clients were of an ethnic background (i.e., African American, Asian American, Latino, and Native American) different from their own. The participants were asked about a specific instance of self-disclosure, the quality of the TR, what was happening before the TSD took place, reasons for the self-disclosure, the actual self-disclosure and its impact. The findings showed that participants typically chose to disclose their responses to their clients' experiences of racism or oppression, with the view that it would enhance and preserve the TR. Additionally, the findings suggested that TSDs helped the clients feel understood and allowed them to open up about other issues. Participants of the study also indicated other variant reasons to self-disclose which included the intent to enhance the TR, the recognition of the role of racism/oppression experienced by clients, and the acknowledgement of their own racist/oppressive views. An additional important finding from the study indicated that the participants felt that they had received insufficient training regarding the use of self-disclosure in their training and none to minimal training regarding the use of TSD in cross-cultural counselling.

The findings of this study parallel views expressed in existing literature. For example, Sue and Sue (2003) and Helms and Cook (1999) posit that TSD may prove to be a useful intervention to show that the therapist is culturally sensitive and therefore is able to gain trust from the client. These studies highlight the importance of being able to demonstrate working with racial issues in therapy (Sue & Sue, 2003; Helms & Cook, 1999). Disclosures made by the therapist where appropriate could highlight the therapist's understanding of client frustration regarding racism (Constantine & Kwan, 2003). Furthermore, the study identified a potential function of TSD – modelling. Some culturally diverse clients are unfamiliar with therapy and the process of it. In these instances, TSD could model appropriate behaviour in therapy and encourage and facilitate the formation of a collaborative relationship (Burkard et al., 2006).

Although the study's sample was small, its findings are perhaps indicative of the contributions of the richness and depth (rather than breadth) which qualitative research can yield. However, the findings

are also based on what the therapists could recall and therefore is subject to memory lapses and distortion. Furthermore, the findings seem to only reflect a positive experience of TSD. One possible explanation for this could be that the participants may have been reluctant to discuss negative experiences of self-disclosing to their clients for fear of being judged or seen as incompetent. Lastly, the findings are solely grounded in the perspectives of therapists and we are missing the perspectives of clients who are at the receiving end of TSD. Exploring the views of clients could suggest very different attitudes which would yield different outcomes. The therapists used in the sample ranged with regards to their level of experience in working with clients culturally different from themselves. This may have influenced the final results of the study. Also, during the recruitment stage, the participants were given the interview protocol before the interview. Prior knowledge of the interview questions may have meant that the participants had the opportunity to respond in a more socially acceptable way (Hill et al., 1997).

In an attempt to address the absence of the clients' view, Bitar, Kimball, Bermudez and Drew's (2014) phenomenological study investigated the effects of TSD on Mexican-American men working with Caucasian American therapists. Four main themes emerged from the data and revealed that TSD is a culturally competent intervention and had several benefits on the clients which included, strengthening the TR, normalising the client's experience, diminishing the power imbalance, and showing the acceptability of self-example. Sue and Sue, leading scholars in the multi-cultural counselling field, put forward, "...a culturally different client may not open up (self-disclose) until you, the helping professional, self-disclose first" (1999, p. 93). Therefore, TSD could be a useful intervention to use with culturally different clients in the hope of being able to enhance and maintain the TR. Several limitations that need to be taken into consideration include; the small sample size and the qualitative methodology used as the issue of generalisability is raised. Participants may have also been hesitant in expressing views that could have been perceived as being critical of the therapist, the TSD or the therapy process, therefore, impacting on the reliability of the findings. The conclusions of this study postulate that TSD is a driving force in facilitating client self-disclosure and enhancing the TR within cross-cultural settings. However, it would be useful to focus on the impact of TSD in other cross-cultural settings (Bitar et al., 2014).

The importance of exploring the impact of TSD in other cultural contexts is raised. Lokken and Twohey's (2004) GT study explored American Indian clients' perspective of Caucasian American counselling behaviour. Participants rated their counsellors higher when they self-disclosed and

pointed out that they were more able to trust their counsellors who self-disclosed, as it gave them an opportunity to learn more about them. Similarly, Cashwell, Shcherbakova, and Cashwell's (2003) quantitative study investigated African American and Caucasian students' preferences for TSD based on the ethnicity of both the respondent and the counsellor. Participants indicated preferences for TSD when the therapist was of different ethnicity. Specifically, the results showed that African American students indicated a stronger preference for TSD than Caucasian participants about personal feelings, sexual and professional issues, and success/failure. This is consistent with theoretical literature on multicultural counselling (Helms & Cook, 1999; Sue & Sue, 1999; Tsui & Schultz, 1985). However, the study used a nonclinical sample and the views of those who presented for counselling services may differ in their preferences for TSD. Therefore, it would be important to see if those who have had real experience of therapy have similar views to those in the study. Cashwell et al. (2003) suggest it might be fruitful to extend the literature by looking at how TSD influences therapy outcomes. However, it would be very difficult to define what constitutes a therapeutic outcome. The concept is very subjective and even if a consensus was reached on how to define it, the question would be whether it can be measured. Lastly, issues of generalisability exist within this study as the sample largely consisted of students from first years. It could be possible that developmental differences exist and that the results could have been different or created bias if the sample included a wider range of students from other years.

Kim et al. (2003) attempted to address the gap identified by Cashwell et al. (2003) using quantitative methodology to explore TSD and East Asian American clients. The participants talked about personal issues in a counselling session with a European American counsellor who either disclosed personal information or abstained from disclosing personal information. The study found that clients' adherence to Asian cultural values and whether they experienced TSD or not did not have an effect on session outcome. Their findings conflict with current theory and research on the effects of TSD on session outcome (Kim et al., 2003). The use of a qualitative approach may be helpful to further explore this idea and to see how SA clients of differing cultural values react to TSD. However, Kim et al. (2003) did show that participants preferred disclosures that provided strategy as opposed to disclosures of approval, reassurance, facts, credentials, and feelings. Clients also favoured disclosures that were about insight and found these helpful. Moreover, disclosures viewed to be more personal by the therapist and the client was regarded as being more helpful.

Research has shown therapists are more likely to self-disclose about their theoretical orientation and credentials (Edwards & Murdock, 1994) and this type of information could be more significant for clients of colour, especially clients from a SA background. For instance, Asian clients tend to show more respect for authority and may perceive therapists to be authority figures (Lee, 1997). With this view, Asian clients may want to know more about their therapists' credentials in order to help them make decisions about continuing treatment (Constantine & Kwan, 2003). Studies have found that highly mistrustful African American clients are more likely to terminate psychotherapy in the initial stages (Terrell & Terrell, 1984) and are likely to disclose less to Caucasian therapists than to therapists from similar ethnic groups (Thompson, Worthington, & Atkinson, 1994).

These studies provide some insight into culturally diverse clients' perceptions of TSD where the findings highlight both a positive and negative experience of TSD. It seems that for some, a high disclosing therapist could be viewed as less professional and could actually hinder clients from self-disclosing to their therapists. However, for others TSD can actually encourage further disclosures from clients as they are more likely to trust their therapist and enable them to feel safe. However, the majority of studies were carried out in America and only one study explored the views of Indian clients (one subgroup that is part of the SA umbrella term). Additional research is needed to increase our understanding of the role and impact of TSD on SA clients, as this may improve the quality of care provided to these clients as well as their overall experience of therapy.

1.4.2 Therapist perspective

TSD is becoming increasingly common, with over 90% of therapists reporting they disclose information about themselves to their clients at least some of the time (Henretty & Levitt, 2010). However, overall therapists report they are cautious when using self-disclosure, and see it as one of the least frequently used techniques (Farber, 2006; Maroda, 2009). Most of the research looking at TSD focuses on the therapist's perspective (Gibson, 2012). One of the most common ways that this has been presented is through case studies, whereby therapists have commented on their own use of self-disclosure (e.g., Cole, 2006; Denney et al., 2008; Guthrie, 2006; Roberts, 2005). The case studies have been able to offer insight into the decision-making processes and the therapist's experience around self-disclosure. It has also allowed the therapist to reflect on how the decision making process surrounding TSD implicates their own needs and interests. This method has allowed for another level of knowledge to be produced since theoretical models and guidelines usually limit their analyses to the client's needs and outcomes (Gibson, 2012). Some writers have also spoken about their own experiences of TSD, as

a therapist and as a client (e.g., Prenn, 2009). However, an obvious limitation of the case study method is that it is based on the perspective of one individual and on the willingness of the therapist to explore the positive and negative impact of TSD. Therefore, this means that case studies are subject to observer bias. Furthermore, as a case study deals with only one person, the results of the study are not generalisable as we cannot be sure whether the conclusions drawn from the case study are representative of the wider body.

Several factors have been found to affect the frequency of TSD. In a review of the empirical Henretty and Levitt (2010) found that TSD seems to be connected with the theoretical orientation of the therapist. Edwards and Murdock (1994) adapted Hendrick's (1988, 1990) Counselor Disclosure Scale in an attempt to measure the content of self-disclosure used by practitioners from different orientations. Potential differences in disclosures due to gender and ethnic origin of participants were also examined. The sample consisted of males and females, 88% of whom were Caucasian. The results indicated that, humanistic therapists used more self-disclosures than psychodynamic therapists. The study also coded for ethnicity however no differences were found between the amounts of self-disclosures made by the practitioners. However, with regards to the number of minority to non-minority participants (88% non-minority vs. 12% minority) it is possible that different cultures could have different views about self-disclosure, and the disproportionate number of ethnic variety in the sample means that it is difficult to understand differences among individual cultures. Further studies using quantitative methods also found that the greatest willingness to self-disclose came from those with a humanistic orientation as opposed to those using a psychodynamic approach (Bianco, 2007; Cowan, Hansen, & O'Toole, 2010; Simi & Mahalik, 1997).

Using qualitative methodology Carew (2009) explored the attitudes of twenty therapists towards TSD over different theoretical orientations (CBT, Systemic and Psychodynamic orientations). Data was gathered using focus groups and analysed using thematic analysis. The study found that willingness to disclose across the different orientations fell along a spectrum which ranged from 'never' for the psychodynamic group, to disclosures used as a therapeutic intervention for the systemic and cognitive behaviour groups, to a particular characteristic of therapy style for the person-centred group. However, within each orientation there seemed to be varied views which fell on a scale regarding willingness to disclose. Throughout all approaches, reasons given for self-disclosing were to normalise or model behaviour, feelings, or experience. Additionally, the belief shared by all was that self-disclosure is a bonding, empathic, sharing intervention that helped to address power imbalances in

the relationship, which supports arguments put forward by multi-cultural scholars (Constantine & Kwan, 2003; Vasquez, 2009). However, some were concerned with the negative effects of TSD, particularly how it could take the focus away from the client's issues and become therapy for the therapist. Although the study demonstrates the complexity of TSD and factors that influence it, there are important limitations to consider. For instance, all participants were Caucasian and their sexual orientation and ethnicities were unknown. The results therefore are only applicable for this group of participant but also important aspects of cultural difference that could occur are unknown (Carew, 2009). Furthermore, although it is mentioned that some participants held a bias against TSD due to the negative effects, the study did not expand upon this to provide a full account of what the negative effects might be.

Understanding why therapists self-disclose is important. Thus, Mathews (1988) designed a survey to examine the perceptions of therapists on their use of self-disclosure. Two hundred and eighty-two therapists completed the survey and sixty therapists participated in an interview. The most frequently cited reasons for self-disclosure included to model and educate, to facilitate the TR and to promote autonomy. Reasons for not self-disclosing included moving the focus away from the client to the therapist, contaminating the transference and issues with boundaries. Interviews with therapists offered further insight into how helpful self-disclosure was perceived to be. For example, in the therapist interviews conducted by Mathews (1988) one participant stated:

Certain clients begin to develop a stronger sense of themselves when they receive a lot of reflecting or mirroring of their thoughts and feelings. One of the ways that I do this, is by sharing things about myself. It also helps them develop boundaries between what they think and feel versus what someone else might think or feel. (p. 525).

A further account by another therapist stated "sharing something of myself with a client, by me being disclosing with them, is an important way to help them feel less alone, less crazy... it frequently helps them feel more hopeful" [sic] (p. 526). Detailed accounts like this are valuable because of the implicit assumption of knowledge that is produced out of clinical experience. However, the majority of participants (65.8%) who were interviewed for this study were either psychiatrists or licensed social workers. Therefore, the findings of this study are limited to this specific client group, whose responses could have been influenced by their own theoretical underpinning. It is likely for this to be heavily influenced by the medical model and rational approach of 'science', rather than considering working

in a holistic way, which captures the importance of meaning, subjectivity, values, feelings, and mutually constructed realities that underpin the field of counselling psychology (Blair, 2010).

Studies have also investigated the content/type of disclosures used by therapists. Generally, they have shown the most frequent disclosures made by therapists related to their theoretical approach, beliefs regarding the effectiveness of treatment approaches, apologies for alleged mistakes made by other professionals, expressions of respect towards the client, emotions mirroring those of the clients and coping strategies (Henretty & Levitt, 2010). Subjects that therapists tended to steer clear of included dreams, sexual attraction toward the client and personal problems (Davies, 1994). In a paper presented at the annual meeting of the Society for Psychotherapy, Lane, Farber and Geller (2001) suggested that the common subjects disclosed included those aspects suggested by Davis (1994) and Henretty & Levitt (2010). These findings are consistent with those of Knox and Hill (2003) who proposed that revelations that are too personal should be avoided as they may frighten or burden the client and could indicate that boundaries have been crossed therefore impacting the TR.

Using qualitative methodology Glue and O’neilla (2010) explored psychologists’ experiences of self-disclosing with an emphasis on their views on the content of the disclosure when working with clients. Three Danish and three English psychologists participated in interviews, which were analysed using IPA. According to the psychologists who participated in this study TSD should be about and beneficial to the therapeutic alliance, be managed carefully and used appropriately. Furthermore, it was their view that there is a need to maintain stronger boundaries when working with specific clients, for example those with mental health problems and offenders. The findings also suggested the importance of admitting to errors made with a client to ensure that the TR is not affected and to maintain congruence and integrity. Lastly, it was viewed that self-disclosure used by psychologists is based on their level of experience and in “the moment” subjective decisions as to whether it is thought to be of benefit to the client and/or the TR. Such evidence related to the usefulness and impact of TSD is valuable but is rooted in the perceptions of the therapists; it would also be worthwhile to understand how TSD is experienced by the client.

The studies reviewed here highlight from a therapist’s perspective when TSD may lead to a positive impact on the TR and indeed when it may not. When TSD is considered to be appropriate it seems it can normalise or model behaviour, alleviate power imbalances in the TR and facilitate the therapist-

client bond. However, importantly, it is viewed that TSD can also take the focus away from the client, frighten or burden them and actually hinder the TR and cause issues with boundaries. Farber (2006) argues that the decision making process involved in choosing what to disclose, when to disclosure and ultimately whether to disclose is very idiosyncratic and is influenced by a number of different factors which include the therapist's theoretical orientation, client diagnosis, treatment length and the nature of what is going on in the moment. Farber (2006) further suggests that different types of disclosures may be appropriate in different situation with different clients.

1.4.3 Client perspective

Limitations of the aforementioned studies highlighted the importance of exploring the perspectives of clients. Many different methods have been employed to study the impact of TSD from the perspectives of clients. Researchers have used standardised videos of mock client-therapist sessions, each differing in the amounts of TSD and have asked individuals to watch these videos and rate how competent they think the therapist is (e.g., Myers & Hayes, 2006). Some have used narrative or conversational analysis methods to study TSD (Leudar et al., 2006) whilst, others have used experimental designs, whereby clients have been exposed to some sessions with TSD and some sessions without (Henretty & Levitt, 2010). Retrospective methods have also been used, where clients have been asked about their experience with TSD and their views of its impact on the TR (e.g., Lokken & Twohey, 2004).

Myers and Hayes' (2006) analogue study examined how perceptions of the therapists and the session are affected by TSD. Caucasian American undergraduate students were shown three videos which simulated a therapy session. The first tape showed the therapist making three general self-disclosures, the second showed three countertransference disclosures and the third showed the therapist making empathic statements rather than self-disclosing. Results showed a majority of participants rated sessions as deeper and the therapist as more expert when the therapist made general self-disclosures compared to no disclosures, but only when the TR was considered as positive. When the TR was considered as negative, participants viewed sessions as shallower and the therapist as less professional when the therapist made either general or countertransference disclosures compared to no disclosures. A potential limitation is whether the data gained from undergraduate students under experimental conditions is considered meaningful to the practice of psychotherapy. However, an advantage of an experimental design like this is that it allows for certain variables of interest to be manipulated such as the working alliance. It would be considered unethical for the working alliance to

be manipulated in a natural setting study as the alliance is closely related to therapy outcome (Horvath & Symonds, 1991). Furthermore, it would not be realistic or ethical to carry out these studies with actual clients and actual moments of self-disclosure, and the process of observation would undoubtedly change any interaction. Another limitation of this study is that the data was collected after a single observation of a brief segment of therapy. This does not reflect the complex nature of what therapy is like. For instance, Safran and Muran (1996) suggest that the working alliance is formed through a rupture and repair cycle. Observing this on a single occasion would not sufficiently reflect this multifaceted process. It is difficult to generalise the findings of this study due to the convenience sample used. Furthermore, findings of the study are also limited by the therapist and client in the videotapes both being Caucasian, as were the majority of participants in the study. It would be useful to expand upon this study by focussing on the cultural context in which disclosures are made and how they are perceived (Myers & Hayes, 2006). Despite the limitations of this study, the findings highlight the importance for therapists to assess the working alliance before self-disclosing.

As important as it is to examine the TR between TSD and the process of therapy Barrett & Berman (2001) state it is equally important to assess the impact of TSD on therapy outcomes. They conducted an experiment to examine whether TSD made in response to client disclosures could have an impact on therapy outcomes. Eighteen therapists at a university counselling service were told to increase the frequency of self-disclosures made during the treatment of one client and to limit the number of self-disclosures during the treatment of another. Following the first four sessions, assessments of distress and client perceptions of the therapist were obtained. Analysis of the data showed that clients who were under the increased TSD condition reported lower levels of distress and also liked their therapist more. This suggests that TSD can improve the TR and also the outcome of therapy. The findings from this study and also the findings from Myers and Hayes's (2006) study, support the claims of theorist Jourard (1971) who states that TSD can develop the TR. It does not appear as though culture or ethnicity had been accounted for in these studies as the only demographic details provided about the participants and therapist was gender and age. Therefore, the representativeness of the sample could be questioned.

Several studies have found TSD has a positive impact on the counselling process and therapy outcome (Barrett & Berman., 2001; Hill, Helms, Spiegel, & Tichenor, 1988; Knox et al., 1997; Myers & Hayes., 2006; Ramsdell & Ramsdell, 1993). The studies showed clients found the TSD more helpful than other forms of verbal responses. Although these studies are valuable and relevant to practice, most of the

studies comprised of Caucasian American participants and were quantitative. However, a recent qualitative study using a phenomenological approach was conducted by Audet and Overall (2010) which explored TSD and the TR from the client perspective. The sample consisted of five males and four females, eight of whom were Caucasian and one Hispanic. The participants were interviewed and focused on three areas: TSD and the TR, impact of TSD on therapy process, and implications for therapy outcome. The study found TSD can both help and hinder the TR. Participants found TSD contributed to the early development of the client-therapist relationship. They also found the use of disclosure made them feel as though the therapist was attentive and responsive towards their needs and disclosing helped engage them in a meaningful way. However, some participants felt as though TSD created ambiguity about the therapist and their role. Some participants felt the disclosure weakened the therapist's professional role and made them feel as though they were the therapist. The lack of cultural representation in the sample of this study limits the findings to the experiences of Caucasian clients. As the phenomenon of disclosure and its given meanings are likely to be culture-bound (Cashwell, Shcherbakova, & Cashwell, 2003; Constantine & Kwan, 2003), it seems plausible that further research is needed with other cultural groups.

Although multiple therapeutic benefits of TSD have been identified, TSD also carries risks associated with the blurring of boundaries and the potential to diminish professional qualities of the therapist in the eyes of their clients, as highlighted in the previous study. Very little is known about the impact TSD could have on therapy boundaries and therapists' professionalism from the perspectives of clients. In an extension of the previous study, Audet (2011) offers an insight into the experiences of nine participants on their views of the impact of TSD on therapy boundaries and therapist professionalism. Findings highlighted that participants offered their opinions based on their own experiences of what distinguished between too much and too little disclosure and found both positive and negative effects of TSD on therapy boundaries and therapist professional qualities. Disclosures that were described by the participants as infrequent, low-to-moderately intimate, and similar to their experiences were considered positive. Whereas, disclosures that were too frequent, repetitive, lengthy with unnecessary detail, unrelated with their issues or personal values, or poorly attuned to their needs was experienced as negative.

Wells's (1994) qualitative study showed seven out of eight clients reported to have a negative first reaction to their therapists self-disclosing. The disclosures consisted of intimate details about the therapists' lives that related to the concerns of their clients (e.g., therapists sharing their own struggles

with substance abuse, romantic relationships, and familial conflict). Initial reactions reported by the clients of this study included feeling “stunned,” “offended,” “scared,” and “pissed off”. Furthermore, reactions to subsequent disclosures made by the therapist were influenced by the quality of the TR. For instance, disclosures were received more favourably if the quality of the relationship was perceived to be better (Wells, 1994). Findings from this study also parallel those from another qualitative study that found a link between perceptions of TSD and the quality of the TR, normalisation of client concerns, and client insight (Knox et al., 1997).

Very few empirical studies have asked clients how they experienced their therapist’s self-disclosing and fewer have asked clients about the impact of non-disclosure. A mixed methods study conducted by Hanson (2005) investigated clients’ views of how TSD, and non-disclosure, affected them. Eighteen Caucasian participants from Canada, currently in therapy, volunteered to be interviewed. The data was firstly examined for incidents of disclosure and non-disclosure and coded accordingly. Grounded Theory was the qualitative method used to analyse the data. The quantitative findings showed that participants were two and a half times more likely to view disclosures to be helpful than unhelpful, and twice as likely to experience non-disclosures as unhelpful than helpful. From the qualitative analysis the findings seemed consistent with both theory and previous empirical studies of therapists’ beliefs about the impact of disclosures, the greatest being on the TR. The participants in the study viewed their therapist’s disclosures as helpful and felt that they contributed towards the formation of a positive relationship and were made to feel understood and cared about. One particular theme that came from this study that appears to be absent in other self-disclosure studies was transitioning. Participants reported that their therapist used ‘small talk’ to make a transition into and out of sessions. Participants felt this put them at ease, broke the ice, and made them feel as though the therapist was ‘with them’. Participants felt session transitioning, especially towards the end of the session allowed them to focus their attention on a mundane part of the therapist’s life and give them a sense of therapist’s humanity. This study is one of few that have studied clients’ experiences who are currently in or have had the experience of therapy as opposed to analogue studies where participants are therapists. Using qualitative methodology meant that rich context-related data was gained, which is sometimes lacking in quantitative studies. Although the researcher states a variety of ethnic backgrounds was represented in the study, it should be noted that most of the participants described themselves as White/Caucasian or Canadian. This does not necessarily represent people from other cultures or locations.

Audet and Everall (2003) employing qualitative methodology also explored TSD from the clients' perspectives. Positive and negative experiences from four participants (two males and two females) were obtained. All participants described themselves as Caucasian and had all terminated therapy prior to the interview. Participants gave accounts of their experiences of TSD and their views of the impact TSD had on therapist qualities, the TR, and therapy process. Overall the findings suggested that TSD had both a beneficial and hindering impact on perceived therapist qualities and the therapy process and relationship which was also seen in other studies by Knox et al. (1997) and Wells (1994). Participants formed impressions of their therapist's professionalism and competence after evaluating the content of the disclosure. For instance, participants who viewed their therapist's disclosure as beneficial did not question the professionalism of their therapist. However, when participants viewed the disclosure as hindering, felt that this compromised therapist's professionalism and competence and viewed the therapy as being unhelpful. This finding is consistent with Barnett (1998) who found that the views of clients regarding therapy can change depending on the client's experience of TSD. Furthermore, what also seemed important to the participants of this study was how the therapist revealed personal information. Participants identified "extensiveness" of disclosures—an area that is rarely addressed in the literature (Audet & Everall, 2003). It was viewed that detailed disclosures hindered the client's ability to gain any benefit in comparison to succinct ones and repetitive ones were viewed as boring and lead to gradual disengagement from therapy. Frequent disclosures also resulted in the client questioning the therapist's competence. This raises the issue and question about what constitutes "too much disclosure". In this study, intimate disclosures that were similar to what the client was presenting, when a trusting relationship was already in place, deepened the relationship further and facilitated collaboration.

Due to the qualitative nature of the study the findings cannot be generalised, however they may provide a deeper level of understanding of TSD from the perspective of clients and its potential impact on the therapy process. Those who took part in the study had volunteered to do so. This could present some bias in what the findings suggest as there could be apparent differences between what may have been revealed by those who did not wish to take part in the study compared to those who are willing to participate. The sample also does not represent a culturally diverse sample and therefore, the findings of the study may not be representative of the views of those from different cultures. An important point to consider is that it would be naïve to conclude that any benefit experienced by the participant was solely due to the therapist's self-disclosure.

The literature exploring the client perspective of TSD has found that it can both help and hinder the TR. It has been highlighted by most of the studies that clients felt TSD could diminish the professional qualities of the therapist and they could be viewed as less professional. From the findings of the aforementioned studies, the 'wrong' type of TSD could result in clients viewing their therapist as incompetent and the therapy as unhelpful.

1.4.4 Summary of literature review

Working psychologically with clients requires the use of clinical and cultural formulations and explanatory models. This can help psychologists work in a more culturally competent manner and enable them to gain a better and well informed understanding of their client (American Psychiatric Association, 2002; Harper & Moss, 2003; Kleinmann, 1980, as cited in Bhui & Bhugra, 2004). With regards to SA clients, rather than the client being considered as reluctant to engage in therapy, it is vital that psychologists embrace working in a culturally sensitive way. TSD could be considered a significant enhancement of therapy in a culturally diverse society. However, existing research demonstrates the complexity of the concept of TSD. Various attempts have been made to categorise and define TSD however there has been little consensus on how to conceptualise it. Hence, currently there are no concrete guidelines regarding the use of TSD and this is most likely to be because of TSD essentially being a multidimensional concept.

The various ways in which different modalities have conceptualized TSD has offered a fruitful path of investigation. As expected, various theoretical orientations have different outlooks on TSD. However, therapists who work multi-culturally tend to support the use of TSD, particularly with clients from different sociocultural backgrounds (Jenkins, 1990; Sue & Sue, 1999). Research studies which have focused on understanding TSD have investigated the positive/negative impact, students' experiences and the preferences of therapists, however none has focused on SA individuals (e.g., Barrett & Berman, 2001; Bottrill et al., 2009; Curtis, 1982; Geller, 2003; Myers & Hayes, 2006). The few studies that have explored TSD from a multi-cultural perspective provide some insight into culturally diverse clients' perceptions of TSD. However, most were carried out in America on various populations excluding SAs and only one study explored the views of Indian clients (one subgroup that is part of the SA umbrella term). Furthermore, they have produced inconsistent findings and it seems as though further research is needed to increase our understanding of the role and impact of TSD in multi-cultural counselling. This may improve the quality of care available to SA clients and may also provide valuable information to those who train therapists. Moreover, the limitations identified are important

to address in future studies of TSD. For instance, the majority of prior research favours using quantitative methods and has used student samples. This limits the opportunity to understand and explore the individual subjective experiences of TSD. The results of the studies reviewed here suggest that culture may interact with TSD (Henretty & Levitt, 2010). However, using qualitative methods to explore the subjective experiences of TSD may help elucidate a significant therapeutic process in multi-cultural counselling. Additional research is needed to increase our understanding of the role and impact of TSD on SA clients, as this may improve the quality of care provided to them as well as their overall experience of therapy. Due to the lack of research focusing on experiences of TSD, this study aims to explore SA clients' unique experiences of TSD and may lead to an in-depth phenomenological understanding of their experience.

1.5 Rationale for current study

As discussed throughout this chapter, there remains a dearth of literature and empirical research exploring how SA clients experience TSD. Consistent with the existing literature, a broad definition of TSD is verbal statements that reveal something personal about the therapist (Hill & Knox, 2002). It consists of everything an individual chooses to tell the other person about him/herself. The information can be descriptive or evaluative and can include thoughts, feelings, aspirations, goals, failures, successes, fears, dreams as well as one's likes and dislikes (Snyder, 1974). The way in which TSD contributes to the TR is becoming more apparent, as shown in several studies (Hill et al., 1988; Knox et al., 1997; Ramsdell & Ramsdell, 1993). However, TSD is still relatively unexplored in natural settings (Hanson, 2005). The SA population underutilises therapeutic services (Bowl, 2007; Fazil & Cochrane, 2003; Greenwood et al., 2000) due to various barriers and constraints (Bhui et al., 2002; Blakey et al., 2006; King et al., 2006). One way of potentially being able to better understand this could be to explore the impact of TSD to see how it may or may not aid the SA population in engaging in therapeutic services.

Is TSD a therapeutic intervention or is it a therapeutic mistake? It is helpful? Is it ethical? What does the client think about therapists that self-disclose? The purpose of the following phenomenological study is to explore the experiences of a small number of individuals who have come to the end of a course of therapy and to obtain an in-depth understanding of their experience of their therapist self-

disclosing. The study will aim to elicit participants' perceptions of the therapists' disclosures, and what this meant for them and the overall therapy process.

1.5.1 Relevance to Counselling Psychology

Due to increases in migratory activities, the UK is becoming more multicultural as the Office for National Statistics (2014) suggests. The counselling industry, including theory and practice along with practitioners, operates within this wider context and has experienced similar changes (e.g., therapists and clients from diverse cultural backgrounds). There is an increased need for knowledge on this subject for counselling psychologists to remain professionally competent and current. The Division of Counselling Psychology published a statement in 2001 (as cited in Mytton, 2003) and professional guidelines (Division of Counselling Psychology, 2005) that stress the importance of therapists' self-awareness and the ability to assess and utilise personal and interpersonal processes in therapy. The notions of anti-discrimination, empowerment, ethical practice, and taking social and cultural backgrounds into account were also described in the statement and these link to counselling psychology's phenomenological and humanistic roots (Mytton, 2003).

Being able to effectively meet the needs of culturally diverse clients, requires competency arising from evidence based knowledge. However, controversy exists about the appropriateness of TSD. In light of the current body of research on improving culturally competent services, research into TSD as a useful intervention remains scant and is relevant to counselling psychologists. Furthermore, Ackerman and Hilsenroth (2001) cite TSD amongst the characteristics and techniques positively impacting on the therapeutic alliance. At the centre of counselling psychology, one will find the relationship between the practitioner and the client (Shillito-Clarke, 2006). The importance of a good TR (Beck, 1995) is consistent with the cornerstones of counselling psychology. Therefore, further knowledge in this area would have implications for clients, service providers and practitioners.

Although TSD research is witnessing a gradual inclusion of the client perspective, our understanding of the phenomenon remains limited. This study provides a window into a client-informed meaning-based understanding of TSD and its potential role in therapy. Client experiences of TSD could further characterise and clarify ways in which the intervention impacts clients, the TR, and the therapy process and outcome, providing results that are potentially relevant to practice. Furthermore, patterns and themes associated with beneficial versus hindering disclosures may inform practitioners of what

works when and with whom, in therapy, promoting therapeutic use of the intervention and diminishing inappropriate use that may harm the client.

The following phenomenological study could help to illustrate aspects not currently considered in the counselling psychology and multicultural counselling fields and clarify the inconsistency observed between the theory and the ethics of TSD. The study could also help counselling psychologists in their training and practice in understanding the helpful and hindering impact of TSD related to working with clients from a particular ethnic group. This study will aim to help counselling psychologists to develop a better understanding of the meaning of TSD for SA clients and how they make sense of it, therefore helping the process of therapy and the TR.

1.6 Aims and research question

The purpose of this phenomenological study was to explore what the experience of TSD means for SA clients in individual therapy. The use of qualitative methodology will potentially provide a more in-depth understanding of this experience from the clients' perspectives, as well as contributing to the existing knowledge base of appropriateness of TSD related to working cross culturally, particularly within a SA demographic. To date there is a paucity of explorations into the experiences of SA clients from their perspective, and an academic lacuna relating specifically to how SA clients experience TSD. Since so little is known about SA clients' experience in this particular context, it is important to acknowledge that there were no specific hypotheses to be investigated. The main research question was therefore:

'How do SA clients experience TSD during individual therapy?'

Relating to this main research question, the following areas were explored:

- What is their understanding of TSD?
- How did they experience TSD?
- What was the impact of TSD?

CHAPTER TWO: METHODOLOGY

The purpose of this study was to explore what the experience of TSD means for SA clients in individual therapy and to provide a comprehensive description of those experiences. The research question of interest to this study was, 'How do SA clients experience TSD in individual therapy?'. This chapter will go through the rationale for the decision to use IPA, what it is, and discuss the epistemological position espoused. A description of participant recruitment, data collection and analytic process will also be offered as well as an outline of the steps taken to meet research quality guidelines. The chapter will also include a reflexive account about how the researcher's experiences, beliefs and values have shaped the research process and understanding of the phenomenon.

2.1. Rationale for a qualitative approach

Quantitative and qualitative research methods differ with regards to the nature of knowledge produced and the different types of questions raised about our understanding of human experience (Bhati, Hoyt & Huffman, 2014). Quantitative methods seek to produce objective, generalisable knowledge and take a nomothetic, positivist position (Willig, 2008). Although valuable in terms of the knowledge produced, quantitative research methods have been criticised as being a reductionist approach in that they cannot adequately encompass the complexity and subjectivity of the individual experience (Giorgi & Giorgi, 2008). Qualitative research methods in comparison are concerned with understanding the contextual, subjective experiences of individuals (Bhati et al., 2014). Qualitative methods produce rich and descriptive accounts of complex phenomenon which are co-constructed between the researcher and participants (Bhati et al., 2014; McLeod, 2003). Although, qualitative methods are not without criticism (Willig, 2008), this approach was considered to be the most appropriate to meet the aims of this study. Qualitative research has increasingly become an important tool in counselling psychology research, particularly in multi-cultural counselling (Ponterotto, 2005). Considering the population of interest in this study, qualitative research was considered optimal.

A further factor that influences the chosen research approach is the researcher's own values (axiology) (Creswell, Hanson, Clark & Morales, 2007). Qualitative research methods are similar to those adopted by the discipline of counselling psychology. For example, McLeod (2003) puts forward that qualitative research is appropriate for counselling psychologists as it employs key skills of empathy and congruence, and the ability to form professional, ethical relationships with others. McLeod (2003)

further suggests that qualitative research has become increasingly evident within the field of counselling psychology, showing its need and value.

There are different perspectives on whether TSD is seen as an appropriate intervention or not and this is influenced by various factors. However, there is little evidence exploring TSD from a client's perspective. Existing research conducted in this area has mostly used quantitative methodologies (Ramsdell & Ramsdell, 1993) employing recordings of short simulated therapy encounters or observer ratings of transcripts (Audet & Everall, 2010). Therefore, there is little insight into the experiences of actual clients in natural settings produced by qualitative research (Hill & Knox, 2002). Additionally, there are theories of counselling Asian clients that suggest that TSD can facilitate the TR (Kim et al., 2003) although most of the existing literature on TSD has been conducted on White or European American individuals (Constantine & Kwan, 2003). Thus, it seems that a qualitative insight into SA clients' experience of TSD is needed. Barker, Pistrang, and Elliott (2002) state that qualitative approaches are ideal for in-depth explorations into experiences, especially in novel areas.

2.2 Ontology and epistemology

The way in which one approaches research and the methods chosen to do this can be guided by philosophical perspectives regarding the nature of reality (ontology), and how one comes to know that reality (epistemology) (Krauss, 2005). Counselling psychology research may focus on the subjective experience, namely the feelings and meanings attributed to that experience (Woolfe, Dryden & Strawbridge, 2003). Therefore, researchers may wish to make use of the available methodology that best fits their belief system and research question (Smith, 2001).

2.2.1 Ontology

A relativist ontology maintains there are multiple, constructed realities as opposed to one single truth (Willig, 2008). A relativist ontology assumes that the world exists in relation to our perception and discards the view that the world consists of structures and objects which are linked through a cause and effect relationship (Blaikie, 2007). In this study a relativist ontological position is adopted as it assumes that reality is constructed inter-subjectively through the meanings and understandings developed socially and experientially. Willig (2008) states that a relativist position also places importance on the multiplicity of interpretations that can be applied to the world. The role of the researcher is to get as close as possible to the participant's experience and to enter their experiential world by stepping into their shoes and looking at the world through their eyes. With this in mind, this

research is phenomenological as it approaches the subject of the study through the experiences and perceptions of the SA participants to enable us to gain an understanding of their experiences of TSD.

2.2.2 Epistemology

Epistemological underpinnings within qualitative research sit on a continuum where on one end is a naïve realist position and on the other is a radical constructionist position (Madill, Jordan & Shirley, 2000). The naïve realist position is the belief that we can see reality as it really is, objectively and without bias, whereas a radical constructionist position is the belief that reality is not discovered but is constructed through language (Lyons, 2007). In the middle of this continuum, lies the contextual constructionist position. This position is based on the assumption that knowledge is contextual and stand-point dependent (Willig, 2008). This means that different perspectives produce different insights into the same phenomenon. This is similar to the critical realism position which postulates that knowledge exists in context and is influenced by the individual's perspective (Willig, 2008).

IPA does not have a definite epistemological position (Smith, 2004). This is viewed as a strength of this approach as it calls for rich analyses which can produce insight into multiple aspects of a phenomenon (Larkin, Watts & Clifton, 2006). IPA aims to give a voice to the participant and bring light to their meaning making process (Larkin et al., 2006). IPA automatically rejects epistemologies in line with the 'scientific method' of knowledge production (i.e., positivism and empiricism). These approaches support the idea of there being a right or wrong way to perceive things in the world and the belief that the phenomenon can be studied without bias (Ponterotto, 2005). IPA seems to be highly compatible with the researcher's axiology and epistemological position as a contextual constructionist. This epistemological position holds that there is no objective truth, instead, favouring the idea that truth and meaning are constructed through our interaction with the world. Therefore, people hold different truths as they construct meaning in different ways in relation to the same phenomenon (Crotty, 1998). Subsequently, such research is concerned with completeness rather than accuracy of representation and is expected to show the relationship between accounts and the contexts within which they have been produced (Willig, 2008).

