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How Therapists Decide to Self-disclose to their Clients: A Grounded Theory Study

Sydney Morgan Reed
smr19a@acu.edu

ABSTRACT

One challenge therapists face when working with clients is whether or not to self-disclose personal information. Therapists may wonder whether it is ethical, and if so, what types of self-disclosure are appropriate, what impact self-disclosure will have, and how to self-disclose. Although much research exists on the benefits and costs of therapist self-disclosure (TSD), the literature on the decision-making process of TSD is scarce, particularly for marriage and family therapists. The objective of this study was to develop a general theory of the decision-making process surrounding therapist self-disclosure for marriage and family therapists. The researcher developed this theory by conducting qualitative interviews from a convenience sample of marriage and family therapists. From these interviews, the researcher searched for themes regarding TSD and developed a theory based on these themes. This theory includes a therapist's personal philosophy of TSD, in addition to common thoughts and feelings occurring before, during, and after the self-disclosure. This theory may inform other marriage and family therapists in two ways. First, it may normalize the decision-making process for them if they experience a process similar to that of the sample. Second, it will give marriage and family therapists a template of what to consider when deciding to self-disclose to clients.

How Therapists Decide to Self-disclose to their Clients: A Grounded Theory Study

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Thesis Committee

Lisa V. Merchant, Ph.D., LMFT, Chair

Lisa Powell, Ph.D., LMFT-S

Michael Pounds, Ph.D., LMFT

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CHAPTER I

INTRODUCTION

The therapeutic relationship consists of two people: the client and the therapist. As such, it is impossible for a therapist to leave themselves out of the relationship, and some researchers and clinicians argue that one of a therapist's greatest assets is themselves, but it can also be a liability (Patterson et al., 2009). Moreover, how much of themselves a therapist should bring into the therapeutic relationship is subjective and often depends on the theoretical model from which the therapist practices (Gehart, 2018).

Therapist self-disclosure (TSD) is one part of the therapist's self that has long been a topic of debate among researchers and clinicians (Henretty & Levitt, 2010; Levesque, 2018). Thus, it is difficult for therapists to know whether or not to self-disclose and how to self- disclose. Despite extensive phenomenological research on the part of the therapist and the client during TSD (Audet & Everall, 2010; Berg et al., 2016; Bitar et al., 2014), some quantitative research on its relationship to therapeutic outcomes and the therapeutic alliance (Jowers et al., 2019; Levitt et al., 2016), as well as models that propose how and what to self-disclose to clients (D'Aniello & Nguyen, 2017; Turns et al., 2018), there is only one study that examines how therapists decide to self-disclose to their clients (Miller & McNaught, 2018). Furthermore, the researchers of this study did not outline a process of decision-making; rather, they gave information about what therapists consider when self-disclosing to their clients. It also only focused on therapists practicing cognitive behavioral therapy (CBT), and the entire sample consisted of

Caucasian females (Miller & McNaught, 2018). Thus, there remains a need for a grounded theory study that develops a general theory of the decision-making process for TSD (Creswell & Creswell, 2018) that also accounts for variety in the therapist's theoretical model, particularly among marriage and family therapists who work from a systemic lens.

The purpose of this grounded theory study was to explore the decision-making process of marriage and family therapists when they decide to self-disclose to their clients and to develop a general theory of this process. Interviews were conducted for this study via a secure videoconferencing platform and included a convenience sample of marriage and family therapists. For purposes of consistency in the study and in the interviews, *therapist self-disclosure* was generally defined as any information the therapist reveals about themselves to the client.

CHAPTER II

LITERATURE REVIEW

Introduction

Therapist self-disclosure (TSD) is difficult to define (Viou et al., 2018) and often depends on the model from which the therapist works (Berg et al., 2016). Some researchers limit their definition of TSD to be what the therapist intentionally says to their clients about themselves (Berg et al., 2016), while other researchers include nonverbal communication in their definition of TSD (Viou et al., 2018), or anything the therapist unintentionally self-discloses that conveys their cultural values (Lee, 2014). Other researchers deconstruct the definition of TSD into different types, such as disclosures that are asides to the therapeutic discussion, disclosures that convey similarities between the therapist and the client, and humanizing disclosures (Levitt et al., 2016). Some scholars examine specific disclosures like the therapist's political stance (Solomonov & Barber, 2019) or sexual orientation (Carroll et al., 2011). Finally, others summarize TSD into four categories: deliberate, unavoidable, accidental, and client-driven (Levesque, 2018). Deliberate TSD is anything the therapist intentionally says or does, such as sharing a personal experience or wearing certain clothing or jewelry, like a wedding ring. Unavoidable TSDs include aspects of the therapist, such as race or gender, that the client can observe. Accidental TSDs occur when the therapist is caught off guard or sees a client outside of the therapy room, and client-driven TSDs come from information the client searches for about the therapist, such as their social media accounts

or websites (Levesque, 2018). In short, TSD encompasses a wide range of therapist behaviors and communication, and there is no universal definition of TSD (Henretty & Levitt, 2010). This paper will review the literature on therapist self-disclosure by first examining the benefits of therapist self-disclosure, then discussing cautions to therapist self-disclosure, and finally outlining the therapist's decision to self-disclose.

Benefits of Therapist Self-Disclosure

The research establishes several benefits of TSD. These benefits include strengthening the therapeutic alliance (Levitt et al., 2016) and normalizing clients' experiences (Bitar et al., 2014; Levitt et al., 2016). Conveying the therapist's cultural competence (Bitar et al., 2014) and providing a forum for therapeutic transparency (Turns et al., 2018) are also benefits of therapist self-disclosure.

Therapeutic Alliance

A strong therapeutic alliance seems to be one of the primary benefits of TSD (Bitar et al., 2014; Levitt et al., 2016; Miller & McNaught, 2018; Taherian et al., 2014). Research about the common factors that influence the success of therapy asserts that 30% of the success of therapy is due to the therapeutic alliance (Asay & Lambert, 1999). TSD is one way to strengthen this alliance (Bitar et al., 2014). When therapists self-disclose to their clients, it models to the client how to disclose themselves and, in so doing, builds rapport and trust (Bitar et al., 2014; Levitt et al., 2016; Miller & McNaught, 2018). These types of self-disclosures can be statements that convey similarities between the therapist and the client, especially in the realm of political self-disclosure (Solomonav & Barber, 2019) and the disclosure of the therapist's sexual orientation (Carroll et al., 2011). Clients who perceive therapists to be similar to them on the surface level and on the inner level

are more likely to disclose themselves, and they find therapists who self-disclose more attractive (Tanaka, 2013; Tanaka & Umemoto, 2013). Thus, therapist self-disclosure can be used to help increase clients' openness when the purpose is to establish similarities between therapist and client (Bitar et al., 2014).

