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THERAPIST SELF-DISCLOSURE WITH ADOLESCENTS: A CONSENSUAL QUALITATIVE RESEARCH STUDY

by

Jacquelyn J. Smith, M.A.

A Dissertation submitted to the Faculty of the Graduate School,
Marquette University,
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Milwaukee, Wisconsin

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ABSTRACT
THERAPIST SELF-DISCLOSURE WITH ADOLESCENTS:
A CONSENSUAL QUALITATIVE RESEARCH STUDY

Jacquelyn J. Smith, M.A.

Marquette University, 2010

Surprisingly little empirical attention has focused on therapist self-disclosure as an intervention with youth. Given the dearth of research in this area and the rising interest in evidenced-based practice, this study hoped to provide a deeper understanding of the effective use of therapist self-disclosure with adolescents. Twelve master's- and doctoral-level child therapists were interviewed regarding their use of therapist self-disclosure with adolescent clients. Participants largely felt that it was important to use therapist self-disclosure carefully and for the benefit of the client. Most participants had some level of training on therapist self-disclosure and felt that the intervention can be beneficial. Overall, certain types of self-disclosure were viewed as more effective than others when participants were driven by specific intentions. Specifically, therapists shared past experiences and helpful strategies when they sought to model/teach or normalize an adolescent's experiences, while self-involving disclosures were used to get "unstuck" in therapy or provide direct feedback. When participants discussed a specific instance of therapist self-disclosure with an adolescent, all identified positive effects of their therapist self-disclosures, but their paths to achieve these effects varied. Results indicated that the initial therapeutic relationship influenced the intention behind therapist self-disclosures, as well as the actual content of the disclosures. Limitations and implications for training, practice, and research are addressed.

Preface

This study focuses on therapist self-disclosure with adolescent clients in individual therapy. I selected this topic for two reasons. First, I am interested in therapy processes and outcomes, qualitative research, and research related to youth; thus, this project presented a unique way to blend these three interests. Second, the relatively limited prior research in this area made it an apt topic for further study. I am hopeful that this research has provided a deeper understanding of how and why child therapists use therapist self-disclosure as an intervention with adolescent clients.

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Jacquelyn J. Smith, M.A.

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I: STATEMENT OF THE PROBLEM

In recent years, the number of children and adolescents (individuals under the age of 18) entering therapy has been increasing (Friedman, 2001). However, research on psychotherapy processes and interventions with children lags far behind that on adults (Farber, 2006). It is thus crucial that investigators examine therapeutic processes for children and adolescents, because work with these populations is inherently different from work with adults. Therapy with youth, for example, must be adjusted and delivered based on each individual's developmental level. Furthermore, inclusion of parents and other family members is more likely to occur in child psychotherapy than adult psychotherapy. Because of these considerations, therapists may change the language used in psychotherapy (i.e., concrete language for younger children, abstract language for adolescents), the techniques used within the session (e.g., play therapy for younger children), and the theoretical conceptualization (e.g., family systems approach) when working with youth. One therapeutic technique that may be used in therapy with children and adolescents is therapist self-disclosure. Although this technique is not specific to child therapy, much of the extant literature has focused primarily on the process and effects of therapist self-disclosure with adults, not children, in therapy. Because of the aforementioned differences between adult and child therapy, it is important to examine therapist self-disclosure with children (for this study a subgroup of children ages 14-18) rather than to assume that the intervention has similar intentions and effects for both adults and children. Further discussion regarding potential purposes and outcomes specific to therapist self-disclosure with youth are addressed below.

Although therapist self-disclosure with adult clients has been a much-examined

intervention (Farber, 2006; Matthews, 1988; Pope, Tabachnick & Keith-Spiegel, 1987; Ramsdell & Ramsdell, 1993), therapist self-disclosure with child clients has received little empirical attention. Farber (2006) noted that this lack of research on therapist self-disclosure with children is consistent with psychotherapy research in general: Studies on child psychotherapy variables are much more rare when compared to research on the same variables with adult clients. Past research in therapist self-disclosure with adult clients has examined the frequency, type, content, and effects of self-disclosure, but little parallel research exists on these components of therapist self-disclosure with children/adolescents. Additional research is thus vital to inform the intervention's effective practice and delivery. Of the limited literature on therapist self-disclosure with children that exists, the majority has focused on the theoretical rationale for the use of therapist self-disclosure with children. Scant empirical attention has been given to the effectiveness of this intervention with clients under the age of 18. Only one empirical study, a broad survey of therapists, has been published on therapist self-disclosure in individual therapy with child patients (Capobianco & Farber, 2005). Furthermore, researchers have not addressed how psychologists who work with youth decide whether, and how, to use therapist self-disclosure.

With respect to the wider body of psychology literature, there has been a push in recent years for more studies on the effectiveness of therapeutic practices, resulting in increasing attention on identifying empirically supported practices. Research suggests that therapist self-disclosure with adults is viewed positively by clients and is linked, albeit indirectly through variables such as the therapeutic relationship, to positive therapy outcomes (Barrett & Berman, 2001; Hill & Knox, 2002; Knox, Hess, Peterson, & Hill,

1997). If similar results are found for children, therapist self-disclosure may be viewed as an effective tool for therapy, one that is supported by empirical research. Studies such as the one proposed here will allow us to begin to understand the process of self-disclosure with younger populations.

Rationale for the Study

Since no empirical attention has been given to the in-depth process of therapist self-disclosure with adolescent patients, this study aimed to provide a vivid, more contextual understanding of the antecedents, use, and effects of therapist self-disclosure in individual therapy with children greater than age 14 but under age 18. Furthermore, the intention of this study was to substantiate or provide evidence against the theoretical literature on therapist self-disclosure with adolescents. By gaining a close understanding of child therapists' experiences using therapist self-disclosure, I hoped to improve the profession's understanding of the effective use of therapist self-disclosure with adolescents.

In this study, I interviewed licensed clinical/counseling psychologists and master's level counselors who primarily work with children/adolescents regarding their use of therapist self-disclosure with 14 to 18-year-old clients. Data were analyzed using consensual qualitative research (CQR; Hill, Thompson, and Williams, 1997; Hill et al., 2005). Unlike many quantitative methodologies, which often neglect the unique experiences that occur within psychotherapy, CQR brings the individualized experiences of participants to the forefront. CQR offers a way of analyzing data that stays true to participants' words and experiences as they naturally occur. Since research on therapist self-disclosure with children is still in its infancy, the discovery-oriented CQR method

was an appropriate choice, as it cultivates an openness to all findings instead of only hypothesis-driven findings. CQR strives for detailed descriptions and an understanding of processes and individual experiences, which were missing from the current literature on therapist self-disclosure with youth.

Following completion of this dissertation, the researcher plans to pursue publication of her findings so that therapists who work with adolescents may use the information to inform their practice of self-disclosure. Additionally, the results provide directions for future research on this topic.

Research Questions

The primary research questions of this study were as follows:

Question 1: How do child therapists use therapist self-disclosure in therapy sessions with adolescents (i.e., individuals between ages 14 and 18)?

- *What factors or contextual issues affect child therapists use of therapist self-disclosure?*
- *What elicits child therapists use of therapist self-disclosure?*
- *What are some representative examples of therapist self-disclosure with adolescents?*
- *How does therapist training affect therapist's use of self-disclosure?*

This question allowed for a deep understanding of the use of therapist self-disclosure with adolescent clients. Specifically, the question sought to address how a therapist uses self-disclosure with an adolescent client. Information regarding the general manner in which therapist self-disclosure is conducted, factors or contextual issues that affect use of therapist self-disclosure, how self-disclosures are elicited, representative

examples of therapist self-disclosures, and the impact of training on therapist self-disclosure with adolescents was of interest. As previously mentioned, the lack of empirical attention on therapist self-disclosure with children was a compelling reason for further study of this topic. By interviewing child therapists regarding their experiences using therapist self-disclosure with adolescent clients, this researcher hoped to more fully understand how such therapists use self-disclosure, how their training affects this use, and how other factors (e.g., client characteristics) influence their use of therapist self-disclosure with adolescent clients.

By providing greater understanding of the use of therapist self-disclosure with adolescents, findings related to this question allowed the researcher to compare the current study's findings to the existing literature on therapist self-disclosure with adults. For example, researchers suggested that adults and children may need to be treated differently with regard to therapist self-disclosure, as children are developmentally (cognitively and emotionally) very different from adults given the stage of their brain development (Gaines, 2003). As a result of the aforementioned developmental differences, Gaines suggested that children may receive therapist self-disclosure as a concrete way to build trust (i.e., getting to know the therapist so that the child feels comfortable sharing within therapy). Gaines also proposed that children are less able to understand their therapist's role (i.e., a professional job with boundaries and ethical guidelines), and thus a relationship without self-disclosure may be experienced as distant and rejecting by children, and may lead the child to have difficulty trusting the therapist. Furthermore, literature on therapist self-disclosure with adults suggests that client and therapist characteristics (e.g., theoretical orientation, diagnosis, personality) affect the

frequency and manner in which therapists use self-disclosure (e.g., Dryden, 1990; Edwards & Murdock, 1994; Simi & Mahalik, 1997), but this researcher wondered if the same patterns were found in therapist self-disclosure with adolescents.

Question 2: What are the perceived effects (on the therapist, client, therapeutic relationship, and therapy outcome) of therapist self-disclosure with adolescent clients (age 14-18)?

Little is known about the impact therapist self-disclosure may have on the therapist, adolescent client, the therapeutic relationship and/or the therapy outcome. Other than anecdotal findings (Barish, 2004; Gaines, 2003) and a survey of child therapists (Capobianco & Farber, 2005) in which therapists on average rated self-disclosure with children as "almost never helpful," there is no empirical information available to inform child therapists' practice of therapist self-disclosure. Thus, in an effort to expand knowledge on therapist self-disclosure, this question sought to determine how therapist self-disclosure with adolescent clients affects the therapist, the adolescent, the therapeutic relationship, and the therapy outcome.

Finally, both questions addressed the main goal of this study, which was to gain a deeper understanding of the process and outcomes of therapist self-disclosure with adolescent clients in order to inform future research and practice.

II: REVIEW OF THE LITERATURE

Self-disclosure in Therapy

History of Therapist Self-disclosure

Therapist self-disclosure has long been a topic of discussion in psychotherapy. Early psychoanalysts considered therapist self-disclosure something that could be harmful to clients and clinicians in its blurring of the boundaries and its shifting the focus of therapy from the client to the therapist (Farber, 2006). Freud (1912), in fact, advocated for a "blank screen" approach to therapy where clinicians shared little, if anything, of themselves and instead remained completely neutral and reflective of whatever issues the client was presenting. Thus, therapist self-disclosure was viewed as unacceptable and indicative of a therapist's issues intruding into therapy. Interestingly, however, despite his theoretical objections to therapist self-disclosure, Freud actually disclosed frequently to his patients. For example, he shared personal pictures and information about his family and friends with many of his patients (Gay, 1989; Hill & Knox, 2002; Johnson & Farber, 1996; Lane & Hull, 1990).