This phenomenological research aims to incorporate an understanding of the cultural factors relating to TSD and the process of therapy. With a contextual constructionist position, multiple realities are acknowledged in as much as the individuality of each participant, for instance, underlying beliefs and past experiences may play a role in the meaning prescribed to TSD. Additionally, the context of the therapeutic framework in which TSD is experienced may also affect meaning. The relationship

between participant and researcher may also play a role, with an individual's experience and expectations of relationships perhaps also enacted within the participant-researcher relationship. This researcher's epistemological position embraces Heidegger's view of individuals being present and involved in a significant context, rejecting the idea of a division between the mind, person and world (Larkin et al., 2006). Therefore, the researcher's interpretation of the participants' experience will also be rooted in the researcher's own social, historical and cultural context (Jaeger & Rosnow, 1988). IPA therefore appears most appropriate in being able to uncover both deeper meaning and to remain context specific.

Furthermore, qualitative research with a contextual constructionist position acknowledges the researcher's role as an aspect of context within the research process. This is something on which qualitative research places a great deal of emphasis. As a result, data produced from analysis are the result of an iterative, interpretative process involving reflexivity.

2.3 IPA

IPA is a relatively new qualitative approach used in psychological research that recognises that people see the world in different ways. The aim is to understand and make sense of subjective meanings of experiences. This approach to research is in contrast with the dominant positivist research approach used in psychological research, as it does not test pre-existing hypotheses, or attempt to find a quantitative measure of an objective reality (Smith & Osborn, 2008). IPA was developed as a specific approach to qualitative research in the mid-1990s by Jonathon Smith and since then, other authors have contributed to its growth. Smith, Flowers and Larkin (2009) put forward that IPA is a method of qualitative, experiential and psychological research that has been influenced by three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography. This section will explain the reasons for the choice to use IPA over other qualitative methods. The three areas of the philosophy of knowledge that underpin IPA will also be discussed together with their connections to the approach.

2.3.1 Why IPA?

IPA is one approach of several that could have been chosen. An important part of the research process involves considering how the research question could have been investigated differently and how the phenomenon could be understood differently (Willig, 2008). Prior to deciding to use IPA as the chosen method for this research other qualitative methods were also considered: Discourse Analysis (DA), Narrative Analysis (NA), and Grounded Theory (GT); and compared with IPA.

DA, as described by Potter and Wetherell (1995) focuses on the linguistic aspect of constructing reality, its function and consequences. Therefore, it fits more with a social constructionist epistemology. The aim of this approach is to investigate how individuals use language and the result of this (Willig, 2008). Both DA and IPA are similar in that they share concern with discourse, however IPA considers the role of cognitions and affect, and uses linguistics to understand how individuals make sense of their experiences. Considering the aims of this research DA seems unsuitable as DA would have offered insight into how SA clients who have experienced TSD use language to construct accounts of their experiences. Whereas, the present research is more interested in gaining a more rounded understanding of participants' experiences.

NA is concerned with the subtle and complex ways in which meaning is constructed in the stories people tell about their experiences. This approach analyses the structure of the narrative sequence in order to gain meaning, questioning why the story was told in that order and in that way (McLeod, 2003). The aim of the present research is not to understand the ways in which people organise their experiences of TSD but more interested in what it is like to have experienced TSD from their subjective perspective. NA was not considered as it seemed too narrow in its focus.

GT developed by Glaser and Strauss (1967) is a similar approach to IPA in the way it approaches analysis as well as having some common techniques in producing data. It is also a relatively more established approach. However, the rationale behind choosing IPA and not GT, is that the focus of the study was not on explaining contextualised social processes and developing an explanatory framework of a phenomenon, which is exclusive to GT (Willig, 2001, Starks & Brown Trinidad, 2007). Instead, the objective was to gain detailed insight into participants' subjective experiences. Rather than looking at individual experiences, GT focusses on capturing social processes (Willig & Rogers, 2008), therefore making it a less suitable method for this particular research. Furthermore, the aim of GT is to develop inductive theories that are embedded in the data and applicable to exploring individual experiences (Charmaz, 2003) whereas, IPA focusses on understanding what the individual's perceptions are about the topic of interest (Chapman & Smith, 2002). Finally, GT regards the researcher as more removed from the research and assumes a different epistemological position whereas, IPA considers the researcher as part of the research throughout.

Patel and Mahtani (2007) highlight the Eurocentric nature of the theories, interventions and research in psychology and the need for "more socially responsible and relevant research". The aim of IPA research is to generate knowledge about the quality and texture of experience as well as its meaning

within a particular social and cultural context and it is through this lens that this research was undertaken. Smith et al. (2009) summarises that the aim of IPA is to conduct a detailed exploration of, and make an attempt to understand, individuals' lived experience, and how they make sense of these experiences; it also considers the experiences of the group as a whole, which goes in line with the aim of the research project and fits in well with the researcher's axiology and epistemological position.

2.3.2 Theoretical underpinnings

IPA has been influenced by three key areas of the philosophy of knowledge. One of the philosophical underpinnings of IPA is 'Phenomenology'. The leading figures in phenomenological philosophy are Husserl, Heidegger, Merleau-Ponty and Sartre. Phenomenology is a philosophical approach that aims to understand an experience rather than to discover what is "really" going on. Husserl's work established that phenomenology is concerned with capturing the way things appear to us in experience: one's feelings, thoughts and perceptions of that experience (Willig, 2008). Heidegger studied Husserl's early writings and had his own ideas about phenomenology, which he described in his major work *Being and Time* (1962). The development of Husserl's work by Heidegger, Merleau-Ponty and Sartre resulted in a view that the individual is embedded and immersed in a world of objects, relationships, language and culture (Smith et al., 2009). This saw a move away from Husserl's descriptive work towards a more interpretative position with a focus on understanding a person's involvement in the lived world and their relationship to the world and others, rather than seeing the person in isolation. Therefore, IPA research is influenced by phenomenology in its aim to capture and explore the meanings an individual assigns to their experience.

The second major philosophical underpinning of IPA comes from hermeneutics, which is the theory of interpretation. The researcher's attempt to understand other people's relationship to the world in IPA research is essentially interpretative and also focusses on the individual's attempt to make meaning out of their experiences (Smith et al., 2009). IPA research recognises the way in which people understand their experience and is influenced by the meaning they give to it (Willig, 2001). Therefore, people can experience the same phenomenon or event in multiple ways. IPA encourages the researcher to immerse oneself in the world of the participant. Although it is impossible to experience another's world, the aim is to attempt to 'walk in their shoes' and see the world how they see it. However, IPA is aware that access to another's world is a complex process due to the researcher having their own views and beliefs. Therefore, the researcher attempts to examine and share their assumptions in the context of the research (Finlay & Gough, 2003). Thus, the process of interpreting the phenomenon or data unavoidably involves both the participant's and the researcher's sense-

making. This process is described as a double hermeneutic process whereby the researcher is trying to make sense of the participant, who is trying to make sense of their world (Smith et al., 2009). IPA acknowledges that the process of analysis is repetitive and is based on a hermeneutic circle. A key step in the analysis stage of IPA is that the process is iterative, which means that the researcher moves back and forth through the data. Smith et al. (2009) suggest that in order to understand any given part, one must look at the whole, and in order to appreciate and understand the whole, one must look at the parts.

Idiography is the third philosophical underpinning of IPA. In keeping with idiographic philosophy, IPA makes a commitment to ensure that analysis is thorough and systematic as the detail and depth of analysis is important. IPA research therefore, employs a small sample size that has been chosen purposefully to meet specific criteria so as to value each participant's individual account. This means that each account is examined in detail one by one. Once all accounts have been examined in detail an attempt is then made to conduct cross-case analysis to look for and identify any commonalities and discrepancies. This approach means that it is not concerned with generalising findings to larger populations but in producing detailed knowledge about the perceptions and understandings of a small group (Smith et al., 2009). As a result, IPA becomes a particularly useful approach when the research is looking at complexity, process or novelty (Smith & Osborne, 2008). Due to the lack of literature giving a voice to SA clients' experiences of therapy, alongside the lack of research into their experiences of TSD, IPA fits together with the aims of the research. Although IPA conducts in-depth analysis on only a small number of participants, its aim is still to contribute to the existing literature. Therefore, the findings generated can contribute to and be discussed in relation to the wider existing psychological literature (Smith & Osborn, 2008).

2.4 Reflexivity

It is recognised that in qualitative explorations the researcher can influence and shape the process at a personal level (personal reflexivity) and at a theorist level (epistemological reflexivity) (Willig, 2008). Reflexivity is important as it allows the researcher to focus and reflect on the ways in which they are implicated in the process and its findings (Willig, 2008).

Throughout the remainder of the thesis, several accounts of reflexivity will be made. These accounts will be highlighted through the use of italics and I will use the first person. An important part of the qualitative research process in IPA is for the researcher to understand and present his/her preconceptions about the research (Finlay & Gough, 2003). I hope that these accounts will provide a satisfactory illustration of how my personal interests, values, experiences and ideas have shaped the research process, and help the reader evaluate my perspective and interpretation of the data, ensuring that the research process can be scrutinised throughout.

2.4.1 Epistemological reflexivity

During my training I had been exposed to many theoretical perspectives, leading me to constantly challenge and question my previously held assumptions and beliefs. As an A-Level psychology student, I was introduced to quantitative methods as the original ideals of science because they favour objectivity and lead to testable hypotheses, and cause and effect relationships. As an undergraduate psychology student, emphasis was on the traditional positivist epistemology and again supported the objective and reliable methods of investigation. However, when I entered a psychology Master's program I was introduced to qualitative methodology. With my roots embedded in a positivistic background and my style of thinking a reflection of this, being introduced to another way of questioning reality and how meanings are formed was challenging. For me this was a new way of thinking about the world and how knowledge is constructed. It inspired me to want to engage in phenomenological research and attempt to create reality rather than discover it. This led to me using mixed methods in my final dissertation as I still felt caught between the two paradigms.

Now as a PsychD in counselling psychology student I wanted to fully embrace phenomenological methodology and challenge my old ways of thinking, learning what to do with my own assumptions and ideas as a researcher and appreciating and exploring others' reality and experience. My experience of TSD was two-fold, one where I self-disclosed to a client and another where I was at the receiving end of TSD. When entering this research process, I was able to understand and reflect that I too was a

participant in my own research. As a SA trainee counselling psychologist who had also been a client, researching other SA clients, I was trying to explore their meanings whilst processing my own. As Heidegger put it “we are thrown into this pre-existing world of people, objects, language and culture, and cannot be meaningfully detached from it” (as cited in Smith et al., 2009, p. 17).

I now disagree with the assumptions of the positivist position, as I believe and understand that knowledge and meaning is constructed from experience, and that people can experience the same event or phenomenon in different ways, thus favouring phenomenological ideas (Willig, 2001). My view is that the meaning of an experience can be understood reflecting upon its status as an experience and its wider meanings (social, cultural and psychological), thus, favouring contextual constructionist ideas. In my clinical work, I started to understand how difficult it was for me to put aside my own assumptions about what a client was bringing to therapy. This led me to think about how I could never truly understand another individual’s experience. With this in mind, it was essential that I was aware of how my own assumptions could obscure my practice, and so I began to understand that my interpretation of their experience would inevitably incorporate both my own and their sense-making. This understanding was a process critical to not only my clinical work, but also to my research project. Throughout the research process, I kept a reflective diary, which I used to raise my awareness and ensure that I was constantly mindful of these issues.

2.4.2 Personal reflexivity

It is important to make explicit my personal and professional influences, my values, biases and experiences that have influenced my decision to conduct this research. I am a 30-year-old British Indian woman. My religion is Hindu and I can speak Gujarati fluently. Both my grandparents originated from India and moved to Uganda, where my father was born. My mother was born in India. My parents came to the UK in the early 1970’s and I was born in London. Growing up as a British Indian has sometimes felt to be a ‘culture clash’, for example, when Western and Indian family values have been incompatible. This has required me to go through a process of personal negotiation which culminated in the development of a hybrid identity. According to Allport (1954) and Sartre (1976), the process of building self-definition and developing a sense of self occurs through contrasting ourselves with others, leading to an awareness of difference.

Through discourses within my family and wider Indian communities, I have become aware that psychological help is conceptualised differently in the two primary cultures to which I belong. There exist differing levels of stigma and differences in how languages can carry different and powerful

meanings of the same concept when translated. I have noticed how the everyday terms for someone who would want to receive psychological help in Gujarati are very stigmatising and are equivalent to the term 'mad' in English. I have observed how within the Indian culture, discussing issues or difficulties should be kept within the family and should not be discussed with those outside the family including professionals. The comments that I received from my family when I told them about having to have personal therapy as part of the doctorate were full of misunderstanding and negativity. They were not able to understand the reasons why I have to have personal therapy and asked me questions such as "why do you have to talk to a therapist, why can't you talk to us".

Through my experience of being a trainee counselling psychologist and working in various placements embedded within the dominant Western culture, I have realised the importance of understanding clients' subjective worldviews and what they think is helpful for them, not making assumptions about these. I have worked in placements which have catered for SA people and have become increasingly mindful of the value of considering the impact and influence of culture upon a person and how clinical services and professionals could consider these more in clinical practice.

The assumptions that I bring to this research derive from my upbringing, and professional and personal experience to date. I think issues of culture, family values, support, and social isolation may be pertinent to SA participants, similar to those found in Western research findings. However, I anticipate that some of these issues may be experienced differently and carry different significance due to occurring in a SA cultural context. I also believe that there may be references to issues that may seem more culturally embedded within SA cultures and related to family values specific to SA communities for example, family disgrace, shame, dignity and honour.

During my doctoral training, personal therapy was something that I was very much looking forward to. I chose to see a Psychodynamic therapist as I was attracted to the deeper level of analysis of myself. As an enthusiastic client/trainee wanting to learn about myself but also wanting to learn how to be a therapist I remember naively asking her questions about herself in the first few sessions to no avail. However, towards the end of the therapy in the last session, she disclosed a lot of personal information about herself in relation to my culture. I remember being surprised that she knew quite a bit about 'being Indian' and that she was sharing this with me. But at the same time I do remember feeling annoyed, wondering why she was only telling me this at the end.

Throughout my training, my clinical framework has predominantly followed a Cognitive Behavioural approach, although I would consider myself as an integrative practitioner. Over the years I have learnt to pay closer attention to all aspects of my responses to clients in relation to myself. It could be said that the use of self-disclosure is more accepted within a CBT framework as it can help to normalise the client's experience (Goldfried et al., 2003). During my training I have had the experience of self-disclosing to a client who was the same age and from the same cultural background as me. The reason for my decision to self-disclose to this particular client was to normalise her experience and to foster the TR. The client was finding it particularly difficult to talk about her experience of being in a relationship that her parents disapproved of. She was feeling shameful, guilty and judged and these overwhelming feelings were affecting other parts of her life. Having personally been in a very similar position I felt that in that moment self-disclosing to this client would be particularly useful as it could help the client trust me and not feel isolated in her experience. The client reported she found it helpful to know others have felt the way she was feeling and have had similar experiences to her, regarding her parents. My supervisor, an integrative practitioner, but having a psychodynamic background, however, felt that my actions were not appropriate and concentrated on how I could avoid disclosing in future sessions. I was left feeling confused and left wondering "is there a line of when to self-disclose or not self-disclose? Where is the line? Did I cross the line?". I felt that my experience of self-disclosing in a session with a SA client, who felt that my intervention was helpful and having a supervisor who disagreed with my intervention, is the root of why I would like to explore this area further, specifically with SA clients. On reflection, it was interesting for me to think about how the same event (self-disclosing) was experienced in very different ways by myself, the client and my supervisor. My reflections about this influenced the epistemological position I take to research and how I am most interested in understanding individual people's feelings, thoughts and perceptions of something that exists in the world.

2.5 Research design

The aim of this research was to explore what the experience of TSD means for SA clients in individual therapy. Smith et al. (2009) suggests there are several suitable methods of collecting data, but state that in-depth interviews generate the richest accounts of people's experiences. The study used qualitative methodology and involved collecting data through semi-structured interviews as they facilitate a comfortable interaction, guided by a loose agenda (Smith et al., 2009; Willig, 2008).

2.5.1 Sampling and inclusion criteria

IPA supports the use of purposive sampling of small, broadly homogeneous groups (Smith & Osborn, 2008). Six participants were selected through purposeful criterion sampling to ensure that the participants selected would yield an in-depth understanding of TSD. Smith and Osborn (2008) state that a homogenous sample helps to ensure only one phenomenon is present and being described. With this in mind, all participants were required to meet six inclusion criteria.

The six criteria included, firstly, that participants identified as SA. Secondly participants needed to be 18 years of age or older. Thirdly, it was required participants would have had a minimum of four sessions, to allow for the experience of self-disclosure to emerge. The fourth criterion was participants had experienced their therapist self-disclosing, defined as 'any instance during therapy when your therapist shared or revealed information about his or her personal life'. The fifth criterion was participants were willing and able to discuss their experience in an individual face-to-face interview in English. Lastly, participants should have completed contact with their therapist to minimise any possible impact on the TR created with their therapist and termination of therapy should have been within the preceding year to limit distortions in recall of memory.

Initially, an additional inclusion criterion was included which was for participants to have seen a South Asian therapist. This was to ensure as homogeneous a sample as possible could be recruited to account for the requirements of conducting an IPA piece of research. This criterion was later excluded due to difficulties experienced in the recruitment process. I reflect on this further in the section below.

2.5.2 Recruitment process

Initially, contact via email and telephone was made with a range of mental health and counselling services that catered for SA clients in London. The aim of the research and what it involves was explained and discussed with the managers of the services, who agreed to assist with recruitment. A

record of this correspondence is provided in Appendix A. Numerous temples and community centres that cater predominantly for SA clients were also contacted as well as sending an advert to the Black and Asian Counselling Psychologists Group. A poster advertising the research was then placed on noticeboards of each waiting room of the services that agreed to take part in the study. The poster (see Appendix B) briefly explained what the study was about and gave contact details of the researcher, should clients wish to take part in the study or to find out more.

Initially response was slow and no services responded to my initial email. I contacted 32 mental health and charity services. I followed up each service with a telephone call 3 weeks later and again response was slow. On reflection I think I underestimated how difficult and time consuming the recruitment stage would be. I reflected on this with my supervisor and we discussed changing the inclusion criteria to include clients whose therapists' ethnicity was not just restricted to SA as this was the initial criteria. This appeared to be the right decision as soon after changing the inclusion criteria 2 participants who met the criteria expressed interest in wanting to participate. I continued to search for services that I could approach as well as using all of my contacts (supervisors, colleagues at my placements) to find a further 6 participants. Through this word of mouth process, I was able to recruit a further 4 participants. Smith et al. (2009) recommends that for a doctoral research project, between four and ten participants "seems about right" (p. 52). Due to the decision that between six and eight participants would need to be recruited, a final reminder email was sent out to all services approached. I was hoping that I would be able to recruit a further 2 participants, however I decided that I would stop the recruitment process by the end of May 2014 in order to have sufficient time to analyse the transcripts. Smith et al. (2009) reminds us that it is "important not to see the higher numbers as being indicative of 'better' work" (p. 52). By the end of May, I had recruited 6 participants. I felt this was sufficient and the recruitment stage ended.

2.5.3 Participants

All participants who took part in the study met all six inclusion criteria. In order to report on the homogeneity of the sample in more detail, demographic information was collected using a demographic form which the participants completed at the start of the interview (see Appendix C). For purposes of confidentiality all names were changed, and anything that could potentially identify a participant was omitted. The most relevant data has been collated in the table below.

Table 1

Participants Characteristics and Demographics

Participant pseudonym	Gender	Age	Ethnicity	First or Second Generation	Ethnicity of therapist	Therapeutic approach used by therapist	Number of session completed
Rashmi	Female	30	British Indian	Second	British white British Indian	Psychodynamic CBT	6 5 months
Karina	Female	33	British Indian	Second	British White	CBT	6 months
Rani	Female	26	British Indian	Second	British Indian	Integrative	25
Amira	Female	25	British Bangladeshi	Second	White others	CBT	4
Anita	Female	24	British Indian	Second	British White	Integrative	28
Viraj	Male	31	British Indian	Second	British White	Person centred	11

The research described and interpreted the experiences of 6 adults (5 females and 1 male) aged between 24-33 years. Five participants defined themselves as British Indian and one participant as British Bangladeshi. All of the participants were born in the UK. Four participants defined their therapist's ethnicity as British White and 1 participant described their therapist as British Indian. Of the 6 participants, one participant saw two therapists where one was British White and the other as British Indian. The theoretical orientations of therapist were: Psychodynamic, CBT, Person Centred and Integrative. The number of sessions completed by participants ranged from four to six months. All sessions were for individual therapy.

I was disappointed that I had only managed to recruit six participants and I remember feeling under pressure to ensure that through the interview I collect rich and detailed accounts from the participants. By noticing my feelings, I was able to consider how my disappointment may impact the interview process, and that I need to be mindful not to 'push' the participants to provide an account, in order for the interview to remain participant led and a true account of experience.

2.5.4 Semi-structured interviews

It is recommended by Smith and Osborn (2008) that one way to collect data for an IPA study is to conduct semi-structured interviews. This way of collecting data allows the researcher and participant to take part in a discourse in which the researcher is able to adapt questions according to each participant's response and to further explore areas of interest which arise. Use of semi-structured interviews in IPA also allows greater flexibility and richness of data and allows access to participants' perceptions, feelings and understandings in an original way (Smith & Osborne, 2008).

2.5.5 Interview schedule

The interview schedule (see Appendix D) was devised using guidelines set by Smith and Osborn (2008). Firstly, broad areas to be covered in the interview were identified. These were: understanding of TSD, experience of TSD, and impact of TSD. These areas were then placed in a logical order based on how sensitive the area was. For example, questions that were most sensitive were left until later in the interview to allow the participant to become more relaxed and comfortable in the interview (Smith & Osborn 2008). Opening the interview with a broader discussion of the participant's understanding of TSD hoped to create a relaxed environment and ease the participant into the interview process. Appropriate questions relating to each area were then devised and possible prompts constructed to help elicit further information.

The interview schedule was designed to guide rather than dictate the interview in order to facilitate the participants in telling their story in their own words. Open-ended and non-directive questions were used in order to facilitate exploration and elaboration by participants. As suggested by Smith and Osborn (2008), the interview was conducted to enable the participant to take an important role in how the interview proceeded. To allow for this to take place, the interview schedule was memorised and used as a guide to ensure that general areas of interest were covered. However, the exact order and wording of the questions were changed depending on the participant's response to the previous question and to follow the participant's line of thought and facilitate the natural unfolding of each participant's stories (Willig & Stainton Rogers, 2008).

The initial interview schedule included much broader questions about experiences of therapy and its effects on life after therapy. However, on reflection and after discussing this with my supervisor it was decided to omit these questions as I possibly would have been faced with the dilemma of what themes to include in the analysis as the themes may have been about many other things and not just self-disclosure, which was the phenomenon of interest.

2.5.6 The interview procedure

Participants were met outside the venue by the researcher and accompanied to a quiet, comfortable interview room. They were given time to settle and make themselves comfortable and were then asked to read the participant information sheet (see Appendix E). Confidentiality was discussed regarding the participants' identity and in what circumstances confidentiality would be broken (i.e., harm to self or others). Each participant was given the option to withdraw at any stage. Following their agreement, participants were asked to read and sign two copies of the consent form (see Appendix F) to evidence their full, informed consent; one was kept by the researcher, the other by the participant. The participant was then also given the demographic form to complete. Whilst the participant completed these forms, the researcher reviewed a checklist to ensure the correct procedure was being followed and that all forms had been completed (see Appendix G). When participant and researcher were ready, following the guidance defined by Smith et al. (2009), key points related to the interview process and what to expect (see Appendix H) were discussed with the participant and an opportunity to ask any questions was offered. Once any questions were answered, the semi-structured interview then began. Each interview was audio taped using two recording devices. Interviews ranged from 30 to 50 minutes. At the end of the interview, participants were fully debriefed and given the opportunity to share their experiences of what it was like to take part in the interview. Lastly, the participants were given a full debrief information sheet containing the contact details of appropriate forms of help should they require them (Appendix I). Participants were thanked for their time and then escorted to the exit. All participants who volunteered to take part in the research received no payment for doing so, however, light refreshments and snacks were provided.

The interviews were held in a pre-booked private room. For my personal safety I told a close friend of my location and timings of the interviews with the intention of checking in and out with them prior to and at the end of each interview. I was very pleased with the how the interviews progressed, and was confident about how much the participants had shared as well as how open they were about their experiences. What was surprising was that some participants talking about how useful and therapeutic the interview was. They mentioned that the interview allowed them to reflect on their experiences of TSD, realising that it had actually been helpful and how they were pleased that they were given this opportunity to reflect on this and share their experiences. This made me feel pleased with the choice of questions included in the interview schedule as I understood their comments as a confirmation they were appropriate questions to ask. It also made me feel as though I had been successful in creating a relaxed and non-judgmental environment in which they felt free to talk about their experiences.

2.5.7 Transcripts

A verbatim, numbered transcript was produced for each interview (Smith et al., 2009). The transcription included every word that would be subjected to IPA analysis, including mispronunciations and repetitions. Elongated pauses and laughter were also included in the transcripts to enable the data to remain as true as possible to the original account. All names and identifying information were changed to protect participants' anonymity. Each transcript was then reviewed against the recording to ensure accuracy.

2.6 Analytic strategy

As highlighted above, IPA was used to analyse the transcripts of the semi-structured interviews (Smith & Osborn, 2003; Smith et al., 2009). There is no one way of conducting analysis in IPA, however Smith et al. (2009) provides a set of flexible guidelines in approaching analysis.

In line with IPA's idiographic commitment, the first stage involved the analysis of each transcript individually. Each transcript was read and re-read initially with the tape of the interview playing alongside several times to allow the researcher to become as close to and familiar with the text as possible. From this, it was possible to highlight richer or more detailed sections and begin to become immersed in each participant's world. The transcripts were set up so that there were two large margins on each side which would be used for annotations. The lines were also numbered so the data could easily be identified in the later stages of analysis.

Stage two involved carefully examining the text, each time re-reading it with a different focus. Colour-coded exploratory notes were made in the right-hand margin. Firstly, the transcript was read with a descriptive focus. Descriptive comments (in pink) were made about the content of what had been said. Notes about the key objects of concern in the participant's life-world were made (e.g., relationships, processes, events, places, values and principles) and the meanings of these things for the participants (Smith et al., 2009). The transcript was then re-read with a linguistic focus and notes were made (in blue) exploring the use of language (i.e., pronoun use, pauses, laughter, the function of language, repetition, tone, metaphor, fluency) (Smith et al., 2009). The text was then re-read with an interrogative focus. Conceptual comments were made (in purple) about what key objects might mean to the participant. The aim of this stage is to move beyond the surface level towards a deeper, more interpretative understanding of the participant's experience.

Surprisingly, the interpretative process felt very natural and intuitive. I used my own experience of TSD as a touch-stone to help me ask questions of the text and enhance my empathetic understanding of their experiences (Smith et al., 2009). I kept my reflective diary in which I wrote initial notes, first impressions and free associations about each transcript as well as recollections of the interview process and observations about the transcript.

The third stage involved a higher level of interpretation of concepts but at the same time being grounded in the actual accounts and words of the participants. The colour-coded notes were transformed into concise phrases or themes. The left-hand margin was then used to write down the 'emerging themes'. The development of initial notes into themes was continued through the whole transcript and this process was repeated for each individual transcript. (See Appendix J for an example of stages one to three.)

As I engaged with the text I imagined the participant's voice which enabled me to become that much more immersed with the text. Re-reading these notes gave me a good impression of the participant's narrative as a whole, at face-value (Gee, 2011).

Stage four involved listing, on a separate sheet of paper the emergent themes in chronological order. They were cut up so each one was on a separate piece of paper. The themes were then laid out on a large table to allow for any connections between them to be identified. Some clustered together naturally and were given a superordinate label; this process is called 'abstraction'. Some reached superordinate status because others clustered under them ('subsumption'). Themes were also examined for oppositional relationships between them ('polarisation'). 'Contextualisation' looked at connections between the themes according to particular moments or events. The frequency with which a theme emerged was also considered ('numeration'). The themes were then grouped according to the connections made and theme clusters were created. During this iterative process, the theme clusters were checked in the transcripts to ensure that they were consistent with what the participants were actually saying. Each transcript was analysed in the same way to this level, and each time it was important for the researcher to pay attention to any new themes that emerged from the transcripts, to ensure each new transcripts was analysed according to the themes that had emerged from it, rather than the previous transcript. From these clusters, superordinate themes were identified, and again more themes were discarded and others scrutinised and reviewed (Willig, 2008). A table of superordinate themes with the corresponding sub-themes for each participant was compiled. (See Appendix K for an example)

Stage five involved moving to the next participant's transcript and repeating stages one to four. This process was again repeated for the other four participants.

The analysis process was a very long and tiring process and I often felt very overwhelmed at the amount of commitment that was needed, something that I had not initially anticipated as a beginner in IPA. However, I stayed focussed and was committed to going through each transcript thoroughly to ensure validity of my findings (Yardley, 2000). It was also important that I treated each transcript on its own to do justice to its own individuality. In order to stick to the idiographic commitment needed for IPA I had to 'bracket' the ideas that emerged from each transcript when working on a new transcript. Smith et al. (2009) states that "even though you will inevitably be influenced by what you have already found [...] your fore-structures have changed" (p. 100). However, keeping a reflective diary allowed myself to stay mindful of this and I was able to continue to follow the steps outlined by Smith et al. to allow new themes to develop.

Stage six involved printing the superordinate themes for each participant and looking for patterns across the six participants. Different coloured paper was used to represent each participant (e.g. Rashmi was green, Rani was orange). The superordinate themes were then grouped using abstraction, subsumption, contextualisation and interpretative grouping to identify the overall super-ordinate themes shared by all. A framework was developed with four super-ordinate themes and sub-themes under each. Verbatim quotes from across all the interviews were extracted in order to support and illustrate each super-ordinate theme and component sub-themes, and compiled into a table (see Appendix L). This formed the narrative structure of the analysis section.

The last stage involved writing up the findings. The super-ordinate themes were discussed, analysed further and interpreted with supportive quotes from the participants (Smith et al., 2009). The findings have been explained with existing literature in the discussion section of this paper.

I had a dilemma when it came to choosing which themes to focus on in the final write up. There seemed to be more material than I could include and felt that individual stories were lost in this process, an inevitable part of IPA.

2.7 Quality and validity

Qualitative research has often been evaluated according to the criteria for validity and reliability used for quantitative research. However there has been increasing dissatisfaction with this approach. Smith

et al. (2009) recommend Yardley's (2000) guidelines and describe how they can be applied to an IPA study. The researcher followed these guidelines for this research.

2.7.1 Sensitivity to context

Yardley (2000) spoke of the need for qualitative research to demonstrate sensitivity to context. Smith and Osborn (2008) argues that the researcher should show this in the very beginning stages of the research process, and can be demonstrated through the expression of sensitivity to the socio-cultural setting of the research study, the existing literature around the topic area, and the material obtained from the participants (Smith et al., 2009; Yardley, 2000). The existing theoretical and empirical literature outlined Chapter One shows the lack of literature regarding SA clients' experience of TSD in individual therapy. This gap led to the development of a suitable research question. The Discussion Chapter then demonstrates how the analysis relates to this literature and the potential contributions of the findings to clinical practice. Research must also show sensitivity to the socio-cultural context of participants. This has been demonstrated through the use of open ended questions in each interview as this will encourage participants to respond freely and enable them to talk about what is important to them (Wilkinson, Joffe, & Yardley, 2004). Furthermore, the analysis section will show a substantial number of verbatim quotes from the participants' accounts to support the argument being made.

2.7.2 Commitment and rigour

Smith et al. (2009) put forward that with IPA, there is an "expectation that commitment will be shown through the degree of attentiveness to the participant during data collection and the care with which the analysis of each case is carried out" (p. 181). As a trainee counselling psychologist, the researcher used her clinical skills to make the participant feel comfortable and to ensure they felt listened to. Rigour refers to the thoroughness of the study. This has been demonstrated by the carefully selected inclusion criteria of the sample to match the research question and for the sample to be as homogenous as possible. Commitment and rigour is hopefully demonstrated by the thoroughness of the analysis and the systematic procedures followed. Furthermore, the Analysis Chapter will show extracts from each participant to illustrate each sub-theme.

2.7.3 Coherence and transparency

Transparency is concerned with how clear the stages of the research process are described in the write-up of the study. This has been shown in the previous sections of this chapter, but in order to enhance the transparency of the analysis process, a paper trail has been provided in the appendix

section. Reflexivity is also an important part of the study's transparency, and this has been shown throughout the chapters, through the use of reflective paragraphs.

One of the criticisms of IPA is that readers must effectively trust that the data is genuine and has been fairly represented & analysed. Therefore, given that researchers do not tend to offer access to full transcripts because of confidentiality/ethical issues, in the Appendix section I used excerpts from different participants. The reason for this is because I felt there was less chance of identifying individuals but also believe it showed that I did not just look at one participant in detail and skim the rest.

2.7.4 Impact and importance

Yardley (2000) suggests that the validity of a research project is based upon whether or not it produces something interesting, important or useful. This is demonstrated in the Discussion Chapter. Additionally, Yin (1989) points out that one way of checking the validity of one's research project is to organise and file the data in a way that somebody else could follow the chain of evidence that starts from the initial documentation through to the final report. This has been demonstrated by keeping a trail which includes initial notes on the research question, the research proposal, an interview schedule, audio tapes, annotated transcripts, tables of themes, draft reports and the final report. Furthermore, a researcher who had no part in the study was approached and asked to check the final report of the themes to check it is plausible or credible. This demonstrates triangulation and the validity of the themes.

2.8 Ethical considerations

The proposal for this study received ethical approval from City University's Ethics Committee (Appendix M). Full care and consideration was paid to the ethical implications of the study throughout its progress in accordance with the BPS Code of Ethics and Conduct (2009).

2.8.1 Informed consent

The participant information sheet, which outlines the aims of the research and the procedures of taking part, was given to each potential participant. Providing this information sheet ensured they had the opportunity to consider all of the information prior to taking part in the research. If the participant was interested in taking part in the research they were then expected to make contact with the

researcher. An opportunity to ask further questions was given to each participant before arranging a time for the interview. Before the interview, it was ensured the participant had fully understood the information outlined and a verbal account of the information was also given. The consent form was then given to each participant to read. A further opportunity to ask the researcher any questions before signing the consent form was given. Each participant was reminded of his or her right to withdraw from the study at any time up to two weeks after the interview date. This time limit was set to ensure that the researcher was not left without any usable data during the write-up period prior to submission. The participants were reminded they did not need to give any reason should they wish to withdraw. The procedure for conducting the interview, destroying the interviews and corresponding transcripts and analysis was explained.

2.8.2 Confidentiality

Confidentiality was fully outlined to each participant at the start of the interview. They were informed that all identifying information from the written transcripts would be removed, and a pseudonym would be assigned to them. Further to this, any information that could lead to their identification, and all third parties and place names, would be omitted from the transcripts. Participants were informed that all of the information they provided and the transcribed interviews would be stored under their pseudonym, and that all of the information they provided together with the transcripts and recordings would be secured in a lockable storage device. The participants were also informed that the audio tapes used during the interview would be destroyed once the study had been assessed and marked and that transcripts of the interview would be kept for a period of five years in line with the requirements of the university but also in case the study is published in an academic journal, but would then be destroyed. The participants were informed of the circumstances under which confidentiality may need to be broken, specifically, if the participant provided any information that could suggest illegal activity or could cause harm to themselves or others.

2.8.3 Potential distress

It was not expected that taking part in the research would cause any harm to the participant. However, as the participants were talking about their experience of therapy this may have evoked certain feelings. For this reason, an ethical consideration was the potential distress this could cause. This was addressed by providing detailed information prior to the interview regarding what the actual interview and taking part would involve. Additionally, participants were also made aware that they did not have to answer any questions that they did not wish to answer, and that they could take small breaks during the interview at any time. A distress protocol (see Appendix N) was devised and would have been

implemented if the participant showed any signs of distress during the interview. Participants were also given a list of useful services should they have needed it. The participants were informed that the researcher is an experienced Mental Health worker who works in a secondary care mental health context and who is also undergoing professional training in counselling psychology; the researcher therefore had experience in managing situations where distress occurs.

These protocols were actually not needed as none of the participants interviewed became unduly distressed.

At the end of the interview the participants were fully debriefed and given the opportunity to share their experiences of what it was like to take part in the interview. Lastly, the participants were given the full debrief information sheet containing the contact details of appropriate forms of help should they require them.

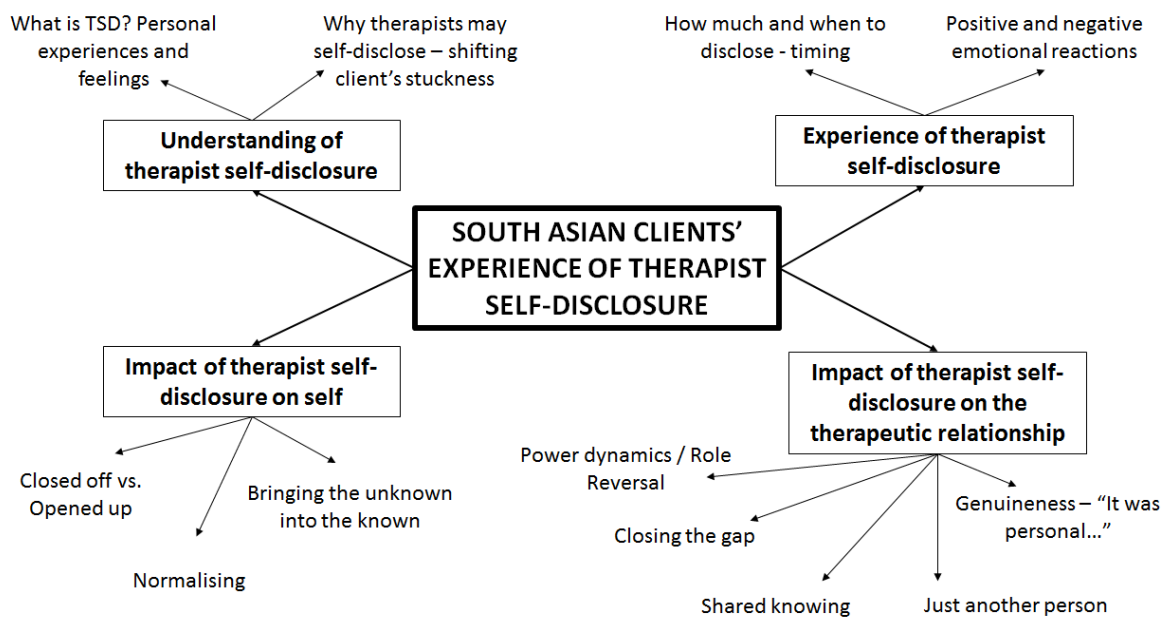
CHAPTER THREE: ANALYSIS

3.1 Overview

This chapter presents the analysis gained using IPA for semi-structured interviews with six SA clients. Through this analysis four super-ordinate themes were identified, each with sub-themes as shown below and as illustrated in Figure 1. The sub-themes have been numbered from 1-12. The researcher chose to number them this way as an acknowledgement of the fluid nature of the boundaries between themes and the fact that there is a certain amount of crossover, which is inevitable because experience is not a selection of distinct aspects. A thematic map has also been included, but some themes might arguably go under different theme headings.