Therapeutic Transparency

Therapeutic transparency, while not exactly the same as therapist self-disclosure, could be considered a form of self-disclosure. Researchers define *therapeutic transparency* as being open about which therapeutic model the therapist uses, how the therapist believes change occurs, and why the therapist asks certain questions or uses particular interventions (Turns et al., 2018). Sharing one's beliefs about how change occurs is personal, and as such, the therapist is deliberately revealing something about themselves: his or her core beliefs about human nature and growth. When a therapist is transparent with his or her clients, it changes therapy in two ways. First, it removes some of the mystery in therapy (Friedburg et al., 2013). Second, it reduces the power differential between the therapist and the client (Audet, 2011; Bitar et al., 2014; Friedburg et al., 2013). Certain therapeutic approaches call for transparency as an intervention, such as cognitive behavioral therapy (CBT) and the humanistic therapy approaches like emotionally focused therapy (EFT) or symbolic-experiential therapy (Friedburg et al., 2013; Gehart, 2018; Turns et al., 2018). All of this in turn strengthens the therapeutic alliance as it allows for collaboration between the therapist and the client, and it increases the therapist's perceived competence and credibility (Audet, 2011; Turns et al., 2018).

Normalizing Clients' Experiences

Therapist self-disclosure is often beneficial for clients because it normalizes the clients' experiences (Bitar et al., 2014; Levitt et al., 2016). When therapists self-disclose, it shows their humanity (Audet, 2011; Levitt et al., 2016; Miller & McNaught, 2018). Some researchers assert that humanizing disclosures, such as sharing issues the therapist struggled with in the past (Audet, 2011), are the most beneficial therapist self-disclosures (Levitt et al., 2016). Demonstrating their fallibility as people gives clients hope that they are not alone in their struggles, that they can be better, and that their therapist understands them (Audet & Everall, 2010).

When therapists do not mask all of their emotional reactions to the client it is also a form of self-disclosure (Viou et al., 2018). Researchers found this emotional expression to be essential to the therapeutic relationship, that it motivates the clients to change, and that it shows clients alternative ways of experiencing their own emotions (Viou et al., 2018). When therapists are comfortable with their humanity—whether it be in the form of emotional expression, making mistakes, or experiencing hardship—and disclose this to their clients, it gives the client permission to be comfortable with their humanity as well (Audet & Everall, 2010; Bitar et al., 2014; Viou et al., 2018). This information holds across several mental health professions; peer mentors in recovery from severe depression, who then self-disclose to clients struggling with severe depression, benefit the clients when the intent of the self-disclosure is to help the clients feel like they are not alone in their experiences (Truong et al., 2019). In short, when therapists humanize themselves through self-disclosure, it normalizes the clients' life experiences (Levitt et al., 2016).

Cultural Competence and Considerations

Clinicians and researchers continue to advance the field of psychotherapy, particularly in stressing the importance of cultural competence and intersectionality (Addison & Coolhart, 2015; McGoldrick & Hardy, 2008). In order to exhibit unconditional positive regard for their client(s), the therapist must explore their identity and biases so that when they enter the therapy room, the therapist can "go beyond the dominant values and explore the complexity of culture and cultural identity, not without values and judgments about what is adaptive, healthy, or 'normal' but without accepting unquestioningly our society's definitions of these culturally determined categories" (McGoldrick & Hardy, 2008, p. 10). This is the definition of cultural competence. Understanding intersectionality is included in this definition; the therapist must understand that some people experience oppression on multiple fronts (Addison & Coolhart, 2015). When the therapist understands and internalizes this, then

> . . .intersectionality can serve as a bridge between the connections among members of a group based on their shared experiences, and their disconnects based on their differences. This provides the possibility for collective action against oppression and bonding over shared experiences. (Addison & Coolhart, 2015, p. 440)

Therapist self-disclosure is one way to bridge this gap. When the therapist openly acknowledges the hardship clients face because of their cultural identity, they are disclosing to the client the therapist's beliefs about society and the world. This type of self-involving disclosure, when the therapist shares their emotions about what the client just said or who the client is, is known as *immediacy*. Immediacy is beneficial to the

client as the therapist's use of immediacy increases the therapist's attractiveness and expertness to the client (Henretty & Levitt, 2010; Jowers et al., 2019; Tanaka, 2013). The therapist can validate the differences between themselves and the client based on unavoidable TSDs like race, religion, or gender, and in so doing, they demonstrate to the client positive regard and cultural competence (Levensque, 2018; McGoldrick & Hardy, 2008). However, not all cultures advocate for TSD. In some Eastern cultures, clients may perceive healthcare providers who self-disclose to be less trustworthy than those who do not (Tanaka, 2013). Clients may find these providers more attractive, but less trustworthy, and in this case should stick to self- involving disclosures, which increase the provider's expertness (Taherian et al., 2014; Tanaka, 2013).

For some time, researchers and clinicians believed that sharing the same gender, race, or cultural background was necessary for therapy to be effective, but research shows that is not always the case (Tanaka & Umemoto, 2013; Zane & Ku, 2014). Some researchers found that when clients see therapists who are the same gender as them, they are more likely to be open about their sex lives, but on all other accounts, the gender mismatch does not make a difference in the amount of disclosure the clients give the therapist (Zane & Ku, 2014). Ethnic match is not a factor either (Zane & Ku, 2014). Other researchers discovered that individuals who identify with others on a surface level and an inner level are more likely to disclose to them than people with whom they do not perceive to have any similarities (Tanaka & Umemoto, 2013). Thus, unavoidable TSDs may matter in some instances, but not always.

Inherent in the cultural competence discussion is the importance for therapists to not offer interventions that only align with their cultural or societal values onto their

clients because when therapists do this, they unintentionally disclose and impose their values (Lee, 2014). Therapists should never assume they know exactly how their clients think or feel because everyone has lived a different life. When prescribing interventions, the therapist should consider the client's cultural background, particularly when it differs from the therapist's (Addison & Coolhart, 2015; Lee, 2014; McGoldrick & Hardy, 2008). Maintaining a stance of curiosity, positive regard, transparency, and collaboration allow the therapist and client to have a mutual understanding of the client's culturally-informed needs (Lee, 2014; McGoldrick & Hardy, 2008).