In response to Freud's philosophical views against therapist self-disclosure, clinicians such as Ferenczi (1926) and Khan (1986) actively experimented with therapist self-disclosure, engaging in mutual analysis with clients that involved frequent, explicit, and personal therapist self-disclosure (e.g., therapist openly sharing vulnerabilities, mistakes, and weaknesses; asking for client's help in working through issues; sharing harsh personal reactions to clients calling them "cruel" and "lazy"). Although one may argue that clinicians such as Ferenczi and Khan were utilizing therapist self-disclosure in inappropriate ways (i.e., overstepping boundaries, moving focus onto therapist rather than

client), these clinicians did highlight the importance of a clinician being an active participant in therapy. Rather than remaining a "blank screen" as Freud (1912) recommended, Ferenczi and Khan actively engaged in therapy, sharing their personal experiences from their lives and their reactions to the clients. The anticipated results of their self-disclosures were thought to be an infusion of greater energy into the session and more efficient progress (i.e., because therapists offered immediate self-disclosure about their observations and feelings toward the client, therapist self-disclosure served to bring client symptoms to immediate attention in the session and speedier resolution) (Farber, 2006).

As an outgrowth of Freud's (1912) theoretical stance against therapist self-disclosure, and the clinicians who radically disagreed with him (such as Ferenczi and Khan), researchers and clinicians began to seek a philosophical middle ground with respect to therapist self-disclosure, one in which active participation (by both the therapist and the client) became the focus of treatment (Farber, 2006). Rather than upholding Freud's "blank screen" or partaking in frequent, explicit therapist self-disclosures as practiced by Ferenczi and Khan, clinicians and researchers started to consider the importance of therapist self-disclosure as a way to be a mutually involved participant in therapy while still respecting the importance of maintaining boundaries (Farber, 2006). Through this balance, it was believed that therapist self-disclosure would demonstrate the therapist's vulnerabilities and subjective experiences and, in turn, build trust within the therapeutic relationship (but not create a relationship of dependency) and stimulate the client's exploration of painful, previously avoided topics (i.e., the client would take the lead from the therapist and would become willing to share his/her own

experiences).

As a result of this greater attention to the therapist's role (i.e., therapist balancing self-disclosure with respect of boundaries), therapies that valued the therapist as a co-participant in the therapeutic process (e.g., humanistic, existential, relational) gained momentum (Farber, 2006). For example, therapists such as Harry Stack Sullivan (1953), an American object-relational psychiatrist, began advocating for therapists to share mistakes, feelings, and personal issues that may be affecting therapy with clients. Other researchers and clinicians were inspired by Sullivan's work and thus began to incorporate more therapist self-disclosure into their practices (Aron, 1996). Additionally, Sullivan opened therapists' eyes to the notion that therapist self-disclosure could serve as an innovative expression of countertransference experienced by the therapist (i.e., therapists could share relevant and appropriate countertransference reactions through self-disclosing to their clients). As a result, therapists were able to use their subjective experience as a therapeutic tool in treatment, and therapist self-disclosure gained acceptability as an intervention. Furthermore, therapists were free to bring more of their personal experiences (e.g., struggles they experienced and how worked through them) and their experiences of the client into the session (thus allowing the client to experience the therapist as transparent, authentic, and trustworthy).

In summary, over the last forty years, humanistic, existential, and interpersonal therapies have become more common. The rise in these therapies has resulted in increased flexibility and attention to therapeutic relationships, which have in turn expanded the role of therapist. Now, it is much more permissible for therapists to employ self-disclosure than it was in the times of Freud (Farber, 2006). Some therapies, such as

rational-emotive therapy, have even gone so far as to promote the use of therapist self-disclosure (Dryden, 1990). An in-depth discussion of therapist self-disclosure within a variety of theoretical frameworks is presented later in the literature review, but it is important to note that many contemporary clinicians view thoughtful use of therapist self-disclosure as a way to interact openly and genuinely with clients and to communicate ideas, feelings, and observations that may otherwise remain unknown to the client (Farber, 2006). In fact, researchers have confirmed the utility of therapist self-disclosure by demonstrating that this intervention can aid in the resolution of treatment impasses (Safran & Muran, 2000). Essentially, although therapist self-disclosure was once a forbidden technique, it is now utilized by many clinicians as a helpful psychotherapeutic tool.

Definitions and Categories

Initial research defined self-disclosure as permitting one's true self to be known to others (Jourard, 1971). Jourard believed that human beings learn about themselves through self-disclosure and are challenged by how much to share of themselves with others. Barry Farber, a well-known researcher of self-disclosure in therapy, acknowledged Jourard's beliefs and asserted, "all disclosures reflect decisions about the boundaries between the private self and the outer world" (p. 1). However, disclosures may take many different forms depending on their content and on the persons delivering and receiving the disclosure. Essentially, "disclosures involve negotiating an appropriate balance between the helpfulness of sharing a part of ourselves with another and the inappropriateness or even danger of overdoing it, of perhaps sharing too much too soon" (Farber, p. 1). Within the context of psychotherapy, self-disclosure (both client and

therapist) allows for an exchange of information between therapist and client, which is thought to stimulate self-awareness and reflection (i.e., self-disclosure promotes interaction between therapist and client that hopefully results in therapeutic progress) (Fisher, 1990).

One specific type of self-disclosure, therapist self-disclosure with youth, was the focus of this study. Because research on therapist self-disclosure with children is so limited, this researcher looked to the definitions of therapist self-disclosure within the adult psychotherapy literature for guidance. Therapist self-disclosure with adults has been variably defined in the literature. In a recent review of research on therapist self-disclosure, Hill and Knox (2002) developed the following general definition: Therapist self-disclosure is "a therapist statement(s) that reveals something personal about the therapist" (p. 255). Mathews (1988) offered a similar but more detailed definition of therapist self-disclosure as the revealing of facts or feelings the therapist has experienced in his or her life, as well as revealing feelings s/he experiences toward the client. This study defined therapist self-disclosure as follows: Therapist self-disclosure involves therapists sharing information about themselves and/or about their reactions and responses to adolescent clients as they arise in therapy (Knox, Burkard, Edwards, Smith, & Schlosser, 2008).

In addition to various definitions of therapist self-disclosure, researchers have developed a variety of ways to classify types of disclosures. McCarthy and Betz (1978) classified therapist self-disclosures as either self-disclosing disclosures or self-involving disclosures. Self-disclosing disclosures reveal information of a personal, non-immediate nature (e.g., "I like to crochet in my spare time"), while self-involving disclosures

involve the therapist sharing immediate reactions about him/herself in response to the client or the therapeutic relationship (e.g., therapist saying "I'm feeling angry with you [the client]"). Others have offered a distinction in type of therapist self-disclosure by discriminating intrapersonal (i.e., information about the therapist's life outside of therapy) from interpersonal (i.e., information about the therapist's experiences of the client or the therapeutic relationship) self-disclosures (Nilsson, Strassberg, & Bannon, 1979).

Another method of categorization divides therapist self-disclosures into four subtypes: disclosures of facts (e.g., where the therapist was trained, professional experience); disclosures of feelings (e.g., therapist's emotions in specific situations); disclosures of insights (e.g., sharing an experience similar to the client's and describing what the therapist learned from it); and disclosures of strategies (e.g., explanation of a technique the therapist has found helpful) (Hill & O'Brien, 1999). Knox and Hill (2003) have more recently recommended three additional subtypes: disclosures of reassurance/support (e.g., therapist reveals that he/she has felt similar to the client); disclosures of challenge (e.g., therapist shares experience of a struggle similar to client's issue); and disclosures of immediacy (e.g., therapist makes a statement of his/her feelings toward the client in-the-moment).

Yet another method of separating self-disclosures is by distinguishing between positive and negative self-disclosures (Farber, 2006). A positive self-disclosure might involve a therapist sharing feelings of pride with a client after having seen the client work through a difficult situation, whereas a negative self-disclosure could include the therapist sharing feelings of frustration with the client because the client has consistently

disregarded therapy homework. However, some viewed this distinction as pejorative and preferred the distinction of reassuring versus challenging (Hill, Mahalik, & Thompson, 1989). Additionally, this method of delineation seems somewhat subjective and potentially confusing, particularly in cases when a self-disclosure may initially be perceived as negative (e.g., a therapist sharing that he is angry with a client), while the eventual outcome may be positive (e.g., the client realizes how his/her behavior may make others angry and positively changes his/her mode of communication).

To summarize, a variety of categorizations of therapist self-disclosure have been proposed, and future research may benefit from addressing possible relationships between different types of therapist self-disclosure and other factors (e.g., therapist theoretical orientation, client characteristics, therapeutic goals and outcome). However, this study sought to specifically examine how therapist self-disclosure is used with adolescent clients. Because very little is known about therapist self-disclosure with this population, the study did not solicit information regarding particular types of self-disclosure (other than to ask for representative examples of therapist self-disclosure), but instead examined therapists' experiences using any type of therapist self-disclosure.

Theoretical Perspectives on Therapist Self-Disclosure

In addition to considering definitions and classifications of therapist self-disclosure, it was also important to consider the impact of theoretical orientation on a therapist's use of self-disclosure. As previously mentioned, therapist self-disclosure has recently become a more accepted clinical tool. However, its use varies across theoretical perspectives. The following sections offer brief summaries of the use of therapist self-disclosure within common theoretical frameworks.

Psychoanalytic/Psychodynamic theories. Therapist self-disclosure has been hotly debated in psychoanalytic theories (Lane & Hull, 1990). Historically, many psychoanalytic and psychodynamic clinicians believed in therapist anonymity. For example, Freud (1912) advocated for therapists as a "blank screen" who were to reflect clients' projections rather than disclose anything personal. Therapist self-disclosure was thus viewed as detrimental to therapy, in that it would draw the focus away from the client and to the therapist, thus derailing therapy. If therapists did self-disclose, it was seen as an expression of the therapist's attending to her/his own needs rather than the client's. Additionally, many psychoanalytic practitioners viewed and continue to view self-disclosure as a possible boundary violation, and therefore report using significantly less disclosure than do practitioners from other theoretical orientations (Edwards & Murdock, 1994; Goldstein, 1997; Lane & Hull, 1990).

However, Lane and Hull argue that therapist self-disclosure may be a helpful intervention for psychodynamic clinicians as long as it is intentional and delivered with a purposeful rationale. For example, a therapist may share his/her experience of losing a loved one with a client dealing with death, but such information should only be shared when the disclosure is delivered to convey empathy rather than to meet the therapist's need to share personal information or evoke sympathy. Additionally, therapists' self-disclosures that involve sharing personal reactions expose clients to another person's experience of them, which may thereby increase clients' self-awareness (e.g., as a result of a therapist sharing that he/she feels frequently criticized after challenging a client, the client may realize his/her tendency to respond defensively). Furthermore, Goldstein (1997) believed that therapist self-disclosure can increase the chances of clients'

successful engagement and treatment, by allowing clients to experience the therapist as an empathic, genuine, actively engaged participant in therapy. More recent literature affirms that therapist self-disclosure continues to be more widely used and accepted by psychodynamic clinicians. For example, Geller (2003), a psychoanalytic clinician and researcher, recognized that his exposure to Irving Yalom and the principles of authenticity and egalitarianism made him more likely to employ therapist self-disclosure intentionally as a therapeutic technique.