- **Understanding of therapist self-disclosure**
 1. What is TSD? - Personal experiences and feelings
 2. Why therapists may self-disclose – shifting a client’s stuckness
- **Experience of therapist self-disclosure**
 3. How much and when to disclose - timing
 4. Positive and negative emotional reactions
- **Impact of therapist self-disclosure on self**
 5. Normalising
 6. Bringing the unknown into the known
 7. Closed off vs. Opened up
- **Impact of therapist self-disclosure on the therapeutic relationship**
 8. Power Dynamics / Role Reversal
 9. Closing the gap
 10. Shared knowing
 11. Genuineness – “It was personal...”
 12. Just another person

Figure 1: Thematic map representing the super-ordinate and sub-themes²



What is provided is one possible construction of the phenomenon of TSD experienced by SA clients. Smith et al. (2009) highlight that, when using IPA, the unearthing of themes is grounded in the researcher engaging in a double hermeneutic. For this reason, the researcher acknowledges that the themes identified are a subjective interpretation, and another researcher may have identified different themes from the accounts.

The super-ordinate themes and the contributing sub-themes will be explored in written narrative in the remainder of the chapter. Although the four super-ordinate themes were common across the six accounts, there were areas of difference and divergence, which will also be discussed. Selected verbatim quotes³ from the participants are presented to illustrate these themes, and further exemplar quotes for each super-ordinate theme and corresponding sub-themes are shown. (See Appendix L)

² Super-ordinate themes are shown in bold font and sub-ordinate themes in regular font.

³ Participant and position in the transcript is denoted by '(Participant pseudonym: Line Number)' and follows each quote.

3.2 Introduction to the super-ordinate themes

The four super-ordinate themes offer an overall account of what it is like for six SA clients to experience TSD. In relation to the research question, the participants' descriptions in this study offer a window into how they understood TSD, how they may experience it and the impact of it on them and the TR. The contextual elements of TSD which benefit as well as hinder the TR are also included. The first superordinate theme highlights the participants' understanding of TSD. This includes their views on what occasions they would consider acceptable or appropriate for their therapist to self-disclose. The content of the TSD appeared to be an important aspect of the participants' experience and was integral in shaping their overall understanding of the information received and whether this was received favourably or unfavourably. Therefore, the subsequent super-ordinate themes go on to highlight the perceived impact the TSD had on them as individuals but also the instances of where it was found to contribute to or take away from the experience of therapy and impact the TR. The TSD was found to impact themselves, the TR and overall therapy in both positive and negative ways and will be explored further in this chapter.

With regards to the perceived impact on them, the participants used the TSD to challenge their own negative thoughts and emotions. Disclosures made by the therapist were used as evidence to reformulate their experience and allowed them to see another perspective resulting in a reduction of negative emotions such as anxiety. This also resulted in an enhancement of their sense of self. Additionally, the self-disclosures allowed the participants to build trust between them and their therapist which functioned to build a connection between them both, and enhance the TR further. The TSD allowed the participants to place their therapist in to a known category which gave them a sense of closeness with the therapist and a feeling of knowing and being known by the therapist, as well as also a sense of knowing the 'the person' beyond the role of a therapist. This allowed the participants to open up further in their therapy sessions. Although the data which emerged from the participants reflect quite a positive view of TSD, negative aspects were also revealed and were represented by two participants. Those instances have been included within the relevant sub-themes to highlight that TSD was not always experienced positively but that it was negative or ambiguous in its helpfulness. The researcher did not create a separate theme to encapsulate the negative experiences as there was not enough data that would constitute a theme in itself. However, these experiences were just as important as the positive ones and therefore the researcher has ensured that the negative impact of TSD has been discussed and has been clearly included in the results.

It is important to draw the reader's attention that whilst the researcher acknowledges the overlap between/within themes, there was sufficient evidence in the data to warrant the arbitrary lines that have been drawn between them as best representing the participants' experience. There was a large amount of overlap between the super-ordinate themes, in that the idea of connection or disconnection with the therapist emerged as being integral to, and having a bearing on, the participants experience as a whole. This overlap is evident within the super-ordinate themes despite their separate presentation. Therefore, one element that is common throughout this section is the connection participants felt to themselves, to their therapist and to the wider world. This emerged as being entwined with the impact of TSD which manifested in a variety of ways. This aspect could therefore be described as a thread that spans all of their lifeworld. In addition, due to the vast quantity of material gathered and the need to prioritise, not every aspect of the participants' narratives can be uncovered as this would be outside the scope of the report; however, the researcher intends to highlight some of the interesting and representative quotations that have arisen during the research process.

3.3 Super-ordinate theme one: Understanding of therapist self-disclosure

The first super-ordinate theme, 'Understanding of therapist self-disclosure', captures how the participants understood and viewed their therapist's self-disclosure. In line with a phenomenological stance, at the start of the interview the participants were asked to describe what the concept of therapist verbal self-disclosure meant to them. According to Larkin et al. (2012), this is a primary aim of IPA. In addition, this theme explores the participants' views of why their therapist chose to self-disclose and the significance of when and how often it took place.

3.3.1 Sub-theme 1: What is TSD? - Personal experiences and feelings

All six participants understood the concept of TSD as the revelation of personal experiences or feelings that were related to their experience which was found in some way beneficial to them and the therapeutic process. The disclosures of personal experiences and feelings could be understood as one way of forming a connection between therapist and client:

To me that means when a therapist tells me something something about themselves, their experience, their feelings, just something that relates to them that could be beneficial to me. (Amira: 3-4)

Well I understand it to be when a therapist tells you about something that's personal to them, so them disclosing information about themselves to you, an actual real experience they've had and sharing that with you in relation to something that you've been talking about. (Viraj: 3-5)

For Karina, her understanding of TSD implied that it would almost be vital to her having a positive experience of therapy and something she would expect from a therapist:

I understand it to be someone who can actually relate to the issues I have, someone who can actually share their feelings and experiences with you and umm someone who can, you know give you open and honest advice and guide you through whatever issue you have because they've been through it and they share that with you. (Karina: 2-5)

Although a psychodynamic concept, Anita highlighted in her understanding of TSD the disclosure of countertransference feelings. This perhaps highlighted for Anita the importance or the expectation of a two-way/dynamic nature and experience of the TR:

My understanding of that is when a therapist shares other feelings or thoughts that they're having with the client. It can be in terms of how their client is making them feel, or it can be where they just talk about maybe a personal experience they've had about their own life. (Anita: 3-5)

Despite the participants understanding TSD as beneficial, negative aspects did emerge from the data. At times participants spoke about how the content of the self-disclosure seemed incongruent with their needs. This could have indicated poor responsiveness by the therapists to their process or therapeutic needs. Within Rashmi and Rani's narrative there was evidence of the TSD leading to their struggle of being understood by their therapist due to the inappropriateness of the content.

Here Rashmi was being quite dismissive of her therapist's TSD. It seemed she did not mind the 'analogy' itself, but perhaps more that her therapist made it about herself. This may have been too intrusive for Rashmi and caused her to feel that her therapist had invaded her space:

...but it's just...her example it wasn't the analogy wasn't a problem, it was the analogy she used, it was about her life and it was just a really silly example. (Rashmi: 80-82)

Rashmi continued to reflect on the content of the disclosure. It was interesting to note her use of the word 'throwing' here as it could be interpreted in different ways. One interpretation could be that Rashmi was taken aback by the information revealed to her, perhaps 'thrown' out of her own space into the space of her therapist. Another interpretation could be that Rashmi felt her therapist was 'throwing' away (not listening) to her experience:

...that's a very like a very throwing statement that she made but I didn't think like obviously that wasn't her intention. (Rashmi: 36-37)

It seems from Rashmi's quotes the content of the TSD meant her therapist was perhaps careless with what had been revealed to her or that her therapist had not given enough thought about why and what they were self-disclosing.

Rani reflected on a similar experience where the content was viewed as inappropriate. Rani further highlighted in her quote that her therapist should have been more aware of how the TSD could have been received and the implications this could have had on her. Being aware of this shortfall in her therapist may have further added to feeling disconnected:

"I don't think it was inappropriate that she self-disclosed, I think self-disclosure can be quite interesting, you know, they know everything about you, you kind of want to know a little bit about them as well. But I think she could have chosen a better thing to self-disclose...and been a bit more mindful, yeah I guess been a bit more mindful about how I could have responded to that." (Rani: 58-62)

Rani further reflected on her understanding of what was disclosed to her:

"I think the content wasn't the right content. I get that she wanted to say she was scared of flying but she could have told me that and that alone rather than telling me reactions to flying

and perhaps the scenes she has made in the past. So I think the content could have been changed and if the content wasn't what it was perhaps it would have had a very different reaction from me. It wasn't that she self-disclosed it was the fact of what she told me and the extremity of her experience and her reactions of her phobia.” (Rani: 90-96)

It seemed Rani viewed her therapist critically for behaving in an unacceptable way. Rani understood why her therapist self-disclosed, as she says this, but it was when her therapist disclosed the details of her personal experience that then revealed something about her that made Rani feel uncomfortable. Speculatively, acquiring the knowledge of her therapist having a panic attack on the plane may have resulted in her doubting her abilities as a professional and may have meant that she had lost confidence in her therapist. This interpretation seems plausible as later in the narrative Rani said:

I had no reason to lose faith in her abilities but that disclosure had caused me to. (Rani: 121-122).

There also seemed to be a sense of contention for Rani between the boundaries of her external and internal world. Perhaps, for Rani there was a violation of these boundaries as it seemed on one level she felt close to her therapist but on another felt pushed away as she did not want to be drawn into her therapist's internal world. If this was to happen it may have suddenly made her feel as though her therapist was not that rock she perceived her to be and again may have made Rani question her abilities. It seemed as though the disclosure revealed imperfections about her therapist beyond what Rani was willing to accept or understand, which consequentially weakened her perceived respect for her. From Rani's quote we are able to get a deeper understanding of her expectations of therapy. It would seem that Rani perhaps had some preconceived expectations of therapists perhaps leading to an underlying belief that they are 'superhuman'. She compared her therapist to 'superheroes' twice in the narrative and although she said she did not expect her therapist to be like a 'superhero' there was an expectation of her therapist being 'a certain type of person' and being able to 'handle certain situations'. It seemed perhaps Rani forgot that therapists are human and that they too have negative or difficult experiences and feelings.

For Rashmi what was disclosed to her did not convey attunement to her personal experience and she therefore understood the TSD as her therapist not paying attention to her needs and that she was not being understood. This may have impacted upon the TR and caused Rashmi to feel cut off from her therapist:

I felt that it was the example given and it just didn't relate to what my problem was so it felt that she hadn't listened to me. (Rashmi: 211-212)

It is interesting to note that Rashmi and Rani were the only two participants who experienced TSD in a negative way. Rashmi saw a therapist culturally different to her whereas Rani saw a therapist who was culturally similar. For Rani, seeing a therapist from the same cultural background may have meant she felt connected to her through their assumed cultural similarity; however, it seems that the incongruent content of the TSD perhaps disconnected her from her therapist, regardless of being ethnically matched. Despite the difference of cultures of Rashmi and Rani's therapist, it seems as though one was drawn into the other's world of chaos and another felt unheard. Consequently, this could have caused them to question their therapists' competence. However, their quotes suggested that TSD was not a problem in itself, but that the content was key in shaping the overall experience of therapy. Furthermore, it does not seem from their transcripts that the ethnicity of the therapist had an impact on how the TSD was experienced.

3.3.2 Sub-theme 2: Why therapists may self-disclose – shifting a client's stuckness

Participants' accounts reflected a recognition of why they thought their therapist self-disclosed in that instance and also gave thought to what the rationale for their therapist self-disclosing could have been. Four of the participants reflected on feeling stuck and at a complete loss in their lives; it was at this point that the disclosure took place:

I experienced her sometimes disclosing personal experiences when she felt it was appropriate or when we were trying to resolve some of my stuckness. (Anita: 45-47)

As Rashmi made sense of her experience she acknowledged being stuck in that moment in time and her therapist self-disclosing at that particular moment:

...it was quite an emotional time at that point because I was quite stuck so she was trying to give me strategies to become unstuck. (Rashmi: 18-19)

Considering Rashmi's previous views of her therapist's disclosure not being carefully considered and irrelevant, perhaps there was a parallel process happening here with her and her therapist both feeling at a complete loss and not knowing what to do. It seemed her therapist was trying to offer her something to take away a shared feeling of 'stuckness' which resulted in Rashmi viewing her therapist as perhaps careless. This interpretation seems reasonable as throughout her narrative she repeatedly used the word 'trying' of her therapist. This perhaps represented the therapist's difficulties and constant efforts in attempting to provide something that would be beneficial for Rashmi. The use of the word 'trying' could have also reflected Rashmi's frustrations or exasperation of the shared experience of her and her therapist having difficulties and being without an answer.

It is also interesting that from Rashmi and Anita's quotes, it seemed as though they both perceived TSD to be some sort of therapeutic tool or intervention used to provide them with answers to their problems or a plan to help them with their troubles.

This feeling of 'stuckness' can again be seen in Karina's quote:

So when I had gone I spent a good four, five sessions just talking about how I was feeling but I wasn't getting anything out of it. It felt like there is no resolution... there's no answers to my questions. So when she disclosed her kind of, well when she related to what I was going through I felt a lot more relaxed because I knew she wasn't judging me, she actually, she knew where I was coming from. (Karina: 18-23)

More than just feeling stuck Karina seemed to be feeling hopeless about her difficulties. However, hearing the TSD seemed to help reduce her anxiety and feeling of isolation but also increased her sense of self by reducing feelings of shame.

Further on in Karina's quote her language use arguably reflected her experience of feeling stuck:

So... I was just hitting a brick wall all of the time. So I was going over the same thing over and over and over again, the same problems. (Karina: 26-27)

She repeated the words ‘*over and over*’, verbally recreating what she was doing in her therapy. Initially, there seems to be a real stop and starting of time in her experience and interestingly her choice of phrase ‘*hitting a brick wall*’ suggested a very sudden halt in her process. But then there was a juxtaposition of time again by the sense of going ‘*over and over*’, suggesting a never ending of experience, almost like a vicious cycle.

Viraj’s quote reflected a sense of human isolation and a feeling of detachment from others. He used an idiom of not being able to ‘*see the wood from the trees*’ to mirror this and to reflect his inability to see the bigger picture:

Well we were talking about some of my issues at the time, we were talking about my confidence issues, me maybe overthinking what other people thought of me when I was out and about with friends and family and so forth, that’s when he told me about similar issues he had in the past with confidence levels and you know not being so sure about himself. I was really struggling at the time to see beyond my issues and I was just so concrete in how I was thinking about myself and couldn’t really see the wood from the trees, if you get me. I felt I was just going round and round in circles. It felt quite lonely to be honest with you. (Viraj: 18-24)

In a similar way to the others, Viraj also seemed to share this feeling of ‘*stuckness*’ as he too talked about doing the same thing repeatedly to no avail. There seemed to be an overarching sense of participants feeling at a complete loss or disconnection to their lifeworld and could well explain why they entered therapy – to get some sort of resolution, direction or answers.

Overall, this super-ordinate theme demonstrates the participants’ understanding of the concept of TSD. Their understanding of what TSD encapsulated, how they made sense of why their therapist self-disclosed to them. There seemed to be particular significance on the content of the disclosure and the impact this had. Speculatively, it seems as though when the disclosure is ‘good’ it has the potential for connecting however when it is ‘bad’ it can disconnect in quite an explicit way.

3.4 Super-ordinate theme two: Experience of TSD

When asked to describe what it was like to receive TSD, the participants' descriptions varied but placed importance on the timing and frequency of it and also included a range of emotional responses. This superordinate theme attempts to capture this and the reasons behind it. Two sub-themes are presented. The first considers the timing of the TSD and the perceptions of the participants on when and how much therapists should disclose. The second explores the emotional impact of receiving the TSD and includes both positive and negative reactions.

3.4.1 Sub-theme 3: Timing - when and how much to disclose

Participants spoke about the timing of the TSD and how this was an important aspect of their overall experience of TSD and how they received the TSD. Here Rashmi talked about her second therapist who also self-disclosed. She reflected on how her therapist self-disclosed towards the end of the therapy where presumably her goals for therapy had been met and where therapy may not have been as 'emotional' as it may have been when she first started:

she self-disclosed at that point when it got a bit more light hearted when it wasn't so intense or when I wasn't so anxious. (Rashmi: 184-188)

Perhaps for Rashmi the emotional experience was so overwhelming that there was no room for another in that space which could have been why her first TSD experience seemed to be out of place. Although her quote refers to timing in the sense of when the disclosure took place, it also seemed to centre on Rashmi's emotional experience, how it was and how it changed over time.

Furthermore, for Rashmi the timing of the self-disclosure seemed to influence her view of her therapist. It seemed as though the latter therapist had given thought to when she should self-disclose as opposed to the former therapist. This seemed to result in Rashmi feeling more confident in the abilities of her therapist which served to enhance the connection between them. Again, Rashmi's emotional experience appeared important to her in relation to timing.

...the fact that she told me after it actually improved my confidence in her because I felt that she was equipped with the all the skills to help me cope and that she had helped me a lot and so I felt that she was in a really good position to help me and that she had helped me but that

was when she chose to self-disclose. It was at a neutral moment not at a really anxious or stressful moment. (Rashmi: 204-208)

Rani also reflected on the significance of timing in her experience of TSD. It seemed as though at the beginning Rani found the timing of the self-disclosure inappropriate which may have meant that she would not be able to carry on with the sessions. But it seemed that over time she was able to resolve that struggle or difficulty, stay in therapy and feel happy with her decision to do so. Rani's experience showed a virtuous circle of experience and connection whereby, at the beginning there was connection before the disconnect between her and her therapist however through time, in the end a stronger connection was created through a reconciliation of experience.

For me now thinking about it now, perhaps timing is important, being able to judge it and you know she was really good but I think if she had timed things a bit better but then again how would you know when to time things but the fact that I went to her again after shows that although her timing was a bit off key sometimes it didn't stop me from seeing her it didn't make me say ok well that's it I'm done. (Rani: 394-398)

The next quote seemed to invoke experience of time and space. Anita made reference to when her therapist self-disclosed and also the connection she made to the perceived power imbalance that existed for her. The use of the word "probably" conveyed uncertainty, but it appeared Anita did not rule out the idea that earlier disclosures may have been more beneficial for her:

I think if she told me something about herself in the beginning it wouldn't have been such a surprise when she did self-disclose. I don't really know what I would have wanted to know, just something about her, was she married, did she have children, a little bit about her background, about how much we relate or not. I don't know. If she had done that it probably wouldn't have felt so much like she was taking the control of the room. (Anita: 159-164)

For Anita it seemed important that if TSD was going to be used, she would have felt more comfortable or would have preferred knowing other information about her therapist to begin with. For Anita, the timing of her therapist's self-disclosure did not seem to be as important to her than for others.

Two participants also reflected on how often the TSD took place and how this was related to their expectations of their therapist and also the impact this had on them and the therapy process. For Karina the disclosure seemed to be a significant moment for her:

I don't expect her to relate to everything single issue I have, I wouldn't want her to, that one time was enough for me. (Karina: 145-146)

For Karina, the one disclosure was enough whereas it appeared as though Viraj would have liked more. Perhaps the TSD made Viraj feel closer to his therapist by hearing and seeing a more personal side of him. This may have further established the connection between him and his therapist:

He didn't self-disclose again. I wouldn't have minded if he did because it was helpful and eye opening for me hearing his experience. But it was also ok that he didn't. (Viraj: 96-97)

3.4.2 Sub-theme 4: Positive and negative emotional reactions

This particular sub-theme incorporates a range of feelings experienced by the participants in response to the TSD. Rashmi's initial reaction to TSD was anger and annoyance, emotions that are fairly invasive, blurring the connection between her and her therapist. Rashmi did not accept the severity of the therapist's experience as comparable to her own and interpreted the discrepancy as her therapist either not understanding her situation or being unwilling or incapable of helping her address her problem:

I think for me the type of what the the exact incident was it actually made me quite angry because her self-disclosure if you compared it to what I was going through was very very different situation so I didn't think her way of of giving me an example was anywhere near what I was going through so it felt that she belittled me in what I was feeling. (Rashmi: 31-34)

It seems Rashmi really struggled with the disclosure's relevance and became frustrated with and isolated from the therapeutic process. In her narrative there was a sense of feeling the frustration emotionally but also in very a physical way:

...she used to say you just seem really more drained and you seem more tired than you are normally in sessions, you seem a lot more quieter but I guess for her she probably relayed it

back to just being exhausted from the situation rather than with her but I guess it may have been a combination of both. (Rashmi: 119-122)

Rani reflected on how she felt after receiving the TSD. There was a sense of not knowing or confusion about how to react or what to say in response to the revelation made by the therapist. For Rani, this confusion was particularly evident from her use of language, which was quite muddled at the start of the quote. In addition, Rani's reference to rules here perhaps reflected the importance of having boundaries in therapy to make her feel comfortable in knowing what to expect from therapy. For Rani it seemed that the therapist had crossed these and perhaps caused her to feel uncontained sending the relationship into turmoil. The confused or unknown space that Rani found herself in, clearly mirrored how she felt:

I remember just being a bit awkward about it, me personally just thinking what do I say to you, I don't really, like am I meant to first of all I didn't know am I meant to talk about her disclosure, are we meant to spend some time on it because I know its therapy and its not meant to be about them but I'm happy to speak it. So it was kind of just like I didn't know what to do because she kind of just chucked it in and then it was kind of just like ok, but am I allowed to talk about it, I didn't know what my rules were, and I didn't want to have the awkwardness of yes let's bring it back to you, back to what you want to discuss. So I guess I wasn't really given any cues to what to do with that other than that just to take it and feel better but because it didn't make me feel better it was kind of a bit of awkwardness in the room for me. (Rani: 131-140)

Anita's language use in the quote below and the contradiction of words further indicated a sense of ambivalence and feeling of unease. It would seem her confused state caused slight disorder and this was reflected in her chaotic use of language:

Ahh I was umm.....it's not that I wasn't, it's not that I was uncomfortable it was...umm.....it....it almost felt like a change to how therapy has sort of been with us, it brought in something, something new and it wasn't even something you expected, sometimes it can feel like it was out of the blue, but it wasn't out of the blue, it was within the context of what we were talking about but just the idea of someone suddenly bringing something personal, that they never have for several weeks feels a little uncomfortable in some ways. (Anita: 125-131)

It seemed Anita questioned her emotions about the sudden disclosure but at the same time was aware that it was not out of context and that it was in line with what they were talking about. It seemed Anita was reflecting on a sense of shock at receiving the disclosure.

Feeling 'shocked' and 'surprised' was also reflected in two other participant's accounts. Perhaps the shock demonstrated a shift in their perception of the therapist as the person in control. It seemed Anita had certain expectations of her therapist, expecting them to be a certain way, the expert, the person who is going to make everything better. However, the disclosure challenged her fantasy about the therapist and she saw a different side of her. Anita maybe saw the vulnerable side of her therapist, eliciting feelings of shock of what she saw, the all-knowing therapist as a human, which caused her to feel surprised:

Initially I was quite shocked [laugh] if I'm honest with you because you know you go through a lot of sessions where it's always all about you and I guess for me at the start of our sessions, I didn't really know her, I just made my own assumptions about her and so when I first experienced her talk about her own personal experience, it it did surprise me. (Anita: 122-125)

Umm I was surprised to be honest because like I said you have this notion of what you see on TV, you're going to talk and they're just going to listen. (Karina: 59-60)

However, Anita later reflected on a feeling of containment suggesting perhaps a sense of spatial and emotional comfort:

Umm it definitely surprised me but putting it into context of what I was saying I think it was umm containing. (Anita: 131-132)

The sharing of similar feelings or relating to the experience alleviated feelings of distress and anxiety and four out of the six participants reported feelings of relief and ease. Karina specifically talked about how her 'stress levels came down' (Karina: 21-22). Amira and Viraj also talked about how the TSD made them feel relaxed and comfortable both emotionally and physically and how for Amira this feeling of ease resulted in reducing her feelings of shame:

I just wanted her to know how I was feeling and then in that session when she disclosed I just felt relieved like I wasn't alone. I remember feeling physically more relaxed and I was no longer talking in shame. (Amira: 156-158)

Within Amira's account there was evidence of her referring to the Cartesian mind-body dualism. There was a sense that Amira was reflecting on being upset in the embodied sense but also standing outside of herself and seeing herself looking physically relaxed. There was a sense that the TSD made her 'feel' relaxed in the body but also 'psychologically' relaxed in the mind:

She made me feel she made me feel relaxed, she made me feel less anxious because at that time of my life I was so anxious and I was so upset within me and at myself. (Amira: 35-37)

Viraj's use of the 'black cloud' metaphor perhaps reflected his emotional and cognitive pain of not being able to see the light, deal with the unpleasant realities of life and being in a hopeless state. In addition, it also seemed to reflect in a physical way the weight of his pain. For Viraj, the TSD moved the black cloud from over his head and moved it into a shared space between him and his therapist as presumably the pain was now a shared pain which made it easier for Viraj to deal with but also made him feel at ease in both an emotional and physical sense.

Yeah it made things more comfortable, it'll sound odd but it felt lighter, maybe I felt lighter in a way like something had moved off me, like the black cloud had moved away from me. It was still there but it wasn't just my black cloud and it didn't have to hang over just me. I guess what I'm trying to say is that I felt more relaxed, more positive I think with my problems. (Viraj: 87-90)

Viraj highlights his sense of feeling special perhaps or different from others who go to therapy and how this feeling was a result of the TSD.

It made it easier for me that my therapist knew what I was going through and had shared similar feelings and experiences to me, and maybe that doesn't happen with all therapists or with other people. But for me, I am very grateful for my experience and how it helped me with my problems. (Viraj: 101-104)

Overall, this super-ordinate theme illustrates how the participants experienced the TSD. When the TSD took place in the therapy process and how many times it occurred had a bearing on how TSD was experienced. The super-ordinate theme also reveals the emotional experience of TSD. Some participants found the TSD evoked feelings of anger and uneasiness whereas others found they felt more relaxed and comforted. The combination of these different aspects of experience offers some insight into the potential significance of the timing of TSD and the influence it can have on the TR.

3.5 Super-ordinate theme three: Impact of therapist self-disclosure on self

This super-ordinate theme, 'Impact of therapist self-disclosure on self', considers how the TSD directly impacted the participants sense of self but also their individual involvement in the therapy process. The TSD was used to challenge their own negative cognitions about their emotions and use the TSD as evidence to reformulate their experience. This helped to reduce anxiety regarding both their negative self-concept and meta-cognition of emotion. The theme also encapsulates how the participants used the TSD to gain a greater sense of self and a better sense of their being in the world. Some participants seemed to be in conflict with themselves regarding their feelings. There was a strong sense of not knowing what was 'normal' with regard to their feelings or behaviour and this seemed to be related to a low sense of self-esteem:

So she did, she made me realise that it was ok and that it's normal and I wasn't a failure.
(Amira: 65-66)

3.5.1 Sub-theme 5: Normalisation

Five of the participants talked about how the TSD normalised their experience by hearing that their therapist had also been through a similar situation or shared similar feelings. For Anita it seemed that the disclosure may have been the only way that her anxiety could have been reduced. The TSD also seemed to lead to a less negative view of herself:

Yeah I think that it just normalised some of my anxieties which I think sometimes you can't normalise unless someone shares that experience with you or really kinda gets you and says you know you're not the only one kinda thing. (Anita: 132-135)

Karina, Anita and Viraj showed how normalisation of their experiences through the TSD allowed them to recognise what was common to others. The TSD seemed to provide them with the notion of 'strength in numbers' as the TSD seemed to counteract their feelings of alienation and difference from others. Although their quotes represented their unique intersubjective experience, their individual experiences are also inevitably embodied and emphasises the existence of social, historical and contextual influences on the lifeworld (Eatough & Smith, 2008):

So because she talked about her experience and how I could relate to it it made me feel as though ok this just doesn't happen to me that it does happen to other people as well. (Karina: 93-95)

I think on one hand it made me feel umm yeah like I wasn't the only person that has been through this kind of stuff but that there's lots of people that go through this kind of stuff and yeah it made me feel more comfortable about what I was going through. (Viraj: 26-28)

For Anita it seemed as though her therapist became the container of her feelings, emotions and struggles providing her perhaps with a sense of safety:

And it was just normal...normalising the whole experience, like I wasn't the only one and that it wasn't unusual. That felt really containing. It felt appropriate. (Anita: 118-120)

For these participants, the TSD seemed to give them strength within themselves through knowing that they were not by themselves or the only ones to have experienced that particular difficulty.

The therapist self-disclosing their experience to show the normality of their client's feelings had greater meaning for Anita, who felt that the disclosure also meant that the therapist understood her and her experience at a deeper level:

When she has disclosed it it has been appropriate to what I've been saying so on the other hand it does normalise my feelings and makes me feel that she really does understand because she's gone through it or because she's experienced it. (Anita: 155-157)

In the disclosures the therapists made, they used themselves as examples to normalise the feelings of the participants. For Karina, Amira and Viraj hearing this from someone who was seen as a professional had greater meaning for them:

...and her, as a professional sharing her experience that she has felt the same way as I did, just made me feel relieved and not so alone in what I was feeling. (Karina: 107-108)

And I guess my therapist telling me something about herself, her experience made me think about how useful it was for me to hear that she, a professional had shared the same thing as me. It was just really great. (Amira: 181-183)

I mean he's a therapist and for him to share that he had experienced confidence issues and actually share that with me, it takes someone quite strong to do that and I really appreciated it. (Viraj: 37-39)

Viraj seemed to gain strength from his therapist's disclosure. He saw the therapist as he wanted someone to help him with his low self-esteem. As a result of the TSD Viraj perceived his therapist as someone who was resilient and strong and may have given Viraj that same resilience and made him feel empowered and modelled that he too could get through his difficulties.

The participants highlighted in their experiences of TSD that the sharing of similar feelings could have quite a profound impact on a person's sense of self by making them feel empowered and hopeful. They have captured how normalisation of feelings provided them with the evidence of accepting what is also common to others, and reducing a sense of alienation and feeling of difference from others.

3.5.2 Sub-theme 6: Bringing the unknown into the known

Participants expressed that when their therapists shared that they had felt similar emotions in the particular situation being spoken about; they were able to acknowledge emotions that they were previously unaware of or denying:

She could understand the emotions because I didn't understand what that emotion was, you know I just thought I shouldn't be crying, I should hold it in and I have to be happy but then she explained to me that all of what I was going through is normal. (Karina: 95-98)

That was an experience she shared with me and helped me to...to think about...you know to tap into feelings that I wasn't necessarily aware of or saying out loud but that I was definitely feeling. (Anita: 116-118)

For Amira, the example provided by her therapist gave her reassurance that she could reflect on what was going on for her and acknowledge it in a safe and contained environment:

She's made me she made me realise to accept the situation for what it is and not to cover it up and not to umm not to umm disguise it or not to pretend and say I'm ok because then later on it'll come to a point where I will break down like the way I did then. (Amira: 45-48)

As Viraj and Amira describe below, the therapist's self-disclosure allowed them both to recognise and accept their feelings:

So hearing her experience just really helped me ...and feel ok about what I was feeling. (Amira: 54)

Yeah it made me feel more comfortable about what I was going through. (Viraj: 28)

Four of the participants' accounts also highlighted the importance of the use of TSD in allowing them to see another perspective that was perhaps previously unknown to them:

But also to perhaps umm let me know that change can occur umm and yeah I think that was her purpose. (Rani: 28-30)

And it was helpful that she disclosed that that's how she felt and the process she went through and what she had learnt and she wasn't saying that this is how it is for you but she was giving me another way of seeing things and how it's a learning curve. That was really really helpful. (Anita: 113-116)

It really did help me...see me from another person's perspective. I was able to see myself in a third person point of view just because she disclosed feelings that were similar to mine when I was experiencing the hardship. (Amira: 25-28)

Karina's quote perhaps tells us something about her own world and how she seems to envisage it in a physical sense. She reflects on the weight of her problems and how they have placed a heavy burden on her shoulders. There is evidence of a physical relief she felt by receiving the TSD. Perhaps this relief came from the weight now being a shared weight between her and her therapist. Furthermore, perhaps for Karina this was one of the first times someone was helping her to see things from another perspective, one that it seems she was unable to see from previously:

I felt that I weight had been lifted off my shoulders because I wasn't, I was, because she was understanding where I was coming from she was giving me the answers to look at the problem I had in a different way. (Karina: 71-73)

Overall, the participants used the information revealed to them to normalise their experience which as a result enhanced their sense of self and reduced their anxieties but also allowed them to see their problems from a different perspective. Additionally, the TSD was used to gain a new perspective or understanding about the experience and themselves.

3.5.3 Sub-theme 7: Closed off vs. Opened up

Therapists' self-disclosures of feelings or similar experiences to the participants were significant moments that impacted on the individual participant's involvement in the therapy process. This was experienced both positively and negatively. Rashmi and Rani both reflected on how their experiences of TSD resulted in them not giving as much information or detail to the therapist as they had been prior to the TSD. As a result, this impacted upon their view of the therapy and the therapist causing a

disconnect in the relationship and questioning the therapist's abilities. It is important to note here that both Rashmi's and Rani's reactions to the TSD were about the content of the disclosure rather than the use of TSD.

...when she made that statement I think for me it closed off my relationship with her a bit more because it just felt like well I don't really think you understand me or that you see that you're going to be able to help me because you can't really put what I'm going through on a level that matches it. (Rashmi: 51-54)

I felt it made it about her and that it made it about her and it also belittled my struggle that I'd got or the stress that I had it sort of made it smaller than it was. (Rashmi: 105-106)

The TSD for Rani seemed to have evoked a strong reaction in her, so much so that she was distracted away from what her therapy was about and why she was there, and was more focused on her changed view of her therapist:

I think it was just me judging her and I think I was preoccupied with that judgement I had of her rather than actually talking about me or talking about therapy or caring about it and I was just preoccupied away from what therapy was and again I think it's the content rather than that she told me, I think it just moved me away from it. (Rani: 143-147)

On the other hand, four out of the six participants had favourable experiences whereby they felt their therapists' disclosure was important in changing the therapy process as it facilitated a deeper level of work and as a result fostered the relationship:

So hearing her experience just really helped me open up. (Amira: 54)

Karina spoke about how at the beginning of therapy she would hide things from her therapist and not tell her everything for the fear of being judged. The TSD allowed Karina to open up to her therapist but also talk about other important issues which she had withheld prior to her therapist self-disclosing:

And my therapist telling me how things were for her when she had a child made me feel normal and open up a lot more. You know at the beginning I didn't tell her everything, I'd hide

certain things, because I didn't want her to think I'm being dramatic or judge me. I held so much back at the beginning, I just told her the bare minimum. I was telling her I was fine but I wasn't, I wasn't at all. (Karina: 132-136)

Karina may have felt unaccepted before and during the first part of therapy. It seemed as though the TSD may have had an impact on her sense of self, enabling her to feel more accepting of herself allowing her to self-disclose further to her therapist without feeling ashamed and feeling confident and comfortable in doing so.

...it allowed me to backtrack and I was able to talk about the things I hadn't told her because I felt at that point I could (Karina: 138-139)

Similarly, Viraj also talked about how hearing the therapist's personal experience allowed him to continue with the sessions but also talk about his feelings at a deeper level:

You know not only did they know a lot of stuff about me through the sessions but you know they'd now started opening up about who they are to me so it made it feel like it was easier for me to sort of continue with the sessions and not hold back with emotions and really tell the truth as such about what was going on and what my thoughts and feelings were yeah. (Viraj: 72-76)

It seemed for most of the participants the TSD made them feel comfortable about their experience but also at ease with being with the therapist. Hearing that their therapist had been through a similar experience and the sharing of similar feelings allowed the participants to be able to talk about previously held back material and really show their true selves to the therapist without feeling ashamed or judged as they too had been given an insight into the true self of their therapist. "Opening up" in therapy can be very difficult and for this group of participants but their therapists were able to help in this process by self-disclosing something personal about themselves in relation to what the participants had been talking about. However, if the TSD was perceived to be inappropriate it resulted in participants 'closing off' and holding back from the therapy process. This impacted upon how the participant then directed the therapy session and what they chose to focus on and steer away from.

3.6 Super-ordinate theme four: Impact of therapist self-disclosure on the therapeutic relationship

The super-ordinate theme, 'Impact of therapist self-disclosure on the therapeutic relationship', includes the participants' perception of power between them as the client and their therapist. Participants referred to the TSD as important agents of change in therapy that either alleviated or heightened the power imbalance in the relationship. However, the theme also includes how the TSD was used to establish a sense of trust between the participant and their therapists, therefore fostering a connection and building the therapeutic alliance. Being able to place the therapist into a known and trusted category enabled further disclosure from the participants as clients. The sense of being understood facilitated how much as clients they felt able to reveal and appeared to establish a positive alliance. Additionally, this super-ordinate theme reveals how participants' descriptions of knowing information about their therapist that had not been explicitly revealed, further enhanced the TR. This included recognition of genuineness and conceptualising that the therapist had stepped out of their role to reveal a more personal aspect of themselves. The self-disclosure made by the therapist was ultimately used by the participants to enhance a sense of connection. There are some general overlaps between this theme and some of the quotes used in the other themes. For example, this superordinate theme and superordinate theme three both talk about reducing intra and interpersonal isolation. However, the quotes selected for this theme will show the reader how the TSD specifically impacted the relationship between the therapist and the client.

3.6.1 Sub-theme 8: Power dynamics/Role reversal

All six participants reflected on their perceptions of the power dynamics between themselves and their therapists. An extract from Rani and Anita's accounts reflected their struggle with the power imbalance after the TSD perhaps resulting in a disconnect in the TR:

It kind of out did mine a little bit well a lot. I didn't feel it was a competition or anything like that but it kind of just...it became more about her than me. (Rani: 96-101)

There was a sense of spatial reflection in Anita's quote. It appeared that the space in which she found herself in affected the way she felt but also had an impact on her view of the space, something that was once hers but was then taken away through the TSD:

I felt that there was a change in our relationship. It felt that that space had suddenly brought something new. It suddenly felt that it wasn't completely about me that it was ok for her to choose when she could bring her own stuff. I guess in some way you could think it almost felt as though she suddenly had control because she chose to bring that when she never did before which...umm which felt weird. (Anita: 137-141)

Anita seemed very concerned about the change in power between her and her therapist after receiving the disclosure. She almost seemed consumed with the whole notion of space and power and feeling that someone else was taking up her space.