Cautions in Therapist Self-Disclosure

Coupled with the research about the benefits of therapist self-disclosure are the cautions of therapist self-disclosure, or in other words, when TSD is negative (Henretty & Levitt, 2010). These cautions involve ethics (Dickens & Park, 2016), disclosing too early and too much (Jowers et al., 2019), and damaging the therapeutic relationship (D'Aniello & Nguyen, 2017).

Ethics

One of the largest arguments against therapist self-disclosure is that it is not ethical (Dickens & Park, 2016). The American Association of Marriage and Family Therapy (AAMFT) has a set of guiding principles to help inform therapists in their ethical decision-making: autonomy, beneficence, nonmaleficence, justice, and fidelity (AAMFT, 2015). The American Psychological Association (APA, 2017) has similar guiding principles: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. However, neither ethics code explicitly states whether or not TSD is ethical or not ethical (AAMFT, 2015; APA,

2017). Several researchers assert that not disclosing to clients is unethical if there is certain information the clients want or deserve, such as the plan for their treatment or a knowledge of the therapist's core values (Henretty & Levitt, 2010). Thus, therapists should rely on principle ethics when deciding whether or not to self-disclose to their clients, meaning, they should ask themselves if their self-disclosure aligns with the guiding principles of their profession's ethics code (Dickens & Park, 2016).

Disclosing Too Early and Too Much

When therapists self-disclose too early and too much in the therapeutic process it can cause negative therapeutic outcomes (Jowers et al., 2019). In general, therapists with the least experience self-disclose the least (Henretty & Levitt, 2010) and therapists in private practice and clinics are at risk of self-disclosing too much (D'Aniello & Nguyen, 2017). However, therapists-in-training who experience anxiety are more likely to disclose this anxiety to their clients, which causes problems in the therapeutic alliance (Jowers et al., 2019). They are also more likely to self-disclose early in the therapeutic relationship if they exhibit problematic interpersonal characteristics, such as self-centeredness and difficulty investing in relationships (Jowers et al., 2019). Supervision between supervisors and trainees is an ideal time to model to trainees what appropriate self-disclosure looks like; namely, that appropriate self-disclosure normalizes the trainee's feelings, it humanizes the supervisor, and it increases trust in their relationship when the supervisor's disclosure matches the trainee's concerns (Clevinger et al., 2019). Often, therapists find that too much disclosure early in the therapeutic relationship causes discomfort and confusion for clients about what they are to expect from therapy (Berg et al., 2016). Some clients find that TSD is helpful early on when it is "small talk" or other

conversation that "breaks the ice" and takes the client out of the spotlight (Audet & Everall, 2010, p. 333). However, when the TSD is about the therapist's poor choices or exhaustive information about the therapist's life and family, it causes the clients to wonder about the therapist's role and competence (Audet & Everall, 2010). Extensive TSD also leads the client to question the relevance of the disclosure and to feel misunderstood by the therapist, like the therapist does not care about the client's needs, only their own needs (Audet & Everall, 2010).

Boundary Confusion

Another component that comes with therapist self-disclosure is the potential for some boundary confusion, which is a considerable factor of the ethics debate (Audet, 2011; Audet & Everall, 2010; Berg et al., 2016). Clients may wonder how they are supposed to respond when their therapist self-discloses something personal, such as a poor decision the therapist made (Audet, 2010). The client may feel pressure to act as the therapist and provide comfort or advice because the therapist—the person who should help the client—is the one expressing a need (Audet & Everall, 2010). At times, clients perceive that the information the therapist discloses reflects how the therapist views the client, for example, like the client is the therapist's friend or even a parent (Audet, 2011). Under all of these instances, the therapist may be harming the client because they are not providing the services the client needs, which is a violation of the ethical principle of nonmaleficence (AAMFT, 2015; APA, 2017).

The Decision to Self-Disclose

Several researchers developed recommendations for therapists and the process they should undergo when they self-disclose (D'Aniello & Nguyen, 2017; Henretty &

Levitt, 2010). Using their own experiences, clinicians also developed a set of recommendations for therapist self-disclosure (Berg et al., 2016; Lu and Jiang, 2013; Miller & McNaught, 2018; Solomonov & Barber, 2019). Several themes emerged from these studies and reviews. First, the therapist should preliminarily think about the purpose of the self-disclosure (D'Aniello & Nguyen, 2017; Miller & McNaught, 2018), and later reflect on this purpose after the therapist disclosed (Miller & McNaught, 2018). Second, when using self-disclosure with a client, the therapist should ask themselves what benefit will come to the client as a result of the disclosure and if it will move therapy forward (Berg et al., 2016; D'Aniello & Nguyen, 2017; Lu & Jiang, 2013). Third, the therapist must consider how this will impact the boundaries and the roles in their relationship (Berg et al., 2016; Miller & McNaught, 2018). Finally, the therapist should think about what damage the self-disclosure could do overall: if it will completely remove the professionalism in their relationship (Miller & McNaught, 2018) and if it will negatively impact the client as person—such as leaving them feeling misunderstood or confused (Audet & Everall, 2010; D'Aniello & Nguyen, 2017). The overall conclusion each of these researchers and clinicians come to is that the self-disclosure must always be about helping the client, and not about the therapist.

Although several researchers outlined principles and recommendations for how, when, what, and why to self-disclose to clients (D'Aniello & Nguyen, 2017; Henretty & Levitt, 2010), there is little research on the actual processes of therapists when they self-disclose (Lu & Jiang, 2013; Miller & McNaught, 2018), particularly for couple and family therapists. From the research that exists, there are several instances under which therapists decide to disclose. Therapists will sometimes self-disclose when they perceive

an impasse in therapy or their relationship with their client, when neither aspect of their therapeutic experience is progressing (Lu & Jiang, 2013; Miller & McNaught, 2018). Therapists report that TSD under these circumstances manages their therapeutic relationship and can reestablish a ruptured or struggling alliance (Berg et al., 2016; Miller & McNaught, 2018). Another circumstance under which therapists self-disclose is when the client asks for it (Berg et al., 2016; Lu & Jiang, 2013), but Miller and McNaught (2018) suggest that the therapist must consider their own protection. Finally, therapists self-disclose to gently challenge their clients' unreasonable ideas and share similar experiences they had (Lu & Jiang, 2013). Because these studies about TSD are primarily phenomenological studies, there is information about the experience of TSD for the therapist and the client, but little information about the process of the therapist's decision to self-disclose. There is no literature on whether TSD is premeditated, in-the-moment, or a mixture of both, or how therapists decide what kind of information to disclose and what they consider in this decision. The question of what happens after they disclose—such as regret, anxiety, and such—and if they consider this in their decision-making process likewise remains unanswered. It is also unknown if previous positive or negative experiences with self-disclosure impact their decision.