Humanistic theories. Clinicians endorsing a humanistic approach assert that self-disclosure demonstrates therapists' genuineness and positive regard for clients by allowing the therapist to interact with the client naturally and authentically (Robitscheck & McCarthy, 1991). As a result of this interaction, clients are able to view therapists as "real" people who can share and communicate in the therapy experience. This connection between humanistic therapist and client is not surprising, given the appreciation for authenticity and mutuality that characterizes the humanistic orientation (Goldstein, 1997). Furthermore, Rogers (1951) viewed therapist self-disclosure as a catalyst for client openness, trust, intimacy, self-awareness, and change. For the humanistic therapist, self-disclosure is thought to bring therapist and client closer, to model clients' personal growth, and to reduce feelings of loneliness through validation (Lane & Hull, 1990). Through therapist self-disclosure, therapists are able to confirm clients' experiences as natural and human.

Behavioral/Cognitive-behavioral theories. Broadly speaking, behavioral and cognitive-behavioral clinicians appear accepting of therapist self-disclosure when used to strengthen the therapeutic relationship and effect client change (Goldfried, Burckell, &

Eubanks-Carter, 2003). Dryden (1990) emphasized that therapist self-disclosure is appropriate and necessary within rational-emotive therapy (RET), for doing so models the process of problem solving, provides hope, builds trust, and strengthens the therapeutic alliance by highlighting the shared humanity between client and therapist. Aaron Beck, father of cognitive behavioral therapy, viewed therapist self-disclosure similarly, as a way to role model, teach problem-solving skills, and enlighten clients about the ways others may be seeing their actions (Beck, Freeman, & Associates, 1990). For example, when a therapist shares a personal experience, the client may learn another method for confronting a problem and as a result, he/she has gained a new skill and may have more hope and trust in the therapist.

Another potential outcome of therapist self-disclosure in behavioral/cognitive behavioral therapies is for clients to feel as valuable as their therapists (a main tenet of these theories). By self-disclosing, a therapist demonstrates his/her willingness to engage and be vulnerable within the therapy setting, mirroring what is expected of the client (although more self-disclosure is expected for the client) and introducing a certain level of equality in the relationship. Thus, therapist self-disclosure can serve as a vehicle to reduce therapist power by showing the therapist's authentic self. Furthermore, some CBT practitioners believe therapist self-disclosure increases client self-disclosure, particularly when clients have little experience sharing about themselves (Walen, DiGiuseppe, & Dryden, 1992). Finally, Goldfried, Burckell, and Eubanks-Carter (2003) suggested that therapist self-disclosure within a cognitive-behavioral framework can enhance positive expectations and motivation, strengthen the therapeutic bond, and reduce client fears.

Despite support for therapist self-disclosure as an intervention within behavioral

and cognitive-behavioral therapies, there are a number of circumstances in which therapists of this orientation advise against self-disclosure (Dryden, 1990). While such circumstances have been explicated within the behavioral/cognitive-behavioral literature, one may argue that they extended to other orientations, as well. First, it is not recommended that therapists disclose in the early stages of therapy, nor should they disclose with clients who could use the information to harm themselves or their therapists (Dryden, 1990). Disclosing early in the relationship may alienate the client and lead him/her to think that the therapist is self-disclosing in an attempt to move the focus of therapy away from the client. In addition, clients who are not able to process a therapist's self-disclosure in a rational and logical manner, or those who pose a danger to themselves/others, may misinterpret the therapist's disclosures. For example, clients with distorted thought processes may have a difficult time separating their experiences from their therapist's or may misinterpret the intentions behind self-disclosure (e.g., therapist sharing personal information could be misinterpreted by an irrational client as a romantic advance). Dangerous clients could feel threatened and upset by a therapist's self-disclosure regarding feelings of frustration with the client, thus potentially putting the therapist and client (or others) in danger.

Feminist theories. Since their inception, feminist theories have supported the use of self-disclosure as an intervention that can facilitate growth, equalize power within the therapeutic relationship, decrease shame, encourage empowerment, and build a solid relationship between therapist and client (Mahalik, VanOrmer, & Simi, 2000). The Ethical Code of the Feminist Therapy Institute even includes a guideline for the use of therapist self-disclosure, which suggests that self-disclosure conducted with the purpose

of facilitating the therapeutic process is appropriate as long as it is done with discretion and in the interest of the client (Feminist Therapy Ethical Code, 1999). Furthermore, clinicians who practice from a feminist standpoint believe that therapists should self-disclose about their beliefs and lifestyle (e.g., religious background, sexual orientation, political views, socioeconomic status) so that clients may make informed decisions about whether or not to work with a therapist. Because the therapeutic relationship in feminist therapy is founded on equality, it is crucial that a therapist share information about him/herself in order for a client to determine whether the two will be a good fit for therapeutic work. Similar to other theoretical perspectives on self-disclosure, feminist therapists are advised to refrain from self-disclosure when it risks blurring the boundaries between client and therapist, creates a false sense of empathy, or is used to reduce therapist isolation (Brown & Walker, 1990).

Multicultural theories. Multicultural theorists advocate the use of self-disclosure as a way to build rapport and earn trust, particularly with clients from cultural backgrounds and lifestyles different from that of the therapist (Sue & Sue, 1999). In order to use therapist self-disclosure effectively with clients from different multicultural background, a variety of factors must be considered (Constantine & Kwan, 2003; Helms & Cook, 1999; Jenkins, 1990; Sue & Sue, 2003). Race, ethnicity, spirituality, sexual orientation, and values and beliefs are just a few such factors mentioned in the literature. Jenkins, for instance, pointed out that a therapist must be fully aware of the racial context in which s/he and the client live in order to use self-disclosure effectively in therapy with minority clients. In particular, some cultures view therapist self-disclosure as helpful, while others are more likely to respond negatively to therapist self-disclosure, particularly

when it occurs early in therapy. Helms and Cook, for example, suggested that African American clients may be more willing to engage in therapy and discuss race-related topics with culturally different therapists who are willing to self-disclose, for when a client sees his/her therapist take a risk and demonstrate a willingness to share and examine multicultural issues, trust may be fostered (Sue & Sue, 2003). However, it is important to recognize that clients from some cultural backgrounds may view therapist self-disclosure as a boundary violation. For example, Cherbosque (1987) found that Mexican students viewed non-disclosing therapists as more professional and trustworthy than disclosing therapists. Based on these observations, Constantine and Kwan suggested that therapists first address *inescapable* self-disclosures (e.g., skin color) in therapy with culturally dissimilar clients before using deliberate self-disclosures of various natures, as initial *inescapable* disclosures can guide the process of additional therapist self-disclosure(s).

Summary. Among these theoretical frameworks, there are notable similarities in approach to therapist self-disclosure. Most types of therapies appear to endorse the use of therapist self-disclosure when done with purpose and intention. Furthermore, therapist self-disclosure is thought to demonstrate therapist authenticity and to build the therapeutic relationship by fostering trust and openness in the client. Therapist self-disclosure, however, should not shift the focus of therapy away from the client, nor should it be used with dangerous or thought-disordered clients. Of additional significance is the fact that among the theories, no specific attention was given to therapist self-disclosure with child/adolescent clients.

Empirical Research on Therapist Self-disclosure with Adults

Beyond the theoretical literature, there is also a fairly solid foundation of empirical research on therapist self-disclosure, often examining the frequency, content, reasons for and against therapist self-disclosure, and effects of therapist self-disclosure.

Frequency. Farber (2006) noted difficulty in assessing the frequency of therapist self-disclosure given the multiple definitions and ways of measuring (i.e., frequency, outcome, type of self-disclosure, self-report vs. observation) the intervention. Overall, however, research indicates that therapist self-disclosure occurs relatively infrequently in therapy (Hill & Knox, 2002). In an extensive literature review, Hill and Knox noted the frequency of therapist self-disclosure to range from 1-13% of interventions (averaging 3.5% across studies). When Ramsdell and Ramsdell (1993) surveyed former clients who had seen therapists from various orientations, 58% reported that their therapist had self-disclosed at least once, although only a small percentage (6%) said their therapist had disclosed 10 or more times. When psychologists and marriage and family therapists were surveyed, results indicated that over 70% used self-disclosure at least occasionally (Pope, Tabachnick & Keith-Spiegel, 1987). Mathews' (1988) findings were similar, with 62% of therapists reporting at least occasional self-disclosure. Thus, research findings indicate a wide range in frequency of therapist self-disclosure. The variation in findings may be driven by the divergence in definitions and measurement of therapist self-disclosure. Furthermore, some studies asked whether or not therapists use self-disclosure rather than how frequently they use it (which makes it difficult to gain a clear picture of the frequency of therapist self-disclosure).

There appears to be no difference in self-disclosure rates by gender of the therapist, ethnic background, or years of clinical experience (Edwards & Murdock, 1994;

Simon, 1990). Frequency does, however, appear to be affected by theoretical orientation. For example, humanistic and feminist therapists appear to self-disclose more than psychoanalytic therapists (Edwards & Murdock, Simi & Mahalik, 1997). A study by Kelly and Rodriguez (2007) found that frequency of therapist self-disclosure also seems to be impacted by the gender of the client, with therapists self-disclosing more often to female clients. Furthermore, the same study determined that therapists were more likely to self-disclose to clients with lower levels of symptomatology than clients with higher levels of symptomatology. Kelly and Rodriguez did not investigate the motivation for these differences in rates of disclosure.

Another study on the frequency of therapist self-disclosure by Barrett & Berman (2001) manipulated the number of therapist self-disclosures (i.e., use of five therapist self-disclosures with one client and zero therapist self-disclosures with another client). Their findings indicated that the therapists who self-disclosed in response to client self-disclosures (i.e., five reciprocal self-disclosures) were more well liked as therapists than those who did not disclose at all. Furthermore, clients reported less symptom distress after treatment when they had therapists who self-disclosed reciprocally (five times in the session) rather than therapists who never self-disclosed. However, this study failed to address the content of the disclosure, which could also potentially affect clients' response to the therapist. Additionally, this study was conducted with predominantly Caucasian, undergraduate students serving as clients, thus limiting the study's generalizability.

To summarize, it appears that most therapists (humanistic and feminist more so than psychoanalytic) use self-disclosure, although they do so somewhat sparingly. Furthermore, some research shows that therapists who employ self-disclosure are better

liked and have clients with lower self-reported distress levels than therapists who do not self-disclose.

Content. Research indicates that therapists are more likely to self-disclose information related to their professional background (e.g., training, theoretical orientation) and less likely to self-disclose information about their sexual practices or beliefs, dreams, or personal fantasies (Edwards & Murdock, 1994; Robitschek & McCarthy, 1991). Interestingly, one survey of therapists indicated that 40% had shared details of current personal stresses with a client, such as the death of a family member (Borys & Pope, 1989). Other research has found disclosures designed to give hope, or to strengthen or repair ruptures in the therapeutic relationship, are the most common (Lane, Farber, & Geller, 2001). Lane, Farber, and Geller also reported that therapists endorsed the following self-disclosure content areas as advancing treatment the most: respect or admiration of the client, emotional reactions to the client, attitudes toward child-rearing, opinions regarding prognosis of treatment, feelings that parallel those of the client, apologies for mistakes, reactions to how a client expresses him/herself, and strategies for coping with stress. Overall, therapists are more likely to employ self-disclosures that have content related to professional background, reactions to the client, psychotherapeutic process, or normalization of client issues. However, it is important to realize that the majority of research on the content of therapist self-disclosure was collected via therapist self-report, which introduces the potential for bias and error through social desirability and inaccurate memory. For example, if a therapist thinks researchers/clinicians believe that therapist self-disclosure is inappropriate, he/she may be less likely to report his/her use of therapist self-disclosure, or may acknowledge using only those disclosures deemed

most safe or appropriate.