There were times when I tried to ask her about her but she kinda diverted my questions and then she kinda chose when she wanted to disclose and what she wanted to disclose. I didn't have that choice or that control, she did. I'm disclosing everything and that's my space and when she disclosed it almost became a shared space in some way but it's like she controls that. (Anita: 150-154)

Within Karina's quote there was an interesting use of the analogy 'tables have turned'. This perhaps reflected an anticipated change in the relationship *if* her therapist had continued to self-disclose. The boundaries of the relationship may have shifted and there was a sense of roles being reversed. Karina was accustomed to being the focus of the session, she was the object being seen, and then suddenly through the self-disclosure this was reversed and her therapist, the seer became the seen and Karina became the subject. Karina's account showed her taking on the role of the therapist and in a spatiality sense, sitting on the other side of the table and taking the role of the therapist:

...she was my therapist so if she had kept on disclosing I think I would have got annoyed because it's my session I don't really wanna hear all about her I don't want her to relate to every single thing I've gone through so I appreciate that she didn't and it probably would have made me defocussed on what I was thinking about and my problems and what I was going through and maybe would have started focussing on her then it would have been like the tables have turned and I'm listening to her and I would have been talking more about what happened in her life, 'how did you feel?'. So I appreciate her not going across those boundaries. I think it would have just turned into a coffee morning with her, it wouldn't have stayed professional. (Karina: 192-200)

Similarly, Rani and Amira do mention that they found themselves taking the role of the listener and stepping outside the role of the client. Rani seemed to take on the role of a carer as the TSD made her see her therapist as a 'vulnerable person'; she reflected on the impact that this had on the TR:

I kind of felt that.....I had to save her and rescue her and make sure she feels ok for telling me what she told me umm rather than be like ok great thanks for that, I'll take it on board. (Rani: 289-291)

However, for Amira it seemed as though taking on the role of the therapist perhaps allowed her to see herself in the therapist which was powerful enough that it gave her the confidence to let the therapist help her:

In a weird way, when she disclosed it felt like I was the therapist and she was the client...it was like we were in sync we knew what we were thinking at that point...it did feel like role reversal it did feel like as if I was listening to her difficulty at one stage so I think if she didn't disclose I still would have been really distraught and I wouldn't have been able to, I wouldn't have let her help me. (Amira: 140-149)

Viraj seemed focussed on that moment in his session and tried to absorb all that the therapist was offering him. There was an interesting notion of role reversal here as it seemed Viraj was trying to put himself in the place of the therapist and perhaps had empathy for his therapist. This is maybe similar to the process that Karina experienced when she talked about the turning of tables:

I didn't think therapists talk about themselves. I just thought it's not something they do. So I remember just being really quiet and listening to everything he was saying. I remember trying to picture him in the experience he was describing to me. (Viraj: 46-49)

For two of the participants the therapist self-disclosing actually alleviated the perceived power imbalance between the client and the therapist but also allowed the participants to feel a sense of safety and security:

umm I think it kind of took away a bit of the power that therapists have which is a good thing, you know we're just two people in a room. (Rani: 402-404)

It felt that we were on the same level and felt more secure with her. You know she didn't have to say 'oh I've been through this and I've been through that, everything will be ok', that boundary was there which was good because then it would have made me feel like she was just talking to a friend. (Karina: 147-150)

3.6.2 Sub-theme 9: Closing the gap

There seemed to be a 'gap' between the participants and their therapists. This gap perhaps signified that we cannot ever truly 'know' someone else's experience and therefore are ultimately alone in our experience. This sub theme explores how the TR was strengthened by the TSD. All six participants described an increase in trust as one factor that brought them closer to their therapist:

Her sharing her experience with me made me feel like I could trust her more, trust what she was saying more. You know she's gone through the same experience I have. (Karina: 126-127)

After she disclosed I think I just trusted her more. (Amira: 131-132)

Rani paid attention to trust being a two-way process and perhaps symbolised her perception of an equal relationship into which she had entered:

So I'm glad she did self-disclose because it meant that she kind of trusted me to have told me. (Rani: 62-63)

Anita and Viraj both reflected on their experiences of having to disclose personal information to someone they were not familiar with. More importantly how doing this and not receiving the same sort of information back could impede the development of the relationship. For Anita and Viraj the TSD allowed them to connect with their therapist on a deeper level, which allowed them to feel closer and at ease:

I think it's quite scary talking to someone about your personal things and deep stuff and not really get anything back, or know anything about them, it can feel really scary and in some ways just by having a little bit of details can sometimes ground someone and help you to picture that person and almost helps you to develop that trust quicker than if you're constantly

questioning or trying to work out who this person is and umm what she's all about. (Anita: 187-191)

I'd never seen my therapist tell me anything about things they'd struggled with in the past and on one side it made me feel more comfortable umm but in terms of the I think it made me feel umm like I could trust this person a bit more. (Viraj: 65-72)

It is interesting to note the use of repetitive language in Karina's quote below. Karina's incomprehension about both herself and others is striking. This is emphasised through her repetitive language which conveys emotional conflict and the sense of turmoil she experiences, leaving her feeling disconnected from herself and others:

I couldn't understand why I was going through this. I couldn't understand why people around me couldn't understand how I was feeling and I was getting quite emotional because I couldn't get the answers I wanted, I couldn't understand why no one else around me could understand it and it got to a point where it was really emotional, that's it I couldn't handle it anymore so when she disclosed what she had gone through and how she had felt that's when my kind of stress levels came down, that's when I felt that somebody could actually relate to what I was going through and I could actually relate to her and that somebody else actually understood me. (Karina: 27-34)

However, for Karina the sharing of information through the TSD seemed to have an impact on an intersubjective level where she reflected on her relationship with her therapist and the changes perceived in the 'bond' between them. For Karina the TSD provided her with reassurance that she was in 'safe hands', and that her own problems were shared by others:

I think it's because what she described was so close to my heart that's all it needed, that bond was there after that and that's all I needed to feel safe I guess. That connection was there, I didn't need anything else. She just knew where I was coming from. (Karina: 186-188)

Viraj also reflected on the bond with his therapist after he received the disclosure:

It made me feel closer to him as well. (Viraj: 72)

Similarly, Rani reflected on the impact the TSD had on the TR. It almost seemed as though Rani felt somewhat special to have received such personal information about her therapist and because of that she inevitably felt closer to her therapist and saw their relationship develop:

It made me feel kind of a bit good to know that and I kinda felt like things had moved on because obviously I'm normally speaking and she was telling me stuff about her so it felt like things had advanced. (Rani: 72-74)

Participants also viewed the TSD as something that alleviated the loneliness that they once felt in their experience and the impact this had on the therapy process:

It just puts it all in perspective and you don't feel alone in your experience. That's a really nice feeling to not feel alone in what you're going through. (Amira: 194- 195)

Anita echoed this view and reflects on the TSD abating the isolation she felt in her experience:

It normalised some of my anxieties and I felt less lonely, less alone umm and I think that's the thing with therapy, sometimes you can be heard but not understood and we kinda seek both and in that particular moment I did feel both heard and understood which I think strengthens our relationship and makes it more trustworthy in some way. (Anita: 167-170)

Anita described becoming aware of a change in a state of isolation. As a direct result of this she also seemed to experience a change in feeling 'heard and understood'. There was a definite temporal sense of before and after in the extract as she compares her current state of connection with her former state of connection. Her use of language was interesting and served to heighten the comparison particularly when she said '*in that particular moment*' generating a sense of finality, as if she could never go back.

For Viraj, the sharing of experiences served to form and enhance a connection between him and his therapist but seemed to also answer his sub-conscious question of ‘does this person understand me?’ to ‘he does understand me’:

I knew from the experience he shared with me that he got me that he got what I was going through so it just made the whole process of therapy that much easier. (Viraj: 76-78)

Anita also referred to the use of TSD perhaps as a natural way of her therapist connecting with her and being able to convey to her that she does truly understand the experience being disclosed to her. Her language use here is interesting as she moves from ‘when they’ to ‘when she’ and is a good example of language reflecting her experience perhaps. It seems ‘they’ is quite distancing, but then she uses ‘she’, a more direct and personal way of addressing her therapist. this perhaps reflects a parallel to the shift in closeness following TSD:

I think when she did self-disclose it was her way of letting me know that she too has felt that pain and that it resonated with her and that on some level she she understood even if...I think sometimes when they, when she discloses personal stuff it's it's almost another way of...of kind of telling you that you kind of get it but not necessarily being able to tell you in a single word about what your pain might be but sharing an experience is almost a similar way of saying I get what you're saying, I understand what you're going through, because I've been through it. (Anita: 93-98)

Anita referred to a shared pain as perhaps being the medium that enabled her and her therapist to bond with each other. Perhaps for Anita ‘shared pain’ went beyond shared experience as allowing an emotional connection or bond to be formed. This may highlight one of the benefits of TSD in that it has the ability to facilitate a bond and/or connection between two people through the sharing of experience but also as a way of empathising. It seemed Anita too saw TSD as a therapeutic tool.

3.4.3 Sub-theme 10: Shared knowing

Five participants had positive experiences whereby they felt the disclosures made by their therapist allowed them to ascertain a similarity between their therapist and themselves. Participants whose therapists disclosed information similar to their experiences, contexts, and situations felt their therapists understood them better, could relate to them, or could identify with what they were

experiencing. Rashmi and Rani reflected on how being from the same cultural background as their therapists impacted upon how they received the disclosure made by their therapist.

For Rashmi using the self-disclosure from her therapist to replace the unfamiliarity of the TR with the known confines of a familiar relationship or context facilitated feeling understood. It seemed the disclosure was experienced as being more appropriate and relevant:

...you know the second therapist was from the same cultural background as me, she was Asian so am I. So she knows what I mean when I'm talking about my family and what it means to tell them this thing. She knows because she's Asian so her self-disclosure was just so much more valid and real because she understands how it is. (Rashmi: 237-241)

we actually had a very similar way of looking at things and had a very similar history in our lives. (Rashmi: 172-173)

Rani echoed this view and for her the TSD facilitated a reduction in anxiety and allowed her to disclose what she wanted to without holding back. Rani perhaps perceived her therapist to be more attentive or interested in what was being discussed because of their expressed similarity. Such disclosures seemed to halt initial concerns of being judged or perceived negatively by her therapist and perhaps if her therapist had not disclosed this may not have been possible:

The fact that she allowed me to feel comfortable and I think it's her self-disclosure of her saying you know I've got this and then it allowed me to not hold back. I told her the good parts the bad parts I didn't feel like I had to defend my culture, she knew it so she knows there are bits that are lovely and bits that are terrible so I could just be and say. (Rani: 271-274)

For Karina, the similarity between her and her therapist revealed by knowing her therapist's family status, rather than diminishing her expert status, meant for her that she was understood more but also added greater power to her words:

...you know I knew she had a family, so she understands where I'm coming from...when I found out she had the same issue as I did and she felt the same as I did her guidance just felt more real and honest. (Karina: 113-119)

Karina who saw a therapist from a different culture to her own further reflects on the connection formed through a perceived similarity. She reflected on how her culture's view of therapy as taboo, 'You know coming from an Asian background, you don't go around telling people your problems, you keep it to yourself or you deal with it yourself'. She highlighted that within the culture there is a strong sense of isolation and pressure to keep things to oneself for fear of being judged. This perhaps painted a picture of Karina's world, one in which she felt alone, was unable to share her experience with others and felt ashamed. Karina placed emphasis on receiving information from a professional who was culturally different to her and how it was perhaps a more valid and an unbiased perspective. It seemed that the TSD 'was a turning point' for her in making her feel more connected to her therapist through the shared experience:

"I feel I had someone to talk to who is completely out of my circle. You know talking to a friend and a therapist is two complete different things. Your friend or your family will always side with you or they'll tell you things and sometimes they give really bad examples to try and make you feel better but they're your friends. But a therapist is a professional and as an Asian, you know I think my view of therapy is really different now." (Karina: 207-211)

Once again, Rani talked about how the implicit similarity revealed by the TSD increased her sense of being understood by the therapist, which perhaps she believed could not have been achieved from someone with a different experience. Furthermore, it seemed as though the sense of being understood and connected to the therapist through the TSD may have also enabled Rani to feel understood or accepted by the wider system she refers to:

Because you know if she didn't tell me she understands about SA community then umm I guess she would hear things she knows already and I might have felt as though she doesn't

understand but the fact that she told me helped me a bit because I was like great she knows, she knows that I have this whole system that I need to discuss. (Rani: 245-248)

For Viraj, it seemed his therapist purposefully shared information and used himself as an example to create a sense of similarity between them both to diminish Viraj's anxiety and sense of isolation. This seemed to facilitate a connection but also enabled Viraj to use that to help him problem solve and move forwards:

So he kind of used his experience to help mirror back parts of me. So he was trying to show me my experience experienced by him and how he went through what I was going through. (Viraj: 14-16)

In this sub-theme the participants have illustrated how both implicit and explicit similarities established between them and their therapists contributed to a sense of being understood and served to enhance the relationship further.

3.6.3 Sub-theme 11: Genuineness – “It was personal...”

Participants spoke about how the use of TSD enabled the therapist to reveal a different side to themselves that had not been seen by the participant. A sense of authenticity, warmth and caring for the client was shown through the use of self-disclosure which served to further enhance the TR and also assisted in establishing a more egalitarian relationship. The following extracts show how the revealing of genuineness was understood by the participant as the therapist perhaps going beyond their professional role to help them:

I'll never forget her and what she did for me and just how genuine she was with me. (Amira: 173-174)

When she talked about her break up, it kinda showed a sense of genuineness in her. (Anita: 101-102)

I don't know, it just has a different effect, like a more real and genuine effect. Something I guess more...significant and honest. (Viraj: 43-44)

Although Rashmi previously reflected on the content of the TSD being inappropriate and how this made her feel as though the therapist had not understood the extent of her issues, she later reflected on the authenticity of the therapist in using self-disclosure to help her:

I think she genuinely wanted to give me an example of a bad time to break news to somebody so she genuinely wanted to give me an example of what would be a bad time... I genuinely think she wanted me to not make not the same mistake. (Rashmi: 74-76)

Karina talked about her prior expectations of therapy and what she thought therapy would be like. Karina's therapist self-disclosing to her seemed to change her prior views of therapy and seemed to serve as a more natural way of helping her which for her was beneficial:

The worse thing is and this is where my perception of therapy changes, is that you have a problem you go to see a therapist but do they really understand your problem, are they actually listening, that's a problem I had, this is the reason why I didn't want to go to therapy, because yes they're listening but do they really understand, can they really put themselves in my shoes and when I found out she had the same issue as I did and she felt the same as I did her guidance just felt more real and honest. (Karina: 114-119)

Karina's quote gave the impression that she perhaps had an issue being seen as a number. It seemed it was very important for her problems to be solved but more importantly that the person helping her actually understood her and who she was as a person. The TSD seemed to allow Karina to see that her therapist did understand as she shared a similar experience and hence why she could help with the problem.

For Amira, the therapist's disclosure of personal experiences similar to that of hers held greater weighting and offered a level of expertise that was beyond a 'textbook'. Perhaps for Amira this meant that the TSD was born out of real experience and that her therapist was being intuitive to her needs

in that moment by self-disclosing. The therapist sharing a similar experience with Amira perhaps showed a different side of them, reflecting a sense of genuineness:

But I think when she shared her experience it it was personal it wasn't it wasn't like from a textbook or something. It felt real, it was like a conversation with someone who wasn't judging me. (Amira: 77-79)

3.6.4 Sub-theme 12: 'Just another person'

The sharing of personal information or experiences added an extra dimension for participants, who understood this as knowing their therapist beyond their professional role. Participants drew parallels with other well established relationships such as with friends or family when talking about their relationship with their therapist. It seemed for the participants the use of TSD to convey familiarity of the therapist played an important part in enhancing the TR and feeling known and understood:

She kinda made me feel like I was talking to a mum, not just a therapist, not just a friend but she understands exactly what I went through. (Karina: 98-100)

Rashmi seemed to grow accustomed to the feel good factor of being in a relationship and having companionship and someone to share with. However, she was aware that in reality the relationship she had formed would inevitably come to an end and this seemed difficult for Rashmi. It seemed as though she may have preferred the relationship to have continued:

If I knew that she wasn't a therapist I'd probably stay friends with her but because we put a very formal end to the sessions obviously that's the end of our relationship now so we don't have a relationship anymore but she felt like somebody that I could easily be friends with. (Rashmi: 251-254)

It is interesting to note in Karina's quote, her use of past then present tense. She begins by reflecting on the impact the TSD had on her but she is not perceiving it as past, but as present. Knowing someone and being known seemed important for Karina especially if it was someone who had shared a similar experience to her. From Karina's narrative there was a strong sense of feeling alone in her experience and not knowing anyone who had been through something similar. It is plausible that Karina may have

felt so disconnected from others in the past that now knowing that someone else had shared a similar experience was invaluable. Her use of language suggests it is something that she still holds on to today:

When she told me her experience, I felt like, hold on I'm not talking to a therapist anymore, I'm talking to a friend. Because I'd been there already it made me feel like I know her. (Karina: 60-62)

Within the narratives, there were also distinctions made between what a friend is like and what we expect from them compared to what we expect from a therapist. Rashmi and Karina both reflected on disclosures they had received from friends and it seemed that when the content of these disclosures are 'bad' it is easier to forgive as they are your friends. However, for Rashmi receiving information from a professional especially if it was perceived as a 'bad' disclosure, would be unforgivable due to her perception of what a therapist should be like.

Yeah I guess it's like when you speak to friends for example friends tend to self...they always give you examples of their own lives all the time and sometimes friends use really bad examples that are nothing on par with what you feel but then they're your friends but if you're seeing a therapist professionally you don't really want them to give you information about their lives. (Rashmi: 64-67)

It is interesting though as when Rashmi experienced the disclosure as 'good' her views about the therapist disclosing were very different, so much so that she wanted to know more about the therapist:

"For me surprisingly I actually wanted to know about her a lot...I actually felt it would have been a lot more helpful if I knew her background." (Rashmi: 165-173)

In a similar way, the TSD had a greater weighting for Viraj as he also compared the TSD to disclosures made by friends but how coming from a professional had greater meaning as it exhibited therapist expertness in a more experiential way:

I mean like I know everyone at some point in their lives has confidence issues and stuff, but I guess hearing a professional talk about it is quite different than hearing say your friend talk about it with you. (Viraj: 40-43)

For Karina, Rani and Amira, the revelation of past struggles, flaws and hardships appeared to humanise their therapists. For the participants this reciprocal exchange may have meant that a more egalitarian relationship, almost a friendship, was created but may also have functioned to normalise their experience even further and facilitated a view of the therapist as not being superior to them:

That's when for me she became human, she became a person to me, not someone just sitting there. (Karina: 155-156)

Umm I think it's helped me add a bit more of a human aspect to therapy, that it's ok, it's ok if you don't have your life all together, you or the therapist. (Rani: 401-402)

Amira seemed very much aware of the boundaries that existed between her and her therapist however, still reflected on wanting or there being more to their relationship than just a client-therapist relationship. Her quote here perhaps reflected the genuine bond she felt to her therapist:

I just thought to myself I can just stay here the whole afternoon and just talk to her and tell her everything and you know and ask her for advice, like what do you think I should do, but I know she couldn't tell me what to do and make my decisions for me. I think I just felt closer to her, like I knew her as a person not just as a counsellor. (Amira: 151-154)

It seemed as though Anita had a preconceived idea of what her therapist was like or would be like. In this extract Anita was given an insight into the world of her therapist which resulted in her feeling equal to her therapist. It seemed that through the TSD a metaphorical bridge had been created between their two worlds. A bridge that was usually a one-way bridge had become open in both directions:

I think for me it makes her more human when she shares it, it reduces some of that mystery and it makes you feel like you are talking to another person, another human being which can sometimes be really nice because it kinda just feels normal. (Anita: 98-101)

Anita further illustrated a parallel process between her struggle to know herself and the uncertainty that this brought, alongside the uncertainty about who the therapist was. This is perhaps alleviated by the humanising process through TSD:

It demystifies this kind of unknown and I think sometimes, I think with a lot of people we we do struggle with the uncertainty and the unknown and I think it kinda just helps. Just puts this person into perspective and it just umm humanises a person, that she does have a life [laughs] outside of this. (Anita: 191-194)

This sub-theme has shown how the TSD allowed the participants to relate to their therapist on a deeper level and they seemed to experience a real journey through the therapeutic relationship. It is also important to highlight that at times, although the TSD seemed to have a humanising effect, at the same time there may also have been a sense of loss. Although seeing the therapist as 'just another person' was experienced positively within the therapeutic context, there may have been a potential, unanticipated loss due to the crossing of therapeutic boundaries, that is the unconscious disadvantage of losing a therapist (despite gaining a friend), but this seemed to be outweighed by the largely positive experience of TSD. Perhaps the more negative aspects are not as apparent to the participants in the moment, because of the human desire to connect, which again enhanced the therapeutic alliance and seemed to change previous views of therapy.

Overall, this super-ordinate theme has illustrated the ways in which the participants viewed the TSD and the impact it had on the TR. There were negative and positive experiences within the different parts of this theme and seemed to alter how the participants were in the therapy session which resulted in changes in the TR and overall therapy process. The self-disclosures made by the therapist also posed issues of power and emphasised the perceived power and control that the therapist has over the client in the therapy process. This super-ordinate theme also highlighted how through the TSD the participant felt closer to the therapist and as a result enhanced the therapeutic alliance. Although participants did not reflect much on what the relationship was like prior to the TSD from the above narratives it could be interpreted that the relationship may have been formal, rigid or impersonal, drawing an image of the therapist as cold and detached. However, it seems that through the TSD the perceptions of the participants had altered and the TSD enabled a positive relational aspect to emerge.

3.7 Chapter Summary

To summarise, the analysis focussed on four super-ordinate themes: 'Understanding of therapist self-disclosure', 'Experience of therapist self-disclosure', 'Impact of therapist self-disclosure on self', 'Impact of therapist self-disclosure on the therapeutic relationship'. Within these super-ordinate themes were sub-themes that explored a variety of different facets.

The first super-ordinate theme presented was 'Understanding of therapist self-disclosure' which looked at how the participants understood and viewed the TSD therapist's self-disclosure. There was an exploration of what they considered acceptable or appropriate for therapists to disclose as well as their perception of why their therapist may have chosen to disclose personal information in that moment.

The second super-ordinate theme was 'Experience of therapist self-disclosure'. This theme considered the importance of the timing of the disclosure and also considered the frequency with which TSD took place. Participants also described a range of emotional responses towards TSD. These illuminated different aspects of their experience and created a deeper understanding of the nature of such disclosures. Furthermore, it highlighted the potentially significant influence of their timing and frequency within the TR.

The third super-ordinate theme was 'Impact of therapist self-disclosure on self'. This theme explored how the participants' account of TSD served to normalise their distressing experience in order to ease their sense of loneliness and to enhance their sense of self. The theme looked at how the TSD was used by the participants to gain new perspectives and understanding of themselves and their experiences. The theme also considered how the TSD either enabled or discouraged participants from self-disclosing further in therapy and the consequences of inappropriate disclosure on self.

The fourth super-ordinate theme to be presented was 'Impact of therapist self-disclosure on the therapeutic relationship'. This highlighted the contexts in which explicit changes to the TR were experienced as a result of TSD. The disclosures also drew attention to issues of power and control

within the therapeutic space which further impacted upon the TR and process. Consequently, the theme explored the ways in which the TSD enabled the participants to feel connected or disconnected to their therapist.

A theme that could be described as a thread woven throughout the analysis, spanning all themes and binding them together, was the impact of TSD on the participant's sense of connection to themselves, their therapist and their lifeworld. This feature emerged across participants and across themes and although it was presented as a discrete cluster it is something that permeated across the analysis.

CHAPTER FOUR: DISCUSSION

This chapter discusses the findings of this study, which used IPA to explore the overall research question in light of the existing research and literature outlined in Chapter One. Smith et al. (2009) specified “it is in the nature of IPA that the interview and analysis will have taken you into new and unanticipated territory” (p. 113). For that reason, the research will also draw on new areas in this chapter. Specifically, the literature is used to illuminate participants’ perspectives on ‘Understanding of therapist self-disclosure’, ‘Experience of therapist self-disclosure’, ‘Impact of therapist self-disclosure on self’, and ‘Impact of therapist self-disclosure on the therapeutic relationship’, which comprise the four super-ordinate themes found to capture SA clients’ experiences of TSD. Following the broad thematic path through the analysis, the themes will be presented under the headings ‘Conceptualisation, content and delivery of TSD’; ‘Impact of TSD’; and ‘Connection with self, others and their lifeworld’.

This chapter will then offer a critical evaluation of the current research together with recommendations for future studies. Implications for counselling psychology practice will be discussed, followed by a reflexive summary of how the present study has shaped the researcher’s attitude towards TSD in the therapeutic context.

The main research question was:

How do SA clients experience TSD during individual therapy?

Relating to this main research question, the following areas were explored:

- How do SA clients make sense of TSD?
- How did SA clients experience TSD?
- What was the impact of TSD?

4.1 Conceptualisation, content and delivery of TSD

In line with the phenomenological stance of this research, participants were firstly asked about their understanding of TSD. All six participants understood TSD as the revelation of personal experiences or

feelings which related to their own. The disclosures made by the therapists were self-disclosing and non-immediate disclosures (disclosure of personal information regarding the therapist's life outside the therapy) (Knox & Hill, 2003). Participants did not make any reference to self-involving/immediate statements (reactions within sessions) which, literature states as being the most helpful because of the focus it places on the TR (Myers & Hayes, 2006; Tantillo, 2004). Perhaps participants were able to recall the distinct experiences revealed to them by their therapist, as opposed to the immediate disclosures that may have occurred more quickly, or were forgotten or incorporated under the participants' expectations of therapy. An intersubjective understanding of TSD puts forward that 'the subjective self and its annunciations are a co-construction with the other' (Lijtmaer, Moodley, & Sunderani., 2013, p. 790). It is plausible that the participants found personal disclosures facilitated a truer experience of their therapist, enhancing intersubjective connections, which are arguably more memorable than self-involving statements. This may have facilitated the creation of a joint experience – dynamic inter-subjectivity in the lifeworld, rather than the participant hearing a statement which may have meant something or nothing to them. The self and the other are intertwined and subjectivity is constructed in the intersubjective relationship (Lijtmaer et al., 2013). TSD can be an important part of this two-way communication whereby the internal and external worlds of both client and therapist, while separate and independent from each other, together can result in the forming of a strong therapeutic alliance and ultimately making the experience more memorable (Moodley, 2007).

There have been studies to show that 'personal storytelling' can help lead to positive outcomes (Keehn, 2015). The literature shows that sharing and listening to personal stories leads to an increase in engagement (Zuniga, Mildred, Varghese, DeJong, & Keehn, 2011) and results in positive learning outcomes, for example development of critical thinking skills, increased empathy, and helping individuals form meaningful connections with others (Keehn, 2015). Although these studies were looking at how students learn from listening to personal stories it could be plausible that something similar happened with the participants when considering how TSD of the non-immediate type may be more valuable to the client than immediate statements. On a human level when things are made personal you are opening them up to an intersubjective encounter.

Participants seemed to evaluate the TSD for its relevance. The appropriateness of context and the relevance of disclosures are important factors as to how the TSD is perceived and in this study were equally important to the participants. The common denominator across this was they were all disclosures about personal experiences or feelings, and fitted the needs of the participants in that moment. In most cases participants viewed the content of the TSD as appropriate, though there were

two who perceived the TSD as inappropriate. If the disclosure was seen to be congruent with the needs of the participant, the therapist was seen to be understanding and thoughtful. However, occasions where the disclosure was considered to be incongruent from what had been disclosed by the participant, unexpected, or undesired from the therapist appeared to take away from what was considered meaningful to the participant and the therapist was viewed as being someone who lacks understanding and responsiveness. Rashmi and Rani felt the disclosures were inappropriate, however their narratives indicated TSD was not a problem in itself, but the content of the disclosure was key in shaping their experience as alienating, leaving them feeling misunderstood and unheard. On the other hand, for Amira, this difference resulted in her having to reposition herself in relation to her therapist (a role-reversal of therapist and client) and for Rashmi her experience illustrated how a good TR changed after a perceived bad TSD. This shows the potential impact of TSD on the relationship. However, it is important to note that the content of the self-disclosure was key in these cases rather than the use of self-disclosure itself. The right type of disclosure seemed to contribute to a sense of connection between the two parties and overall contribute to the therapy process, whereas the wrong type of disclosure seemed to disconnect the participant and their therapist in quite an explicit way.

It is interesting to note that the most potentially controversial content areas as proposed by Gutheil and Gabbard (1993) (sexual issues, personal fantasies, dreams or financial information) were not what therapists disclosed as this could have been very damaging to the therapist-client relationship. Although the therapists did not step into controversial content Rashmi and Rani expressed they found the TSD damaging on various levels (losing confidence in the therapist, invasion of space, questioning the therapist's competence, experiencing disconnection) however, neither participant spoke to their therapist about the 'damage'. Rashmi spoke about how her relationship with her therapist "*closed off*" and how she felt she would not gain much more from the therapy. Whereas for Rani, although she also "*closed off*" about the particular subject she was discussing it seemed that she was able to work through the difficult experience and go on to create a strong bond with her therapist.

The experiences of the participants are consistent with those found from previous research. For example, Audet and Everall (2003) also found in their study when disclosures were seen as helpful they were viewed as something they could connect to or apply to their own issue. However, disclosures viewed to be less relevant reflected to clients that their therapist did not fully understand their problem and led to a diminished view of the therapist's ability. From this study what is not known is the impact the incongruent disclosures had on the therapy process as a whole. The present study revealed from one participant that the exposure to her therapist's imperfections or 'realness' did not

compromise the TR. Instead, the participant continued with therapy and when further disclosures were made by the therapist she viewed them as helpful.

Perhaps of greater importance to the participants was not whether or not the therapist self-disclosed but how they self-disclosed. The nature of the TSD, which includes factors such as frequency, intimacy, similarity and timing seemed to impact upon how the self-disclosure was received and whether it went on to impact the therapy process. The participants reflected on several instances of TSD, however felt that the one time was enough to have a beneficial impact. Karina did reveal how she wouldn't have wanted her therapist to disclose frequently as this would have deprived her of her therapy time and taking the focus away from her. This has also been cited in the literature as reasons not to disclose (Mathews, 1989; Simone et al., 1998).

The timing of when to self-disclose was another important factor for the participants. The actual decision to self-disclose for some participants seemed to be the product of the therapist's perceived intuition in the moment or a perceived recognition of the participant's feeling of '*stuckness*' and perhaps their own '*stuckness*'. Four of the participants experienced their therapists self-disclosing when they were feeling 'stuck' or at a complete loss. Some participants did have some thoughts of when a therapist should self-disclose and when they should avoid it. For example, Rashmi preferred it when her second therapist disclosed when the "*nature of the therapy sessions had calmed down*" compared to her first therapist who disclosed at "*an emotional time*". Watkins (1990) looked at how the 'optimal' frequency of disclosure could be determined and concluded that it should be used moderately. Although this acts as a guideline to the use of TSD it is very broad and does not actually provide any real guidance as to what is considered 'optimal' frequency of TSD.

However, within the narratives of the participants there were differences of opinions regarding the timing of the TSD. Therapist intuition or recognition of the participant's '*stuckness*' is only one way in which the participants interpreted their therapist's decision to self-disclose. Amira described the TSD as something more than '*textbook*' and seemed to imply that it was perhaps born out of real experience and not just knowledge. This idea is similar to Orange and Stolorow's (1998, p. 534) proposal that "exploration, inquiry, play, and the development of new and/or revised psychological organisation" is stimulated when two individuals meet in the intersubjective field. They further put forward that in a therapy context, both client and therapist are concerned about whether it is safe for them to share their feelings, emotions or thoughts. Therapists may convey their own sense of personal and shared safety as they decide how and what to disclose to their clients. Orange and Stolorow

further put forward the idea that if therapists consider the emotional safety of the client as imperative to the therapeutic work they must ask how various forms of responses impact upon the safety of the therapeutic frame. They further state that the decision to do so is not 'routine, default, or a procedure' (p. 534). The ideas of Orange and Stolorow will be discussed in more detail further into this chapter. Further research on the concept of therapist intuition might be helpful and inform whether the decision to self-disclose is based on experience, knowledge or both.

Overall, participants perceived TSD as beneficial whenever it took place in their therapy. However, those participants who experienced TSD early in therapy, reported feelings of uncertainty and difficulty. This is consistent with Wells (1994) who found that TSD which precedes the creation of a good TR could overshadow the client's needs (Myers & Hayes, 2006). However, several of the participants stated that the relationship had already been sufficiently established. Therefore, what emerges from the findings of this study is that there is a definite sense of relational timing than temporal. Although these two concepts are intrinsically interrelated the appropriateness of TSD seemed to be related more to whether or not there was a good therapeutic bond in place beforehand rather than the timing in terms of number of sessions.

In this study it seemed as though TSD had great impact on how the TR was perceived by the participants. Whether the TSD was viewed to be positive or negative seemed to impact the participant's experience of warmth and safety within the TR. This is slightly different to Myers and Hayes (2006), who found that the way the TR is perceived impacts directly on whether the TSD is perceived positively or negatively. Unsurprisingly, this is perhaps a good illustration of the multi-directional nature of relationship dynamics. Various studies have reflected a different emphasis on the direction of impact, for example, that TSD has an impact on the TR (Bitar et al., 2014; Burkard et al., 2006; Hanson, 2005; Mathews, 1988) or that the state of the TR impacts the individual's experience of TSD (e.g., Audet & Everall, 2003; Myers & Hayes, 2006). However, it seems likely they are both relevant as the present study suggests. The TSD seemed to be a powerful and influential factor in how the participants experienced the relationship and the therapy process but for those who had experienced a negative experience of TSD were able to continue with their therapy and talk about it in a positive way, presumably because a good TR had already been established.

Existing literature has shown that there is little consensus on how to conceptualise TSD. Although TSD remains a complex concept, the participants from this study provide some consistency regarding how TSD can be understood and some important factors such as timing and frequency of TSD that are

important to consider. For these participants there was particular significance placed on the relevance of content of the disclosure and the impact they felt this had. From their narratives it seemed as though when the disclosure was 'good' it had the potential for connecting however when it was 'bad' it could disconnect in quite an explicit way. Their experiences of these different aspects of TSD offers some insight into the potential significance of content, timing and frequency of TSD and the influence it can have on the TR and process.

4.2 Impact of TSD

Participants perceived TSD to be an important part of their therapies. They also were to varying degrees affected both positively and negatively by the information revealed to them, suggesting a potency of TSD that is consistent with earlier research (e.g., Hill et al., 1988). TSD was perceived to have both beneficial and hindering effects however; it seemed to have an overall positive impact for this group of SA participants.

One possible explanation for why the present research may have reflected an overall positive experience of TSD could perhaps be a reflection of SA culture itself. Cultural values held by those of the East and the West vary significantly and encourage very different lifestyles (Shariff, 2008). Western individualistic cultures tend to value independence and individuality. Zaidi, Couture-Carron, and Matlicka-Tyndale (2016) suggest that Western cultures place importance on the needs of the individual first, and then of the family unit formed by the individual, over and above those of the family of origin. They further propose the role of parents of those in the West is to teach children to make their own decisions and their own judgments, and to promote them in developing their own independence from the family of origin. The needs of the individual are prioritised and not expected to be ignored, and in fact be considered before the needs and desires of the parents (Dodd, 1973; Wakil, Siddique, & Wakil, 1981; Zaidi & Shuraydi, 2002). However, Triandis (1995) argues that SA culture (Eastern culture) prioritises collectivist needs and desires and emphasises the importance of strong family ties. Wardak (2000) suggests the family structure and the way in which it functions overshadows any other relationship. All decisions, however big or small, are discussed with family members and are always made in accordance with how it may impact the family (Ayyub, 2000), as well as the wider social network (Wardak, 2000). In stark contrast to Western culture, collectivist values prioritise the needs and hopes of the family of origin above those of an individual family member (Huisman, 1996) and individuals are not regarded as independent of the family structure. Furthermore, within SA culture

there is great importance placed on maintaining the family reputation (Ayyub, 2000; Dodd, 1973). As Wardak (2000) suggests, family honour should be maintained at all costs, and as a result, as Dwyer (2000) explains, individuals must behave in very modest and respectful ways. In relation to psychological therapy, D'Ardenne and Mahtani (1999) suggest that minority ethnic clients tend to view the therapist as someone who holds professional and cultural power and is perceived to have more status and knowledge than themselves. They argue that this can potentially cause challenges in the therapeutic process especially when therapists do not acknowledge this and instead deny the existence of this power dynamic. This is particularly important to consider with SA clients who carry upmost respect for those in a position of authority and who may find it difficult to disclose their true feelings or thoughts. The participants of this study may have felt uncomfortable discussing potentially harmful experiences of TSD with their therapist or even with the researcher as their cultural values emphasise that they should behave in humble and respectful ways. Consequently, speaking about something in a negative way may have resulted in them being seen as criticising which may perhaps impact their reputation. Thus, the findings of the current study might suggest that TSD facilitates therapists to show their true selves and model such behaviour to the client, an equal participant in the TR, and encourage open dialogue.

The SA community operates within a hierarchical family structure, where feelings and emotions are not freely expressed (Laungani, 2004). Even in highly emotionally charged situations, internalised familial norms discourage younger members of the family from openly expressing negative emotions towards their elders (Laungani, 2004). The suppression of emotional conflicts can discourage an individual from experiencing the full expression of emotions (Uba, 1994). As a result, many SAs are taught self-control and to restrain from experiencing potentially disruptive emotions (Kaneshige, 1973; Leong, 1992; Tinloy, 1978; Uba, 1994). SAs who value the suppression of strong negative emotions may find the process of emotional expression to be difficult and uncomfortable. This may have been the case for the SA participants of this study, who expressed more positive reactions towards the TSD than negative. With this in mind, counselling psychologists could use their own disclosures of negative emotions to model and encourage their SA clients to feel comfortable in doing the same. However, as some participants of this study described, the content of the disclosure was vital to how the TSD was experienced overall. Therefore, counselling psychologists would need to ensure that the way their disclosure is worded and delivered does not result in the client believing the therapist is saying that their negative emotions result from the client, as this might further alienate SA clients from engaging in therapy.

Although SA cultural values encourage individuals to suppress unpleasant emotions or to keep issues to themselves or within the family unit, participants in this study identified that TSD may be one way of allowing SA clients to feel free to discuss their issues with a professional, as TSD seemed to contribute to the perception of therapist trustworthiness and authenticity. Being understood by the therapist seemed vital for the participants of this study. However, from their descriptions it appeared that they wanted something more than a simple reflection and something 'more than just textbook'. They wanted to know that the therapist really understood what they were saying and was not judging them. Perhaps their desire for this grew from their culture's hindrance of this and it seemed that for these participants the TSD allowed them to gain a 'real sense' of who the therapist was and relate to them on a deeper level and enter into a relationship which may be new to them.