Conclusion

This review outlined different aspects of therapist self-disclosure, namely the benefits and potentially harmful aspects of it as well as the decision-making process therapists experience when self-disclosing to clients. The benefits of therapist self-disclosure include strengthening the therapeutic alliance, allowing for therapeutic transparency as an intervention, normalizing client experiences, and humanizing the

therapist (Audet & Everall, 2011; Berg et al., 2016; Levitt et al., 2016; Viou et al., 2018). TSD also models to clients that sharing personal struggles is safe in therapy, reduces the therapeutic hierarchy, and helps them feel like they are not alone (Audet, 2011; Bitar et al., 2014). Therapists who self-disclose can demonstrate to clients their cultural competence, allowing the clients to feel understood, particularly through self-involving disclosures (Jowers et al., 2019; Tanaka, 2013). When therapists are not culturally competent, they may unintentionally disclose their cultural insensitivity to their clients through the interventions they recommend (Lee, 2014). Other potential areas for caution are disclosing too much information and disclosing too early in the therapeutic relationship (Audet & Everall, 2010; Jowers et al., 2019), and confusing the boundaries which leads to a question of therapist and client roles (Audet, 2011; Audet & Everall, 2010; Berg et al., 2016). All of these cautions call ethics into question (Levesque, 2018). Several researchers and clinicians offer recommendations for when, how, and what to disclose to clients (D'Aniello & Nguyen, 2017; Henretty & Levitt, 2010) based on research and therapist experiences (Lu & Jiang, 2013; Miller & McNaught, 2018). Overall, therapist self-disclosure can be beneficial when practiced carefully, and when the client is the focus of the disclosure.

CHAPTER III

RESEARCH METHODS

Methodology

This qualitative study employed Charmaz's constructivist grounded theory to answer the overarching question of how therapists decide to self-disclose to their clients. Grounded theory as a form of qualitative research was originally created by sociologists Barney G. Glaser and Anselm L. Strauss in the 1960s (Charmaz, 2006; Creswell, 2007). It came about as a way of "developing theories of research grounded in data rather than deducing testable hypotheses from existing theories" (Charmaz, 2006, p. 4). In the subsequent decades, grounded theory and its practices evolved and proliferated, and there exist several major practices of grounded theory, some of which operate from a social constructivist philosophical orientation (Creswell, 2007). Social constructivists seek understanding of the world with the underlying belief that meaning is subjective; it is influenced historically, culturally, and socially through cultural and social norms and people's interactions with others (Creswell, 2007). This study will use Charmaz's constructivist grounded theory, which assumes that researchers "construct [their] grounded theories through [their] past and present involvements and interactions with people, perspectives, and research practices" (Charmaz, 2006, p. 10). Constructivist grounded theory relies on the participants' experiences and perspectives as it aims to develop a theory surrounding some process that all of the research participants experience (Creswell, 2007). As such, the researcher plays a key role in the development of

grounded theory research, because they are the one who interprets the data and makes meaning of it (Charmaz, 2006).

This grounded theory study developed a model of therapist self-disclosure through interviews with four Licensed Marriage and Family Therapist Associates (LMFT Associates), one of which is dually licensed as a Licensed Professional Counselor (LPC). This study answered the overarching question of "How do therapists decide to self-disclose to their clients?" along with these sub-questions: 1) What types of information or experiences do therapists disclose to their clients? 2) Do past experiences with therapist self-disclosure, as a therapist and as a client, inform their decision? 3)When do therapists decide to self-disclose? 4) What happens for the therapist before, during, and after the disclosure, for example, what feelings and thoughts do they have, and does this inform their future decision-making?

Sampling Procedures

To gather participants for the study, the researcher sent an email to the Abilene Christian University (ACU) Marriage and Family Therapy (MFT) graduate email list. A link to a google form was attached to the email, so it was a volunteer, convenience sample. See Appendix B for the text of the email as well as the text of the Google form. The informed consent to research was available on the Google form for the participants to read and electronically sign as well. As indicated by the email, the sample included currently practicing marriage and family therapists who graduated from a marriage and family therapy master's program and implied that the sample is over the age of 18. There were no other limitations (gender, ethnicity, etc.) on the sample criteria. After receiving responses in the Google form, the researcher called the potential participants to ensure

they met the study inclusion criteria (MFT master's program, currently practicing as a therapist), and if they did meet the criteria, to schedule a time to conduct the interview. Prior to the interview, the researcher emailed the participants a link to a videoconference meeting for the date and time they scheduled. See Table 1 for participant demographic information.

Table 1

Participant Demographic Information

Participant	Sex	Race	Licensure	Theoretical Orientation
1	Female	White	LMFT-Associate & LPC	Integrative
2	Female	White	LMFT-Associate	EFT, Gottman, Solution-Focused, CBCFT
3	Male	White	LMFT-Associate	EFT, narrative, CBT
4	Female	White	LMFT-Associate	Solution-Focused, Bowen

Data Collection

Since the participants already signed the informed consent to research electronically on the google form, at the beginning of the interview the researcher briefly reviewed the informed consent to research and asked if the participants had any questions. Once their questions were answered, the researcher verbally administered the demographics survey listed in Appendix C and recorded the participants' answers manually.

After the participants completed the demographics survey, I proceeded to the interview. I began video recording the interview using the recording feature on the videoconferencing platform, and I also took field notes during the interview. I gave the participants the following definition of therapist self-disclosure on which to base their

responses: “Therapist self-disclosure is any information the therapist chooses to verbally reveal about themselves.” Then I led the participants in a discussion using the interview survey questions listed in Appendix C. I asked some follow-up questions in addition to the survey questions listed in Appendix C to gather more information from the participant. After the interview was complete, I stopped the video recording and asked if the participants had any questions. I uploaded the video interview onto a flash drive that remained in the clinic to protect the confidentiality of the participants. I kept the field notes in a folder in the clinic as well. I interviewed four participants, and the interviews lasted about 30 minutes each. The participants were not compensated for their time.