Reasons for self-disclosure/non-disclosure. Research examined therapists' intentions for delivering or refraining from self-disclosure. Among therapists' reasons for using self-disclosure are a desire to increase the perceived similarity between therapist and client, model appropriate behavior for the client, foster a therapeutic alliance, validate or normalize clients' experiences, offer alternative ways to think or act, and appease the client (Edwards & Murdock, 1994; Lane, Farber, & Geller, 2001; Simon, 1990). Likewise, other researchers have asserted that therapist self-disclosure serves one or more of five functions: expression of an idea, self-clarification, social validation, relationship development, and social control (Derlega, Margulis, & Winstead, 1987). Furthermore, researchers have found that therapist self-disclosure promotes client self-disclosure (Hendrick, 1987; Knox & Hill, 2003; Watkins, 1990). Some have even suggested that withholding therapist self-disclosures may actually present a barrier to therapeutic progress, as clients may refrain from sharing if they feel that their therapists are unwilling or unable to reciprocate (Safran & Muran, 2000). Therapists reported avoiding self-disclosure if the self-disclosure would result in any of the following: fulfill the therapist's needs, move the focus from the client to the therapist, interfere with the client's flow of material, burden or confuse the client, intrude on the client, blur boundaries, overstimulate the client, or contaminate the transference (Edwards & Murdock, 1994; Simon, 1990).

In general, then, therapists use self-disclosure when it is thought to benefit the client (e.g., improve the therapeutic process and relationship, normalize/model, encourage client self-disclosure) and are less likely to self-disclose when it may derail

therapy or fulfill the therapist's desires. Again, much of this research was based on direct therapist report and thus introduces methodological problems associated with self-report. Specifically, a therapist's subjective views and perceptions of others' opinions on the appropriateness of therapist self-disclosure may influence his/her report of motivation for or against use of therapist self-disclosure. Furthermore, the majority of these findings were either anecdotal in nature (based on researchers' personal experiences in the case of Derlega, Margulis, & Winstead, 1987) or based on data collection that limited therapists' response (Likert scale for Edwards & Murdock, 1994; fill- in-the-blank for Lane, Farber, & Geller, 2001). None of the studies appear to have provided therapists with the opportunity to explain in detail their reasons for using or not using therapist self-disclosure.

Effects of therapist self-disclosure. The effects of self-disclosure are mixed depending on the definition, means of assessment, and criteria used in the research. In a research review of 18 analog studies of therapist self-disclosure based on the perceptions of individuals not in therapy (i.e., undergraduate students presented with a stimulus of self-disclosure), 14 studies reported positive perceptions, 3 reported negative perceptions, and 1 reported mixed perceptions (Hill & Knox, 2002). Furthermore, Hill and colleagues (1988) found that therapists and clients perceived therapist self-disclosure differently: Clients gave the highest ratings of helpfulness and experiencing (i.e., being involved with their feelings, self-understanding) in response to therapist self-disclosure, whereas therapists gave lower and more variable ratings of helpfulness to their self-disclosures.

In another study on the consequences of therapist self-disclosure, Knox, Hess, Petersen, and Hill (1997) interviewed therapy clients about the effects of helpful therapist

self-disclosure. Clients reported that helpful therapist self-disclosures helped them achieve insight and see their therapist as more real and human. The latter finding was tied to an improved therapeutic relationship. Furthermore, clients shared that their therapists' disclosures made them feel better because their experiences were normalized. Similar to findings of other research studies (i.e., research demonstrating therapist self-disclosure elicited client self-disclosure; Hendrick, 1987; Watkins 1990), a few clients even began to self-disclose more of their own thoughts and feelings and make positive changes in their lives as a result of the therapist's self-disclosure. This research only examined the effects of helpful therapist self-disclosures, which leaves one to wonder about therapist self-disclosures that clients perceive as unhelpful.

Although the immediate effects of therapist self-disclosure appear predominantly positive, studies on longer-term effects of therapist self-disclosure have had mixed results. In their review of the literature, Knox and Hill noted older correlational studies that found either no relationship or a negative relationship between the frequency of therapist self-disclosure and treatment outcomes, as rated by client, therapist, or observer (Braswell et al., 1995; Coady, 1991; Hill et al., 1988; Williams & Chambless, 1990). However, the definitions of therapist self-disclosure and assessment methods varied widely among these studies.

Results of two other studies on therapist self-disclosure and treatment outcome, however, were positive. Ramsdell & Ramsdell (1993) surveyed former therapy clients and found that clients rated therapist self-disclosure as beneficial for therapy. In addition, a previously mentioned study found that clients receiving reciprocal therapist self-disclosures reported less symptom distress and a greater liking for their therapist than

those who did not receive therapist self-disclosure (Barrett & Berman, 2001). Another study discussed earlier found improved therapeutic relationship and increases in client insight and positive changes in clients' lives in cases involving therapist self-disclosure (Knox, Hess, Petersen, & Hill, 1997). In sum, research indicates that therapist self-disclosure is often perceived as immediately helpful to clients and non-clients, but more research is needed on the long-term effects of therapist self-disclosure.

In order to better understand these mixed results, one must consider methodological factors that may have influenced the findings. Although the research did consider both client and therapist perspectives, multiple definitions and measures of therapist self-disclosure were used throughout the studies, which may have affected how participants responded or how data were recorded. For example, a study in which therapist self-disclosure was defined as sharing personal information about the therapist (e.g., marital status, life experience) might produce substantially different findings than a study in which therapist self-disclosure was defined as the therapist revealing his/her reactions to the client with the client. With respect to using different measures of therapist self-disclosure, data collected via interview versus survey (e.g., rating scales) could potentially yield different results (i.e., surveys may limit the depth and context of data or bias them in one particular direction). Additionally, some studies clearly examined effects within a specific time frame (e.g., immediate effects, long-term effects), while other studies did not indicate the time frame for effects. For the studies that did not specify a time frame, it is difficult to fully grasp their findings (e.g., were effects described in the results immediate, long term, or somewhere in between?). Thus, future studies should clearly articulate inclusion/exclusion criteria (i.e., what specifically

constitutes therapist self-disclosure) and the way in which therapist self-disclosure will be measured (i.e., observation, self-report of client or therapist, outcome survey, interview, etc.). Gathering information from client, therapist, and observer at multiple points in time, for instance, would help reduce the amount of bias introduced by data collection at one point in time from the perspective of one sole individual. In addition, any long-term effects of self-disclosure should be examined with respect to the type of therapist self-disclosure being investigated, although it is difficult to determine long-term effects of a single intervention. The longer the interval between therapist self-disclosure delivery and data collection, the greater the amount of bias that is introduced, for individuals may remember the self-disclosure inaccurately as more time passes. Furthermore, any therapy or non-therapy events (e.g., additional self-disclosures, ruptures in the therapeutic relationship, therapeutic progress, events in clients' lives outside of therapy) that happen in the time between therapist self-disclosure and data collection may unduly alter clients' reports regarding the initial therapist self-disclosure.

Clearly, research has yielded a greater understanding of the frequency, content, reasons for and against, and effects of therapist self-disclosure with adults. In adult therapy, research indicates that self-disclosure is used by therapists, albeit relative infrequently (Hill & Knox, 2002; Matthews, 1988; Ramsdell & Ramsdell, 1993), and that therapist self-disclosure content is often related to professional background, reactions to the client, psychotherapy process, and normalization (Borys & Pope, 1989; Edwards & Murdock, 1994; Lane, Farber, & Geller, 2001). Additionally, clinicians and researchers now know more about the reasons therapists deliver/abstain from therapist self-disclosure and the effects of therapist self-disclosure. We cannot conclude, however, that similar

reasons and effects hold true for therapist self-disclosure with children/adolescents.

As previously mentioned, work with children and adolescents is inherently different from work with adults and must be adjusted based on the individual's developmental level and inclusion of parents/family members in therapy (Gaines, 2003). Therapists who work with younger populations often alter language, techniques, and client conceptualization based on the developmental stage of the child. In this researcher's professional experience, therapists who work with children seem to self-disclose (both professional and personal information) significantly more than therapists who work mainly with adults. Perhaps this is because the relationship with the child or adolescent and his/her family is predicated on knowing and trusting the therapist (more so than in adult therapy as children are viewed as a vulnerable population) – it seems that parents and children feel validated and comforted knowing about their therapist's personal and professional experiences (i.e., self-disclosures about the therapist's own children or family members and training related to therapy with younger populations make child and adolescent clients and their families feel more at ease). Furthermore, this researcher believes that therapists who work with youth are more likely to disclose shared interests (e.g., "I like that sports team, too." or "I also enjoy kayaking.") or past childhood experiences (e.g., "I remember middle school being a difficult time.") than therapists working with adults. While the goal of therapist self-disclosure with adult and child clients may be the same (i.e., to build trust, model, etc.), this goal may be achieved through self-disclosures with containing different content (e.g., personal information vs. immediate reactions to the client). Additionally, therapist self-disclosure with youth may be further differentiated depending on the developmental level or age of the client.

Anecdotally, I believe that therapist self-disclosures with a young child looks are likely more simplistic (i.e., “my favorite food is pizza”) than therapist self-disclosures with an adolescent (i.e., “I had a similar experience being ostracized by my peers when I was your age”). With these ideas in mind, the extant research on therapist self-disclosure with adult clients presented a framework and some important methodological implications to be considered (e.g., clearly operationalized definition and inclusion/exclusion criteria), but clearly, research that specifically examines therapist self-disclosure with younger populations was warranted.

Self-disclosure in Therapy with Children

As mentioned earlier, much of the literature on therapist self-disclosure is focused on therapy with adult clients. This disparity between research on therapist self-disclosure with children and therapist self-disclosure with adults is not an uncommon pattern for psychotherapy research: The examination of child psychotherapy variables often lags behind research on the same variables conducted with adult samples (Farber, 2006). For clarification purposes, the research that addresses therapist self-disclosure with children does not differentiate developmental groups within youth (e.g., young child vs. adolescent). Rather, the research uses the word “child” to describe individuals from birth to 18.

Theoretical literature. Although several authors have proposed a number of advantages of therapist self-disclosure to children (e.g., increased client comfort and willingness to engage in therapy, modeling effective strategies, acceleration of therapeutic gains), there is little empirical research to substantiate these assertions (Gaines, 2003; Gardner, 1993). Furthermore, similar to the benefits of therapist self-

disclosure identified in adult research, Barish (2004), Gaines (2003), and Leichtentrett and Schechtman (1998) believe that therapist self-disclosure with children has the capacity to strengthen the therapeutic bond, facilitate engagement in therapy, and encourage self-disclosure on the part of the child client. Gaines further suggested that when a therapist self-discloses to a child, the child is more likely to engage in meaningful play, explore emotions, change negative self-judgments, remain open to therapy, and (with adolescents) increase the capacity for self-observation. Interestingly, Gaines also proposed that the content of a therapist's self-disclosure is not as important to a child as is the therapist's willingness to open up to the child that is conveyed through self-disclosure. For example, it likely would be more important for a child to know that his/her therapist is amenable to sharing information than it would be to know the information itself (e.g., marital status).