Referring back to Lokken and Twohey's (2004) study (reviewed in the Introduction) which looked at American Indian students' views of therapist behaviours, the most prominent theme identified was the attitude of the professional. The participants made reference to the presence of behaviours that reflected respect, genuineness, and caring. Participants identified that through the TSD they felt more comfortable and more connected to their counsellor as it built trust and credibility, but also facilitated them in being able to discuss more as the TSD allowed them to feel equal to them through finding common ground. The findings of this study are in line with those of the present one and seem to suggest that although SA cultural values emphasise suppressing negative emotions or refraining from disclosing issues to others outside of the family unit, participants in both studies identified that through the TSD they actually felt able to discuss their issues with a professional and view their therapist as trustworthy. Furthermore, as Netto et al. (2007) pointed out in their study, the qualities of a counsellor participants' valued most were active engagement in the process, being 'heard' and treated with respect. It could be suggested that appropriate TSD might arguably demonstrate all of these things.

Most of the participants perceived their therapist to have a clear intention for the disclosure. Participants reflected that their therapists were seeking to normalise or reassure them through the TSD. This process of normalisation involved the therapist communicating to the participant that things do not often work out the way you intend them to, that change can occur, that they are not alone in their experience, and that their feelings were not unusual. Within the narratives, participants referred to a process of secondary interpretations of their emotions (i.e., depressed about being depressed, ashamed about being anxious) whereby negative beliefs about oneself are maintained (Teasdale, 1988). It is suggested by Goldfried (2001) that TSD could be used to counteract this secondary process

by effectively and immediately providing self-disclosures of similar feelings rather than making attempts to explain this phenomenon. For the participants in this study, hearing that their therapist had experienced similar emotions as them normalised their own emotions but also allowed them to challenge their thoughts about their emotions and use the TSD as evidence to reformulate their experience. For example, for Karina the TSD helped to reduce her anxiety regarding both her negative self-concept and meta-cognition of emotion. The participants' experiences also align with the author's own experience (as cited in the beginning of the thesis); providing further support for the existing literature that suggests that TSD can be used to normalise a client's experience but furthermore, can enable them to formulate a more accepting view of oneself (Edwards & Murdock, 1994; Goldfried et al., 2003; Knox et al., 1997).

Participants also used their therapist and the self-disclosure as models to make changes in themselves. As suggested in the literature (Bandura, 1986; Constantine & Kwan, 2003; Goldfried et al., 2003; Knox et al., 1997; Kottler, 2003; Weiner, 1978; Wolpe, 1984) modelling can encourage clients to increase their disclosures in the session, recognise and change negative behaviours and reinforce more helpful ones. For the participants who were unfamiliar with the process of therapy, TSD seemed to model appropriate behaviour in therapy, and encourage and facilitate the formation of a collaborative relationship, which seems important for those from BME populations.

The findings of this study offer greater weight to the theories of the leading figures in the multi-cultural counselling arena. Sue and Sue (1999) put forward the assumption that a culturally different client may not self-disclose until the therapist self-discloses first. This was true for four of the participants, who saw therapists culturally different to them. Consistent with the existing literature (e.g., Cashwell et al., 2003; Lokken & Twohey, 2004) they all reflected on how receiving the TSD facilitated a deeper level of work allowing them to open up and self-disclose to their therapists but also talk about other important issues which they had previously withheld.

However, the findings from Wetzel and Wright-Buckley's (1998) study highlighted that therapist and client ethnic matching also seemed to have a positive impact on how TSD was received. The participants were more likely to self-disclose, feel safe and trust their therapist when matched by ethnicity compared to not being matched. With regard to the present study, Rashmi and Rani were the only two participants who saw therapists from the same cultural background as them. Interestingly, Rashmi saw two therapists, one culturally different to her and one culturally similar. She experienced TSD in a negative way with the former therapist (culturally different) and positively with

the latter (culturally similar). Meanwhile, Rani saw one therapist culturally similar to her but recalled two distinct experiences of TSD and viewed one as positive and the other as negative.

When seeing therapists from a similar culture, both Rashmi and Rani felt that the TSD allowed them to open up and self-disclose further, which is consistent with the findings of the Wetzel and Wright-Buckley (1998) study. Rani specifically reflected that disclosures made in relation of their shared culture was received favourably as *'I didn't feel like I had to defend my culture, she knew it so she knows there are bits that are lovely and bits that are terrible so I could just be and say'*. In the UK it would be very difficult for SA clients to find SA therapists when they need them and where they need them. Therefore, we have to consider making the best of what we do have. Ideally we would match everybody if that is what they wanted, but the research shows that ethnic matching does not necessarily effect the therapeutic bond and/or outcome of therapy. Hence, some people may prefer someone of the same culture and that may also be to do with age or gender, while others may prefer to have someone from a different culture. If you are of the same culture it may be easy to make assumptions that you know what the other person is going through or the client may think that they know because they are from the same culture. However, there are vast differences within cultures and everyone experiences culture in different way. It might be that someone from a different culture asks the questions with more curiosity. It is very difficult to say because of the subjective nature of culturalisation: we are in a cultural context and it is inevitable to have things in common but how we experience them will be different. There are mixed views on the impact of matching and not matching the ethnicity of the therapist and the client. From the present study it seems that ethnic matching can be both helpful and unhelpful for this group of SA participants in the context of TSD.

Many SA clients may view their own personal disclosures in therapy as potentially conflicting with their cultural values, such as going to therapy in itself is a particular challenge (Kim & Omizo, 2003). Others may not have the experience or have had a model for how to disclose. The therapy context which requires personal disclosures for such individuals could feel quite intimidating and difficult. This is particularly pertinent for SA clients given that their values encourage them to suppress their pain, suffering and anger (Kim & Omizo, 2003). Therefore, through the TSD the therapist can provide a model for how to disclose and provide the client with an example of how clients can move from a state of isolation to being more connected and open (Bitar et al., 2014). For instance, within Rani's narrative there were references made to how the TSD allowed her to feel more comfortable and not

withhold information. Perhaps the disclosures made by the therapists provided the participants a sense of safety that difficult feelings or issues could be explored with containment. Therefore, TSD might also be more powerful when a SA therapist models this.

Previous research has demonstrated that TSD is viewed more favourably by clients when those disclosures are related to their feelings (Hill et al., 1998; Knox et al., 1997). For the participants the TSD seemed to have a bearing on how involved they became in therapy. For most, the TSD acted as an invitation to fully offer themselves in the therapy process and facilitate deeper and broader exploration of issues. Amira in particular showed how the TSD provided not only an example of disclosure but also a validation of her feelings that she had so far rejected. The TSD also enabled participants to gain new insights or a new perspective on themselves, their experience or situation. Moreover, they reflected that they were able to learn something new about themselves and acknowledge feelings and thoughts they had previously ignored. Furthermore, the participants were able to reformulate their experiences and see their problems from a different point of view, one that was more helpful and one that enabled them to develop a better sense of self. Bandura (1986) referred to models and 'observers' as having specific characteristics that enable a learning process to take place. He suggested that observers (clients) who have low self-esteem and models (therapists) who show stature and prestige provide the most favourable conditions for change. Therefore, taking these findings into consideration it could be assumed that TSD encourages the disclosures of clients even further. It seems that the therapist's disclosures of similar feelings in similar situations offered the participants with a different and new way of thinking about themselves and their situations. Given the findings of this study TSD could be an important technique to use with SA clients as a way of establishing and strengthening the therapeutic alliance but importantly encouraging disclosure.

Having illustrated the benefits of TSD experienced by the participants, it is clear that it plays an important part in the development of the TR. However, consistent with Zur (2007) and Peterson (2002), there is a fine line to tread, whereby TSD may cross over into less helpful and even damaging territory. Normalising the difficulties of a client by self-disclosing could belittle the client's unique experience, as was reflected by Rashmi. It was interesting that for Rashmi the TSD came from a model with which TSD broadly conflicts. Within this model, it is argued that TSD, specifically of the therapist's feelings, thoughts or experiences, is inappropriate and may negatively impact the TR and process of therapy (Goldstein, 1994). This seems to have been the case with Rashmi's experience where she reported feeling 'angry' and 'belittled' and felt that the shared experience actually 'closed off' the TR. Indeed, Roberts (2005) warns that TSD should be used with caution.

Similarly, Rani also reacted negatively towards her therapist's disclosure; however, her experience of TSD came from an integrative therapist. Within an integrative framework, it seems that self-involving/immediate disclosures are more acceptable, which were not the type of disclosures made by Rani's therapist. For instance, Finlay (2016) suggests that the therapist should share some of the transference and projective identifications with the client by being open and curious. When working integratively there is an emphasis on the therapist and client understanding what the relational processes means and as a result being able to bring any projection to the foreground and working through it. It could be assumed that those therapists using a psychodynamic and integrative approach may have received inconsistent or no training with regard to TSD because of how their chosen approach views the use of TSD. It may have left the therapist feeling unprepared to use TSD and consequently resulted in the negative reaction from the participants. In Carew's (2009) study, the findings suggested that classical training influenced the usage of TSD. This suggests that perhaps the past training of the integrative therapist and the psychodynamically trained therapist influenced them in their willingness or experience of using TSD.

It is also interesting to reflect on the positive experiences of TSD in light of the modality the participants experienced therapy. These experiences came from those who saw a therapist using a CBT or person-centred approach, which research shows views the use of TSD in a positive way. In CBT, Goldfried et al. (2003) argue that TSD can be an effective tool for strengthening the TR and facilitating change in the client. It is suggested that disclosures of personal feelings or experiences can validate a client's reaction and is one way of therapists being able to display empathic understanding (Goldfried, 2003).

In relation to person-centred therapy, Rogers (1951) states clearly the importance of ensuring a therapist takes an open, collaborative and genuine stance in therapy and endorses the use of TSD. Further to this, the value of congruence and transparency is well articulated and therapists are encouraged to give information about themselves to the client in order to enhance the TR (Carew, 2009). It is therefore understandable that positive experiences came from those participants who experienced therapy from modalities that endorse the use of TSD.

The researcher was struck by the resilience of a couple of the participants who viewed the TSD as inappropriate and may have caused a rupture. It is interesting to note that despite these participants describing the content as inappropriate resulting in feeling disconnected from their therapist and disengaging from the process in that moment, they did not terminate therapy. Instead they seemed

to resolve this experience and maximise the potential they believed therapy had to offer. It seems plausible that participants experienced positive aspects earlier on in the relationship which may have enabled them to reconcile the negative consequences of TSD. If these positive elements were not established the participants may have terminated prematurely. However, the negative experiences did not seem to change their view about therapy and cause them to terminate, nor did it hinder the progress or work of the therapy.

The importance of attending to ruptures in the TR has been highlighted by Safran and Muran (1996). They suggest this is an important and inevitable part of therapy. For three of the participants TSD caused high levels of anger, frustration, and uncomfortableness; however, they were able to resolve this experience and in the end the relationship seemed to shift and enhance their work on a deeper level. An important point Rani made was the confusion of what to do after the therapist had disclosed. Is it the client's responsibility to respond and to explore the disclosure or is it the therapist's? Hill and Knox (2009) suggest that problems that arise in therapy should be addressed there and then. This will result in the problems being resolved quicker and will serve to enhance the relationship. Safran, Muran, Sanstag, and Stevens (2002) (as cited in Hill & Knox, 2009) put forward that being able to work through ruptures is important in creating change in therapy. They further suggest somewhat sweepingly that when resolving ruptures, initially the client experiences anger, then disappointment in being let down by their therapist and finally begins to feel vulnerable which allows him/her to express the need to be taken care of by the therapist. However, Rani and Rashmi, who felt angry or annoyed did not voice their concerns to their therapists, but interestingly, somehow were able to reconcile this difficulty and continue with the therapy. The TSD may have allowed them to see the real therapist, and they were able to understand the rationale of TSD, this overshadowed the initial feeling of anger they felt. This links in with the idea of temporality in which there seemed to be a global sense of gain punctuated by feelings of uncomfortableness, which is a very human experience. This does raise concerns however for counselling psychologists to be aware that there may be clients who may not be able to reconcile the difficult experience.

4.3 Connection with self, others and their lifeworld

The TSDs were ultimately used by the participants to enhance a sense of connection between themselves and their therapists. Arguably, connection could be seen as an impact of TSD as it is something that came as a result of the disclosure. However, the researcher felt it was such a strong theme with findings that permeated throughout the narratives and justified more exploration in this

section. Corey (2005) suggests that the humanity of the therapist is essential for connecting with clients and further argues that if “we hide behind the safety of our professional role, our clients will keep themselves hidden from us” (p. 17). Therapy is thought to be a “human rather than technical endeavour”, and therefore requires an authentic human relationship which is facilitated by therapists “own genuineness and aliveness” (Corey, 2005, p. 17).

In accordance with the Hanson (2005) study, the participants’ appreciation for the therapy process increased after the TSD as it showed a more human side to the therapist. This is consistent with the participants of this study who also seemed to value this realness or genuineness and felt that it improved the connection between them and their therapist. This is also consistent with Hill, Mahalik and Thompson’s (1989) study, which showed that those who are open about their personal weaknesses and vulnerabilities are viewed as empathic, warm and credible and therapists who disclose their professional skills and experiences are seen to not possess those qualities. This is reflected in the content of self-disclosures reported by the participants. The findings of this study are also consistent with Knox et al. (1997) who showed that clients reported positive outcomes when their therapist was viewed like a real person and not a distant experienced professional. However, when looking closer at the participants’ accounts, what was revealed was that even when therapists disclosed similar experiences or feelings some participants perceived their therapists differently. This could reflect that the nature of self-disclosure is of less importance than the way it is delivered, for instance, warmth, similarity, timing, intimacy and wording may be more important when self-disclosing. This is in line with Audet and Everall’s (2003) study which showed that the impact of TSD is dependent on the context in which it takes place and the way it is being delivered. This is also consistent with participants who said TSD was not a problem in itself.

The importance of trust in the TR is imperative. Sharing information with a complete stranger may be particularly difficult for SA clients, for whom trust may already be lacking (Blakey, Pearce, & Chesters, 2006; Bhui & Rüdell, 2002; Bhui & Bhugra, 2002; Goldberg, 1999; King, Weich, Nazroo, & Blizard, 2006). The findings of the current study suggest that participants experienced enhanced trust in their therapist due to the TSD. It provided them with a degree of intimacy depicting a more human view of their therapist and enabling them to be placed in to a familiar category. For Karina this was feeling ‘*relieved*’ by her perception of her therapist as a ‘*mum not just a therapist*’. This facilitated a strong sense of connection being formed. This is consistent with Goldfried et al. (2003) and Lane and Hull (1990) who state that a therapist who self-discloses can create an atmosphere of transparency and increased trust and intimacy by revealing that they too have experienced some of the same struggles

and difficulties. These findings further concur with those from the Lokken and Twohey (2004) study who found that participants were able to trust counsellors who self-disclosed more than those who did not, as it gave them an opportunity to learn more about the counsellor. These findings are also consistent with theories of counselling Asian clients (Helms & Cook, 1999; Kim et., 2003; Sue & Sue, 1999).

Social identity theory, originally formulated by Tajfel (1981), proposes that a social identity is the part of an individual's self-concept that develops from perceived membership in a particular social group. He suggests that individuals perceived to be members of an in-group are viewed more favourably, are more cooperative and are more often rewarded. It is plausible that the similarity of their therapist to familiar concepts of others (e.g., friend or mum) formed an 'in-group'. The forming of a perceived in-group between the participant and therapist took place more overtly when the therapists revealed information that established a similarity between the two individuals. Thus, through the TSD the therapist started as an out-group member and then became an in-group member. Interpersonal theory proposes that TSD facilitates positive outcomes if the therapist is perceived to be an expert, attractive or trustworthy (Strong, 1968). Therefore, establishing a similarity to oneself could have increased the perceived attractiveness of the therapist (Edwards et al., 1994) and as a result foster the connection.

Orange and Stolorow (1998) discuss self-disclosure from an intersubjective point of view which seems to fit in with the idea that TSD can quite directly enhance a sense of connection between the two parties involved in the therapeutic encounter. They suggest that intersubjective theory acknowledges that within a relational field, it is inevitable for two subjective worlds to continually self reveal to each other. The therapist's subjectivity is arguably as important as that of the client and that one way to bring these both to the foreground is through self-disclosure. Farber (2003) who shares this view suggests that the therapist no longer is seen as the only expert in the therapeutic encounter. Instead, of observing and analysing a client's thoughts, feelings and behaviours, he or she is part of a bidirectional field whereby both the therapist and the client co-construct meaning of what they are experiencing. Self-disclosure could play a vital role if a shift from an intra-psychic to a more relation model that focuses on the mutual interaction of two people takes place (Bridges, 2001). Intersubjective theorists put forward that TSD is unavoidable and place particular importance of disclosing in the therapeutic frame (Bridges, 2001). Therapists bring their whole selves into the therapeutic room, their knowledge and professionalism as well as their identity, character and spirit.

As a result, therapist genuineness is strongly connected to a sincere interaction and engagement with the therapeutic process that encourages openness (Lietaer, 2001; Wyatt, 2001).

This emphasis on connection and collaboration is consistent with multi-cultural counselling as well as several other culturally sensitive approaches to treatment. For example, the primary goal of Relational-Cultural Therapy is to foster mutuality, authenticity and mutual empowerment (Sparks, 2009). As Rani explained, *“umm I think [the TSD] kind of took away a bit of the power that therapists have which is a good thing; you know we’re just two people in a room”*. The common assumption for participants was that therapy would perhaps be a one-way process, in which they talk and the therapist listens. However, TSD seemed to help change these perceptions and form a context in which the client felt empowered and connected to themselves and others.

Research on the impact of client attachment also shows that secure attachment to the therapist is positively correlated with increased self-disclosure (Saypol & Farber, 2010). All of the participants described feeling more comfortable, relieved or closer to the therapist after he or she self-disclosed. For the participants, TSD was a way of building trust, shifting the TR and creating an intersubjective space where they felt safe. This is in line with the work of Fife et al. (2014) who recognised the importance of the therapist’s way of being as imperative for clinical work and the TR. They presented a model that suggested that for effective therapy to take place, therapists need to not only consider what they do, but also who they are and how they regard clients. They go on to argue that the effective use of skills and techniques is reliant on the quality of the TR, which in turn is dependent on the therapist’s way of being and their in-the-moment stance or attitude towards clients, which may refer to TSD. By simply moving from a formal interaction to a more personable one, TSD can help build a relationship between the client and therapist and enable the client to feel at ease in the therapy setting.

In this study and other research studies (e.g., Knox et al., 1997) TSD had a noticeable impact on the power dynamics/role reversal between the participant and therapist. Disclosures showing the *‘humanness’* of the therapists promoted a greater sense of equality within the relationship. It seemed as though participants could position their therapists simultaneously as both *‘professional’* and *‘just another person’*. However, although Vasquez (2009) found TSD to engender egalitarianism this study suggests this is not always the case. For example, there were occasions where revelations of therapist *‘genuineness’* was not always beneficial to the TR and actually resulted in the participant questioning their abilities. They reported feeling as though their space had been taken away from them; it was in

these instances where themes of 'loss of control' and 'power imbalance' were strongly reflected on, resulting in participants explicitly disconnecting from their therapists and the therapeutic process.

However, four out of six participants reflected on how the TSD alleviated the perceived power imbalance between them and their therapist, and meant that they felt a sense of safety and security and that a more balanced relationship was formed which allowed them to feel connected to their therapist. As Vasquez (2009) argues TSD could be one way to reduce the power imbalance that can exist in the therapist-client relationship. Bitar et al. (2014) found that a more collaborative alliance was formed when clients experienced TSD. These findings are also in line with the multi-cultural perspective where it is suggested that TSD can equal power dynamics and create a feeling of solidarity between the therapist and the client (Vasquez, 2009). As we saw with the participants in this study when they shared an experience with their therapist that resulted in feelings of shame or failure it was helpful that their therapist also shared a similar experience to demonstrate non-judgmental understanding. This was seen to be quite critical in being able to reduce the power imbalance and strengthen the alliance and connection. This supports Goldstein's (1994) suggestion that reducing the sense of alienation experienced by clients can facilitate the forming of a strong therapeutic bond. Furthermore, research (i.e., Segal, 1991; Lee, 1997) shows that respect in SA culture can create and/or add to a power imbalance but the findings of this study are consistent with previous research which suggests TSD can help reduce this. It is therefore vital that a skilled therapist is able to balance their potentially perceived dominant position and reduce the power imbalance to create a two-way open stance of respect and equality (Bitar et al., 2014). The findings of this study strongly suggest that appropriate TSD is one potentially effective way to do this.

Throughout these chapters the researcher and other scholars have referred to TSD as an intervention or a technique (e.g., Goldfried et al., 2003). Anita and Rashmi also seemed to reflect on TSD as it being a therapeutic tool. However, the emphasis placed on the genuineness of the therapist that came through the participants' accounts speaks of TSD being more than just a tool. This is debatable and perhaps TSD could actually be seen as a way of therapists expressing genuineness to enhance connection with the client and facilitating the TR with the client. Participants reflected on this genuineness as enhancing the connection between them and their therapist, therefore, indicating that the genuineness or congruence of the TSD could be a way of facilitating connection. This is in line with the core conditions psychologists should display in order to improve a client's condition (Rogers, 1961).

Furthermore, there seemed to be a strong sense of participants wanting their therapist to understand them and offer something 'beyond textbook', or beyond simple reflection of what they had recently disclosed. They appeared to seek and value understanding and acceptance of their experiences. The present study is consistent with the findings of other qualitative research (e.g., Knox et al., 1997), as overall participants seemed to appreciate the genuineness of their therapist that was revealed through the TSD and did not pose a threat to the therapist's perceived professionalism or expertness. Comparably, Edwards and Murdock (1994) also found that the main reason therapists attributed to their self-disclosures was to increase similarity between themselves and the client, with increasing expertness listed as the least cited reason for disclosure. For the participants it seemed that TSD provided an impression of expertness that was more concerned with trusting the therapist to understand their experience from a more 'lived from' perspective. These findings are also in line with the interpersonal theory that suggests that therapist's attractiveness, trustworthiness and expertise are not mutually exclusive (Strong, 1968). Instead they are all related and TSD includes these concepts to increase trust in the therapist and as a result enhance the connection between the two parties; it also increases the likelihood for the client to disclose further.

Although some participants viewed TSD as an "intervention" that according to Bitar et al. (2014) could be viewed as something forced or scripted, others experienced it as a natural part of the therapy. Being able to connect with a client could be quite challenging particularly with SA clients, whose values emphasise collective needs, interdependency and conformity (Ponterotto et al., 1995). The participants also experienced TSD as a way of maintaining genuineness and authenticity – key aspects of a relational approach. Further, when the therapist self-disclosed an event/experience whereby he/she felt misunderstood, the participant felt less isolated and different from others. It allowed them to feel that their therapist actually understood and empathised with their difficulty. For some participants this enabled them to continue with therapy and change their initial pessimistic views about therapy and its benefits. Given the reluctance of SA clients to seek or remain in therapy TSD could be an important technique to use as a way of engaging them in the process.

Participants talked about '*connection*', '*alleviation of power imbalance*', '*deeper level of work*', '*genuineness*'. These factors seem to have constituted important qualities in empowering the participants and healing. The findings are consistent with Hanson's (2005) study which showed that participants viewed TSD as helpful, were made to feel understood and cared about. A sense of genuineness, authenticity and empathy shown by therapists are closely linked together (Cooper,

2004). However, in this study empathy did not emerge as a theme but it may have been implied implicitly by participants when referring to their therapist's showing genuineness and authenticity.

With this group of participants there was an overall positive experience of TSD. They saw their therapists show openness, strength, vulnerability, and sharing strong feelings. The use of TSD in this way facilitated the therapeutic alliance but also developed an experience of client 'self-cohesion'—where participants felt internal emotional integration through the connection to another person who has shared a similar experience (Bitar et al., 2014). The TSD encouraged trust, empathic understanding, and credibility of the therapist, which are in keeping with the values of counselling psychologists. Generally, this helped to develop a sense of similarity and connection between the participants and their therapists. However, it is important to keep in mind that there were two participants who experienced the TSD as belittling or irrelevant to what they had been discussing. The mix of experiences is also consistent with previous research and not really surprising in the context of the TR, the quality of which is the key to how TSD is received. This perhaps underlines the significance of the relational and dynamic nature of how therapy, and within that, TSD, is experienced and perceived. The thoughtful use of TSD can equalise the TR and enhance connection between the therapist and client as it seems the TSD enables clients to perceive the therapist as more human. Authenticity and genuineness shown by the therapist are particularly valued by multicultural models of interventions and as Vasquez (2009) argues, these qualities can enhance the therapeutic alliance. TSD thus could be one way to increase support and connection with the client.

4.4 Critique of the present research and direction for future studies

4.4.1 Qualitative methodology

Qualitative methodologies are limited by the fact they seek depth not breadth, and therefore the findings produced by such methods cannot be generalised. However, in line with the aims of this study the qualitative method adopted means its strength lies in its contribution to building a richer understanding of SA clients' experiences of TSD and its impact on individual therapy. In addition, it facilitates a rich contextual understanding which quantitative research may not seek to capture (Hanson, 2005). There seemed to be an emphasis on more positive aspects of TSD. However, having revisited the data it was found that this was not an imbalance, but was merely the experience of this particular group of participants. Interestingly, the two participants who had a negative experience of TSD received the disclosure from therapists who practised a modality where self-disclosure is not

considered common. However, it is possible that one of the reasons why the experiences came out as positive overall was that they felt a loyalty towards their therapists because even when things are difficult there is still a connection, a bond, and a close relationship. Furthermore, the fact that the researcher was a training counselling psychologist may have also impacted on the participants wanting to present an overall positive experience of TSD. A further explanation that could be considered is one regarding culture. As highlighted previously, within the SA community there is a cultural tendency to hold back from expressing negative emotions particularly with their elders or with people of authority (Laungani. 2004), which may be another reason why the experiences of the participants emerged more positively.

The accounts provided by the participants were from those who had concluded therapy within the preceding year, in an attempt to limit distortions in memory recall. Therefore, specific instances of disclosure, particularly for participants who had longer term therapy is open to criticism of possible distortions and omissions of experience (Giorgi & Giorgi, 2003). Memory recall could be changeable and subject to interpretation. Consequently, it could be argued that IPA explores memory of experience rather than experience itself, an issue which at present seems vague. Nevertheless, if representations of participants' experiences without insinuation about truth or reality are considered, analysis of such narratives might be seen as valid in IPA.

A follow up interview could have been scheduled after the initial interview and before data analysis begun. This would have offered the researcher the opportunity to clarify any information from the first interview and to explore additional reactions of the participant that may have arisen as a consequence of the initial interview (Burkard et al., 2006). However, doing this could introduce the issue of participants having time to think about their answers and changing their minds based on wanting to please or wanting to present a different perspective. It would be important for the researcher to set the expectation from the start that participants would not be permitted to re-do the interview and that the follow up interview was solely for clarification.

Although the interview was semi-structured and aimed to obtain the individuals' subjective accounts, a broad definition of self-disclosure was included in the information sheet in order to ensure participants knew what the study was about. Therefore, it is possible that participants may have felt the researcher had preconceived ideas about the nature of TSD. This may have tentatively prompted

the participants when thinking about what they understand TSD to be and could have meant that their understanding was limited to what they had already been exposed to.

4.4.2 Use of IPA

IPA was used as it was believed to be the most appropriate method to address the research aim. An idiographic approach emphasises the individual subjectivity of each individual however, IPA also seeks to understand the nature of a specific experience across the homogenous group to elicit the underlying structures of the meaning-making of that group. Therefore, IPA gives a voice to a specific group of people resulting in an account of the experience of TSD that stays true to the fundamental phenomenological concern of how the world 'appears' to that specific group. The findings of this study therefore have outlined an account of experiences that has been co-constructed between the research and the participants' perspectives (Bhati et al., 2014; McLeod, 2003), facilitated by the use of semi-structured interviews. The semi-structured interviews were led by the participants and it is believed this method would have counteracted the possibility of participants changing their views or opinions to fit into those of the researcher. Overall, a positive account of TSD appeared to be experienced by the participants, but the qualitative approach adopted by the researcher facilitated a more nuanced understanding that included both positive and negative experiences within a general context of positive responses. However, what may be interesting to explore in the future could be the perspectives of clients with an overall negative experience of therapy and how TSD may have emerged within that particular context.

However, some criticisms of IPA as a methodology were put forward by Willig (2008). She states that IPA has conceptual and practical limitations and acknowledged several ideas about the role of language. IPA is dependent on the participant being able to use language to communicate their experience to the researcher and the method is grounded in the belief that an individual is able to express the richness of experience via language. Thus, IPA assumes that participants' accounts reveal something about their experiences through expression of their thoughts and feelings (Kvale, 2009). However, Willig (2008) proposes that not all individuals can utilise language in such a way as to effectively communicate the richness of their experiences (Willig, 2008). With that being said, in this study there were instances where participants were able to use language to reflect their experience. For example, this can be seen in Karina's quote where she reflects on '*hitting a brick wall all of the time*' and '*going over the same thing and over and over again*'. Her choice of words and tone of voice recreated her experience of repetition, in the interview. This makes explicit, her verbal expression of

her experience of repetition in therapy. IPA prioritises individual lived experience and how individuals make meaning of that. As such it assumes that language directly reflects experiences of a particular event and situations (Lyons & Coyle, 2007).

In addition, an obvious criticism of IPA is that in the analysis the researcher chooses which quotes to present and the reader is not provided with the entire transcript. This is a criticism of IPA regarding transparency. Thus when the themes were presented and it seemed that there was a lack of balance it may strike as unusual however, when the transcripts were revisited it was felt that the way the themes were presented best reflected this group of participants' experience.

It is suggested that the findings from IPA studies can be further illuminated through theoretical generalisability in relation to existing professional and experiential knowledge (Smith et al., 2009). Smith et al. go on to state that IPA does not avoid generalisation from the findings, but does so with caution—locating findings within the particular context in which they are situated. One of the aims of the study was to construct helpful insights which could be used to enrich therapists' understanding of self-disclosure when working with SA clients. Willig (2008) also states that qualitative phenomenological research can be used to inform recommendations for improving practice with clients in counselling psychology.

4.4.3 The sample

The sample for this study was purposive and self-selected from a group of individuals who belonged to a particular ethnic group. In accordance with IPA, the sample is small and thus the findings are not generalisable. Further, the study is not representative of all SA individuals who have had therapy as IPA prioritises the broad underlying structures of the experience in question for this group and not all SA individuals who have experienced TSD in therapy. In addition, those individuals participating in this study were all second generation SAs, providing a fairly homogenous sample. It could therefore be assumed that having been raised and educated in the UK the participants may have adopted the norms and values of British culture. Therefore, changes in views across generations about therapy, seeing a psychologist, and accessing mental health services means that the context within which the participants accounts are embedded, may differ between other generations. Therefore, future research may explore the views of other generations. This study represents a starting point for understanding SA clients' experiences of TSD. Thus, it is important to note that the researcher's aim was not to produce generalisable findings but to unfold new ideas and explore the subjective experiences of SA clients (Willig, 2008). Furthermore, the sample used in this study was recruited

without an attempt to control for homogeneity regarding the orientation of the therapist. This is likely to have had some sort of impact on how the TSD was received considering the various orientations have different views regarding the appropriateness of TSD. Adopting a more focussed approach by recruiting solely those that experienced one modality may have produced different results.

The recruitment stage was particularly difficult and took longer than expected, perhaps due to the naivety of the researcher. Furthermore, experiences of therapy may be considered a culturally sensitive topic to explore and as a result may have been one of the reasons why the researcher experienced difficulties in recruiting participants to the study. However, the researcher could have recruited within the NHS and given more time, could have widened the area and broaden recruitment to outside London.

Only one SA male client was successfully recruited for the study and although this study was not exploring gender it may emphasise a potentially female perspective. Future research might explore the experiences of men as it is possible they may be more sensitive/susceptible to cultural biases regarding therapy (Lindinger-Sternart, 2000). In retrospect, the researcher could have approached male-only services in an attempt to recruit more male participants. The participants in this study were volunteers. This suggests that they were open to discuss their experience of TSD with the researcher. However, their views and experience could have differed from those who did not volunteer to participate. For the individuals who did contribute to this research, as evidenced by some of the participants, their experience of TSD could have been particularly significant to them, generating a range of thoughts or feelings and could have indicated that they had a personal interest in the subject matter. For those individuals who did not participate, TSD may not have been significant to them at all. Future research could focus specifically on a group of individuals who had negative experiences of TSD.

Initially, an additional inclusion criterion was included which was for participants to have seen a SA therapist. This was to ensure as homogeneous a sample as possible could be recruited to account for the requirements of conducting IPA research. This criterion was later excluded due to difficulties experienced in the recruitment process. In this study two participants were ethnically matched and four saw Caucasian therapists. Of the two participants that saw therapists from the same ethnic background, one described a negative and positive experience of TSD whereas the other seemed only

to experience TSD in a positive way. The remaining participants all saw Caucasian therapists and all experienced TSD in a helpful way. In light of research evaluated in the Introduction, exploring the impact of ethnic matching of therapist and client, it is difficult to say whether or how removing this initial inclusion criterion may have impacted the results due to inconsistent findings found in other studies as well as in the current one. As Sue (1998) argues, ethnic matching may not be effective for all and it is important to ascertain in what contexts it may be.

4.4.4 Researcher's bias and subjectivity

In qualitative research, it is important to consider the researcher's position within the study. The researcher cared deeply about the topic being investigated; therefore, issues of stake and interest may have been present throughout the research process, particularly during the interview. For instance, verbal and non-verbal nuances, such as agreement or disagreement, or the parts of the clients' stories that the researcher chose to probe further, whilst potentially ignoring other parts, could have been present. The researcher was therefore mindful to ask participants for experiences that reflected both positive and negative experiences of TSD. It was also important that the researcher was aware of the contextual constructionist position of the study and therefore, did not assume that there was one truth that could be discovered and that discoveries made would vary and be dependent on the context in which the data were collected and analysed. To potentially deal with biases and presuppositions that may have arisen, the researcher engaged in reflexivity via a reflective diary throughout the research process (Morrow, 2005). The researcher made notes of areas of interest and issues of stake in the hope of being able to maintain as neutral position as possible in subsequent interviews. However, it is important to note that a totally neutral position can never be assumed as a counselling psychologist researcher.

Additionally, participants were informed of the status of the researcher as a trainee counselling psychologist. Although participants were informed that their responses would remain anonymous, participants may not have disclosed information that could be viewed as critical of therapists, TSD, or therapy, therefore, possibly impacting on the credibility of the findings.

Finally, whilst keeping in mind that in IPA one makes an effort to set assumptions and preconceptions aside, interestingly and contrary to expectations not much information emerged about culture and how that perhaps impacted on their experience of TSD. In keeping with IPA methodology, the semi-

structured interview was focussed on one phenomenon, TSD; therefore, specific questions were not asked about the participants' culture. Issues of culture may not have emerged so noticeably in the narratives due to the construct of enculturation (i.e., the extent to which individuals adhere to the norms of their indigenous culture) (Kim et al., 2001). It was suggested by Kim et al., (2001) that Asian Americans' adherence to their cultural values is an important indicator of their enculturation. For example, it would be expected that those who have recently immigrated would adhere more strongly to their cultural values than those who have been born and brought up in the host country. However, Kim et al. (2003) found from their study that clients' adherence to Asian cultural values and whether they experienced TSD or not did not have an effect on session outcome. With regard to this study, those who participated were all born in the UK and perhaps are many generations removed from immigration. Therefore, they may not strongly adhere to their cultural values and so enculturation may not be such a problem for them. Hence, why cultural did not emerge as a distinct theme in itself. The present study perhaps provides further support for the Kim et al. (2003) study in that cultural issues or values did not seem to manifest to a great extent in the participants' experiences of TSD.

4.5 Implications for Counselling Psychology Practice

Few studies have explored issues of ethnicity and diversity in relation to TSD, and this is important, especially given that multicultural therapists are inclined to advocate the use of TSD to reduce the power imbalance between therapists and clients, to decrease feelings of shame that clients may experience and to encourage further self-disclosures from clients. Due to the lack of research exploring the SA populations' experience of TSD, this research has to be contextualised within a field of research exploring other populations, primarily the American populations' experience of TSD. However, there are some gaps because although there is research that applies more broadly to people of that part of the world, there are inevitably cultural differences and this research is specific to the SA population. This study provides a significant contribution to an understanding of the phenomenon of TSD and appears to be the first study to be conducted exploring SA clients' experience of the phenomenon. Searches of the literature showed that there is a dearth of research exploring SA clients' perspective of TSD.

The study has provided an understanding about these participants' feelings and thoughts about TSD through an 'inside view' as a result of this qualitative design. By having a deeper understanding of the

impact of TSD, therapists will hopefully be able to make more appropriate decisions regarding their use of self-disclosure and may also feel more confident in doing so, by seeing the benefits it can have. As Sue and Sue (1999) state, one way of therapists becoming culturally competent could be to learn when and how to use self-disclosure. The findings of this study therefore provide some principles for using TSD with SA clients.

The analysis shows that TSD can, from the perspective of SA clients, be beneficial to the client and the TR. As Knox et al. (1997) stated, therapists would be more confident in using TSD effectively if there was a deeper understanding of the experiences of TSD. Thus this study discovers important insights into the experience of TSD from the perspectives of SA clients. This knowledge could enable counselling psychologists to use TSD with more positive results. The findings indicate a role for TSD with SA clients in challenging the beliefs of an individual by both normalising emotional reactions and modelling alternative responses. The superordinate theme 'Impact of therapist self-disclosure on self' captures the instances of where this was viewed to be helpful and shows examples of how therapists' revelations of how they felt similar emotions in similar situations provided participants with a model for acceptance of flaws and a model for seeing things from a different perspective. This seems particularly important for SA clients, where adherence to their cultural values stresses they should restrain from expressing strong emotions, particularly negative ones (Laungani, 2004). However, the findings also suggest that disclosure of the 'wrong' type can explicitly impact the individual and the TR in a negative way. In line with existing literature this therefore suggests that it is the careful use of TSD that is most beneficial.

The superordinate theme 'Understanding of therapist self-disclosure' captures a further implication of this research in that self-disclosure is best used when therapists share personal feelings or experiences that match the client's experience and that once enough information has been given about how one can approach a similar situation, enough has been disclosed. Counselling psychologists may look at some of the inappropriate examples of TSD that were reported by participants and view them as things not to share with a client. However, considering that this research included six participants and two of them had negative experiences of TSD, counselling psychologists need to be assessing each client's reactions to their style of working and have a sound understanding of the TR with that particular client.

Another important implication is that the TSD enabled participants to view their therapists as 'real and

genuine' and promoted openness with further disclosures from the participants. Furthermore, the TSD facilitated the TR further by fostering a bond and connection between the participant and their therapist. As a result, participants felt comfortable and at ease with discussing issues previously held back without feeling ashamed or selfish. Although SA cultural values see one's own sense of self as existing in relation to others, and pursuing one's own goals that go against those of the family is seen to be selfish (Segal, 1991), for this group of participants it seems that the TSD, which allowed for a real connection to be formed, enabled them to feel comfortable to discuss whatever was important to them. This was something that explicitly emerged from all the participants' accounts.