Data Analysis

After the completion of the interviews, I transcribed each interview using transcription software available through the Abilene Christian University library. This document was also uploaded onto the flash drive that remains in the clinic in order to protect confidentiality. Once the transcription process was complete, I hand-coded the transcriptions according to constructive grounded theory practices, first with initial coding and then with focused coding (Charmaz, 2006). In the initial coding phase, I summarized the data by giving each word, line, or segment a name using a phrase in gerund form, for example, “reflecting on previous self-disclosures.” I did this in detail for each interview. After this phase, I moved onto focused coding, where I focused on the most frequent and significant codes from the initial phase and created codes that are more conceptual, but still focused on action. From these codes emerged categories (Charmaz, 2006).

Throughout the entire research process, I employed memo-writing. Memo-writing allowed me to analyze the data and codes during each phase of the study and theorize them (Charmaz, 2006). In my memos, I conversed with myself: I reflected on the ideas I had about the data and about the analysis, I compared and contrasted the data, and I made my questions and conclusions concrete. These memos were informal, in the language of the researcher, and had no particular method. They existed for me to transcribe my thoughts and ideas (Charmaz, 2006).

Each of these phases of data analysis—interview transcription, initial coding, focused coding, and memo-writing—occurred simultaneously. I began writing memos while developing the study. Transcription took place after each interview, as did initial and focused coding. These codes informed future interviews and future coding. Through this process of comparing codes, categories, and memos, a theory emerged about the decision-making process for therapists who self-disclose to their clients. Ideally, I would reach the point of saturation with her interviews, but as my time to conduct this study was limited, the theory I developed remains in the preliminary stages and requires future research.

Crucial to constructive grounded theory is the role of the researcher and her personal interest in the subject matter (Charmaz, 2006; Creswell, 2007). In the weeks preceding meeting with clients in the therapy room for the first time, the question of whether or not to self-disclose information to my clients, and if so, how, were consistently running through my mind. With my particular religious background, I wondered if someone would ask me to disclose that information, or if they would deduce it if they discovered that I earned my bachelor's degree from a university that the church I

belong to sponsors. I wondered how this information may impact them or impact how they view me as a therapist. The same questions ran through my mind about disclosing much of my personal information such as my personal experience with mental health, my family of origin, my marital status, if I have children, and such. Having previously seen several psychotherapy professionals of various theoretical backgrounds and certifications, I also thought about my experiences being on the client-end in therapy. I recalled several instances in which these therapists self-disclosed to me, and evaluated when I considered TSD to be helpful versus when it was not helpful. All of these thought processes occurred before I even entered the therapy room with clients, and through this study I found some of the answers to my questions about how to self-disclose to my clients.

CHAPTER IV

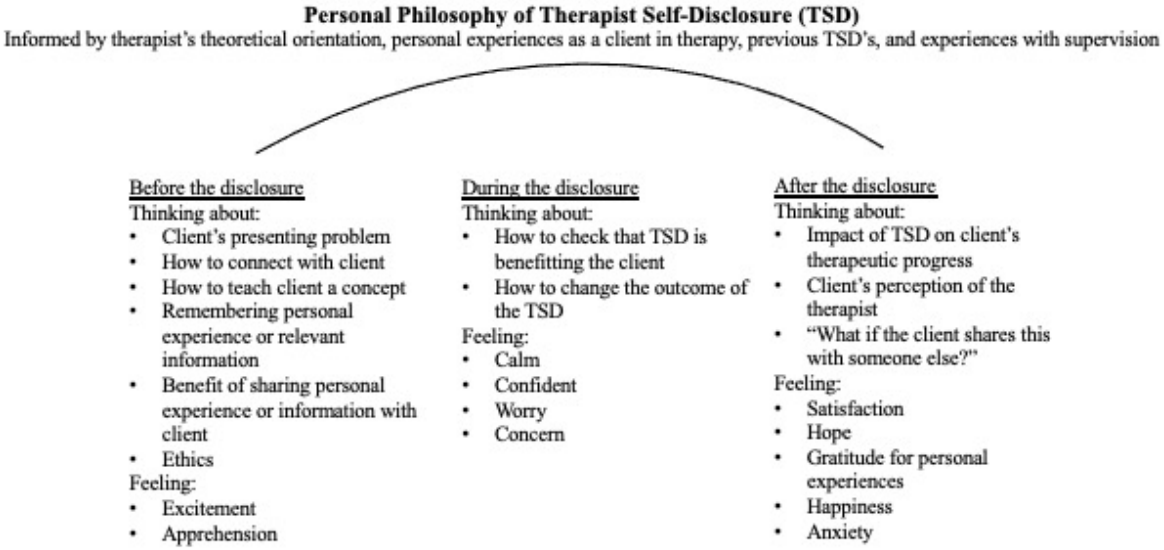
RESULTS

Results

Through the interviews, coding phases, and memo-writing, I developed a theory surrounding how therapists decide to self-disclose to their clients. This theory begins with an overarching umbrella of a therapist's personal philosophy about TSD. Under the umbrella lie three categories of TSD: the therapist's thoughts and feelings before, during, and after the self-disclosure. See Figure 1 for an outline of this theory.

Figure 1

Personal Philosophy of Therapist Self-Disclosure (TSD)



Personal Philosophy of Therapist Self-Disclosure

A clear theme that emerged from the data is that each participant had a personal philosophy of self-disclosure. One participant coined this term when they stated, "one thing that's important that I want to bring up is, I don't know if personality is the right word, but my philosophy of personal experience. . ." The participant went on to explain that they are willing to share personal experiences very readily, and as such, they support and use TSD under certain circumstances. While the other three participants did not specifically name their opinions and uses of TSD as a philosophy, each participant seemed to have one, and these philosophies mediated their decision to self-disclose to their clients. These philosophies were informed by the participants' theoretical orientation, their experiences in supervision, their personal experiences as a client in therapy, and previous experiences when they self-disclosed as a therapist.

Theoretical Orientation and Change

The therapist's theoretical orientation and beliefs about change played a role in some participants' philosophy of self-disclosure. One participant discussed their use of attachment theory in their therapeutic work. They stated,

> I think the main reason why I choose to self-disclose for the most part is because, because I mostly…try to do attachment-based work…If I believe that the therapist acts as a sort of pseudo attachment figure then I have to give my clients a real person to attach to.

This participant went on to comment about other post-modern therapists and their use of TSD. Another participant described their desire to be warm and empathic for their clients because they believe that it sets the stage for therapy. In the words of another participant,

“I self-disclose in every session that I have. I do. Because that's how I make things work.” Thus, the participants’ personal philosophy of self-disclosure includes an aspect of how they believe change happens in therapy—their theoretical orientation.