Other researchers have highlighted the importance of using a developmental perspective as a framework for therapist self-disclosure with younger clients (Papouchis, 1990). For example, if a therapist deflects a child's personal question while this child is trying to find his/her place in the world, the child may have a more difficult time developing a true sense of reality as the therapist is withholding information from the child (Ross, 1964). As an illustration, if a therapist refrains from answering an adolescent client's question regarding the therapist's marital status, the client may decide the therapist is unwilling to be genuine. Additionally, the client may make judgments about the therapist (and other health professionals) and become less likely to share additional information with the therapist.

In general, the theoretical literature on therapist self-disclosure with children

suggests that therapists should respond to children in a self-disclosing matter that is simple and direct. With adolescents, therapists should use more self-disclosure than they would with adults to build trust and understanding with often resistant adolescents (Papouchis, 1990). Therapists who do not self-disclose respectfully and thoughtfully to adolescent clients run the risk of alienating the client, as children are thought to be less likely to share when they do not experience their therapist as a genuine and real individual willing to do the same. Although these recommendations seem sensible, they are theoretically rather than empirically driven, and thus in need of further study.

Additionally, children seem to be an appropriate population with which to utilize therapist self-disclosure. Dixon et al. (2001), for example, asserted that therapist self-disclosure is affected by client variables such that very young or very old clients, those who expect disclosure from their therapist, those from highly expressive cultures, and those who exhibit concrete thinking (such as children) would be most likely to obtain and benefit from therapist self-disclosure. These populations are more likely to have a stronger desire for concrete information about their therapist, such as therapist age and marital status, in order to trust their therapist (i.e., it is easier to trust someone they feel they know on a somewhat personal level). Additionally, the aforementioned populations may need and/or be more receptive to direct feedback from the therapist (i.e., self-disclosures related to how the therapist is experiencing the client in session) in order to achieve insight and change, whereas clients who engage in abstract thought, for example, may not have the same need for direct therapist self-disclosure. However, these ideas are theoretical in nature, as empirical research on therapist self-disclosure with children is still in its infancy.

Empirical literature. Few studies have focused on therapist self-disclosure with children. In a past study on child development, Vondracek and Vondracek (1971) observed the frequency of self-disclosures delivered by children interacting with interviewers (with some interviewers demonstrating self-disclosure and others refraining from self-disclosure). Results showed that children shared more with an interviewer who disclosed to them than to an interviewer who did not. Furthermore, the children's disclosures were similar in content to the interviewer's disclosures, thus supporting the notion of reciprocal self-disclosure. Notably, this study was not specifically on therapist self-disclosure, but rather interviewer self-disclosure with sixth-grade children. Therefore, one cannot conclude that similar findings would emerge in a therapeutic setting. However, the study by Vondracek & Vondracek does suggest the need for further examination of therapist self-disclosure with children as a possible catalyst for child self-disclosure.

Leichtentritt and Shechtman (1998) coded transcripts of a therapist's group therapy sessions with children. On average, the therapist self-disclosed three times per session, and the children self-disclosed 10 times per session. Although Leichtentritt and Schechtman argued that their findings offer support for an increase in child self-disclosure as a result of therapist self-disclosure, the study examined the work of only one therapist within a group therapy setting, thus limiting generalizability. Furthermore, it is unclear how often children self-disclosed before the researchers began examining the effects of therapist self-disclosure.

Only one study has directly examined therapist self-disclosure in individual therapy with children. Capobianco and Farber (2005) surveyed child therapists as to the

frequency, content, and other characteristics (extent to which children solicit self-disclosure, extent to which therapists believe disclosures advance treatment) associated with therapist self-disclosure by having them complete the Therapist-to-Child Disclosure Inventory (TCDI), a Likert-type measure created for the study. They found that therapists estimated the frequency of their self-disclosure to be low to moderate (i.e., 3.7 on a 7-point scale), which is similar to the frequency of therapist self-disclosure with adult clients (Hill & Knox, 2002). This finding may be tied at least in part to the fact that therapists said child clients "almost never" requested personal information of them. Parental status was the most frequently endorsed disclosure item, the most frequently requested disclosure by child clients, and the disclosure that therapists believed would advance treatment the most. Content of other frequent therapist self-disclosures included marital status, school experiences, pets, personal values, and hobbies. Interestingly, Capobianco and Farber also found that therapists rated the usefulness of disclosure as low (i.e., "almost never helpful"). Interestingly, therapist age, gender, and years of experience were not significantly related to any of the disclosure variables. Consistent with research on therapist self-disclosure with adults, psychodynamic therapists in this study self-disclosed less than did cognitive-behavioral or eclectic therapists. However, this study did not examine client variables (e.g., diagnosis, gender, family background, time in treatment), and it is possible that some of these factors could influence a therapist's decision to self-disclose to a child client. Additionally, Capobianco and Farber's study only examined therapist self-disclosures of factual information, leaving one to wonder whether therapists used other types (e.g., reactions to the client) of self-disclosure with child clients.

In conclusion, researchers currently know very little about therapist self-disclosure with youth. Initial research suggests that therapists employ self-disclosure somewhat sparingly with children and that it may be viewed by therapists as not helpful. Research also indicates that the most common therapist self-disclosures with youth clients are of a factual nature (e.g., marital status, hobbies, etc.), but research has failed to examine other potential types of therapist self-disclosure with children/adolescents (e.g., reactions to clients or the therapeutic process). Finally, other than preliminary findings, which suggest that therapist self-disclosure may increase the frequency of children's self-disclosures, little is known about the effects of therapist self-disclosure with youth. Because of the dearth of research on therapist self-disclosure with child/adolescent clients, combined with increasing numbers of youth receiving mental health services, additional examination of this intervention is warranted. Consensual qualitative research (Hill, Nutt, & Williams, 1997; Hill et al., 2005) serves as one methodology that can be used to explore therapist self-disclosure with adolescents.

Consensual Qualitative Research (CQR)

As Hill, Thompson, and Williams (1997) highlighted in their seminal work on consensual qualitative research (CQR), many quantitative methods neglect the unique experiences that occur within psychotherapy. Individualized experiences of therapists and clients can easily be obscured by numbers, and the distinct stories remain unheard. Qualitative research methods such as CQR offer a way of analyzing data that stays true to participants' words and experiences as they naturally occur. While qualitative analysis may be informed by researchers' hypotheses, discovery and an openness to all findings remain hallmarks of the process (Heppner, Kivlighan, & Wampold, 2007). Furthermore,

qualitative research is particularly applicable when one wishes to examine as-yet unexplored phenomena.

History, Theoretical Foundation, and Rationale for CQR

In 1997, Hill, Thompson, and Williams introduced consensual qualitative research (CQR), a method using multiple researchers, a consensus process, and rigorous analysis across a number of participants in search of representativeness of results. By 2005, 27 studies using CQR had been published (Hill et al., 2005), thus establishing CQR as a respected qualitative research method. CQR follows many of the major tenets of other qualitative research (Bogdan & Biklan, 1992; Henwood & Pigeon, 1992). In particular, as a qualitative method, CQR gathers data from natural settings, examines both process and outcome, uses inductive methods of analysis, stresses recognition of context and complexity, and is concerned with describing meaning and gaining understanding from the participant's perspective.

CQR's roots lie primarily in grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990), but also incorporate elements of comprehensive process analysis (CPA; Elliott, 1989, 1993) and Giorgi's phenomenological approach (1970, 1985). Grounded theory's focus on developing networks of related constructs from a particular data set using the *constant comparative method* (Strauss & Corbin, 1990) to repeatedly examine data laid the groundwork for CQR. Similar to grounded theory, CQR research involves continuously revisiting the data to ensure that analysis and findings remain consistent with raw data. Unlike grounded theory, however, CQR defines the sample at the outset of research and then gathers all data using a pre-determined, semi-structured protocol. Furthermore, CQR employs a team of researchers and auditors to achieve consensus and

follows different analysis techniques (e.g., coding data into domains, abstracting the domained data into core ideas, developing cross-case categories that capture common themes in the core ideas) than grounded theory.

Elliott's CPA (1989, 1993) also shaped CQR (Hill, Thompson, & Williams, 1997). Use of teams to reach consensus and analysis methods involving the systematic comparison of data across cases is common to both CQR and CPA. However, CPA focuses on the interpretation of implicit meaning in therapy events (i.e., inferring and drawing conclusions beyond what is actually stated by participants), whereas CQR concentrates on participants' statements and the meaning of those statements on an explicit level.

Finally, Giorgi's phenomenological approach (1970, 1985) is based on the idea that one cannot understand data without studying the context from which they emerge. CQR also believes in gathering information on context to aid in the full description of a participant's experiences by asking questions regarding setting, antecedents, and characteristics of those involved in the topic of interest. However, CQR deviates from the phenomenological approach in that team consensus is viewed as a necessary as part of data analysis (Hill, Thompson, & Williams, 1997), while Giorgi believed that agreement among researchers was not required.

The CQR method (Hill, Thompson, & Williams, 1997; Hill et al., 2005) was thus appropriate for this research study, which sought to examine the relatively unexplored topic of therapist self-disclosure with adolescents. An openness to all findings and a discovery-oriented approach to the examination of therapist self-disclosure adolescents were fostered through the use of CQR. In particular, CQR allowed researchers to capture

a deep, comprehensive account of therapists' perspectives and experiences of self-disclosure with adolescent clients. Inherent to the CQR process, data were gathered from interviews with therapists and examined the impetus, the process, the factors affecting, and the perceived outcomes of therapist self-disclosure with adolescents. Because CQR data analysis occurs inductively, researchers examined themes across participants' unique experiences in search of representativeness of results, while still recognizing the context and complexity of each participant's description.

Purpose of Study

As described in the previous review, there is very little literature on therapist self-disclosure with younger populations. Within the small amount of literature that does exist, no empirical attention has been given to the overall nature and use of therapist self-disclosure with adolescent clients. I chose to limit the current study to therapist self-disclosure with adolescents ages 14 to 18 for developmental and practical reasons. Given the vast developmental differences between young children (e.g., a 5-year-old) and adolescents identified by multiple developmental theorists (Erikson, 1959; Piaget, 1972), the scope of the study was limited to include a subgroup of youth (adolescent ages 14 to 18). Due to adolescents' search for identity development (Erikson) and their increased ability for hypothetical and deductive reasoning which allows them to consider possibilities from multiple perspectives (Piaget), I believed that therapist self-disclosure with adolescents would be more complex and more personal than therapist self-disclosure with younger children (e.g., related to finding one's place in the world rather vs. sharing a favorite food). Additionally, I hoped that it would be easier for participants to identify a high-school adolescent (14-18-years-old), as it likely easier to remember a client within a

specific school level (i.e., high school vs. middle school). I also hoped that participants' descriptions of therapist self-disclosure events with adolescents would yield richer data (e.g., therapist would ideally describe a deeper self-disclosure event than they might share had they been discussing therapist self-disclosure with a young child). I also decided to examine therapist self-disclosure that occurred in the fourth session of therapy or later, as that was when the therapeutic alliance was thought to be established (Horvath & Luborsky, 1993; Saltzman, Leutgert, Roth, Creaser, & Howard, 1976). By limiting data to therapist self-disclosure events occurring during or after the fourth session (e.g., after the therapeutic alliance has been built), I hope to be able to gather data that will be richer and more complex than if I were examining therapist self-disclosure occurring early in therapy (i.e., early therapist self-disclosure may be simpler and only for rapport building).