Furthermore, it is important for counselling psychologists to consider that the participants were very aware of the feelings that resulted from appropriate and inappropriate disclosures. This seems particularly important and provides professionals with additional knowledge about the dynamics of the TR and what may be considered as appropriate boundaries for using TSD. This is particularly important to consider with SA clients given the cultural tendency to hold back disclosure of strong emotional experiences with anyone outside of the family unit or to keep it to themselves. Although the participants of this study seemed to be aware of their feelings in response to the TSD this may not be the case for other SA clients and may also apply to all ethnicities. Therefore, it is an important consideration when working with any client, regardless of ethnicity. Furthermore, if psychologists are aware of this then they will be able to discuss this with their clients and encourage them to speak freely about this.

These and other similar findings regarding the use of TSD may encourage psychologists and other professionals working within mental health services to be open to the possibility of utilising it. TSD emerges from the therapeutic encounter in the here and now and usually requires the therapist to make potentially difficult decisions on the spot which is possibly why it seems to be neglected. Therefore, to disclose personal experiences, feelings, or information should be judiciously deliberated, in the context of the individual client and the TR at that specific moment in time. Furthermore, therapists need to be cautious in their use of self-disclosure with a clear rationale and purpose behind its use. It is for this reason why this research may be of real use, adding clarification and insight into what may be helpful and what not for this population. As noted with the participants of this study, when therapists self-disclosed without thought or a clear rationale, when the reasoning behind the disclosure was not understood by the participant, TSD appeared to have unintentional negative consequences. Therefore, self-disclosures can be risky for the client and therapist, the TR, and could leave the therapist feeling vulnerable. This being said, it is particularly important that appropriate

support for the therapist is provided by their supervisor in the decision making process and to also discuss the post self-disclosure impact with the client.

With the growing body of literature illustrating the potentially varied impact of TSD both on the client and the TR, there is growing rationale to ensure that this skill/intervention/way of being is appropriately addressed in training programs and supervision. TSD can be included within a variety of contexts, such as studying common factors in the TR, culturally competent ways of working, and when considering the therapist's use of self in therapy (Bitar et al., 2014). Using TSD effectively requires significant knowledge about the self, intuition, and openness. Although disclosing is arguably a natural part of us, it does not come naturally in the therapeutic context, and requires therapists, particularly trainees to have appropriate guidance and supervision on the appropriate use of TSD (Bitar et al., 2014). Most therapists either talk about TSD in binary terms: you either do it or you do not. However, as Spinelli (2002) suggested, it is most important to consider when a therapist should self-disclose rather than whether they should do it or not. It is important to treat each client as unique when considering the possible use of TSD. It would seem that for these participants, the content may be more important than timing.

4.6 Reflexivity

The present research has achieved its aim to produce both descriptions and insight into SA clients' experiences of TSD in the therapeutic encounter, via those who have experienced the phenomenon directly. The themes that emerged from the interviews were interrelational and intersubjective (i.e. actively created and co-constructed between the researcher and participants) (Kvale, 2009). It was created through the lens of a contextual constructionist; it is assumed that the interview data reveals something about what it is 'really like' for SA clients to experience TSD, at the same time accepting that what emerged from the data does not offer direct access to the participants' reality (Willig, 2008). The methodology used positions itself in the epistemological 'middle ground' between a naïve realist and a radical constructionist (Willig, 2008). Thus, the findings may be viewed as both discovered and co-constructed through an interpretative process, a double hermeneutic.

What was incredibly encouraging throughout my research process was the reaction of other professionals I spoke to. The practitioners expressed great enthusiasm in the topic and also shared instances where they had self-disclosed. I had expected some hesitancy from others and the interest, enthusiasm and openness of some practitioners was very unexpected.

I acknowledged my preconceptions regarding the positive impact that TSD can have on clients from the outset, and this has certainly emerged as a theme. However, what was surprising for me was emphasis on the connection aspect that TSD seemed to bring about – an aspect of which I was unaware in my preconceptions at the outset.

My position as a trainee counselling psychologist where I am inclined to follow an integrative orientation is very much informed by a relational counselling psychology model which places great importance on the development and maintenance of the TR as an indicator of good practice (BPS, 2006b). As therapists we are constantly disclosing information to our clients. The clothes we wear, the way we greet our clients, the way in which our office is decorated, our facial expressions, are all ways in which we are giving our client an insight into who we are as people. Therefore, I try to ensure that my decision to self-disclose is informed by the needs of the relationship in that particular moment with that particular client. The research study has not made me self-disclose more or less with my clients, but I have gained a much deeper insight into the importance that comes with making this decision and the impact it can have on the other.

Through this research, although it focussed on verbal self-disclosure, I have started to become more aware of how I am dressed and what my clinic room looks like and what these things communicate to the client about me. I had a client who would regularly comment on my figure and what I was wearing and would regularly offer me compliments. We would then begin our work on low self-esteem. I could not help but feel more self-conscious of my physical appearance and what this may have meant for my client and how this made my client feel as the way we looked and our build were completely different. I almost felt bad for the way my body was built as this was one thing my client was self-conscious about. However, it is very difficult to imagine how I would be able to control any of these things and how inherently we can be therapists without disclosing who we are as people. My ongoing struggle with decision making regarding whether or not to use self-disclosure with clients, is complex and in theory is, I hope, part of the process of ‘being’ a reflexive, reflective practitioner.

4.7 Conclusion and Summary

The observations made in the present study revealed interesting and previously unexplored aspects of the experience of TSD. While some of the findings were consistent with previous literature the current research has revealed a new and more nuanced understanding of this experience, particularly

regarding how TSD facilitated a strong sense of connection for the participants between themselves, others and their lifeworld.

The analysis resulted in four super-ordinate themes: 'Understanding of therapist self-disclosure'; 'Experience of therapist self-disclosure'; 'Impact of therapist self-disclosure on self'; and 'Impact of therapist self-disclosure on the therapeutic relationship'. TSD can be experienced as helpful and unhelpful and participants were able to hold both positions as valid. Interestingly, when the TSD was experienced as unhelpful, participants were able to reconcile this part and move forwards in their therapy. Overall the experience of TSD for SA clients appeared to be a positive one. Participants revealed how the experience of TSD had positively impacted on their emotional wellbeing by making it acceptable to feel undesirable emotions and increase their self-esteem. This appeared to leave them with lower levels of distress. Similarly, the experience appeared to positively impact upon the TR which enabled them to feel more connected to their therapist. The findings of this study suggest that TSD is one way of facilitating client self-disclosure, and fostering and maintaining the TR within a multi-cultural counselling context for SA clients. TSD also appears to have other benefits, such as normalising client problems, alleviating power imbalance, and reducing a sense of isolation and increasing a sense of connection with themselves, the other and their lifeworld, which are key components of facilitating culturally sensitive care.

In conclusion, the present study has provided a rich and detailed picture of what it might be like for SA clients to experience TSD. Using the TSD to facilitate and enhance a sense of connection between the participants themselves but also between others and their lifeworld seemed a particularly important part of their experience overall, and something that permeated throughout their narratives. It is hoped that this research can contribute to the bigger picture emerging within current literature. Taking into account the dearth of research exploring the perspective of SA clients, it is hoped this study may provide counselling psychologists with a valuable insight into the lived experience of this phenomenon, which stands to enhance therapeutic practice with this client group. In addition, the observations made may help in devising more effective ways of working with this particular group of clients.

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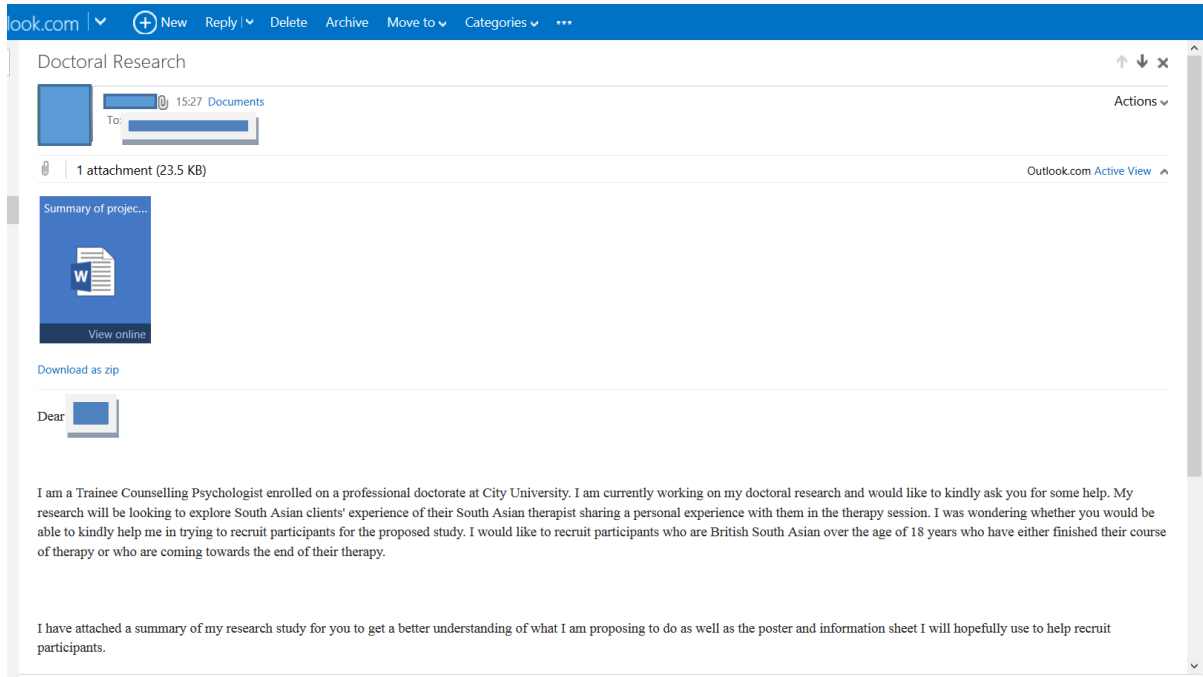
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APPENDICES

APPENDIX A: Record of correspondence – example of email sent to services



APPENDIX B: Recruitment poster

Department of Psychology
City University London



PARTICIPANTS NEEDED FOR RESEARCH IN...

Exploring South Asian clients' experiences of therapist self-disclosure in individual therapy.

ARE YOU SOUTH ASIAN?

ARE YOU AGED 18 YEARS OR OLDER?

HAS YOUR THERAPIST EVER TOLD YOU SOMETHING PERSONAL ABOUT THEIR LIVES?

IF SO THEN PLEASE READ ON...

My name is Sheetal Patel and I am currently studying a Professional Doctorate in Counselling Psychology at City University. My research looks at the how you made sense of and understood your therapist sharing a life circumstance, past experience, personal belief, value or emotional struggle with you during your therapy session. You will be asked about this experience about how it made you feel and how you feel it influenced the therapy process.

You would be invited to attend a one-off face-to face or Skype interview with the researcher to discuss the topic. The interview will last up to 60 minutes, in which you can leave at any time if you wish.

In appreciation of your time, refreshments will be offered on the day of the interview.

For more information about this study, or to take part, please contact:

Sheetal Patel, Trainee Counselling Psychologist

Email: [REDACTED]

This research is supervised by Dr Jessica Jones Nielsen, Counselling Psychologist
City University London

This study has been reviewed by, and received ethics clearance
through the Psychology Department Research Ethics Committee, City University London.

*If you would like to complain about any aspect of the study, please contact the Secretary to the
University's Senate Research Ethics Committee on 020 7040 3040 or via email:*

Anna.Ramberg.1@city.ac.uk

APPENDIX C: Demographics form

Participant demographics form



Your gender: Male ☐ Female ☐

Your age: _____

Your ethnicity: Asian or Asian British: Indian
Asian or Asian British: Pakistani
Asian or Asian British: Bangladeshi
Asian or Asian British: Other (Please specify.....)

Country of origin: _____

Gender of your therapist: Male ☐ Female ☐

Ethnicity of therapist: White: British
White: Irish
White: Other (Please specify.....)
Mixed: White and Black Caribbean
Mixed: White and Black African
Mixed: White and Asian
Mixed: Other (Please specify.....)
Asian or Asian British: Indian
Asian or Asian British: Pakistani
Asian or Asian British: Bangladeshi
Asian or Asian British: Other (Please specify.....)
Black or Black British: Caribbean
Black or Black British: African
Black or Black British: Other (Please specify.....)
Chinese
Other (Please specify.....)

Therapeutic approach used by therapist, if known: _____

Type of therapy: Individual ☐ Group ☐

Number of sessions completed: _____

APPENDIX D: Interview schedule

Understanding of therapist self-disclosure

1. How do you understand the concept of therapist's verbal self-disclosure?

Experience of therapist self-disclosure

2. Did at any point in therapy your therapist self-disclose?
3. So how long were you in therapy when your therapist self-disclosed for the first time?
4. How would you describe the nature of the self-disclosure?
Prompt: e. g. Reflection of own feelings/personal biographical information/relating own experiences?
5. What was happening when your therapist revealed information about him/herself?
Prompt: What were you talking about? (before/ at the time)
6. How did you experience your therapist's self-disclosure?
Prompt: how did you feel, how did you react, how did you receive it?

Impact of therapist self-disclosure

7. Did the content of self-disclosure have an impact on your relationship with your therapist?
8. Did this have any impact on your session?
Prompt: e. g. Did this change the way you communicated?
Relaxed/opened up more or more reluctant to talk about self
Brought focus to my issues or distracted from my issues?
Did this change your perceptions of yourself/ issue/ others?
9. Did this have any impact on subsequent sessions?
Prompt: Did this change the way you communicated?
Relaxed/ opened up more or more reluctant to talk about self,
Brought focus to my issues or distracted from my issues?
Did this change your perceptions of yourself/ issue/others?
10. When did you find your therapist's self-disclosure more beneficial and when did you find it disruptive?
Prompt: in what way did you find it helpful? Were there any times you found TSD disruptive?
11. How has your experience with your therapist's verbal self-disclosure or lack of it influenced your views about therapy?

APPENDIX E: Participant Information Sheet



Participant information sheet

Title of study: To Disclose or not to disclose? An exploration of South Asian clients' experiences of therapist self-disclosure in individual therapy.

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This research study is being carried out as part of my professional doctoral training in Counselling Psychology. In this study I would like to understand how you made sense of and understood when your therapist shared a life circumstance, past experience, personal belief, value or emotional struggle with you during your therapy session. I am interested in what your experience of hearing your therapist tell you something personal about themselves was like and how it made you feel. You will be asked about what your thoughts and views were and how you felt this impacted on the therapy process and the relationship between you and the therapist. The findings of the study will aim to help in developing a better understanding of the way South Asian clients experience therapy and whether therapists sharing personal experiences helps or not.

Why have I been invited?

You are being approached to take part in this study because you are South Asian aged 18 years or older who has had experience of psychological therapy and who has had more than 6 sessions of therapy.

Do I have to take part?

It is your decision whether you decide to take part in the study or not. Participation in the project is voluntary. If you do agree then you will be asked to sign a consent form. If for whatever reason you decide to withdraw from the study, you will have a time period of up to 2 weeks to do so and the information you provide in the interview will not be used in the study. If you do decide to withdraw from the study, this will in no way have any adverse implication for you.

What will happen if I take part?

Firstly, I will then contact you to arrange a time and date that is convenient for you to talk about your experiences. The study will involve having an interview with me for approximately 45-60 minutes. In this interview it is important to me that you feel relaxed and comfortable as possible. I will ask you a

series of questions in relation to what your experience was like of having therapy. Before the interview takes place you will be asked to sign a consent form to agree that you would like to take part in the study.

Some important points:

If you consent, the interview will be audio-recorded, transcribed and segments of this may eventually be incorporated into a report of the findings of the study that will be lodged and available for other interested researcher's to access at City University library. The report will also be accessible to other individuals such as the Research Supervisor and other tutors who will be formally assessing the report. However, you will remain completely anonymous i.e. Your name and any other identifying information will not at any point be made available. The researcher will be the only one who can see this information.

All information that you provide will be secured in a safe place by the researcher. The only exception where confidentiality may need to be broken is if any information you provide suggests any illegal activity or harm to the self or others. In this case, appropriate services or the authorities will need to be informed. The audio tapes used during the interview will be destroyed once the study has been assessed and marked. Transcripts of the interview will be kept for a maximum period of 5 years in case the study is published in an academic journal but will then be destroyed.

The interviews will take place within the premises of City University, London, or in a place of your choice. You will be reimbursed for your travel ticket that you purchase for coming to the university.

As you would be invited to talk about your experiences of therapy, it is possible that this may evoke difficult thoughts and feelings. If you wish, you may also take small breaks during this period to help you feel more relaxed about discussing your experiences. You do not have to answer any questions you do not wish to and have the right to end the interview at any point.

You will have an opportunity to share your experience of what it was like to do the interview at the end and you will be provided with contact details of appropriate forms of help that you may find useful. These will be counselling and general support services.

Your contribution to the study:

Your input and contribution to this study is very much appreciated and will provide valuable information to healthcare professionals who are trying to make psychological therapy services more useful and relevant to South Asians and other ethnic minority groups. I am happy to answer any further questions or queries that you may have.

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: To

Disclose or not to disclose? An exploration of South Asian clients' experiences of therapist self-disclosure in individual therapy.

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

Who has reviewed the study?

This study has been approved by City University London, Psychology Department Research Ethics Committee.

Further information and contact details

Sheetal Patel, Trainee Counselling Psychologist

Email: [REDACTED]

This research is supervised by Dr Jessica Jones Nielsen, Counselling Psychologist, City University London

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

APPENDIX F: Participant Consent Form

Consent Form

Title of Study: *To Disclose or not to disclose? An exploration of South Asian clients' experiences of therapist self-disclosure in individual therapy.*

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped • completing a demographic form	
2.	This information will be held and processed for the following purpose: To help in developing a better understanding of the way South Asian clients experience therapy and whether their therapist sharing personal experiences helps or not. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Researcher

Signature

Date

Name of Participant

Signature

Date

When completed, 1 copy for participant; 1 copy for researcher file.

APPENDIX G: Researchers Checklist

Checklist before interview:

- ☐ x2 glasses of water; light snacks; room temperature comfortable; tissues on side table; lighting appropriate
- ☐ Check phone is on silent
- ☐ Give information sheet
- ☐ Give x2 consent forms to sign
- ☐ Demographic Questionnaire
- ☐ Notepad and pen for note-taking during
- ☐ Dictaphones on x2

Introduce the principles of the interview: (in line with Smith et al., 2009, p.63-)

- There are **no right or wrong answers** - this interview is an **exploration of your experiences**
- My hope is that you are able to talk as freely and honestly as you can about **what your experience of therapist self-disclosure has been like for you**
- It may seem like a one-sided conversation – I'll say very little; some questions may seem obvious but I need to ask them in this way to because **I am trying to make sense of how you understand things**
- **Take your time thinking and talking**
- **I will make notes** about things that I want to ask you about - as a reminder to myself, so I don't interrupt you. Notes will be kept securely and shredded when no longer needed.

Start time:

Estimated end time:

Actual end time:

Checklist post-interview:

- ☐ Thorough debrief and give debrief sheet
- ☐ Time for questions

APPENDIX H: Key points relayed to participant about the interview and what to expect

First, it was made clear there are no right or wrong answers; the interview was framed as an opportunity to tell their story, express their thoughts and feelings, and explore their experiences as they understand them (Smith et al., 2009). It was hoped participants would talk as freely and as openly as possible about what their experiences have been like for them; this was verbalised in the spirit of transparency, with the hope of enhancing their understanding of the interview's purpose.

Second, Smith et al. (2009) recommend highlighting to the participant that it might seem like a one-sided conversation: the researcher will say very little. Furthermore, they suggest explaining that some questions might seem quite obvious, but this is because the researcher is trying to make sense of how the participant makes sense of things. Willig (2008) adds that encouraging participants to 'state the obvious', elucidates their implicit assumptions and perceptions, thus offering greater insight into their reality as they see it. These points were explained.

Third, participants were told to take their time thinking and talking (Smith et al., 2009). It was highlighted that they are viewed as the experiential expert, and I would follow their concerns and tangents. Fourth, participants were made aware I would make notes of key words/topics/phrases I want to learn more about (Smith et al., 2009). This was to help me remember, and later explore, important/interesting aspects of the participant's experiences without interrupting the flow of their narrative. It was clearly stated these notes will be stored confidentially.

To Disclose or not to disclose? An exploration of South Asian clients' experiences of therapist self-disclosure in individual therapy.

Study Debriefing

This study is concerned with understanding how you made sense of and understood when your therapist shared a life circumstance, past experience, personal belief, value or emotional struggle with you during your therapy session. Previous studies have found mixed findings, some finding that therapists sharing personal information with their client is helpful and some studies finding the opposite. This study was really interested in what your experience of hearing your therapist tell you something personal about themselves was like and how it made you feel.

How was this tested?

In this study, you were interviewed for approximately 45-60 minutes. In this interview you were asked a series of questions in relation to what your experience was like of having therapy and experiencing your therapist share something personal with you.

Aim of the research:

The research question of interest to this study is:

‘How do South Asian clients experience therapist self-disclosure in individual therapy?’

The aim of the proposed research is to understand how clients make sense of and understand when their therapist has shared a life circumstance, past experience, personal belief, value or emotional struggle while in session.

Why is this important to study?

Your contribution and input to this study is greatly valued and will provide valuable information to healthcare professionals who are trying to make therapy services more useful and relevant to South Asians and other ethnic minority groups. The findings of the study will aim to help in developing a

better understanding of the way South Asian clients experience therapy and whether their therapist sharing personal experiences helps or not.

What if I want to know more?

If you are interested in the study and would like to know more about study when it is completed please contact:

Sheetal Patel (Trainee Counselling Psychologist) at [REDACTED]

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: To Disclose or not to disclose? An exploration of South Asian clients' experiences of therapist self-disclosure in individual therapy.

You could also write to the Secretary at:

Anna Ramberg

Secretary to Senate Research Ethics Committee

Research Office, E214

City University London

Northampton Square

London

EC1V 0HB

Email: Anna.Ramberg.1@city.ac.uk

Please find below a contact list of forms of help should you need it:

BPS:

<http://www.bps.org.uk/psychology-public/find-psychologist/find-psychologist>

MIND:

15 – 19 Broadway, Stratford, London, E15 4BQ

Tel: 020 8519 2122

E-mail: contact@mind.org.uk

SANELINE:

1st Floor Cityside House, 40 Adler Street London E1 1EE

Tel: 020 7375 1002

E-mail: sanemail@same.org.uk.

Asian Family Counselling Service

Suite 51

Windmill Place

2-4 Windmill Lane

Southall

Middlesex UB2 4NJ

Tel: 020 8571 3933 020 8571 3933 (Mon-Fri 9am-5pm)

E-mail: afcs99@hotmail.com

Confidential counselling service for individuals, couples or families of Asian origin. Counselling is provided by trained counsellors in the main Asian languages. You can have counselling over the telephone or make an appointment to come in.

Confederation of Indian Organisations (UK)

5 Westminster Bridge Road

London SE1 7XW

Tel: 020 7928 9889 020 7928 9889

Email: headoffice@cio.org.uk

Website: www.cio.org.uk

Provides information and advice, and can point you in the right direction for mental health services for South Asian communities across the UK. Also provides counselling and befriending services in certain London boroughs.

Muslim Women's Helpline

Tel: 020 8908 6715 020 8908 6715 or 020 8904 8193 020 8904 8193 (Mon-Fri 10am-4pm)

Website: www.mwhl.org

A faith-based organisation providing confidential information, advice and telephone counselling, as well as some face-to-face counselling, where appropriate.

Samaritans

c/o Chris

PO Box 90 90

Stirling FK8 2SA

Helpline: 08457 90 90 90 08457 90 90 90 (24 hours)

E-mail: jo@samaritans.org

Website: www.samaritans.org.uk

The Samaritans exists to provide confidential emotional support to any person, irrespective of race, creed, age or status who is in emotional distress or at risk of suicide; 24 hours a day. Can be

contacted by e-mail, telephone, writing, or by visiting one of over 200 local branches (details are on the website).

Websites

SpeakUp!

www.speak-up.org.uk

This interactive website will enable people aged 16-25 to share their experiences of mental health services with each other as well as professionals, carers and people involved in community projects. Participants will be able to express their views openly, ask questions and exchange ideas online. It is hoped that this site will help to improve mental health provision across the UK.

Thank you again for your participation.

APPENDIX J: Transcript analysis of Amira's interview

PARTICIPANT 'AMIRA' – signed ethics form and then completed demographic form.

Emergent Themes	Line Number / R or P	Transcript	Initial Noting
Understanding of S.D.	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26	Ok so why don't we begin by you telling me what you understand by the concept therapist self-disclosure? To me that means when a therapist tells me something about themselves, their experience, their feelings, just something that relates to them that could be beneficial to me. So did at any point in your therapy your therapist self-disclose to you? There were some points, I think in my third therapy session where my therapist did disclose to me how she found something difficult because I was talking about my difficulties and I didn't... I couldn't understand why I found something difficult and I wasn't able to accept it because I thought that was me failing but then she gave me her experience where she felt the same that she had failed in something but then she realised it wasn't a bad thing and that's what really helped me get through my get through my therapy and actually understand another perspective because I was able to see me through her if that makes sense. How did it make you feel when she self-disclosed to you? At first when she mentioned it, it didn't make any difference because I couldn't, I couldn't understand it I couldn't see it from my perspective. I was like no that's completely different, were not the same people, we're not in the same job, we're not in the same field and I'm a lot more harder, I was a lot more harsher on myself then than I am now so at first it didn't make no difference and I think she repeated herself in that therapy session for me to understand that oh my god, I'm actually going through the same thing just in a different context. So how would you describe the nature of the self-disclosure? She basically, she just said it in a way where it seemed ok like she wasn't disclosing anything no case study, she didn't mention any names she merely spoke about herself in a situation and how she felt and the difficulties she faced and they type of feelings that aroused within her which was similar to some of the feelings that aroused within me and that's that was the nature of the self-disclosure from her side, it really did help me... see me from another person's perspective. I was able to see myself in a third person point of view just because she disclosed feelings that were	the SD took place after this feeling of stuckness was out but the time of difficulty. didn't couldn't wasn't a moment in this stuckness, lost, stuck? It's all about them (the therapist) but it benefits the client. • Descriptive • Linguistic • Conceptual Definition of SD - something about themselves experience, feelings, related + beneficial to her. Explicitly saying this 3rd session out of 4 sessions SD - found something difficult - exp where therapist felt the same because she found therapy difficult why she was finding it hard Amira stay in therapy helped Amira another perspective seeing herself in the therapist at first. made no difference couldn't - repeated - different, not the same initial reaction this client feeling emotions overwhelmed by her own issues that she can't see outside this. - she does acknowledge that she was harsher on herself back then why did the therapist repeat herself. Now would this be happened. Did the therapist know that Amira's not really listening or in a position to take it on, so I should say it again. Realisation that she's going through the same exp.

Simple intervention making it personal

not simply simply makes comparison between talking about herself + talking about case studies making it personal

But the repetition was the turning point it seems. Disclosed feelings that were similar

Reasons for going to therapy.	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59
Normalising			R4		P4																												
Putting things into perspective																																	
Realisation																																	
Emotionality																																	
Prior views about therapy																																	
How S-D has helped.																																	
Impact of S-D																																	
Normalisation																																	
Therapist vs. family																																	
Validating feelings																																	
Another example of																																	

similar to mine when I was experiencing the hardship, for the reason why I went to her in the first place.																																	
How did that make you feel, knowing that she had gone through the same experience as you or felt the same sort of feelings as you?																																	
At first nothing, but the second time it made me realise that it is ok not to be ok if that makes sense. <u>its fine</u> it doesn't mean that I am a failure it doesn't mean like that I'm not capable it just you know... <u>everyone</u> has weaknesses, <u>everyone</u> has strengths and that was my, that wasn't my strength and <u>you</u> know <u>its</u> ok because the nature of my job was so hard, that it's to be afraid, <u>its</u> ok to be stressed and all these reasons because I was really hard on myself and she made me feel she made me feel relaxed, she made me feel less anxious because at that time of my life I was so anxious and I was so upset within me and at myself and I thought to myself that 'I'm a failure and that I shouldn't have I shouldn't have allowed myself to get to that position where I needed therapy because I never saw myself as someone that would need therapy especially with the field that I work in, I work on a mental health ward, so I have a lot of conversations with my patients, <u>I just never</u> thought that I would be kind of in that patient seat. Even though I wasn't a patient and I'm a client it's still the same thing and I <u>just never</u> thought that I would be at the receiving end as I've been at the giving end all this time. So she she helped me she helped me reflect, that's one of the <u>biggest things</u> I've achieved after my therapy sessions. <u>She's</u> helped me reflect, she's helped me feel less anxious... she's made me she made me realise to accept the situation for what it is and not to cover it up and not to umm not to umm disguise it or no to pretend and say I'm ok because then later on it'll come to a point where I <u>will</u> break down like the way I did then. The whole time I just kept everything to myself, I couldn't really speak to my family, as they wouldn't understand it, or they would just tell me to <u>get over it</u> and <u>go back to work</u> as that's what's most important, or they would be more concerned about what other people would think if they saw me upset and down or if I wasn't going to work. I didn't even tell my family that I was having therapy, they just wouldn't have <u>understood</u> it. They're old school like that. Talk to us beta, you don't need to talk to outside people... that's what they would say.																																	
So hearing her experience just really helped me open up and feel ok about what I was feeling. She was telling me that as a counsellor you know people often umm perceive that counsellors can solve your problems but that's not often the case, they guide you and they help you come up with solutions. So she was saying how when she was umm practising her counselling in her early years it was difficult for her to help some clients who were really strongly under the impression that counselling would solve their problem and when they were unable to come up with																																	

It's ok & Normalising her problem																																	
Putting things into perspective																																	
Realisation																																	
Feelings - related																																	
- less anxious																																	
thoughts - in a failure																																	
Never - never thought she'd be having therapy.																																	
helped me reflect in session but also has taken this out of session																																	
helped her to not hide things (disguise) or to pretend																																	
the SD - normalised her problems allowing this to happen.																																	
family couldn't really understand but therapist could. Family would maybe advise her as she doesn't want this. They wouldn't have understood it.																																	
Validating her feelings																																	
the actual disclosure																																	

APPENDIX K: Example table of superordinate themes and corresponding sub themes for Karina

Superordinate Theme and Emergent Themes	Line Number	Key Words
<i>Understanding of therapist self-disclosure</i>		
Understanding of therapist self-disclosure	2-5	Relate to issues, share their feelings and experiences, give you open and honest advice
Examples of therapist self-disclosure	7, 22, 90	Personal experience, relating to what I was going through, being a first time mother
<i>Experience of therapist self-disclosure</i>		
Timing	7	Sixth session
Frequency	146, 193-195	One time was enough for me, if she had kept on disclosing would have made me defocussed
Acceptability	111, 12-125	You don't expect them to tell you about themselves, if she hadn't told me I'd think does she really understand,
Stuckness	19, 20, 26, 27-31, 51	Not getting anything out of therapy, no resolution, hitting a brick wall, I couldn't understand, pointless, waste of my time,
<i>Impact on self</i>		
Normalisation	95, 98, 104, 130, 133	It does happen to other people, normal, it's not just me, I am being normal, made me feel normal
Empowered	81	I can deal with this problem now
Allowed reflection	56, 158, 169	I could understand where my life was going, problems became clearer, made me think about what was going on for me,
Understood emotions	22-23,	She knew where I was coming from, She understood
<i>Positive and negative emotional reactions</i>		
Surprised	59	I was surprised
Listened to / not alone / safe	94, 105, 108, 148, 162, 187	This doesn't just happen to me, not alone or isolated, not so alone, secure with her, listened to, felt safe,
Less stressed / calmer / relaxed / comfortable	22, 32,41, 49, 71, 108, 142, 145, 146, 168, 187	Relaxed, stress levels came down, calmer, calmer, weight off shoulders, relieved, felt a lot more relaxed, less stressed, more comfortable, comfortable, relaxed, the connection was there,
Positivity	65, 139	Happier, positive, felt better

Not judged	22, 40, 160	She wasn't judging me, not judging me, she's not judging me,
<i>Impact of therapist self-disclosure on self</i>		
Opened up	41, 43, 113, 122, 133, 138, 141, 143, 159, 161, 168, 178, 179	Open up even more, made me open up the way I was thinking, opened up more, open up a lot more, open up a lot more, allowed me to back track, able to talk about things a lot more, opened up about other stuff, opened up, opened up,
Another perspective	40, 72, 75, 176	Different perspective, look at problem in a different way, she showed me to think differently, helped me make sense of what was happening,
<i>Impact of therapist self-disclosure on the therapeutic relationship</i>		
Trust building	62, 126, 127, 142, 147	She trusts me, I could trust her more, trust what she was saying more, trusted her more, that trust was there,
Connection / relating to therapist	33, 62, 65-66, 92, 187, 188	Somebody could relate to what I was going through, I could relate to her, I know her, she could relate to what I was going through because I could relate to what she had been through, she could relate to my experience, that bond was there, she just knew where I was coming from,
Similarities shared	113, 127	She had a family, she's gone through the same experience as me,
Mirroring	63	She opened up so I can tell her more
Understanding	40, 34, 48, 72, 89, 95, 113	Someone else understands, somebody understands me, she could understand, she was understanding, she understood that overwhelming feeling, she could understand the emotion, she understands,
<i>Boundaries</i>		
Power dynamics	147, 197	We were on the same level, tables have turned, start focussing on her,
Friend vs. therapist	61, 99, 128, 207	I'm talking to a friend, talking to a mum not just a therapist, talking to another mum, talking to a friend and therapist is two complete different things,
Boundaries	145, 149, 183, 193, 194	I don't expect her to relate to every single issue I have, that boundary was there, that boundary was always there, if she had kept on disclosing – annoying, it's my session, don't want her to relate to everything,
Professionalism	200	It wouldn't have stayed professional
<i>More than a therapist</i>		

Professionalism	210	Therapist is a professional
Experiential expert	107, 199	A professional sharing her experience, her guidance felt more real and honest
Humanness	156	She became human, she became a person to me,
<i>Asian culture</i>		
Views of therapy	12, 13, 17, 35, 67, 214, 217, 228	Reluctant, deal with your own issues, White lady – not going to understand my culture, not Asian, don't go round telling people your problems, keep it to yourself

APPENDIX L: Illustrative quotes for super-ordinate themes and sub-themes.