Supervision

The participants’ experiences in supervision impacted their decision to self-disclose. For one participant, their supervision experiences encouraged their use of TSD and it seems to have become part of their personal philosophy of TSD. They described how they participated in co-therapy with their supervisor, and previous to this they viewed TSD as “a big deal, and you shouldn’t really do it.” However, in co-therapy, their supervisor would occasionally self-disclose, and as a result the participant noticed that it was “so natural for her”, and it helped them “feel more comfortable with [TSD].” For two other participants, their experiences being supervised discouraged their use of TSD, and seem at odds with their personal philosophy. One participant explained, “I'm a lot more rigid and professional when I was doing [supervision] because I thought that’s really what they were looking for.” For another,

> I would be less likely to disclose where I am being supervised just because I know that there are different views on it. And even though it’s more congruent for me to do whatever I feel like is most effective regardless of who's watching I think I am more aware of it and am more like reticent to, to self-disclose if I'm being supervised.

Personal Experiences as a Client

Another aspect of the participants’ personal philosophy of TSD is influenced by their experiences as a client in therapy. One participant explained how they wanted to

mimic their therapist's use of self-disclosure because it made her "so comfortable," and they "always loved his style." For another participant, their two therapists had the opposite effect. One therapist never self-disclosed to this participant, and the participant noted that they "never built rapport," and therapy was "cold". The participant explained that their other therapist "didn't seem comfortable with me asking [questions]." As a result, this participant chose to be the opposite of their therapists in their use of TSD. This participant invites questions as an attempt to be warm and make their clients comfortable.

Previous TSDs

The final category that emerged from the data that informed the personal philosophy of the participants is their previous use of therapist self-disclosure. Some participants explained that their positive experiences with self-disclosure contribute to their future confidence with it and that their negative experiences with self-disclosure influence the manner in which they self-disclose in the future. For example, one participant discussed how they realized that self-disclosing certain information with adolescents is not as effective as it may be with adults, and as such, they choose to hold back more information during TSD with adolescents than they would with adults. They explained, "I think we share so much as human beings in the experience of life that there are things we can bond over without getting too into things." Another participant stated that a TSD that initially caused some concern for the participant in how the client was responding, in the end created an opportunity for "connection". This participant described how their past experiences with self-disclosure contribute to their continued "comfortability" with TSD. Finally, another participant explained how a TSD that did not foster a connection that the participant was hoping to create serves as "a reminder that in

the other times I've self-disclosed to clients that it does work, it's just that occasional one that doesn't care." Whatever the influence may be, each participant described some level of influence from previous TSDs on their current use of TSD.

Before the Disclosure

From the responses of each participant, it is clear that the majority of the decision-making process of therapist self-disclosure occurs before the actual disclosure. For the participants, there was a "thinking" component and a "feeling" component that accompanied their decision to disclose.

Thinking

The bulk of the decision-making process for participants when deciding to self-disclose to their clients was cognitive. Several categories of what the participants were thinking about emerged from the data, particularly for the participants who described experiences of deciding to disclose in the moment. Only one participant shared an experience where they decided to self-disclose prior to the session, which will be discussed later. From the responses, there was no particular order to what the participants thought about prior to the disclosure, but all of these categories presented themselves at some point for the majority of the participants. First, each participant paid attention to the client's presenting problem, stuckness, or resistance to treatment. Second, the participants thought about how to get their clients unstuck, and what they needed to help them do so. Third, each participant thought about a past personal experience or a hypothetical situation using their personal life that related to the presenting problem. Fourth, the participants considered how the disclosure would benefit the client. For two participants, they described that their TSDs were teaching moments. For two other participants, they

explained that their TSDs served to help them connect with the client. Throughout this entire process, each participant emphasized that they thought about how this TSD would benefit the client, and one participant specifically discussed ethical boundaries. In the words of one participant, "It's [the client's] therapy—they pay me. It is really about them."

For the participant who described their decision-making process for TSDs before the start of the session, the thinking component shared some similarities with in-the-moment disclosures, but also differed. This participant explained that part of their personal philosophy of TSD is to always disclose about their experience with addiction and eating disorder treatment with clients who share that presenting problem. Ergo, they think about the client's presenting problem, similar to the cognitive process of in-the-moment disclosures, but they decide ahead of time to disclose their experience with addiction and eating disorder treatment. Similar to the other participants, this participant thinks about the benefit to the client, and uses the TSD as a teaching moment, but they emphasized that treatment for addiction and eating disorders are different because "you share a language," and they want their clients to know that they share that language. This participant also discussed the boundaries of the disclosure, that they think about sharing sufficient information with the client that fosters connection, but is not overbearing. Thus, the cognitive process for this participant is somewhat similar to the participants who utilize in-the-moment disclosures, but there are some differences.

Feeling

For the participants who chose to disclose in the moment, the feeling aspect of their decision-making process was more positive. For two of the participants, they

described the thinking processes first, and that after they decided cognitively to disclose to their clients, they experienced excitement at the prospect of the TSD helping them connect with the client or provide a teaching moment. One participant explained that their feeling came first. They described how they were feeling empathy for the client, which led to the cognitive process of wondering how to connect with the client, which ultimately led to the idea to self-disclose.

The feeling process for the participant who decided before session to disclose to their client is more different than the thinking process between the two types of TSDs. Whereas the other participants experienced excitement at the prospect of self-disclosing something that would lead to greater connection between them and the client or create a teaching moment, this participant felt apprehension. They knew of the pressure for this client to receive inpatient treatment, so they felt the weight of that pressure the night before the session. They experienced anxiety related to the session with this client and, as a result, knew that they would need to self-disclose their experience in inpatient treatment to help this client enter inpatient treatment. In this way their feeling process was similar to the participant who felt empathy for the client first, then decided to disclose. This participant felt apprehension and pressure, and then cognitively decided that the TSD would lead the client in the treatment direction they needed to take.

During the Disclosure

Because the participants were focused on sharing their personal experiences during the disclosure, there was not as much data related to process that emerged from the interviews. However, two participants discussed during their positive experiences with TSD, that they were thinking about how to check that the disclosure was benefitting

the client: that in the moment of the disclosure they were considering how the client was perceiving the disclosure, being conscious of how much information to share and what language to use so that it was benefitting the client. These same participants described the feeling aspect of the disclosure, and that during the disclosure they felt "calm" and "confident." In the words of one participant, "Once I get in there, I am good to go."