Thus, this study sought to begin to fill a substantial gap in the research about therapist self-disclosure with youth (specifically adolescents) by using the consensual qualitative research method to gain a vivid, contextual understanding of the use and effects of therapist self-disclosure with adolescent clients. Based on this understanding, I hoped to improve the profession's knowledge of the effective use of therapist self-disclosure with an adolescent population.

III: METHOD

For the purposes of this study, I used the definition of self-disclosure from a previous study (Knox, Burkard, Edwards, Smith, & Schlosser, 2008): When verbally self-disclosing, a therapist revealed information about him/herself, and/or revealed reactions and responses to the adolescent as they arose in therapy. CQR (Hill, Thompson, & Williams, 1997; Hill et al., 2005) was well suited to examine the relatively unexplored topic of therapist self-disclosure with adolescents, as it would foster a detailed, in-depth account of the therapist's perspective and experience of sharing him/herself with an adolescent client. This first portion of this chapter (CQR Method) offers a broad overview of the CQR process and evaluation of CQR research. The latter sections of the chapter (Participants, Procedures for Collecting Data, and Procedures for Analyzing Data) address how the CQR method was applied with respect to this study.

CQR Method

Hill et al. (1997) outlined the key components of CQR: (1) data are gathered using open-ended questions in order not to constrain participants' responses, (2) the method relies on words rather than numbers to describe phenomena, (3) a small number of cases is studied intensively, (4) the context of the whole case is used to understand the specific parts of the experience, (5) the process is inductive, with conclusions being built from the data rather than imposing and testing an *a priori* structure or theory, (6) all judgments are made by a primary team of three to five researchers so that a variety of opinions is available about each decision. Consensus is used so that the best possible understanding is developed for all data, (7) one or two auditors are used to check the consensus judgments to ensure that the primary team does not overlook important data,

(8) the primary team continually goes back to the raw data to ensure that their results and conclusions are accurate and based on the data (Hill, Thompson, and Williams, pp. 522-523).

Furthermore, CQR data analysis involves three primary steps: Responses to open-ended questions for each case are separated into domains or topic areas; for each domain in each case, summaries or core ideas are developed; cross analysis occurs by constructing categories from core ideas across cases (Hill, Thompson, & Williams).

Reaching consensus is an integral part of CQR, one based on Marshall and Rossman's (1989) assertion that multiple perspectives decrease researcher bias and increase approximation of the "truth." In CQR, researchers independently examine the data and then discuss their ideas as a group until they agree on the one interpretation that they believe is most suitable. Hill et al (1997) emphasized that the consensus process hinges on "mutual respect, equal involvement, and shared power" (p. 523). Furthermore, reaching consensus requires patience and time, and it should not be rushed.

Initial Steps

Developing research questions, choosing a research team, choosing and recruiting a sample, and developing a protocol are the main steps when planning a CQR study (Hill, Thompson, & Williams, 1997). One should begin by focusing on a specific area of interest that lends itself well to the CQR approach. Hill et al. suggested that psychotherapy events and inner experiences (which are often complex, relatively subjective, and descriptive in nature) are particularly well suited for CQR, while research comparing treatments or examining the frequency of a particular event are more appropriately studied quantitatively. In particular, topics that have received little

empirical attention and those that lend themselves to in-depth discovery are also appropriate for CQR. Researchers should explore the literature in the area of interest, as doing so will aid in the development of research questions and the resulting interview protocol. The research questions and protocol should be natural extensions of the literature.

Another step involves choosing and structuring a research team. Hill, Thompson & Williams (1997) recommend selecting team members who interact well, respect each other, and are able to resolve power differences but also challenge each other through negotiation and problem-solving skills. Team members need to feel committed and involved in the research process, as well. Auditors must be attentive to detail so that they may thoroughly check the work of the primary team. Recently, it has also been suggested that auditor(s) be experienced with qualitative research and have a good grasp of CQR so that they may comprehensively evaluate the other team members' analyses (Hill et al., 2005). Attention must also be given to group dynamics: In order for research to proceed effectively, Hill, Thompson, and Williams stressed that the research atmosphere be one in which everyone feels safe to share her/his thoughts and opinions.

Choosing a sample is the next step in CQR, and begins with defining the population. Important consideration of the inclusion and exclusion criteria for those who participate in the study is necessary for sound data collection and analysis. Finding cooperative, articulate participants who are familiar with the topic under study is crucial. Since one of the main goals of CQR is to gain a deep understanding of an event, individuals must be able to communicate their experiences in a coherent, explicit manner. Hill, Thompson, and Williams (1997) recommended employing criterion-based sampling

(Goetz & LeCompte, 1984), or setting the criteria for the population prior to collecting data. Hill, Thompson, and Williams noted that although random sampling is ideal, it is often difficult in psychotherapy research because of availability and willingness of participants. Therefore, researchers should explicitly state the limitations of their sample selection process. Furthermore, selection criteria should be defined clearly and specifically. Not only does this approach demonstrate sound research practice, but it also allows researchers to clearly explicate the context of the study's findings by describing the sample and commenting on the transferability of the results. Other considerations for sample selection include recency of experience. Participants who have somewhat recent experience with the research topic should also be selected, as distant experiences are more likely to be distorted. Researchers must also decide on an appropriate sample size. Hill, Thompson, and Williams suggest that in order to have a large enough sample to determine representativeness, researchers should include at least 8 to 15 participants. After specifying the study sample, participants are recruited. Sending an initial letter and following up with a phone call has been effective (Hill, Thompson, & Williams). Furthermore, targeting those who have personal interest in the topic of study appears to increase participation.

The final step before data collection is the development of the protocol. As mentioned above, researchers should use relevant literature to aid in the development of the interview protocol, as it will allow them to build on the literature and form useful questions. Protocol development often involves brainstorming of questions or general topic areas researchers wish to explore. Research team members may brainstorm individually and then meet as a group, or the team may meet as a whole to develop

protocol ideas. The team discusses possible protocol options, the phrasing of questions, and reaches consensus on protocol items. Once the protocol has been developed, researchers should, as best they can, put aside their knowledge of the relevant literature so that data can be approached in an unbiased manner. In fact, before collecting any data, CQR compels researchers to record their expectations (i.e., beliefs that researchers have formed based on the literature and development of research questions) and biases (i.e., personal issues that may make it difficult to respond objectively to the data) to gain awareness and decrease subjectivity that could interfere with the research process.

While researchers may choose to collect data via questionnaire, telephone interview, or face-to-face interview, Hill, Thompson, and Williams (1997) recommended using telephone interviews either alone or in conjunction with questionnaires, as they allow for the most complete and contextual data collection. Phone interviews allow researchers to probe as needed and seem to provide participants with a certain level of comfort that facilitates further self-disclosure. Conducting interviews over the phone also reduces travel expenses and increases protection of confidentiality for the participant.

The protocol itself should be semi-structured, but also open-ended in order to obtain a full description of the interviewee's experiences. In general, Hill, Thompson, and Williams suggested that interviews begin with "warm-up questions" to gather background information and build rapport. Such opening questions should be followed by a general question about the topic of interest and additional probes to explore the individualized experience of the interviewee. In a 2005 update on CQR, Hill and colleagues suggested that interviewers ask limited numbers of scripted questions (i.e., 8-10 questions in a one-hour interview) to allow participants to fully share their experiences

and researchers to pursue follow-up probes. Researchers may consider conducting pilot interviews with individuals similar to the target population and then revising the protocol to ensure its clarity and effectiveness.

Data Collection

The data collection process consists of conducting interviews, keeping memos about impressions, and transcribing the interviews (Hill, Thompson, & Williams, 1997). It is imperative that individuals conducting interviews possess good clinical interviewing skills (e.g., knowing when to probe, how to maintain appropriate boundaries, and how to encourage the interviewee to participate) so that the most comprehensive data may be obtained for analysis. Consistency can be ensured by having one researcher conduct all interviews, or multiple researchers can conduct interviews to reduce potential effects of interviewer bias. In either case, interviewers should practice beforehand and be sure to obtain informed consent for the interview and taping. During or after each interview, the interviewer should take notes about her/his impressions of the interview, as these notes are often useful for understanding the case during data analysis. Finally, all interviews must be transcribed verbatim (except for sighs, non-language such as "um," fillers such as "you know," etc.). Participant confidentiality must be protected at all times. Therefore, proper names (replaced with a code number) and any other identifying information must be deleted from the transcript.

Data Analysis and Interpretation

Data analysis begins by developing domains, or topic areas (Hill, Thompson, & Williams, 1997). First, researchers brainstorm a list of domains (called a "start list"; Miles & Huberman, 1994) stemming from the literature review and interview protocol

that will be used to separate data into similar topic areas. More recently, researchers have developed the initial list of domains by reviewing transcripts, for doing so allows researchers to work directly from the data rather than from preexisting literature and their expectations (Hill et al., 2005). Through the process of reaching consensus, these domains will continue to change (i.e., domains may be deleted, combined, or added) until the research team feels that they have developed the most appropriate list for the specific data set with which they are working (Hill, Thompson, & Williams). After the initial domain development, every research team member independently reads through each transcript and assigns data to a domain. A few words to a phrase to several sentences of data are assigned to a domain, and every word must be placed somewhere. Data that do not appear to fit into a domain may be moved into an "other" domain to be examined later. If data fit into more than one domain, they can be "double-coded" (Hill, Thompson, & Williams) into multiple domains. After researchers have independently coded data into domains, the entire research team meets to arrive at a consensus decision as to the most suitable domain for the data. Once consensus has been reached, a consensus version (Hill, Thompson, & Williams) for each case is created, which includes the domain titles followed by all of the raw data (transcribed interview excerpts) for each domain.

The second major step in CQR data analysis is the construction of core ideas, which summarize the content of each domain for each case (Hill, Thompson, & Williams, 1997). Similar to Strauss and Corbin's (1990) process of "boiling down" the data, the goal of developing core ideas is to describe the interviewee's response in a briefer, clearer fashion. During this abstraction process, researchers need to stay true to the explicit meaning of the interviewee's words and also maintain a focus on the domain at

hand. Similar to the domaining step of analysis, once researchers have individually developed core ideas, they meet as a group to share and discuss what they have developed until consensus is reached. Although researchers may continue creating core ideas as a team, once team members feel comfortable with the process, they may take turns writing the core ideas and then meeting with the team for reviewing and editing (Hill et al., 2005). After consensus has been reached for the core ideas for each domain of a case, the case is sent to the auditor(s) for review. Hill, Thompson, and Williams suggested that the auditor review and provide feedback about (1) whether the data are in the correct domain, (2) whether all important data have been abstracted into core ideas, and (3) whether the core ideas are concise and accurate with respect to the raw data. Once the auditor's comments are returned, the research team addresses the feedback and reaches consensus about whether to accept or reject each comment.