SUPER-ORDINATE THEME: Understanding of therapist self-disclosure	
SUB-THEME: What is TSD? - Personal experiences and feelings	
Quote	Interview and line number
that would be your therapist telling umm the client or the person that they're treating something about themselves (Mmm hmmm) so either their personal life or something they've experienced or something like that.	Rashmi Lines 3-5
I would say that the therapist was trying to give me an example of umm she was talking about good and bad times to do things and she was trying to give me an example of a bad time that happened to her...	Rashmi Line 11-13
Umm basically she'd been in a similar situation to what I had been but fifteen years before	Rashmi Line 178
...her example it wasn't the analogy wasn't a problem it was the analogy she used it was about her life and it was just a really silly example.	Rashmi Line 81-82
... that's a very like a very throwing statement that she made but I didn't think like obviously that wasn't her intention.	Rashmi Lines 36-37
I felt that it was the example given and it just didn't relate to what my problem was so it felt that she hadn't listened to me.	Rashmi Lines 211-212
...that wasn't a very good example that she's just given me.	Rashmi Line 39-40
Yeah she she still didn't say let's spill all and this is my life story, I still don't know anything really about her but I know that she was in a similar situation and she still didn't say right I've been through everything you've been through, this is how it's going to work, this is what happened for me, the same thing will happen to you, she didn't do that she just let me know that she had been in a similar situation	Rashmi Lines 190-194
I obviously know they're not going to tell me about their problems or anything but I would think they would use a lot of their personal life in the consultation...	Rashmi Lines 132-134
...she disclosed a personal experience that she had relating to the issues that I was having.	Karina Lines 7-8
To me that means when a therapist tells me something something about themselves, their experience, their feelings, just something that relates to them that could be beneficial to me.	Amira Lines 3-4
I think what that means is when the therapist kind of tells you things about their lives, umm things that might not be obvious so kind of I guess let me know about their lives outside of the room, outside of the therapy room and just telling me things that perhaps I wouldn't have known already.	Rani Lines 3-6
the personal one, it was about, so it was about her experiences outside of therapy and it was of a similarity disclosure. So kind of saying that she has had the same experiences to me.	Rani Lines 15-17
I don't think it was inappropriate that she self-disclosed, I think self-disclosure can be quite interesting, you know, they know everything about you, you kind of want to know a little bit about them as well. But I think she could have chosen a better thing to self-disclose...and been a bit more mindful, yeah I guess been a bit more mindful about how I could have responded to that.	Rani Lines 58-62

I think the content wasn't the right content. I get that she wanted to say she was scared of flying but she could have told me that and that alone rather than telling me reactions to flying and perhaps the scenes she has made in the past. So I think the content could have been changed and if the content wasn't what it was perhaps it would have had a very different reaction from me. It wasn't that she self-disclosed it was the fact of what she told me and the extremity of her experience and her reactions of her phobia.	Rani Lines 90-96
She basically, she just said it in a way where it it seemed ok like she wasn't disclosing anything no case study, she didn't mention any names she merely spoke about herself in a situation and how she felt and the difficulties she faced and they type of feelings that aroused within her which was similar to some of the feelings that aroused within me and that's that was the nature of the self-disclosure from her side	Amira Lines 21-25
My understanding of that is when a therapist shares other feelings or thoughts that they're having with the client. It can be in terms of how their client is making them feel, or it can be where they just talk about maybe a personal experience they've had about their own life.	Anita Lines 3-5
Well I understand it to be when a therapist tells you about something that's personal to them, so them disclosing information about themselves to you, an actual real experience they've had and sharing that with you in relation to something that you've been talking about.	Viraj Lines 3-5
Well he spoke about a similar situation that he had been in that was similar to what I was talking about in terms of feeling anxious and having anxiety and not feeling comfortable around a large group of people. So he shared his feelings with me and those were the same feelings that I was talking to him about.	Viraj Lines 11-14

SUB-THEME: Why therapists may self-disclose – shifting a client's stuckness	
Quote	Interview and line number
... I think she was trying to make me feel better... so don't be hard on yourself type of thing.	Rashmi Lines 24-27
I didn't have any empathy for her or understand why she said that statement.	Rashmi Lines 40-41
...it's the first time I've seen a therapist so I to be honest I didn't even think that they wouldn't talk about themselves a little bit.	Rashmi Lines 131-132
I guess it's for me to keep it neutral would've been better.	Rashmi Lines 70-71
...it was only until I had actually dealt with the problem I had with telling my parents that I did actually tell them and things started to get a lot easier for me she actually, I think she lowered her guard a little bit in terms of what her role was going to be for me I guess she knew we were coming towards the end of our sessions and she did start to self-disclose towards the end	Rashmi Line 167-171
...it was quite an emotional time at that point because I was quite stuck so she was trying to give me strategies to become unstuck.	Rashmi Line 18-19
... I was quite stuck so she was trying to give me strategies to become unstuck	Rashmi Line 19
I experienced her sometimes disclosing personal experiences when she felt it was appropriate or we were trying to resolve some of my stuckness	Anita Lines 45-47

So when I had gone I spent a good four, five sessions just talking about how I was feeling but I wasn't getting anything out of it. It felt like there is no resolution... there's no answers to my questions. So when she disclosed her kind of, well when she related to what I was going through I felt a lot more relaxed.	Karina Lines 18-22
So...I was just hitting a brick wall all of the time. So I was going over the same thing over and over and over again, the same problems.	Karina Lines 26-27
Well we were talking about some of my issues at the time, we were talking about my confidence issues, me maybe overthinking what other people thought of me when I was out and about with friends and family and so forth, that's when he told me about similar issues he had in the past with confidence levels and you know not being so sure about himself. I was really struggling at the time to see beyond my issues and I was just so concrete in how I was thinking about myself and could really see the wood from the trees, if you get me. I felt I was just going round and round in circles. It felt quite lonely to be honest with you.	Viraj Lines 18-24
it was more because of my reactions or my critical reactions to myself that the therapist kind of jumped in with her self-disclosure.	Rani Lines 30-31

SUPER-ORDINATE THEME – Experiences of therapist self-disclosure	
SUB-THEME: Timing - How much and when to disclose	
Quote	Interview and line number
it was in the fourth session out of six	Rashmi Line 9
I think the nature of the therapy sessions had calmed down a lot so it wasn't as emotional for my part I wasn't as upset or had as much anxiety...	Rashmi Line 184-185
...she self-disclosed at that point when it got a bit more light hearted when it wasn't so intense or when I wasn't so anxious.	Rashmi Lines 187-188
the fact that she told me after it actually improved my confidence in her because I felt that she was equipped with the all the skills to help me cope and that she had helped me a lot and so I felt that she was in a really good position to help me and that she had helped me but that was when she chose to self-disclose. It was at a neutral moment not at a really anxious or stressful moment.	Rashmi Lines 204-208
So I think it was the timing, yeah if she had made that comment to me after when I was less stressed I wouldn't have thought anything of it but I think that at the time it was just bad timing	Rashmi Lines 212-214
on my sixth session she told me, she disclosed a personal experience that she had relating to the issues that I was having.	Karina Lines 7-8
I don't expect her to relate to everything single issue I have, I wouldn't want her to, that one time was enough for me,	Karina Lines 145-146
if she had kept on disclosing I think I would have got annoyed because it's my session	Karina Lines 193
Yeah, I think it happened a few times but they were more kind of with regards to their career but there was an occasion where it was purely the therapist's personal life.	Rani Lines 8-10
I think I might have been in the sixth or seventh session	Rani Line 13

You know it wasn't a particularly emotional time when she bought it in, I wasn't being emotional, it was just a generic discussion about my phobia	Rani Line 162-163
For me now thinking about it now, perhaps timing is important, being able to judge it and you know she was really good but I think if she had timed things a bit better but then again how would you know when to time things but the fact that I went to her again after shows that although her timing was a bit off key sometimes it didn't stop me from seeing her it didn't make me say ok well that's it I'm done.	Rani Line 394-398
There were some points, I think in my third therapy session where my therapist did disclose to me	Amira Lines 6-7
I think if she told me something about herself in the beginning it wouldn't have been such a surprise when she did self-disclose. I don't really know what I would have wanted to know, just something about her, was she married, did she have children, a little bit about her background, about how much we relate or not. I don't know. If she had done that it probably wouldn't have felt so much like she was taking the control of the room	Anita Line 159-164
On some of the occasions where she has self-disclosed, it's not often (laughs	Anita Line 90
I think it would have been different if she had disclosed some parts of herself from the beginning because it would have been intertwined with how we work together but then to suddenly after a good couple of months to disclose a part of yourself, even though it was appropriate umm it it felt like umm the relationship had kinda changed in some way.	Anita Line 145-149
Umm I think it was quite a few sessions in, I think about eight or nine sessions in.	Viraj Line 9
He didn't self-disclose again. I wouldn't have minded if he did because it was helpful and eye opening for me hearing his experience. But it was also ok that he didn't.	Viraj Lines 96-97

SUB-THEME – Positive and negative emotional reactions	Interview and line number
I think for me the type of what the the exact incident was it actually made me quite angry because her self-disclosure if you compared it to what I was going through was very very different situation so I didn't think her way of of giving me an example was anywhere near what I was going through so it felt that she belittled me in what I was feeling.	Rashmi Lines 31-34
I felt it made it about her and that it made it about her and it also belittled my struggle that I'd got or the stress that I had it sort of made it smaller than it was.	Rashmi Lines 105-106
...such a random thing to say but it really made me angry at the time because it was like well what's that got to do with what I feel...	Rashmi Lines 144-146
and I felt that her example kind of mimicked quite a superficial thing that I am finding hard to tell my parents.	Rashmi Lines 150-151
...I guess for her she probably relayed it back to just being exhausted from the situation rather than with her but I guess it may have been a combination of both.	Rashmi Lines 121-123
I look back on it now it's such an...it's seems quite insignificant but when you're stressed out in that moment it did actually upset me.	Rashmi Lines 106-108
...she used to say you just seem really more drained and you seem more tired than you are normally in sessions, you seem a lot more quieter but I guess for	Rashmi Lines 119-122

her she probably relayed it back to just being exhausted from the situation rather than with her but I guess it may have been a combination of both.	
. So when she disclosed her kind of, well when she related to what I was going through I felt a lot more relaxed	Karina Lines 21-22
when she disclosed what she had gone through and how she had felt that's when my kind of stress levels came down,	Karina Lines 31-32
So I felt a lot more calmer	Karina Line 41, 49
Umm I was surprised to be honest because like I said you have this notion of what you see on TV, you're going to talk and they're just going to listen.	Karina Line 59-60
After my session I felt a lot more positive. I felt a lot more happier.	Karina Line 65
. I just felt a whole lot less stressed out.	Karina Line 145
So initially when she spoke to me I guess, it was nice, I felt privileged to know that information, I felt like I was trusted	Rani Lines 71-72
I remember just being a bit awkward about it, me personally just thinking 'what do I say to you, I don't really' like am I meant to first of all I didn't know am I meant to talk about her disclosure, are we meant to spend some time on it because I know its therapy and its not meant to be about them but I'm happy to speak it.	Rani Lines 131-135
I was kind of worried that she would disclose again and say something that would make me not appreciate her again, if that makes sense	Rani Lines 164-165
So it was kind of just like I didn't know what to do because she kind of just chucked it in and then it was kind of just like ok, but am I allowed to talk about it, I didn't know what my rules were, and I didn't want to have the awkwardness of yes lets bring it back to you, back to what you want to discuss. So I guess I wasn't really given any cues to what to do with that other than that just to take it and feel better but because it didn't make me feel better it was kind of a bit of awkwardness in the room for me.	Rani Lines 135-140
she made me feel she made me feel relaxed, she made me feel less anxious because at that time of my life I was so anxious and I was so upset within me and at myself	Amira Lines 35-37
I think her talking about her feelings and her experience, it just all made sense and made me feel relieved	Amira Lines 104-105
. I just wanted her to know how I was feeling and then in that session when she disclosed I just felt relieved like I wasn't alone. I remember feeling physically more relaxed and I was no longer talking in shame.	Amira Lines 156-158
I think her age maybe had something to do with why I didn't feel understood all of the time and why I think when she self-disclosed it just didn't resonate with me and that made me feel frustrated sometimes.	Anita Lines 103-105
Initially I was quite shocked (laugh) if I'm honest with you because you know you go through a lot of sessions where it's always all about you and I guess for me at the start of our sessions, I didn't really know her, I just made my own assumptions about her and so when I first experienced her talk about her own personal experience, it it did surprise me.	Anita Lines 122-125
Umm it definitely surprised me but putting it into context of what I was saying I think it was umm containing.	Anita Lines 131-132
But it does still weird because it's not something that she did often. It just surprised me each time she did bring something so it felt nice but at the same time not so nice.	Anita Lines 157-159

Ahh I was umm.....it's not that I wasn't, it's not that I was uncomfortable it was...umm.....it....it almost felt like a change to how therapy has sort of been with us, it brought in something, something new and it wasn't even something you expected, sometimes it can feel like it was out of the blue, but it wasn't out of the blue, it was within the context of what we were talking about but just the idea of someone suddenly bringing something personal, that they never have for several weeks feels a little uncomfortable in some ways.	Anita Line 125-131
Well...obviously it made me feel comfortable at the time and and it was quite comforting to hear but when I'd gone away from the session umm later, I was thinking about it and I didn't know whether or not that was normal because you know do do therapists normally self-disclose or not.	Viraj Lines 32-34
Well I was quite surprised, like I said before it's not something that I would expect to happen. I didn't think therapists talk about themselves. I just thought it's not something they do. So I remember just being really quiet and listening to everything he was saying. I remember trying to picture him in the experience he was describing to me.	Viraj Lines 46-49
Yeah it made things more comfortable, it'll sound odd but it felt lighter, maybe I felt lighter in a way like something had moved off me, like the black cloud had moved away from me. It was still there but it wasn't just my black cloud and it didn't have to hang over just me. I guess what I'm trying to say is that I felt more relaxed, more positive I think with my problems.	Viraj Lines 87-90
. It made it easier for me that my therapist knew what I was going through and had shared similar feelings and experiences to me, and maybe that doesn't happen with all therapists or with other people. But for me, I am very grateful for my experience and how it helped me with my problems.	Viraj Line 101-104
. It made me feel that I shouldn't be ashamed of talking about my issues and I shouldn't be ashamed of what I was going through	Viraj Lines 39-40
It made me feel more motivated and stronger in myself that I could actually deal with my problem and learn how to cope, I mean my therapist had done it so why couldn't I?	Viraj Lines 90-92

SUPER-ORDINATE THEME – Impact of therapist self-disclosure on self	
SUB-THEME: Closed off vs. Opened up	
Quote	Interview and line number
...when she made that statement I think for me it closed off my relationship with her a bit more because it just felt like well I don't really think you understand me or that you see that you're going to be able to help me because you can't really put what I'm going through on a level that matches it.	Rashmi Lines 51-54
Well personally for me I think it just closed off, I just wanted to put an end to the session after because oh what's the point you don't really know where I'm coming from umm.	Rashmi Lines 97-98
I think I was a bit I actually felt I was not going to gain much from them so I think I stopped giving as much detail to her as I was before.	Rashmi Lines 115-116
I felt it made it about her and that it made it about her and it also belittled my struggle that I'd got or the stress that I had it sort of made it smaller than it was.	Rashmi Lines 105
I could open up even more to how I was feeling because I was holding a lot of stuff back, I was just discussing how I felt and not, making negative,	Karina Lines 41-44

everybody else was negative against me and things like that so it made me open up the way I was thinking as well.	
When you go into therapy you don't expect them to tell you about themselves and because she was telling me and understanding what I was going through it made me kinda open up more	Karina Lines 111-113
So for her to open up like that had a massive impact on me because I knew any other issues I had revolving my child or my family she would understand. It just made me open up a lot more.	Karina Lines 121-123
And my therapist telling me how things were for her when she had a child made me feel normal and open up a lot more. You know at the beginning I didn't tell her everything, I'd hide certain things, because I didn't want her to think I'm being dramatic or judge me. I held so much back at the beginning, I just told her the bare minimum. I as telling her I was fine but I wasn't, I wasn't at all.	Karina Lines 132-136
It made me open up about other stuff so I started talking more about my family which led onto other issues and that's why I continued to see her for the time I did	Karina Lines 143-145
That session really opened up so many doors for me. I felt I could really talk to her, and I did about so many things.	Karina Lines 161-162
...it allowed me to backtrack and I was able to talk about the things I hadn't told her because I felt at that point I could	Karina Lines 138-139
So when we spoke about phobias I kind of thought in my head 'oh like you can talk' you know a little bit and I guess that stopped me from perhaps opening up as much as I could with her	Rani Lines 119-121
and I think I pulled back from the relationship a little bit because I don't think I, I valued it for a while	Rani Lines 125-126
, I think it was just me judging her and I think I was preoccupied with that judgement I had of her rather than actually talking about me or talking about therapy or caring about it and I was just preoccupied away from what therapy was and again I think it's the content rather than that she told me, I think it just moved me away from it.	Rani Lines 143-147
Yeah I think so yeah because it now became about, it became now more about me trying to pretend that I didn't hear it rather than me just discussing experiences or me or discussing whatever. I think it became more of a how do I not show her that that was something I probably did not want to hear	Rani Lines 149-152
Yeah I think I stopped telling her about, I think, I think the rest of the session was about just life, just general chit chat.	Rani Lines 161-162
So hearing her experience just really helped me open up	Amira Line 54
You know not only did they know a lot of stuff about me through the sessions but you know they'd now started opening up about who they are to me so it made it feel like it was easier for me to sort of continue with the sessions and not hold back with emotions and really tell the truth as such about what was going on and what my thoughts and feelings were yeah.	Viraj Lines 72-76

SUB-THEME: Normalisation	
Quote	Interview and line number
she just let me know that she had been in a similar situation	Rashmi

	Line 193 -194
so I have found it helpful that she had actually been through it and come out of the other side with having a happy life now etc etc etc	Rashmi Line 181-182
So because she talked about her experience and how I could relate to it it made me feel as though 'ok this just doesn't happen to me' that it does happen to other people as well.	Karina Lines 93-95
then she explained to me that all of what I was going through is normal	Karina Lines 97-98
when she shared her experience that's when I really felt like I had answers, that it's not just me. I don't even think I was looking for a particular answer but I think it was you know not feeling alone or isolated.	Karina Lines 103-104
what I was going through or what I thought was going through or the issues I had I thought it was just me.	Karina Lines 110-111
so speaking to my therapist just gave me a sanity check that I am being normal, there isn't something wrong with me.	Karina Lines 130-131
. And my therapist telling me how things were for her when she had a child made me feel normal.	Karina Lines 132-133
and her, as a professional a sharing her experience that she has felt the same way as I did, just made me feel relieved and not so alone in what I was feeling.	Karina Lines 107-108
But after she self-disclosed to me I opened up more, I felt more comfortable, more relaxed and it really made me think about what was going on for me and really made me think about my feelings and what it meant and it really made me think about how I was being in the first five sessions and how I needed to change so I could get something out of the therapy.	Karina Lines 167-171
I just couldn't sense of what was going on for me and hearing her experience and seeing how similar it was to mine just helped me make sense of what was happening for me.	Karina Lines 174-176
Well I think it's just because people judge you. You know coming from an Asian background, you don't go round telling people your problems, you keep it to yourself or you deal with it yourself. You know keep quiet, keep it inside deal with it yourself. And that has to come out somehow and I guess it comes out in a negative way. I mean I don't know any Asian person who's gone to therapy, it's not for Asian people, that's what we think. But now I feel I can tell people about my experience and talk about it and not feel ashamed.	Karina Lines 213-218
I think her intention was to either make feel better, to either make me feel normal, to either make me feel that I can speak, that I can trust her and I know knowing that is perhaps why I carried on attending and carried out speaking to her knowing that her intention behind that was always good and positive and the intention was never to keep me quiet or to be rude or to have a competition with me of who's worse or anything like that. So I think her ability to self-disclose and still make me feel as though I know that's why she did it I think was perhaps a good thing about her self-disclosing.	Rani Lines 250-257
I guess she could share the same hurdles she faced when she was studying, so we had similarities there and I guess that helped to normalise my struggles	Anita Lines 107-109
And it was just normal...normalising the whole experience, like I wasn't the only one and that it wasn't unusual. That felt really containing. It felt appropriate.	Anita Lines 118-120
Yeah I think that it just normalised some of my anxieties which I think sometimes you can't normalise unless someone shares that experience with you or really kinda gets you and says you know you're not the only one kinda thing.	Anita Lines 132-135

when she has disclosed it it has been appropriate to what I've been saying so on the other hand it does normalise my feelings and makes me feel that she really dos understand because she's gone through it or because she's experienced it	Anita Lines 155-157
I think on one hand it made me feel umm yeah like I wasn't the only person that has been through this kind of stuff but that there's lots of people that go through this kind of stuff and yeah it made me feel more comfortable about what I was going through	Viraj Lines 26-28
I mean he's a therapist and for him to share that he had experienced confidence issues and actually share that with me, its takes someone quite strong to do that and I really appreciated it.	Viraj Lines 37-39
And I guess my therapist telling me something about herself, her experience made me think about how useful it was for me to hear that she, a professional had shared the same thing as me. It was just really great. I didn't think therapy would have been like that. I didn't think it would have been so like natural and flowing conversation. I mean it was so simple what she did, but it was so helpful and really changed things for me	Amira Lines 181-186

SUB-THEME: Bringing the unknown into the known	
Quote	Interview and line number
I felt that I weight had been lifted off my shoulders because I wasn't, I was, because she was understanding where I was coming from she was giving me the answers to look at the problem I had in a different way.	Karina Lines 71-73
She could understand the emotions because I didn't understand what that emotion was, you know I just thought I shouldn't be crying, I should hold it in and I have to be happy but then she explained to me that all of what I was going through is normal	Karina Lines 95-98
But also to perhaps umm let me know that change can occur umm and yeah I think that was her purpose it	Rani Lines 28-30
she's made me she made me realise to accept the situation for what it is and not to cover it up and not to umm not to umm disguise it or no to pretend and say I'm ok because then later on it'll come to a point where I will break down like the way I did then.	Amira Lines 45-48
it really did help me...see me from another person's perspective. I was able to see myself in a third person point of view just because she disclosed feelings that were similar to mine when I was experiencing the hardship, for the reason why I went to her in the first place.	Amira Lines 25-28
So hearing her experience just really helped me ...and feel ok about what I was feeling	Amira Lines 54
That was an experience she shared with me and helped me to...to think about...you know to tap into feelings that I wasn't necessarily aware of or saying outload but that I was definitely feeling.	Anita Lines 116-118
And it was helpful that she disclosed that that's how she felt and the process she went through and what she had learnt and she wasn't saying that this is how it is for you but she was giving me another way of seeing things and how it's a learning curve. That was really really helpful.	Anita Lines 113-116
But for me personally yeah it made me feel more comfortable and at ease with the situation...Umm in terms of my confidence levels and my anxiety and	Viraj Lines 35-37

knowing that people go through similar things and you know knowing that worked for me.	
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SUPER-ORDINATE THEME – Impact of therapist self-disclosure on the therapeutic relationship	
SUB-THEME: Power dynamics / role reversal	
Quote	Interview and line number
It felt that we were on the same level and felt more secure with her. You know she didn't have to say 'oh I've been through this and I've been through that, everything will be ok', that boundary was there which was good because then it would have made me feel like she was just talking to a friend.	Karina Lines 147-150
that boundary was always there which was good for me because had she kept on disclosing, even if she did it say on the fifteenth session of the twentieth session I think it would become annoying but it's because I didn't need her to tell me more about herself or her experiences.	Karina Lines 183-186
I probably would have felt that I'd gotten to know her a lot more which is a good thing if she was my friend or if she was someone I'd met in my antenatal class or something but she was my therapist so if she had kept on disclosing I think I would have got annoyed because it's my session I don't really wanna hear all about her I don't want her to relate to every single thing I've gone through so I appreciate that she didn't and it probably would have made me defocussed on what I was thinking about and my problems and what I was going through and maybe would have started focussing on her then it would have been like the tables have turned and I'm listening to her and I would have been talking more about what happened in her life, 'how did you feel?'. So I appreciate her not going across those boundaries. I think it would have just turned into a coffee morning with her, it wouldn't have stayed professional.	Karina Lines 191-200
I think the content placed her in a much more vulnerable position or vulnerable person than I was with flying so I think it made me perhaps use my own ways of umm kind of making her feel better a little bit I think, I mean that's more about me than her	Rani Lines 88-90
It kind of out did mine a little bit well a lot. I didn't feel it was a competition or anything like that but it kind of just.	Rani Lines 96-97
it became more about her than me.	Rani Lines 100-101
I think it became about me making her feel better in the session and to be honest it's not like we were sitting there and she's there with a tear in her eye and I'll be there to help her, I don't she probably even noticed that it had any good or negative impact and I don't know if that's reflection on me and my ability to poker face or whatever but it was kind of like how do I not show that that was pointless, how do I not show that perhaps that wasn't the best thing and I guess my focus became off me and became about her and whether that's a sign of me and my stuff or whether that's just how it happened I'm not sure but the focal then became about her.	Rani Lines 152-159
I kind of felt that.....I had to save her and rescue her and make sure she feels ok for telling me what she told me umm rather than be like ok great thanks for that, I'll take it on board and move on umm	Rani Lines 289-291

umm I think it kind of took away a bit of the power that therapists have which is a good thing, you know we're just two people in a room but I want you to be able to handle my things as well as your things.	Rani Lines 402-404
In a weird way, when she disclosed it felt like I was the therapist and she was the client because after she finished telling me her experience I was like yeah but you're still a counsellor, you're still here and then we paused because I realised what I said, I realised like oh ok so that means I can still continue I can still continue with my work and then she smiled and I think that's what, that's what was really personal as well because it's like we didn't say anything afterwards we paused and she smiled and it was like we were in sync we knew what we were thinking at that point so it it did feel like you know for those ten, fifteen minutes it did feel like role reversal it did feel like as if I was listening to her difficulty at one stage so I think if she didn't disclose I still would have been really distraught and I wouldn't have been able to, I wouldn't have let her help me.	Amira Lines 140-149
I felt that there was a change in our relationship. It felt that that space had suddenly brought something new. It suddenly felt that it wasn't completely about me that it was ok for her to choose when she could bring her own stuff. I guess in some way you could think it almost felt as though she suddenly had control because she chose to bring that when she never did before which...umm which felt weird. Umm it it almost felt like it it changed something, I guess the whole process. It was something that can in that was very different from what had been there for a good couple of months. I guess after she did disclose I felt it kinda gave me permission to or allow myself to to the things that she could bring her stuff in whenever she felt it resonated with me but I think it almost gave her a bit of control over that space just because.	Anita Lines 137-145
There were times when I tried to ask her about her but she kinda diverted my questions and then she kinda chose when she wanted to disclose and what she wanted to disclose. I didn't have that choice or that control, she did. I'm disclosing everything and that's my space and when she disclosed it almost became a shared space in some way but it's like she controls that.	Anita Lines 150-154
I think if she told me something about herself in the beginning it wouldn't have been such a surprise when she did self-disclose. I don't really know what I would have wanted to know, just something about her, was she married, did she have children, a little bit about her background, about how much we relate or not. I don't know. If she had done that it probably wouldn't have felt so much like she was taking the control of the room.	Anita Lines 159-164
Whether or not I'd expected them to say that or not umm I don't know, I don't think it was something I expected he would tell me but you know because I'm the one who's going to the therapy.	Viraj Lines 28-30
I didn't think therapists talk about themselves. I just thought it's not something they do. So I remember just being really quiet and listening to everything he was saying. I remember trying to picture him in the experience he was describing to me.	Viraj Lines 46-49

SUB-THEME: Closing the gap	
Quote	Interview and line number
I felt that that therapist really understood who I was a bit more than other people...	Rashmi Line 160
she understood me so I knew that she was understanding of who I was	Rashmi Lines 229-230
Umm I think it probably drew me a lot closer to her	Rashmi Lines 251
I think it's because what she described was so close to my heart that's all it needed, that bond was there after that and that's all I needed to feel safe I guess. That connection was there, I didn't need anything else. She just knew where I was coming from.	Karina Line 186-188
So I'm glad she did self-disclose because it meant that she kind of trusted me to have told me	Rani Lines 62-63
it made me feel kind of a bit good to know that and I kinda felt like things had moved on because obviously I'm normally speaking and she was telling me stuff about her so it felt like things had advanced	Rani Lines 72-74
After she disclosed I think I just trusted her more	Amira Line 131-132
It just puts it all in perspective and you don't feel alone in your experience. That's a really nice feeling to not feel alone in what you're going through.	Amira Lines 194- 195
I think it's quite scary talking to someone about a your personal things and deep stuff and not really get anything back, or know anything about them, it can feel really scary and in some ways just by having a little bit of details can sometimes ground someone and help you to picture that person and almost helps you to develop that trust quicker than if you're constantly questioning or trying to work out who this person is and umm what she's all about.	Anita Lines 187-191
It normalised some of my anxieties and I felt less lonely, less alone umm and I think that's the thing with therapy, sometimes you can be heard but not understood and we kinda seek both and in that particular moment I did feel both heard and understood which I think strengthens our relationship and makes it more trustworthy in some way.	Anita Lines 167-170
I think her disclosure allowed us to be connected more on a different level, it allowed me to perhaps talk about more difficult emotions and it kinda breaks this unknown bit and just made the relationship stronger.	Anita Lines 194-197
Yeah I mean because we were several sessions in I was getting more and more comfortable with my therapist umm as it was but obviously them actually you know that's the first time they'd told me something quite personal about themselves and something they'd faced and it was more of a negative thing they were telling me. You know I'd always seen my therapist as someone who was stronger but it was quite...I suppose it was it was different because I'd never seen my therapist tell me anything about things they'd struggled with in the past and on one side it made me feel more comfortable umm but in terms of the I think it made me feel umm like I could trust this person a bit more.	Viraj Lines 65-72
I knew from the experience he shared with me that he got me that he got what I was going through so it just made the whole process of therapy that much easier.	Viraj Lines 76-78
. It made me feel closer to him as well.	Viraj Line 72

SUB-THEME: Shared knowing	
Quote	Interview and line number
...you know the second therapist was from the same cultural background as me, she was Asian so am I. So she knows what I mean when I'm talking about my family and what it means to tell them this thing. She knows because she's Asian so her self-disclosure was just so much more valid and real because she understands how it is. She knows because she's Asian so her self-disclosure was just so much more valid and real because she understands how it is.	Rashmi Lines 237-241
So I think with the second therapist our situations was similar but we were also similar as people in terms of our values and things. So that meant that I could relate to her self-disclosure more and that's probably what made it more helpful than the first therapist and her self-disclosure.	Rashmi Lines 244-247
we actually had a very similar way of looking at things and had a very similar history in our lives	Rashmi Lines 172-173
I didn't think her way of of giving me an example was anywhere near what I was going through	Rashmi Lines 33-34
Maybe for her it was on level to what I was I'm I'm going through I was going through but for me it felt like well that's nothing like what I need to do or what my task at hand is	Rashmi Lines 34-36
What made it easier was because she wasn't Asian either. She was a white lady and at first I thought 'well she isn't going to help me, she's not going to understand my culture, so there's absolutely no point talking to her and I also felt at a point that if it was an Asian person I was talking to they would just know what I was going through and make me feel that I was just being stupid or something but because she wasn't Asian it made me feel a lot better when she disclosed her problem because it made me feel like someone else understand what I'm going through, she's not judging me, it's a different perspective that I didn't think I'd get from a therapist.	Karina Lines 34-41
she's opened up about herself so I can tell her more	Karina Line 63
Well when she opened up in that session it allowed me to back track and I was able to talk about the things I hadn't told her because I felt at that point I could	Karina Line 138-139
you know I knew she had a family, so she understands where I'm coming from...when I found out she had the same issue as I did and she felt the same as I did her guidance just felt more real and honest	Karina Line 113-119
I feel I had someone to talk to who is completely out of my circle. You know talking to a friend and a therapist is two complete different things. Your friend or your family will always side with you or they'll tell you things and sometimes they give really bad examples to try and make you feel better but they're your friends. But a therapist is a professional and as an Asian, you know I think my view of therapy is really different now	Karina Line 207-211
Because you know if she didn't tell me she understands about south Asian community then umm I guess she would hear things she knows already and I might have felt as though she doesn't understand but the fact that she told me helped me a bit because I was like great she knows, she knows that I have this whole system that I need to discuss	Rani Lines 245-248
. I was saying well actually this is what it's like, I'm sure you know blah blah blah this is what I've had and I felt as though she could handle that and that I	Rani Lines 279-281

wasn't going to leave this person with a negative viewpoint of a culture that she wasn't part of.	
the fact that she allowed me to feel comfortable and I think it's her self-disclosure of her saying 'you know I've got this' and then it allowed me to not hold back. I told her the good parts the bad parts I didn't feel like I had to defend my culture, she knew it so she knows there are bits that are lovely and bits that are terrible so I could just be and say.	Rani Lines 271-274
My therapist was white British and as a south Asian I think that there's quite a lot of cultural issues in terms of umm family system for example, or umm gender as well as just as being a woman, as a south Asian woman I think it can be very different to being a white British woman as well and I think understanding, her understanding of it can sometimes be not necessarily resonate with my experience or I think sometime she can she tries to understand but I don't think that sometimes she gets it. It kind of makes me feel not understood umm but it also doesn't, it doesn't, it makes me feel sometimes more stuck. Like I don't feel like I'm able to to explain it to her sometimes I feel frustrated because sometimes I just want her to just get it umm but sometimes I find myself really trying to describe how it is and what how my experience is and sometimes you feel that by doing that you're kind of missing the whole point of the issue.	Anita Lines 19-27
so when she does I have found it helpful to some extent but like I mentioned earlier with like relationships when there's a lot more of the cultural elements that comes into it I sometimes haven't found it that helpful.	Anita Lines 90-93
. I guess she just didn't get how it is in my generation growing up and her giving me an example of how it was for her when she was growing up, it was just totally different times and didn't really help me hearing that.	Anita Lines 105-107
When she talked about her break up it kinda showed...that she was trying to be alongside me in my experiences and in how I was feeling.	Anita Lines 101-103
Umm well she brought more of herself in so for example umm with the relationship break up it was helpful on one hand but unhelpful on the other because of some of the cultural differences. Her experience is always going to be very different from mine and there will be some cultural elements that she's just not gonna get. I think some of your culture you know you only really understand it if you've experienced it yourself because it's really hard to put into words. Umm so sometimes I kinda haven't found it helpful umm and kinda, it's really mean to say this but sometimes it felt like I want my space back in that moment, because you just don't get it. I think it's a balance that you need which is really important and maybe that's what we didn't have or struggled with	Anita Lines 176-184
So he kind of used his experience to help mirror back parts of me. So he was trying to show me my experience experienced by him and how he went through what I was going through.	Viraj Line 14-16

SUB-THEME: Genuineness – “it was personal...”	
Quote	Interview and line number
I think she genuinely wanted to give me an example of a bad time to break news to somebody so she genuinely wanted to give me an example of what would be a bad time... I genuinely think she wanted me to not make not the same mistake.	Rashmi Lines 74-76

I didn't really see her as a therapist, I don't know why, I just, it was, I just saw her as someone, that isn't judging me that genuinely wants the best for me and it's not because she's receiving wages or anything like that, it's because she's curious, genuinely curious about how my work affected me about how stressed I was and what she can do to help me accept what happened and move on and leaving the place with hope and not as distressed as I was when I first walked in.	Amira Lines 124-129
I'll never forget her and what she did for me and just how genuine she was with me.	Amira Lines 173-174
, just that you know in therapy when you're giving therapy to someone, just be honest about it is such a big thing. Because some people could disclose an experience but it doesn't help you because it doesn't relate to you and it's not genuine. But when you're really being honest about it and you actually tell them you know feelings that you had that are not so great or you know something that you reflect on being a low point in your life it really does help the person who's sitting on the chair because it's not a nice thing to feel like the patient or the client but when you have that small bit of role reversal for that short period of time you know you listening to someone it really really helps you to reflect on yourself and your own situation because...it just happens naturally and it's so powerful. So I think when therapists are honest from deep within it really helps and the conversation goes a long way	Amira Lines 198-207
but I think when she shared her experience it it was personal it wasn't it wasn't like from a textbook or something. It felt real, it was like a conversation with someone who wasn't judging me	Amira Lines 77-79
When she talked about her break up, it kinda showed a sense of genuineness in her	Anita Lines 101-102
. I don't know, it just has a different effect, like a more real and genuine effect. Something I guess more...significant and honest.	Viraj Lines 43-44
The worse thing is and this is where my perception of therapy changes. Is that you have a problem you go to see a therapist but do they really understand your problem, are they actually listening, that's a problem I had, this is the reason why I didn't want to go to therapy, because yes they're listening but do they really understand, can they really put themselves in my shoes and when I found out she had the same issue as I did and she felt the same as I did her guidance just felt more real and honest.	Karina Lines 114-119

SUB-THEME: 'Just another person'	
Quote	Interview and line number
Yeah I guess it's like when you speak to friends for example friends tend to self...they always give you examples of their own lives all the time and sometimes friends use really bad examples that are nothing on par with what you feel but then they're your friends but if you're see a therapist professionally you don't really want them to give you information about their lives.	Rashmi Lines 64-67
if I knew that she wasn't a therapist I'd probably stay friends with her but because we put a very formal end to the sessions obviously that's the end of our relationship now so we don't have a relationship anymore but she felt like somebody that I could easily be friends with.	Rashmi Lines 251-254

For me surprisingly I actually wanted to know about her a lot...I actually felt it would have been a lot more helpful if I knew her background	Rashmi Lines 165-173
When she told me her experience, I felt like, hold on I'm not talking to a therapist anymore, I'm talking to a friend. Because id been there already it made me feel like I know her.	Karina Lines 60-62
You know talking to a friend and a therapist is two complete different things. Your friend or your family will always side with you or they'll tell you things and sometimes they give really bad examples to try and make you feel better but they're your friends. But a therapist is a professional and as an Asian, you know I think my view of therapy is really different now.	Karina Lines 207-211
she kinda made me feel like I was talking to a mum, not just a therapist, not just a friend but she understands exactly what I went through.	Karina Lines 98-100
that's when for me she became human, she became a person to me, not someone just sitting there	Karina Lines 155-156
Like I said it felt like I was talking to another mum. I didn't have any other mums around me from my antenatal class that I could stay close to,	Karina Lines 127-129
I think I saw her more, I wouldn't say as a friend but not like a therapist. It wasn't so sterile, it felt like I could go in and tell her everything in my time and I don't have to be ashamed anymore because she doesn't work with me.	Amira Lines 129-131
I didn't really see her as a therapist, I don't know why, I just, it was, I just saw her as someone, that isn't judging me...	Amira Lines 124-125
After she disclosed I think I just trusted her more and saw her as a person just like me but someone with a bit more knowledge about therapy stuff I guess.	Amira Lines 131-133
Umm I think it's helped me add a bit more of a human aspect to therapy, that its ok, it's ok if you don't have your life all together, you or the therapist	Rani Lines 401-402
It did remind me that well therapists are people too and that we all have our own stuff.	Rani Lines 404-405
I think for me it makes her more human when she shares it, it reduces some of that mystery and it makes you feel like you are talking to another person, another human being which can sometimes be really nice because it kinda just feels normal.	Anita Lines 98-101
. It demystifies this kind of unknown and I think sometimes, I think with a lot of people we we do struggle with the uncertainty and the unknown and I think it kinda just helps. Just puts this person into perspective and it just umm humanises a person, that she does have a life (laughs) outside of this	Anita Lines 191-194
She wasn't the umm expert or the therapist anymore she just became another human being, as strange as that sounds	Anita Lines 149-150
I guess it was nice, it made her quite human and that she does experience things as well.	Anita Line 166

APPENDIX M: Ethical clearance form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc D.Psych ☒ n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

To Disclose or not to disclose? An exploration of South Asian clients' experiences of therapist self-disclosure in the therapeutic process.

2. Name of student researcher (please include contact address and telephone number)

Sheetal Patel
[Redacted address and telephone number]

3. Name of research supervisor

Jessica Jones Nielsen

4. Is a research proposal appended to this ethics release form? Yes ☒ No

5. Does the research involve the use of human subjects/participants? Yes ☒ No

If yes,

a. Approximately how many are planned to be involved?

8

b. How will you recruit them?

Eight participants will be selected through purposeful criterion sampling to ensure that the participants selected will yield an in-depth understanding of the research focus. Smith, Flowers and Larkin (2009) suggest a sample size of 3-6 participants in an IPA study. Participants will be recruited from South Asian mental health settings such as the Asian Counselling Service and Newham's Asian Women Project (Appendix 1 & 2). These services provide counselling to individuals specifically from the South Asian population. The client group may include those who may or may not have a psychiatric history, sufferers of psychosomatic illness, anxiety, stress, depression, loneliness among other issues.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

There will be 6 inclusion criteria. Firstly, participants will be South Asian. This means that participants will be people who are Indian, Pakistanis or Bangladeshis and has also included Sri Lankans, Nepalese and Maldivian individuals (British Sociological Association, 2005). Secondly participants will be 18 years of age or older. Thirdly, participants will have all completed therapy or will be coming towards the end of their therapy. The forth criteria will be that participants would have received individual therapy from a mental health practitioner such as a psychologist or a counsellor who is also of South Asian descent. The fifth criteria will be that participants would have experienced their therapist self-disclosing defined as 'any instance during therapy when your therapist shared or revealed information about his or her personal life' and lastly the participants should be willing and able to discuss their experience in an individual face-to-face interview. All participants regardless of time since completion of psychological therapy will be included.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? Yes No ☒

d1. If yes, will signed parental/carer consent be obtained? Yes No ☒

d2. If yes, has a CRB check been obtained? Yes No ☒
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

The study will involve having interviewing each participant for approximately 45-60 minutes. Semi-structured interviews will be conducted and the interview will involve asking open-ended questions. (Appendix 3). The interviews will take place within the premises of City University, London.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes ☒ No

If yes,

a. Please detail the possible harm?

It is not anticipated that any physical or mental harm or discomfort would be experienced by the participants in the study. However uncomfortable or difficult feelings could be evoked by participating in the study as participants will be asked to talk about their experiences in therapy.

b. How can this be justified?

The information sheet (Appendix 4) given to participants highlights this issue and what the study is about and participants will be encouraged to read the information sheet before signing the consent form (Appendix 7).

The proposed study would like to obtain descriptions of how clients experience therapist self-disclosure, and whether they view it as helpful or not could inform the debate about the effect self-disclosure has on the therapeutic relationship and the client. A phenomenological study like the one proposed could help to illustrate aspects not currently considered in the Counselling Psychology field and multicultural counselling and clarify the inconsistency observed between the theory and the ethics of therapists self-disclosing. The study could also help Counselling Psychologists in their training and practice in understanding the helpful and hindering effects of self-disclosure related to working with clients from a particular ethnic group. This study will aim to help Counselling psychologists to develop a better understanding of what South Asian clients feel about their therapists self-disclosing, therefore helping the process of therapy and the therapeutic relationship.

c. What precautions are you taking to address the risks posed?