When these two participants described experiences of TSD when the situation did not seem to be going well at first, the process was similar to when the TSD seemed to be going well. One participant described a TSD happening in the moment, and the other participant described a previous TSD that was impacting the client in the moment, and the processes resembled each other. At some point during the experience, they realized that the TSD could be perceived as negative, and their perceived benefit of the disclosure to the client was lacking. During this thinking process, both participants were thinking about how to change the outcome of the disclosure. They were feeling worry and concern with how the TSD was impacting the client. For one participant, they decided to cut the disclosure short. The other participant determined it was an "opportunity for a little bit of repair and . . . connection", and decided to address the impact this disclosure had on the client.

After the Disclosure

Similar to the decision-making process of the participants before the disclosure, the process after the disclosure included several thinking and feeling components, and they were all intertwined. Additionally, these thinking and feeling processes varied depending on the therapist's perception of how the client received the TSD.

For participants who perceived that their client responded well to the TSD, they experienced more positive lines of thinking and feeling. Two participants explained that after the disclosures, they were feeling gratitude and gladness for their personal experiences and that they were thinking about how these personal experiences were benefitting their clients. One participant, who decided to self-disclose to convey empathy and create connection with the client, described how they did not question their decision to disclose after the TSD because they perceived that their client benefitted from the disclosure. Another participant was thinking similarly: their intent of the TSD was to teach a concept, and because the client seemed to understand the concept based on the TSD, they only felt gratitude. A participant who did not disclose a past personal experience but a hypothetical situation involving his life experienced similar happiness to the other two participants because they perceived that their client connected with and benefitted from the TSD.

Only one participant described some anxiety post-disclosure. In both the positive and negative experiences this participant shared, they were thinking about who else the clients would tell and what those people would think about the participant. In the positive experience, they explained feeling satisfaction and hope as a result of the disclosure, perceiving that the client greatly benefitted from the disclosure. In the negative experience, they described feeling anxiety that they shared too much information about themselves with the client. They explained thinking about how to connect with this client, but then realizing who this client may share the TSD with, and this led to feeling anxiety post-disclosure.

CHAPTER V

DISCUSSION

Discussion

I designed this study to reach two objectives: to identify the process of how therapists decide to self-disclose to their clients, and to create a framework for therapists to use when deciding to self-disclose. Through this study I preliminarily met both objectives. One distinction that emerged from the data about therapist self-disclosure is the difference between two types of verbal disclosures. The first is what I came to call "therapist-led disclosures." These disclosures include information that the therapist voluntarily reveals about themselves without prompting from the client. The other type of disclosure is what I call "client-requested disclosures," which is information the client asks the therapist to reveal about themselves. This study developed a theory surrounding the decision-making process of therapist-led disclosures, not client-requested disclosures. This decision-making process includes thinking and feeling components before, during, and after the disclosures.

Limitations

One part of the data that I was expecting to see was how the demographics of the client impacted the participants' decisions to self-disclose. One participant stated that they took this into consideration, but the other three denied that the client's age, gender identity, dyadic presentation in therapy, and presenting problem impacted the decision to

self-disclose. I wonder if years of experience in practice have to do with the lack of data in this area. The average amount of therapy experience between the four participants was three years. I conjecture that the decision-making process may be different for therapists who have been practicing longer, that they take more elements into account than what the client is currently discussing and deciding to disclose in the moment (e.g., various diagnoses, client's presenting problem, how early or late disclosure occurs in the therapeutic relationship, and other demographic information). I also recognize that my questioning may not have allowed this data to come forth.

Another limitation to the study was the time constraint and therefore the number of participants. With each interview I gathered new data, and as such I did not reach the point of saturation. For example, I did not receive any information about when a therapist decides not to self-disclose: if they ever consider self-disclosing but then decide not to. I also did not gather enough data about the specifics of the processes occurring during the disclosure, specifically, the conditions under which a therapist feels concern and worry during the disclosure versus calm and confident. Another study would provide the opportunity to further develop and clarify these processes. Due to the limited number of participants as well, the sample was relatively homogenous: all participants were white and cis-gendered with three females and one male; three identified as Christian; all participants were married. I originally became interested in this research because I identify as a religious minority and I am not married, and I wondered how clients would perceive me if they knew this information about me. Because of the homogenous sample, I am unsure of how applicable the theory that emerged from this study translates to other therapists with minority status.

Clinical and Research Implications

The clinical implications of this research are two-fold. First, it seems that therapists have an underlying personal philosophy of therapist self-disclosure. Due to the fact that there is little research about the decision-making process for therapist self-disclosure, therapists should spend time reflecting on their personal philosophy. They may consider the four aspects that contributed to the personal philosophy that emerged from this data: theoretical orientation and other mechanisms of change, personal experiences as a client in therapy, previous TSDs, and experiences with supervision. They may think of other aspects that contribute to their personal philosophy, for example, demographics of the client, length of treatment, client's presenting problem, and such. Second, therapists looking for a framework with information on how to decide to self-disclose may utilize the theory from this study. They may consider the thinking and feeling components of TSD before, during, and after their disclosures. They can notice this process in themselves—if they experience thinking and feeling simultaneously, or if one component influences another—and make changes to their process based on the perceived outcome of the disclosure.

Because this study developed a theory surrounding the decision-making process of therapist-led disclosures, not client-requested disclosures, there is more research to be done. In addition to the fact that this theory may change with more participants with varying years of therapy experience or minority status, an entirely new study would need to be conducted to develop a theory surrounding client-requested disclosures. I found it interesting that the one participant who stated that they experienced apprehension before a disclosure and anxiety after a disclosure was the only participant who shared

experiences with TSD when they disclosed something potentially shameful; in this participant's case, they shared their experience with addiction and eating disorders. Another participant stated that they never disclose how old they are or how long they have been practicing as a therapist. It leads me to wonder if the content of the disclosure makes a difference on the entire process, and it leads me to wonder how to respond if a client requests this information. Through this study I discovered shame in myself associated with different parts of my identity, and that contributes to my hesitation in sharing this information about myself, whether voluntarily or if a client requests it. Thus, from the participants' experiences and mine, there seem to be several components to the decision-making process for client-requested disclosures, and this decision-making process deserves attention.