Cross analysis is the final step in CQR data analysis. This process involves research team members looking across the core ideas of all cases, within each domain, to determine if there are similarities or common themes among the cases (Hill, Thompson, & Williams, 1997). Essentially, researchers are searching for patterns for how core ideas cluster into categories. The team may brainstorm categories together, or work independently and then come back together as a group to compare categories until consensus is reached. Core ideas may go into one or several categories, or they may be divided among relevant categories. Just like the process of domaining, categories are repeatedly revisited and modified as analysis continues.

As part of the cross analysis, the team examines the representativeness of the sample by determining the frequency of categories within the whole sample. Based on

Elliott's (1989, 1993) methods, the following language is applied to categories: (1) a category that applies to all or all but one of the cases is called *general*, (2) a category that applies to more than half of the cases is called *typical,* (3) a category that applies to either two or three and up to half of the cases is called *variant*, (4) any categories that apply to only one case are dropped. More recently, researchers have suggested (for samples larger than 15) adding a frequency title of *rare* to describe a category that applies to two or three cases (Hill et al., 2005). The addition of *rare* changes the frequency title of *variant* to include more than three and up to half of the cases.

The cross analysis would not be complete without a final review by the auditor(s) to determine whether the core ideas fit well in the specified categories, whether the category labels are appropriate, and whether categories should be further divided or collapsed. Again, the researchers digest each of the auditor's comments and come to a consensus on whether to accept or reject them.

Evaluation of CQR

Although reliability, validity, and generalizability criteria that are applied to quantitative research are not suitable for evaluating qualitative research, it is crucial to examine trustworthiness of the method, representativeness of the sample, testimonial validity, applicability of results, and replication of results when examining qualitative research (Hill, Thompson, & Williams, 1997). Using these parameters, CQR appears to be a viable qualitative method (Hill et al., 2005).

Hill, Thompson, & Williams (1997) define trustworthiness of the method as "the degree to which the results of the study can be trusted" (p. 556). Within CQR, trustworthiness can be demonstrated by careful data collection and analysis, and clearly

articulating the research process and findings so that others may evaluate the research team's work. Specifically, it is recommended that consumers attend to the adequacy of the protocol, the sample selection, the consensus and auditing process, and the consistency of decision-making across cases when evaluating CQR research.

With respect to representativeness of the results to the sample, researchers attempt to demonstrate this by indicating the category frequencies in their results (i.e., general, typical, variant). General and typical categories demonstrate strong representativeness, while variant and rare categories indicate weaker representativeness, respectively.

Testimonial validity, or having participants review the findings to determine whether the interpretations match their experiences (Stiles, 1993), allows researchers to be more confident in their research findings. Essentially, participants can offer additional information that may be relevant to what they shared in their interview, or may suggest changes so that results more clearly represent their experiences.

Applicability of results to practice is another important area to examine when evaluating CQR research. Research should articulately describe the sample and include pertinent contextual information so that consumers can easily determine whether the results may be useful to their practice or research (Hill, Thompson, & Williams, 1997). Highlighting the implications of findings for clinical work or additional research also speaks to the applicability of results.

Finally, readers should consider whether results have been replicated or appear to be replicable when evaluating a CQR study. Time permitting, individuals conducting a study may wish to reanalyze data using another team of researchers. Additionally, another data set could be gathered using the same protocol to determine whether similar

results are obtained. However, neither of these approaches is always practical or an efficient use of time. Therefore, Hill, Williams, and Thompson (1997) suggested that replication across studies by other researchers may be the most appropriate way to assess the validity of findings. Based on this overview of the CQR method, the following sections describe how CQR was applied to this study.

Participants

Therapists

The population of licensed, child-focused, clinical and counseling psychologists (Ph.D. or Psy.D.) and master's level clinicians was chosen as the focus of this study due to their clinical experience and educational training providing treatment to children (determined by presence of at least two classes workshops or continuing education credits in child psychology, current caseload of 50% or more child clients, and supervised clinical experience with children). Furthermore, being licensed professionals ensures a level of professional and ethical knowledge important when examining a highly debated topic such as therapist self-disclosure.

Criterion-based sampling (Goetz & LeCompte, 1984) was conducted using the criteria that follow. In keeping with sample guidelines proposed by Hill, Thompson, and Williams (1997), the sample included 12 licensed clinical or counseling psychologists or master's level clinicians recruited from across the US who work primarily with child populations (i.e., individuals under 18 years of age). In order to participate in the study, the psychologist had to be able to identify and be willing to talk about a specific event in which he/she used therapist self-disclosure in an individual therapy session with an adolescent client (i.e., individual between the ages of 14 and 18). The event must have

taken place in individual therapy within the last two years, and it must have occurred in the fourth therapy session or later. At the time of the event, the individual must have been a licensed clinical or counseling psychologist or master's level clinician. In the event, the participant may have disclosed just one statement or a series of related self-disclosure statements.

Participants were selected via the "snowball technique." This method was selected for multiple reasons. First, distribution of study recruitment materials via relevant listservs (e.g., Society of Pediatric Psychology listserv) was prohibited. Additionally, although random sampling would have been ideal, there was no readily identifiable way to randomly sample all licensed doctoral and master's clinicians who work primarily with children. Furthermore, Hill, Thompson, and Williams (1997) point out that random sampling is very difficult in psychotherapy research because of availability and willingness of people to participate. Therefore, the researcher used existing connections from past practicum placements (e.g., Children's Hospital of WI) and organizations (e.g., Society of Pediatric Psychology) with a variety of clinicians to recruit the sample. Participants were approached via phone conversation or email and asked if they would be interested in participating in a research study regarding their experiences related to therapist self-disclosure with adolescents. If existing connections were unwilling or unable to participate themselves, the researcher asked those individuals to identify other licensed, child-focused, clinical or counseling psychologists or Master's level clinicians who were appropriate for study participation. Initial contact with these potential participants was made via phone or email. Informed consent was obtained prior to participation in the study.

Recruitment yielded 12 participants. All participants (nine women, three men) consented to participate in the study and completed both interviews. All participants identified as Caucasian. They ranged in age from 29 years old to 61 years old (*M* = 37.6; *SD* = 10.10). Four participants held PhDs in clinical psychology, three held PsyDs in clinical psychology, one held a PhD in counseling psychology, two had master's degrees in social work, and two had master's degrees in counseling. All participants had two to six years of supervised clinical experience working with children and one to 36 years post-licensure experience working with children (*M* = 7.29; *SD* = 9.89). Participants could list multiple theoretical orientations: Eleven identified as cognitive-behavioral, five as family systems, two as interpersonal, 1 as behavioral, and 1 as integrative.

Adolescent Clients

The 12 clients who received the TSD were between 14 and 18 years of age (*M* = 16; SD? years); eight clients were female and four were male. Eight were identified as Caucasians, two as Hispanic, one as African American, and one as Bi-racial. Multiple presenting concerns were listed for some clients; thus, the following distribution is greater than twelve: Eight patients presented with mood disorders, five with adjustment to medical issues, three with anxiety, three with family dynamic issues, two with substance abuse, and two with attention difficulties.

Participants also provided information about the frequency of therapy and the therapy setting. The majority of adolescent clients were involved in therapy that occurred biweekly or slightly less often. Variantly (2-6 cases), clients were seen in weekly therapy or therapy that occurred more than once per week. The clients were generally seen in outpatient environments.

Research Team

Three European American graduate students, including the researcher, comprised the primary research team. All three students (Jacquelyn Smith, Julie Janecek, and David Phelps) are currently enrolled in a doctoral program in counseling psychology and have previously been members on at least one CQR team. Although all participant interviews were conducted by Jacquelyn Smith, Julie Janecek and David Phelps participated in all levels of data analysis. Sarah Knox served as the auditor for this study. She is a European American associate professor of counseling psychology who has extensive experience conducting CQR studies.

Biases

Prior to data collection, the primary team members met to discuss their biases with regard to therapist self-disclosure, therapist self-disclosure with adolescents, and any clinical experiences they had with therapist self-disclosure. The other members of the primary research team are referred to here as male researcher and female researcher.

The primary author felt that therapist self-disclosure could be a useful therapeutic intervention, particularly with children. She believed that therapist self-disclosure should always be done with intention, fully thinking through the possible repercussions of self-disclosing to a client. The male researcher felt that therapist self-disclosure had the potential to be an appropriate intervention when used appropriately. Specifically, he felt that with clients demonstrating characteristics of a personality disorder or poor boundaries, one should not use therapist self-disclosure. The female researcher echoed the beliefs of the other two team members that therapist self-disclosure should be used with forethought and consideration of possible ramifications. She felt that too much

therapist self-disclosure had the potential to change the therapeutic relationship into "more of a friendship than a working relationship."

The primary author recalled multiple discussions and training experiences in graduate school and clinical training/supervision that conveyed the message that therapist self-disclosure should be used thoughtfully and in moderation and always for the benefit of the client. The male researcher recalled very limited experiences using therapist self-disclosure with adults in therapy, and he attributed this to messages from supervisors and clinical instructors warning against overuse of therapist self-disclosure. While the female researcher felt that in some instances therapist self-disclosure could be used as a positive therapeutic intervention, she also recalled hearing stories from supervisors about situations where therapist self-disclosure resulted in difficult boundary situations.

Specific to the primary author's therapist self-disclosure experiences with children and adolescents, she believed that therapist self-disclosure occurs more frequently in therapy with children/adolescents than it does in therapy with adults. Although he has not worked with children in therapy, the male researcher believed that therapist self-disclosure with adolescents would likely be more concrete and simple than self-disclosure with adult clients. The female researcher does not work with children/adolescents in therapy, but stated that therapist self-disclosure seemed appropriate as a tool to help build relationships with children and teenagers. She believed that therapist self-disclosure could increase an adolescent's trust in the therapist by helping him/her view the therapist as more genuine.

The primary author identified a number of examples in which she used therapist self-disclosure with adult, adolescent, and child clients, all with positive results. She

recalled experiences whereby therapist self-disclosure normalized the client's experience and appeared to help the client achieve insight. She felt that with adolescents, therapist self-disclosure was a useful tool to validate an adolescent's experience and encourage increased self-disclosure from the adolescent. As the male researcher has never conducted therapy with children or adolescents, he only recalled experiences with therapist self-disclosure in adult therapy. Of the situations the male researcher could recall, he felt that the effects of his self-disclosures were largely positive. In particular, he felt that clients often verbalized relief (when he shared a similar experience with them) or were able to realize new connections related to their concerns (when he shared a reaction to a client). The female researcher reported that she rarely uses therapist self-disclosure in therapy (with adults). In the instances in which she did use therapist self-disclosure, the female researcher cannot recall positive or negative effects; she felt that the therapist self-disclosure did not alter the course of therapy.

Although the primary author's experiences using therapist self-disclosure with adolescents were positive, she believed that results from this study of therapist self-disclosure with adolescents would likely yield some positive, some neutral, and some negative experiences from participants. The primary author questioned whether participants would share negative experiences, as participants could feel embarrassed or fearful of being judged if they discussed situations where therapist self-disclosure did not go well. The male and female researchers believed that participants' interviews would yield situations with mixed positive and negative results.