Contact details of voluntary organisations that participants may wish to use if they do experience uncomfortable or difficult feelings will be given to each participant. (Appendix 6) A distress protocol (Appendix 5) has also been devised for the researcher to follow in the case of the participant feeling distressed.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes ☒ No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes No ☒

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes ☒ No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Audio recordings of each interview conducted will be kept as well as basic information about the participant – age, ethnic background, sex.

12. What provision will there be for the safe-keeping of these records?

Audio recordings will be safely stored by the researcher and then destroyed following completion of the study. Data will be maintained on password protected files, kept in a secure location and locked away safely. Participants will have the right to access copies of a summary of the findings if they require.

13. What will happen to the records at the end of the project?

The audio tapes used during the interview will be destroyed once the study has been assessed and marked. Transcripts of the interview will be kept for a maximum period of 5 years in case the study is published in an academic journal but will then be destroyed.

14. How will you protect the anonymity of the subjects/participants?

Any personal details or information participants provide in the interviews will remain confidential at all times and this will be emphasised in the information sheet. Confidentiality will be assured throughout, however with the exception that if any information suggesting illegal activity where any harm to self or others is revealed. It will be emphasised that all data i.e. names and any other identifying information will be anonymous in the final report.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

All participants will be debriefed at the end of the interview where further details about the study will be given and to also provide the participants with an opportunity to ask any questions or discuss any concerns they have about the interview and the questions asked. (Appendix 8)

Contact details of the researcher and supervisors will also be given to each participant.

Contact details of voluntary organisations (Appendix 5) that participants may wish to use if they do experience uncomfortable or difficult feelings will be given to each participant.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher  Date 30-03-14---

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes **No** ☒
If yes,

a. Please detail possible harm?

b. How can this be justified?

c. What precautions are to be taken to address the risks posed?

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted ☒

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature

Date 08/04/2014

Section D: To be completed by the 2nd Departmental staff member

(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature

Date 8 April 14

APPENDIX N: Distress Protocol

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the research whilst discussing their experience of therapy. It is possible that whilst participants have not previously sought treatment and are not currently receiving treatment for any known mental health problems, they may potentially be suffering from some degree of psychological difficulties.

The researcher is an experienced Mental Health worker currently working in a secondary care mental health context and also undergoing professional training in Counselling Psychology. She therefore has experience in managing situations where distress occurs. It is not expected that extreme distress will occur, or that the relevant action will become necessary. In the scenario where participants become unduly distressed, below is a three step protocol detailing signs of distress that the researcher will look out for, as well as action to take at each stage.

Mild distress:

Signs to look out for:

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless

Action to take:

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

- 1) Uncontrolled crying/ wailing, inability to talk coherently
- 2) Panic/anxiety attack- e.g. hyperventilation, shaking, fear of impending heart attack
- 3) Participant demonstrating extreme difficulties with concentration/attention owing to above

Action to take:

- 1) The researcher will intervene to terminate the interview
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
- 4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to their everyday life difficulties/problems and that most people recover from such psychological distress.
- 5) Ask the participant if they would like to speak to a friend or a member of family (e.g. over the phone) to help reassure them
- 6) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss this further with mental health professionals and remind participants that this is not designed as a therapeutic interaction
- 7) Details of counselling/therapeutic services available will be offered to participants.

Extreme distress:

Signs to look out for:

- 1) Severe emotional distress such as uncontrolled crying/wailing
- 2) Severe agitation and possible verbal or physical aggression
- 3) In very extreme cases- suicidal ideation and plans expressed/possible psychotic breakdown

Action to take:

- 1) Maintain safety of participant and researcher
- 2) If the researcher has concerns for the participant's or others' safety, she will inform them that she has a duty to inform the appropriate mental health services any such as their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then she will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain them and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

PART C – JOURNAL ARTICLE

**Title: A Qualitative Analysis of South Asian Clients’
Experiences of Therapist Self-Disclosure**

Journal of Counselling Psychology

A Qualitative Analysis of South Asian Clients' Experiences of Therapist Self-Disclosure

Sheetal Patel

City University

Abstract

Six adult South Asian (SA) clients were interviewed using a semi-structured interview schedule, about their experience of therapist self-disclosure (TSD). Data was analysed using Interpretative Phenomenological Analysis (IPA). Findings indicated 4 super-ordinate themes: (a) understanding of therapist self-disclosure, (b) experience of therapist self-disclosure, (c) impact of therapist self-disclosure on self, and (d) impact of therapist self-disclosure on the therapeutic relationship. TSD was experienced as helpful and unhelpful and participants held both positions as valid. However, a sense of connection within the narrative of the participants was found in various manifestations and permeated all themes in the analysis. Thus due to the volume of data analysed, this article will emphasise the theme 'Impact of therapist self-disclosure on the therapeutic relationship' **Connection / disconnection with the therapist** and its corresponding sub-themes. The findings of this study suggest that TSD may offer a significant way to increase client self-disclosures, reduce a sense of isolation, allow a deeper sense of connection to form between clients and therapists and develop the therapeutic relationship (TR) within a multi-cultural counselling context. A rich account of a group of SA clients in individual therapy is therefore presented. It is argued that the study provides insights into this lived experience that may be useful for counselling psychologists when working with SA clients, and perhaps other BME clients attending therapy.

Key words: therapist self-disclosure, therapeutic relationship, South Asian, cross-cultural counselling, multicultural

Introduction

The SA community is the largest ethnic minority group in the UK. According to Marshall and Yazdani's (1999) definition, SA means "any individual whose cultural or familial backgrounds originate from the subcontinents of India, Pakistan Bangladesh and Sri Lanka, including people from East Africa" (p. 413).

SA Clients' Access to Mental Health Services

The National Health Service (NHS) provides mental health services to those from all areas of society, however it is embedded within a Western model of psychological health. The UK government has recognised that the uptake of services varies between black and minority ethnic (BME) groups, and this has been a concern for policy makers, clinicians and service users. When accessing mental health care in the UK, inquiries and reports have found that BME populations have received poorer services and health outcomes, in comparison to the White British population (Department of Health, 2008). Furthermore, some BME groups have reported dissatisfaction with mental health services and have reported coercive treatments and adverse experiences (Bhui et al., 2003; Sainsbury Centre for Mental Health, 2006).

A number of factors may explain the variation in access to and utilisation of mental health services. These can include: cultural health beliefs regarding psychological distress, styles of coping, level of knowledge about services in relation to cultural appropriateness and its referral system, previous dissatisfactory experiences of services, social exclusion, language barriers, lack of trust in the service and their cultural and religious needs not being adequately addressed (Bhui & Bhugra, 2002; Bhui & Rüdell, 2002; Goldberg, 1999; King, Weich, Nazroo, & Blizard, 2006). Although there has been an increase in the recognition of the importance of psychological therapy as an early intervention in preventing the deterioration of mental health, (Busfield, 1999; McLeod & McLeod, 2001; Mellor-Clark, Simms-Ellis, & Burton, 2001), Netto, Gaag, Thanki, Bondi and Munro (2001) highlight the need to address the low uptake of counselling services by SA communities.

Developing Culturally Competent Care

Typically, psychological practice focuses on the verbal and emotional expression of the client, together with self-disclosure and insight (Sue et al., 1998). Good practice includes use of clinical and cultural

formulations and explanatory models. These can help professionals work in a more culturally competent way and allow therapists to gain a greater understanding of their client (American Psychiatric Association, 2002; Harper & Moss, 2003; Kleinmann, 1980, as cited in Bhui & Bhugra, 2004). It is imperative for psychologists to be well-versed in a culturally sensitive practice, rather than the client being considered as reluctant to engage in therapy. In addition to these forms of good practice, TSD could be considered the key to providing effective therapy in a culturally diverse society.

Definitions and Types of TSD

Throughout the existing literature, the definition of TSD differs between general and broad to more detailed and distinct definitions. More recently, research has found that the information therapists reveal about themselves can be grouped into self-disclosing/non-immediate statements and self-involving/immediate statements (e.g. Audet, 2004; Audet & Everall, 2003; Farber, 2006; Knox & Hill, 2003). Self-disclosing or non-immediate statements is the disclosure of personal information regarding the therapist's life outside the therapy, for example, life circumstances, past experiences, personal values and beliefs. In contrast, self-involving or immediate statements are the internal cognitions and emotions the therapist has in relation to the TR or the client (Constantine & Kwan, 2003; Knox & Hill, 2003). It is suggested that immediate disclosures are more acceptable forms of disclosures because of the focus they place on the TR (Myers & Hayes, 2006; Tantillo, 2004).

The categorisation of TSD could help in deciding what is acceptable and what is not when self-disclosing. Wachtel (1993) suggests only reactions within-sessions are acceptable, whereas disclosures about therapist's personal experiences are not. Wachtel states when a therapist brings their own experiences into therapy, they are acting in a selfish way and are neglecting the client's needs, whereas within session disclosures show attention to the client's experience. Knox and Hill (2003) claim that disclosures that are too intimate or personal may frighten or burden the client, but suggest that TSD should contain some degree of intimacy. Various attempts have been made to categorise and define TSD, however there is still little consensus in how to conceptualise it. Furthermore, currently there are no concrete guidelines regarding the use of TSD.

TSD in Multi-Cultural Counselling

With the continuous growth of our pluralistic society, there is a demand for mental health services to be culturally sensitive. Multi-cultural counselling is a fairly new paradigm, dating back to the 1970s (Gerstein, Rountree & Ordonez, 2007). Growing recognition of the differences that exist across clients and how traditional approaches that were effective with Caucasian clients, but not beneficial to clients from different cultural backgrounds, encouraged the generation of culturally appropriate theory and practice (Cheek, 1976).

When working in a multicultural context it is important for therapists to be aware of how they see the world from a moral, social, ethical, and philosophical perspective (Lonner & Ibrahim, 1996). The values held by therapists are inherently brought to the therapeutic frame and may not be in line with those of their clients. Some of the frequent cultural biases of counselling were highlighted by Pedersen (1987). These included: an assumption that “normality” is a universal concept; importance placed on individualism and independence; an expectation of openness and “psychological mindedness”; and an expectation of client self-disclosure. Therefore, when working with SA clients, therapists’ awareness of their own frame of reference is particularly important as behaviours such as early disengagement and lack of trust in the therapist, may actually be culturally appropriate.

Therapists working multi-culturally tend to support the use of TSD to convey their sensitivity to working with cultural issues (Burkard, Knox, Groen, Perez, & Hess, 2006; Goldstein, 1994; Jenkins, 1990; Sue & Sue, 1999). With the NHS embedded within a Western model of psychological health, therapists who work with culturally different clients may need to use an intervention like TSD to show they can be trusted (Sue & Sue, 1999). It is proposed TSD can be used to show therapist sensitivity to racial and cultural issues, which can help form a strong TR with culturally diverse clients (Helms & Cook, 1999; Sue & Sue, 2003).

In their book, *Counselling the Culturally Different*, Sue and Sue (1990) state that a culturally diverse client is likely to be particularly apprehensive when seeing a therapist for the first time. Their assumption is that a culturally different client may not self-disclose until the therapist self-discloses first. Consequently, these clients may respond more positively to therapists who reveal his/her thoughts and feelings. However, limited research exists exploring the impact of TSD in multi-cultural

counselling and it seems as though such research is needed to see how it could impact on the development of relationships within this context (Burkard et al., 2006).

The use of TSD with clients from diverse backgrounds is an important aspect of multicultural competence (Helms & Cook, 1999; Sue & Sue, 2003). Barnett (2011) suggests therapists should be aware of the various aspects of diversity of clients and have knowledge about how these can influence their needs. For example, some cultures may view the therapist as aloof and impersonal if he/she refuses to self-disclose. However, in other cultures TSD can be seen as intrusive and unprofessional (Barnett, 2011). Therefore, an important feature of a therapist's ability to be able to provide effective and ethical care, should consist of knowledge of each client's background and how the use of TSD would be viewed and received (Barnett, 2011).

Multicultural models and Vasquez (2009) argue that authenticity shown by therapists is a quality that can enhance the TR. This argument is supported by a case study presented by Constantine and Kwan (2003) which highlighted how the therapist was able to show a sense of caring and connection with her client (a Black female) through TSD. Furthermore, the therapist also created a safe space for the client to share her experiences and feelings with ease. The disclosure enhanced the TR by modelling the importance of speaking about racial, ethnic, or cultural similarities and differences within the therapeutic setting. Constantine and Kwan suggest that TSD could be used to develop and maintain the TR between clients of colour and their therapist, addressing cultural mistrust, showing cultural competence, and exhibiting therapist expertise.

Research Body on TSD

When reviewing the current TSD literature on multi-cultural counselling more conceptual work was found than empirical studies. Regardless of the limited research in this area, there appears to be theoretical agreement on its usefulness when working with clients from diverse backgrounds.

Burkard et al. (2006) explored Caucasian American therapists' use of self-disclosure in cross-cultural counselling, using CQRM (an inductive analytic method, whereby decisions are made by the consensus of a research team). Participants typically chose to disclose their responses to their clients' experiences of racism or oppression, with the view that it would enhance and preserve the TR.

Additionally, findings suggested that TSDs helped the clients feel understood and allowed them to open up about other issues. Although the study's sample was small, its findings are perhaps indicative of the contributions of the richness and depth (rather than breadth) which qualitative research can yield. However, the findings are also based on what the therapists could recall and therefore is subject to memory lapses and distortion. Lastly, the findings are solely grounded in the perspectives of therapists and we are missing the perspectives of clients who are at the receiving end of TSD. Exploring the views of clients could suggest very different attitudes which would yield different outcomes.

In an attempt to address the absence of the clients' view, Bitar, Kimball, Bermudez and Drew's (2014) phenomenological study investigated the effects of TSD on Mexican-American men working with Caucasian American therapists. Four main themes emerged from the data and revealed that TSD is a culturally competent intervention and had several benefits on the clients which included, strengthening the TR, normalising the client's experience, diminishing the power imbalance, and showing the acceptability of self-example. Therefore, TSD could be a useful intervention to use with culturally different clients in the hope of being able to enhance and maintain the TR. Several limitations that need to be taken into consideration include; the small sample size and the qualitative methodology used as the issue of generalisability is raised. Participants may have also been hesitant in expressing views that could have been perceived as being critical of the therapist, the TSD or the therapy process, therefore, impacting on the reliability of the findings. The conclusions of this study postulate that TSD is a driving force in facilitating client self-disclosure and enhancing the TR within cross-cultural settings. However, it would be useful to focus on the impact of TSD in other cross-cultural settings (Bitar et al., 2014).

The important of exploring the impact of TSD in other cultural contexts is raised. Lokken and Twohey's (2004) grounded theory study explored American Indian clients' perspective of Caucasian American counselling behaviour. Participants rated their counsellors higher when they self-disclosed and pointed out that they were more able to trust their counsellors who self-disclosed, as it gave them an opportunity to learn more about them. Similarly, Cashwell, Shcherbakova, and Cashwell's (2003) quantitative study investigated African American and Caucasian students' preferences for TSD based on the ethnicity of both the respondent and the counsellor. Participants indicated preferences for TSD when the therapist was of different ethnicity. This is consistent with theoretical literature on multicultural counselling (Helms & Cook, 1999; Sue & Sue, 1999; Tsui & Schultz, 1985). However, the study used a nonclinical sample and the views of those who presented for counselling services may

differ in their preferences for TSD. Therefore, it would be important to see if those who have had real experience of therapy have similar views to those in the study. Cashwell et al. (2003) suggest it might be fruitful to extend the literature by looking at how TSD influences therapy outcomes. However, it would be very difficult to define what constitutes a therapeutic outcome. The concept is very subjective and even if a consensus was reached on how to define it, the question would be whether it can be measured.

Kim et al. (2003) attempted to address the gap identified by Cashwell et al. (2003) using quantitative methodology to explore TSD and East Asian American clients. The study found that clients' adherence to Asian cultural values and whether they experienced TSD or not did not have an effect on session outcome. Their findings conflict with current theory and research on the effects of TSD on session outcome (Kim et al., 2003). The use of a qualitative approach may be helpful to further explore this idea and to see how SA clients of differing cultural values react to TSD.

The findings from these studies provide some insight into culturally diverse clients' perceptions of TSD. However, the majority of studies were carried out in America and only one study explored the views of Indian clients (one subgroup that is part of the SA umbrella term). Additional research is needed to increase our understanding of the role and impact of TSD on SA clients, as this may improve the quality of care provided to these clients as well as their overall experience of therapy.

Purpose of the Present Study

Given the limitations in prior research, the present study aimed to explore SA clients' experiences of TSD in individual therapy using a qualitative research methodology. Qualitative research is an important tool in Counselling Psychology research, particularly in cross-cultural counselling (Ponterotto, 2005). For this study Interpretative Phenomenological Analysis (IPA) was used to explore and better understand SA clients' experiences of TSD. IPA is utilised when the aim of the study is to understand the subjective experience of a phenomenon and is influenced by three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography. An IPA study focuses on capturing in-depth accounts of people's lived experience, how it is that they experience what they experience-how they view it, describe it, feel about it, and make sense of it (Creswell, 1998; Giorgi, 1985). In this study IPA was used to explore and understand the essences of experience in order to

derive the common themes of experience for SA clients. The findings of this study may help to inform therapists' decision-making processes about the use of the TSD in multi-cultural counselling and how such disclosures could impact the TR.

Method

Participants

Six SA adults (5 female and 1 male) agreed to participate in this study. Participants ranged in age from 24-33 years and were born in the UK. Five participants identified themselves as British Indian and one participant described herself as British Bangladeshi. All participants spoke fluent English. Four participants defined their therapist's ethnicity as British White and 1 participant described their therapist as British Indian. Of the 6 participants, one participant saw two therapists (one white, the other Indian). The theoretical orientations of therapist were: Psychodynamic, CBT, Person Centred and Integrative. The number of sessions completed by participants ranged from four to six months.

Procedure

Purposive sampling of a small, broadly homogeneous group (Smith & Osborn, 2008) was used to select a sample of SA clients who had experienced TSD in individual therapy. Participants were recruited from mental health and counselling services that cater for SA clients. Participants were selected from those who met the inclusion criteria (SA, 18 years or older, had experienced TSD, completed contact with their therapist (minimum of 4 sessions) and were willing to discuss their experience of TSD).

Participants completed a demographic form, which included questions about age, gender, ethnicity, country of origin, gender of therapist, ethnicity of therapist, therapeutic approach taken by therapist and number of sessions completed.

The interview aimed to elicit an account of the participants' experience of TSD and hence a semi-structured interview schedule was used to allow the participants the freedom to speak freely and openly. Use of semi-structured interviews in IPA also allows greater flexibility and richness of data and allows access to participants' perceptions, feelings and understandings in an original way (Smith & Osborne, 2008).

All participants were interviewed individually, lasting from 30-50 minutes and were conducted in a safe and confidential university environment. Interviews were audiotaped, and then transcribed verbatim. They were stored securely, and names and demographic data were anonymised in accordance with BPS ethical guidelines to ensure confidentiality.

Ethical Considerations

Ethical approval was granted by City University's Ethics Committee. Full care and consideration was paid to the ethical implications of the study throughout its progress in accordance with the BPS Code of Ethics and Conduct (2009).

Data Analysis

The transcripts were analysed individually using IPA and followed the procedure documented by Smith, Flowers and Larkin (2009). IPA aims to identify different themes from within the data, selected by, abstraction, subsumption, polarisation, contextualisation and numeration. Initially a transcript was read, and notes made of key phrases, summaries of content, connections between different aspects of the transcript and initial interpretations. From these notes, themes were identified that captured the essence about the quality of what was being said. Checks were continually made to ensure that emergent themes were consistent with the data and not simply a product of expectations that had been shaped by the researcher's own assumptions or the analysis of other transcripts.

This process discovered themes that encapsulated something about the participants' experience of TSD whilst remaining true to the real world views of the participants and offering as full an account as possible.

This process was repeated in turn for each transcript following which a 'super-ordinate list' of all themes across transcripts was generated. The interpretative task of selecting which themes to include or exclude was then repeated. A comprehensive list of super-ordinate themes was generated from this process.

Results

The super-ordinate themes that emerged from the SA clients' accounts were Understanding of therapist self-disclosure, Experience of therapist self-disclosure, Impact of therapist self-disclosure on self, and Impact of therapist self-disclosure on the therapeutic relationship. Smith et al. (2009), highlight that, when using IPA, the unearthing of themes is grounded in the researcher engaging in a double hermeneutic. For this reason, the researcher acknowledges that the themes identified are a subjective interpretation, and another researcher may have identified different themes from the accounts. A sense of connection within the narratives of the participants was found in various manifestations and permeated all themes in the analysis. However, due to the volume of data analysed, this article will emphasise the theme 'Impact of therapist self-disclosure on the therapeutic relationship' and its corresponding sub-themes.

Super-ordinate Theme: Impact of therapist self-disclosure on the therapeutic relationship

This super-ordinate theme captures how TSD was used to establish a sense of connection between the participants and their therapists therefore impacting upon the therapeutic relationship. It illustrates their experiences of being able to place their therapist into a known and trusted category and how this facilitated a deeper level of connection. This theme also reveals how participants' descriptions of knowing information about their therapist that had not been explicitly revealed, further enhanced the relationship.

Sub-theme 1: 6. 'Just another person'

In this sub-theme participants drew parallels with other well established relationships such as friends or family when talking about their relationship with their therapist.

Rashmi was aware that the TR would have to end but it seems she would have preferred it to have continued. She perhaps grew accustomed to the feel good factor of being in a relationship and having someone to share with:

If I knew that she wasn't a therapist I'd probably stay friends with her but because we put a very formal end to the sessions obviously that's the end of our relationship now so we don't have a relationship anymore but she felt like somebody that I could easily be friends with. (Rashmi: 251-254)

For Karina, knowing someone and being known seems important especially if it is someone who has shared a similar experience to her. From her narrative there was a strong sense of feeling alone in her experience and not knowing anyone who had been through something similar. It is plausible that Karina may have felt so disconnected from others in the past that now knowing that someone else shares a similar experience is invaluable. Her use of language suggests it is something that she still holds on to today.

When she told me her experience, I felt like, hold on I'm not talking to a therapist anymore, I'm talking to a friend. Because I'd been there already it made me feel like I know her. (Karina: 60-62)

The TSD had a greater weighting for Viraj as he compared it to disclosures made by friends. It seems however that a disclosure coming from a professional had greater meaning as it exhibited therapist expertise in a more experiential way:

I mean like I know everyone at some point in their lives has confidence issues and stuff, but I guess hearing a professional talk about it is quite different than hearing say your friend talk about it with you. (Viraj: 40-43)

For Karina and Rani, the revelation of past struggles, flaws and hardships appeared to humanise their therapists. For the participants this reciprocal exchange may have meant that a more egalitarian relationship was created:

That's when for me she became human, she became a person to me, not someone just sitting there. (Karina: 155-156)

Umm I think it's helped me add a bit more of a human aspect to therapy, that it's ok, it's ok if you don't have your life all together, you or the therapist. (Rani: 401-402)

Anita illustrates a parallel process between her struggle to know herself and the uncertainty that this can bring, alongside the uncertainty about who the therapist is. This was perhaps alleviated by the humanising process through TSD:

It demystifies this kind of unknown and I think sometimes, I think with a lot of people we we do struggle with the uncertainty and the unknown and I think it kinda just helps. Just puts this person into perspective and it just umm humanises a person, that she does have a life [laughs] outside of this. (Anita: 191-194)

This sub-theme has shown how the use of TSD to convey familiarity of the therapist played an important part in feeling known and understood but also enhance the TR. The TSD also allowed the participants to relate to their therapist on a deeper level.

Sub-theme 2: Shared knowing:

Five participants had positive experiences whereby they felt the TSD allowed them to ascertain a similarity between their therapist and themselves.

For Rashmi using the TSD to replace the unfamiliarity of the TR with the known confines of a familiar relationship or context facilitated her feeling understood. It seemed the disclosure was experienced as being more appropriate and relevant:

...you know the second therapist was from the same cultural background as me, she was Asian so am I. So she knows what I mean when I'm talking about my family and what it means to tell them this thing. She knows because she's Asian so her self-disclosure was just so much more valid and real because she understands how it is. (Rashmi: 237-241)

Rani echoes this view and perhaps perceived her therapist to be more attentive or interested in what was being discussed because of their expressed similarity. Such disclosures seemed to halt initial concerns of being judged or perceived negatively and perhaps if her therapist had not disclosed, this may not have been possible:

The fact that she allowed me to feel comfortable and I think it's her self-disclosure of her saying you know I've got this and then it allowed me to not hold back. I told her the good parts the bad parts I didn't feel like I had to defend my culture. (Rani: 271-274)

For Karina, the similarity between her and her therapist revealed by knowing her therapist's family status, rather than diminishing her expert status, meant for her that she was understood more but also added greater power to her words:

...I knew she had a family, so she understands where I'm coming from...when I found out she had the same issue as I did and she felt the same as I did her guidance just felt more real and honest. (Karina: 113-119)

For Viraj, it seems his therapist purposefully shared information and used himself as an example to create a sense of similarity between them both to diminish Viraj's anxiety and sense of isolation. This seemed to facilitate a connection but also enabled Viraj to use that to help him problem solve and move forwards:

So he kind of used his experience to help mirror back parts of me. So he was trying to show me my experience experienced by him and how he went through what I was going through. (Viraj: 14-16)

In this sub-theme the participants have illustrated how similarities established between them and their therapists contributed to a sense of being understood and served to enhance the relationship and sense of connection further.

Sub-theme 3: Closing the gap:

This sub theme explores how the TR was strengthened by the TSD. All six participants described an increase in trust as one factor that brought them closer to their therapist:

Her sharing her experience with me made me feel like I could trust her more, trust what she was saying more. You know she's gone through the same experience I have. (Karina: 126-127)

Rani pays attention to trust being a two-way process and perhaps symbolises her perception of an equal relationship into which she had entered:

So I'm glad she did self-disclose because it meant that she kind of trusted me to have told me. (Rani: 62-63)

Anita and Viraj both reflect on their experiences of having to disclose personal information to someone they do not really know. But more importantly how doing this and not receiving the same sort of information back can impede the development of the relationship. For these participants the TSD allowed them to connect with their therapist on a deeper level, which allowed them to feel closer and at ease:

I think it's quite scary talking to someone about your personal things and deep stuff and not really get anything back, or know anything about them, it can feel really scary and in some ways just by having a little bit of details can sometimes ground someone and help you to picture that person and almost helps you to develop that trust quicker. (Anita: 187-191)

I'd never seen my therapist tell me anything about things they'd struggled with in the past and on one side it made me feel more comfortable umm but in terms of the I think it made me feel umm like I could trust this person a bit more. (Viraj: 65-72)

It is interesting to note the use of repetitive language in Karina's quote below. Karina's incomprehension about both herself and others is striking. This is emphasised through her repetitive language which conveys emotional conflict and the sense of turmoil she experiences, leaving her feeling disconnected from herself and others:

I couldn't understand why I was going through this. I couldn't understand why people around me couldn't understand how I was feeling and I was getting quite emotional because I couldn't get the answers I wanted, I couldn't understand why no one else around me could understand it and it got to a point where it was really emotional, that's it I couldn't handle it anymore so when she disclosed what she had gone through and how she had felt that's when my kind of stress levels came down, that's when I felt that somebody could actually relate to what I was going through and I could actually relate to her and that somebody else actually understood me. (Karina: 27-34)

However, for Karina the TSD seemed to have an impact on an intersubjective level where she reflects on her relationship with her therapist and the changes perceived in the 'bond' between them. For Karina the TSD provided her with reassurance that she was in 'safe hands', and that her own problems were shared by others:

I think it's because what she described was so close to my heart that's all it needed, that bond was there after that and that's all I needed to feel safe I guess. That connection was there, I didn't need anything else. She just knew where I was coming from. (Karina: 186-188)

Participants also viewed the TSD as something that alleviated the loneliness that they once felt in their experience and the impact this had on the therapy process:

It just puts it all in perspective and you don't feel alone in your experience. That's a really nice feeling to not feel alone in what you're going through. (Amira: 194- 195)

Anita echoes this view and reflects on the TSD abating the isolation she felt in her experience:

It normalised some of my anxieties and I felt less lonely, less alone umm and I think that's the thing with therapy, sometimes you can be heard but not understood and we kinda seek both and in that particular moment I did feel both heard and understood which I think strengthens our relationship and makes it more trustworthy in some way. (Anita: 167-170)

Anita also referred to the use of TSD perhaps as a natural way of her therapist connecting with her and being able to convey to her that she does truly understand the experience being disclosed to her. Her language use here is interesting as she moves from ‘*when they*’ to ‘*when she*’ and is a good example of language reflecting her experience perhaps. It seems ‘they’ is quite distancing, but then she uses ‘she’, a more direct and personal way of addressing her therapist. This perhaps reflects a parallel to the shift in closeness following TSD.

... it was her way of letting me know that she too has felt that pain and that it resonated with her and that on some level she she understood even if...I think sometimes when they, when she discloses personal stuff it's it's almost another way of...of kind of telling you that you kind of get it but not necessarily being able to tell you in a single word about what your pain might be but sharing an experience is almost a similar way of saying I get what you're saying. (Anita: 93-98)

Anita refers to a shared pain as perhaps being the medium that enabled her and her therapist to bond with each other. Perhaps for Anita ‘shared pain’ goes beyond shared experience as allowing an emotional connection or bond to be formed. This may highlight one of the benefits of TSD in that it has the ability to facilitate a bond and/or connection between two people through the sharing of experience but also as a way of empathising.

Sub-theme 4: “Genuineness”

Participants spoke about how the use of TSD enabled the therapist to reveal a sense of authenticity, warmth and caring for them which served to further enhance the TR. The following extracts show how the revealing of genuineness was understood by the participant as the therapist perhaps going beyond their professional role to help them:

I'll never forget her and what she did for me and just how genuine she was with me. (Amira: 173-174)

When she talked about her break up, it kinda showed a sense of genuineness in her. (Anita: 101-102)

I don't know, it just has a different effect, like a more real and genuine effect. Something I guess more...significant and honest. (Viraj: 43-44)

For Amira, the TSD held greater weighting and offered a level of expertise that was beyond 'textbook'. Perhaps for Amira this meant that the TSD was born out of real experience and that her therapist was being intuitive to her needs in that moment by self-disclosing. The therapist sharing a similar experience with Amira perhaps showed a different side of them:

But I think when she shared her experience it it was personal it wasn't it wasn't like from a textbook or something. It felt real, it was like a conversation with someone who wasn't judging me. (Amira: 77-79)

Overall, this super-ordinate theme has highlighted the ways in which TSD enabled the participants to feel connected to their therapists. Participants expressed that sharing of experiences allowed them to feel more comfortable in the TR but importantly reduced a sense of isolation in their experiences and meant they felt connected to themselves, their therapist and to their lifeworld. This super-ordinate theme also showed how the TSD facilitated the development of a positive relational aspect to develop.

Discussion

The TSDs were ultimately used by the participants to enhance a sense of connection between themselves and their therapists. Corey (2005) suggests that the humanity of the therapist is essential for connecting with clients and further argues that if "we hide behind the safety of our professional role, our clients will keep themselves hidden from us" (p. 17). Therapy is thought to be a "human rather than technical endeavour", and therefore requires an authentic human relationship which is facilitated by therapists "own genuineness and aliveness" (Corey, 2005, p. 17).

The participants' appreciation for the therapy process increased after the TSD as it showed a more human side to the therapist. They seemed to value the genuineness and felt that it improved the connection between them and their therapist, thus enhancing the therapeutic work. This is consistent with Hill, Mahalik and Thompson's (1989) study, which showed that those who are open about their

personal weaknesses and vulnerabilities are viewed as empathic, warm and credible and therapists who disclose their professional skills and experiences are seen to not possess those qualities. The findings of this current study are also consistent with Knox et al. (1997) who showed that clients reported positive outcomes when their therapist was viewed like a real person and not a distant experienced professional.

Sharing information with a complete stranger may be particularly difficult for SA clients, for whom trust may already be lacking (Blakey, Pearce, & Chesters, 2006; Bhui & Rüdell, 2002; Bhui & Bhugra, 2002; Goldberg, 1999; King, Weich, Nazroo, & Blizard, 2006). The findings of the current study suggest that participants experienced enhanced trust in their therapist due to the TSD. It provided them with a degree of intimacy enabling a more human view of their therapist and allowed them to place their therapist in to a familiar category. This facilitated a strong sense of connection to be formed. This is consistent with Goldfried et al. (2003) and Lane and Hull (1990) who state that a therapist who self-discloses can create an atmosphere of transparency and increased trust and intimacy by revealing that they too have experienced the same struggles and difficulties. These findings further concur with those from the Lokken and Twohey (2004) study who found that participants were able to trust counsellors who self-disclosed more than those who did not, as it gave them an opportunity to learn more about the counsellor. These findings are also consistent with theories of counselling Asian clients (Helms & Cook, 1999; Kim et., 2003; Sue & Sue, 1999).

Orange and Stolorow (1998) discuss TSD from an intersubjective point of view which seems to fit in with the idea that TSD can quite directly enhance a sense of connection in the therapeutic encounter. They suggest that intersubjective theory acknowledges that within a relational field, it is inevitable for two subjective worlds to continually self reveal to each other. The therapist's subjectivity is arguably as important as that of the client and that one way to bring these both to the foreground is through self-disclosure. Farber (2003) who shares this view suggests that the therapist no longer is seen as the only expert in the therapeutic encounter. Rather than, observing and analysing a client's thoughts, feelings and behaviours, he or she is part of a bidirectional field whereby both the therapist and the client co-construct meaning of what they are experiencing. Self-disclosure could play a vital role if a shift from an intra-psychic to a more relational model that focuses on the mutual interaction of two people takes place (Bridges, 2001). Therapists bring their whole selves into the therapeutic room, their knowledge and professionalism as well as their identity, character and spirit. As a result, therapist genuineness is strongly connected to a sincere interaction and engagement with the therapeutic process that encourages openness (Lietaer, 2001; Wyatt, 2001).

Being able to connect with a client could be quite challenging particularly with SA clients, whose values emphasise collective needs, interdependency and conformity (Ponterotto et al., 1995). This emphasis on connection and collaboration is consistent with multi-cultural counselling as well as several other culturally sensitive approaches to treatment. For example, the primary goal of Relational-Cultural Therapy is to foster mutuality, authenticity and mutual empowerment (Sparks, 2009). The common assumption for participants in this study was that therapy would perhaps be a one-way process, in which they talk and the therapist listens. The TSD however, seemed to help change these perceptions and form a context in which the client felt empowered and connected to themselves and others.

The participants also experienced TSD as a way of maintaining genuineness and authenticity – key aspects of a relational approach. Further, when the therapist self-disclosed an event/experience whereby he/she felt misunderstood, the participant felt less isolated and different from others. It allowed them to feel that their therapist actually understood and empathised with their difficulty. For some participants this enabled them to continue with therapy and change their initial pessimistic views about therapy and its benefits. Given the reluctance of SA clients to seek or remain in therapy TSD could be an important technique to use as a way of engaging them in the therapy process.

With this group of participants there was an overall positive experience of TSD. They saw their therapists show openness, strength, and vulnerability. The use of TSD in this way facilitated the TR but also developed an experience of client ‘self-cohesion’—where participants felt internal emotional integration through the connection to another person (Bitar et al., 2014). The TSD encouraged trust, empathic understanding, and credibility of the therapist, which are in keeping with the values of Counselling Psychology. Generally, this helped to develop a sense of similarity and connection between the participants and their therapists. However, it is important to keep in mind that there were two participants who experienced the TSD as belittling or irrelevant to what they had been discussing. The mix of experiences is also consistent with previous research and not really surprising in the context of the TR, the quality of which is the key to how TSD is received. This perhaps underlines the significance of the relational and dynamic nature of how therapy, and within that, TSD, is experienced and perceived. The thoughtful use of TSD can equalise the TR and enhance connection between the therapist and client as it seems it can enable clients to perceive the therapist as more human. Authenticity and genuineness shown by the therapist are particularly valued by multicultural

models of interventions and as Vasquez (2009) argues, these qualities can enhance the therapeutic alliance. TSD thus could be one way to increase support and connection with SA clients.

Limitations

In accordance with IPA, the sample is small and thus the findings are not generalisable. Further, the study is not representative of all SA individuals who have had therapy as IPA prioritises the broad underlying structures of the experience in question for this group and not all SA individuals who have experienced TSD in therapy. In addition, those individuals participating in this study were all second generation SAs, providing a fairly homogenous sample. However, changes in views across generations about therapy, seeing a psychologist, and accessing mental health services means that the context within which the participants accounts are embedded, may differ between generations. Therefore, future research may explore the views of other generations. A final limitation was that the participants in this study were volunteers. This suggests that they were relatively happy to discuss their experience of TSD with the researcher. However, their views could have differed from those who did not volunteer to participate, with regards to their understandings and experiences of TSD. Future research could focus specifically on a group of individuals who had negative experiences of TSD.

Considering the limitations, this study represents a starting point for understanding SA clients' experiences of TSD. Thus, it is important to note that the researcher's aim was not to produce generalisable findings but to unfold new ideas and explore the subjective experiences of SA clients (Willig, 2008).

Implications

The observations made in the present study revealed interesting and new aspects of TSD for SA clients. TSD can be experienced as helpful and unhelpful and participants were able to hold both positions as valid. They revealed how the experience of TSD appeared to positively impact upon the TR enabling them to feel more connected to their therapist. The findings of this study suggest that TSD is but one way of facilitating client self-disclosure and fostering and maintaining the TR within a multi-cultural counselling context. TSD also appears to have other benefits, such as normalising client problems,

alleviating power imbalance, and reducing a sense of isolation which are key components of facilitating culturally sensitive care.

These and other similar findings regarding the use of TSD may encourage psychologists and other professionals working within mental health services to be open to the possibility of utilising it. TSD emerges from the therapeutic encounter in the here and now and usually requires the therapist to make potentially difficult decisions on the spot which is possibly why it seems to be neglected. Therefore, to disclose personal experiences, feelings, or information should be judiciously deliberated, in the context of the individual client and the TR at that specific moment in time. Furthermore, therapists need to be cautious in their use of self-disclosure with a clear rationale and purpose behind its use. It is for this reason why this research may be of real use, adding clarification and insight into what may be helpful and what not for this population.

With the growing body of literature illustrating the potentially varied impact of TSD both on the client and the TR; there is growing rationale to ensure that this skill/intervention/way of being is appropriately addressed in training programs and supervision. Most therapists either talk about TSD in binary terms; you either do it or you don't. However, as Spinelli (2002) suggested, it is most important to consider when a therapist should self-disclose rather than whether they should do it or not. It is important to treat each client as unique when considering the possible use of TSD.

Taking into account the dearth of research exploring the perspective of SA clients, it is hoped this study may provide Counselling Psychologists with a valuable insight into the lived experience of this phenomenon, which stands to enhance therapeutic practice with this client group. In addition, the observations made may help in devising more effective ways of working with this particular group of clients.

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