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APPENDIX A

Institutional Review Board Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

Dear Sydney,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled

(IRB# 20-143)is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs

APPENDIX B

Solicitation Materials

The recruitment email read as follows:

> Hello Listmates,
>
> My name is Sydney Reed, I am a second-year intern in the MFT program at ACU, and I am conducting a qualitative study on therapist self-disclosure. I am looking for research participants who completed an MFT master's program, and are currently practicing as a therapist, who would be willing to help me in my study. I will be conducting interviews (30-60 minutes) through a secure videoconferencing platform. If you have any interest in participating in my study, please fill out the attached google form with your name, phone number, and scheduling availability. The informed consent to research is also available for you to read and sign on this Google form. I will then give you a call within five days of receiving your form to schedule a time for the interview. Thank you so much for your time and participation.
>
> Sincerely,
>
> Sydney Reed, B.S.

The attached Google form read as follows:

> What is your name?
>
> What is your phone number?

What is your preferred email address?

What days/times are you most available for an interview? (Ex: Mondays and Fridays from 1-3pm)

Did you complete a master's program in marriage and family therapy? Yes/No

Are you currently practicing as a therapist? Yes/No

Thank you in advance for your help! I will give you a call shortly.

APPENDIX C

Survey Questions

Demographics Survey:

1. What is your gender?
2. What is your age?
3. What is your religious affiliation (if any)?
4. What is your ethnic/racial background?
5. What are your credentials (intern, LMFT, PhD, etc.)?
6. How many months/years (in total) have you been practicing as a therapist?
7. Where do you practice (agency, private practice, etc.)?
8. What therapy model(s) do you ascribe to (if any)?
9. Have you ever personally seen a therapist?

Interview Questions:

1. Tell me about a time when you disclosed something personal to your clients and it went well.
    a. When did you decide to self-disclose?
    b. What did you disclose?
    c. Was it an individual, couple, or family?
    d. Did demographics play a role in your decision? male/female, child/adolescent/adult, ethnic background, religious background, etc.

e. What thoughts or feelings did you have before, during, and after the self-disclosure?

f. Does this positive experience inform your current decision-making process?

2. Now tell me about a time when you disclosed something personal to your clients and it did not go well.

a. When did you decide to self-disclose?

b. What did you disclose?

c. Was it an individual, couple, or family?

d. Did demographics play a role in your decision? male/female, child/adolescent/adult, ethnic background, religious background, etc.

e. What thoughts or feelings did you have before, during, and after the self-disclosure?

f. Does this negative experience inform your current decision-making process?

APPENDIX D

Informed Consent

ACU IRB # 20-143 Date of Approval 10/22/2020

Introduction: How therapists decide to self-disclose to their clients: A grounded theory study

In this study, the researcher plans to develop a theory surrounding the process therapists experience when they decide to self-disclose personal information to their clients. The researcher will develop this theory by conducting 30-60 minute interviews with marriage and family therapists who are currently practicing, and ask them questions related to their decision-making process.

You may be able to take part in this research study. This form provides important information about that study, including the risks and benefits to you as a potential participant. Please read this form carefully and ask the researcher any questions that you may have about the study. You can ask about research activities and any risks or benefits you may experience. You may also wish to discuss your participation with other people, such as your family doctor or a family member.

Your participation in this research is entirely voluntary. You may refuse to participate or stop your participation at any time and for any reason without any penalty or loss of benefits to which you are otherwise entitled.

PURPOSE AND DESCRIPTION:

Therapist self-disclosure is a controversial topic, and as such, therapists have much to consider when deciding whether or not to self-disclose to their clients. This study will examine this decision-making process. A study like this has not been conducted before, and will help inform therapists in their future clinical work.

If selected for participation, you will be asked to attend 1 virtual visit with the study staff over the course of 1 day. This visit is expected to take 30-60 minutes. During the course of this visit, you will be asked to participate in the following procedures:

The researcher will email you a link to a videoconference meeting on the date and time you set with her. At the beginning of the videoconferencing interview, the researcher will begin audio and video recording. The researcher will ask you some demographic questions, followed by several survey questions concerning therapist self-disclosure.

The researcher may ask some follow-up questions in addition to the primary survey questions to gather more information from you. After you have finished answering the questions, the researcher will stop the audio and video recording, and end the videoconference.

RISKS & BENEFITS: There are risks to taking part in this research study. Below is a list of the foreseeable risks, including the seriousness of those risks and how likely they are to occur:

Although all of the video recordings and associated documents will be kept in a secure file at the MFI, there is a minimal risk of a confidentiality breach.

There are potential benefits to participating in this study. Such benefits may include increasing your awareness of how you use therapist self-disclosure in your therapy practice. The researchers cannot guarantee that you will experience any personal benefits from participating in this study.

PRIVACY & CONFIDENTIALITY: Any information you provide will be confidential to the extent allowable by law. Some identifiable data may have to be shared with individuals outside of the study team, such as members of the ACU Institutional Review Board. Otherwise, your confidentiality will be protected by these steps: All electronic and paper materials (including video recordings, field notes, and consent forms) related to the study and to your personal information will be stored in a secure file in the MFI. Any and all identifiable information will be removed from any publications or presentations of the results.

CONTACTS: If you have questions about the research study, the lead researcher is Sydney Reed, B.S., and may be contacted by emailing smr19a@acu.edu or calling 801-837-1713. If you are unable to reach the lead researcher, or wish to speak to someone other than the lead researcher, you may contact Lisa V. Merchant, Ph.D., LMFT, by emailing lvm02b@acu.edu or calling 325-665-7480. If you have concerns about this study, believe you may have been injured because of this study, or have general questions about your rights as a research participant, you may contact ACU's Chair of the Institutional Review Board and Executive Director of Research, Megan Roth, Ph.D. Dr. Roth may be reached at

(325) 674-2885
megan.roth@acu.edu
320 Hardin Administration Bldg, ACU Box 29103
Abilene, TX 79699

Additional Information

The researcher will conduct interviews with approximately 4 to 6 participants.

Your participation may be ended early by the researchers for certain reasons. For example, we may end your participation if you no longer meet study requirements, the researchers believe it is no longer in your best interest to continue participating, you do not follow the instructions provided by the researchers, or the study is ended. You will be contacted by the researchers and given further instructions in the event that you are removed from the study.

You will incur any cost associated with volunteering your time to this study. You will not be compensated for your time.

Consent Section

If you voluntarily agree to participate in this study, please click the button next to, "Yes, I consent". Additionally, type your full name into the open field box as a replacement for your signature. If you do not agree to participate in this study, please click, "No, I do not consent". Sign only after you have read all of the information provided and your questions have been answered to your satisfaction. The primary researcher will email you a copy of this form after you sign it electronically. You do not waive any legal rights by signing this form.

- Yes, I consent.
- No, I do not consent.

Please type your name into this open field box to indicate your signature.

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