Procedures for Collecting Data

After initial contact was made with participants, a packet including a cover letter

with relevant study information, consent forms, demographic form, and interview protocol was mailed to the individual (see documents in Appendices). The mailed packets also included a self-addressed stamped envelope for participants to mail the informed consent and demographic form back to the researcher (JS). Once these materials were received, the researcher called or emailed the participant to schedule a time for the initial interview.

Demographic Form

The demographic form gathered basic information about the participant, such as age, gender, race/ethnicity, educational background, degree obtained, theoretical orientation, frequency of therapist self-disclosure, and number of years providing therapy to children (including years of supervised experience). The form also requested a name, email or mailing address (if the participant would like a copy of the results), phone number, and best possible times to schedule the interview.

Interviews, Interview Process, and Transcription

In this study, the researcher completed phone interviews (initial and follow-up) with participants regarding their use of therapist self-disclosure with adolescent clients. The first interview began with a reminder of informed consent, confidentiality (e.g., use of code number rather than participant identifying information), and a review of the definition of self-disclosure being used in the study. Interview questions were divided into three areas: opening questions, self-disclosure event questions, and closing questions. A copy of the interview protocol is attached as Appendix D. Opening questions addressed the participant's use of therapist self-disclosure with adolescents, factors that may affect his/her use of therapist self-disclosure, representative examples of

therapist self-disclosure, and his/her training regarding therapist self-disclosure with adolescents.

Following the opening questions, the participant was asked to identify a specific event in which he/she self-disclosed (either one statement or a series of related self-disclosure statements) in an individual therapy session with a client between the ages of 14 and 18. The event must have taken place in the last two years, and it must have occurred during or after the fourth therapy session. Additionally, the participant must have been a licensed clinical or counseling psychologist or master's level clinician at the time. Questions about the specific event addressed the following areas: therapeutic relationship, nature of therapy, description of self-disclosure, factors influencing the self-disclosure event, the effects of the therapist's self-disclosure, and client/therapy demographic information.

The final section of the interview asked for any additional remarks from the participant, his/her reasons for participating in the research, and how the interview affected him/her. The participant was thanked for his/her participation, and a follow-up interview was scheduled.

The follow-up interview was shorter in length and less structured than the initial interview. The purpose of the follow-up interview was to give the participant a chance to share additional thoughts and to allow the researcher to clarify any unclear content and seek additional data after reviewing the notes or transcript of the initial interview.

All initial and follow-up interviews were conducted by the researcher via the telephone. The interview protocol (Appendix D) was followed for each participant, with the addition of appropriate probes for further information. The initial interview was

designed to take approximately 45 minutes to 1 hour, although this varied slightly by participant. The researcher took notes throughout the initial interview and reviewed these notes later to determine areas that were addressed in the follow-up interview.

The follow-up interview, taking approximately 10 to 15 minutes, was conducted approximately two weeks following the initial interview and before data analysis had begun. At this time, the researcher addressed and clarified information from the first interviews, and gave the participant time to share additional thoughts, feelings, and reactions regarding the study since the last phone contact. Participants were asked if they would like to review and comment on a draft of the final results.

All interviews (initial and follow-up) were audiotaped and transcribed verbatim by this researcher. Minimal encouragers, non-language utterances (e.g., um, uh, etc.), and any identifying information related to the participant or her/his client were excluded from the transcripts. Furthermore, each participant was assigned a code number to ensure confidentiality.

Procedures for Analyzing Data

Data were examined following the CQR method created by Hill, Thompson, & Williams (1997). As outlined above, data analysis contained three main steps. First, the research team developed an initial list of domains through the review of transcripts. After initial domain development, research team members assigned all data to one or more domains. After researchers independently coded data into domains, the research team met to arrive at consensus regarding the suitable domains for the data. Consensus versions (i.e., domain titles followed by raw data for each domain) were created for each case.

In the second major step of CQR data analysis, the research team constructed core ideas to summarize the content of each domain for each case. Research team members rotated the responsibility of developing core ideas to reduce the likelihood of biasing the results and met as a group to review and adjust core ideas until consensus was reached. After consensus regarding core ideas for each domain of a case were reached, the case was sent to the auditor to review whether all important data had been abstracted into core ideas and whether the core ideas were concise and accurate with respect to the raw data. Once the auditor's comments were returned, the research team addressed the feedback and reached consensus about whether to accept or reject each comment.

Cross analysis was the third step in CQR data analysis. At this point, the research team looked across the cores ideas of all cases, within each domain, to determine if there were parallels among the cases. In order to reduce bias within the analysis process, researchers again rotated the responsibility of developing a list of categories that encompassed each domain's core ideas across cases. These categories were brought back to the other research team members to review until consensus was reached. Additionally, frequency labels (i.e., general, typical, and variant) were applied to the data. Cross analysis was completed after a final review by the auditor(s) determined whether the core ideas fit well in the specified categories, whether the category labels were appropriate, and whether categories should be further divided or collapsed. Again, the researchers digested each of the auditor's comments and came to a consensus on whether to accept or reject them.

The remainder of the data and analysis process involved examining patterns or pathways that emerged in the data. The primary researcher looked to see if specific

categories in one domain aligned with specific categories in other domains. Patterns between general and typical categories across domains emerged and are discussed in the discussion section.

Results include the presentation of domains, associated categories, the number of cases that fit into each category, and one or two core ideas from each category. A summary of a prototypical case is included in the results, as well. Further discussion focuses on the meaning of the results, a comparison to previous literature on therapist self-disclosure, and ideas for future research.

Participants were invited to provide feedback on the results and discussion sections of the manuscript (see Appendix E). Five participants responded stating they had no additional feedback, and one of these participants noted a grammatical error, which was corrected.

IV: RESULTS

Contextual Findings

The findings from these questions appear in Table 1 (following this section). As a reminder, categories are labeled with the following frequency descriptors based on 12 cases total: General = 11-12 cases, Typical = 7-10 cases, Variant = 2-6 cases. Themes that emerged in only one case were moved to an "other" category. "Other" results are not described in this manuscript.

Therapist Self-Disclosure Training

Typically, participants reported that therapist self-disclosure was addressed and/or modeled during their clinical training/supervision. One participant stated that therapist self-disclosure specific to adolescents was frequently discussed in coursework and clinical experiences, while another participant noted that general therapist self-disclosure (not adolescent-focused) was addressed in training but not emphasized. Variantly, therapist self-disclosure was minimally addressed or not addressed at all in graduate school training. One participant said that self-disclosure was never addressed in coursework and was only briefly mentioned in practicum training.

When asked to describe the messages about therapist self-disclosure conveyed through training, participants' responses fell into three variant categories. In some instances, participants reported that therapist self-disclosure was discouraged in graduate school and other training experiences. One participant recalled her professors saying that therapist self-disclosure was not a good therapeutic tool to use in therapy. Others variantly received mixed messages about the appropriateness of therapist self-disclosure. One participant recalled receiving competing messages from supervisors regarding the

use of therapist self-disclosure: One supervisor encouraged its use while another said therapist self-disclosure was never necessary. Still others received the message that therapist self-disclosure should be used thoughtfully. One participant was encouraged in training to think carefully about when and why he would use therapist self-disclosure.

With respect to the effects of therapist self-disclosure training on participants' use of the intervention, responses fell into four variant categories. First, participants variantly indicated increased thoughtfulness about therapist self-disclosure. For instance, one participant shared how training influenced her belief that therapist self-disclosure should be planned and fully thought through prior to its use. Second, participants variantly discussed using less therapist self-disclosure and/or associating negative feelings with therapist self-disclosure. One participant recalled that he didn't trust himself to use therapist self-disclosure as a result of hearing stories from faculty about inappropriate use of therapist self-disclosure. Third, some participants variantly responded that training made them more comfortable using therapist self-disclosure. One participant reported that after seeing appropriate examples of therapist self-disclosure on internship and fellowship, she felt more natural using the intervention. Finally, some participants attributed their use of therapist self-disclosure to development rather than specific training. For example, one participant described how her application of therapist self-disclosure developed over time through clinical experiences with a variety of clients. Another participant stated, "I was still naïve after training… I had to develop my use of self-disclosure independently by trying it out in different situations."

General Views of Therapist Self-Disclosure with Adolescents

Participants' comments when describing their general view of therapist self-

disclosure clustered into two areas: a) their use of therapist self-disclosure, and b) the effects of such use. With regard to use, participants typically noted that they used therapist self-disclosure carefully and with appropriate intentions. One participant, for instance, stated that therapists should think through the ramifications of using therapist self-disclosure, such as how it can change the relationship. Another participant highlighted the importance of considering how the self-disclosure applied to the therapeutic situation and whether the self-disclosure was relevant to the goal or topic being addressed in therapy. Also, participants typically responded that therapist self-disclosure should be used in cases where it would benefit the client, not the therapist. One participant mentioned that he only used self-disclosure when it would help the adolescent with a presenting issue. Another individual discussed a commitment to using self-disclosure without expecting personal benefit, stating that it would be inappropriate to self-disclose in order for the therapist to get something from the relationship. Variantly, participants noted that they used therapist self-disclosure in moderation. For example, one participant felt that therapist self-disclosure had a greater impact when used only when needed. Additionally, participants variantly stated that they refrained from using therapist self-disclosure to build the relationship early in psychotherapy. In one case, a participant asserted that tools other than therapist self-disclosure should be used to build the relationship (because therapist self-disclosure should not be used until the therapist knows the patient well). Variantly, participants felt it was appropriate to use therapist self-disclosure to convey benign/superficial information (while sharing more personal information should be strictly limited). One participant stated that he drew a strong line about self-disclosing personal values as that could shift the focus onto the therapist, but

he has self-disclosed about a family pet. Participants also variantly addressed how their use of therapist self-disclosure has changed over time. As one example, a participant discussed using therapist self-disclosure more judiciously later in her career after encountering situations where therapist self-disclosure did not go well.

The second cluster of results focused on the perceived impact of therapist self-disclosure. Here, participants typically asserted that therapist self-disclosure with adolescents could have positive effects. For instance, one participant shared that when therapist self-disclosure was used appropriately, it could enhance the therapeutic interaction by helping the client feel the therapist's empathy. Another participant discussed therapist self-disclosure as a powerful tool that could increase motivation in adolescents and help them connect with their therapist. Variantly, participants noted that therapist self-disclosure could have negative effects. One participant mentioned that therapist self-disclosure with adolescents has the potential to blur boundaries and create a social relationship rather than a therapeutic one. Another participant indicated that self-disclosing a shared experience with an adolescent could invalidate the adolescent's experience.

Frequency of Therapist Self-Disclosure

Three variant categories emerged regarding the frequency with which participants used therapist self-disclosure with adolescents: frequent use (at least once a session), moderately frequent use (approximately once a week to several times a week), and infrequent use (once or twice a month).

Therapist Self-Disclosure Antecedent/Intention

Multiple categories emerged when participants shared what stimulated their use of

self-disclosure and what their intentions were for using therapist self-disclosure with adolescents. Although these topics were queried separately in the interviews, data analysis revealed significant overlap in the categories. Thus, antecedents for therapist self-disclosure and intentions for self-disclosure were collapsed into one domain. Generally, participants noted the goal of strengthening the therapeutic relationship. For example, participants mentioned using therapist self-disclosure when they sensed that an adolescent wanted to connect with the therapist and when they (participants) wanted to increase an adolescent's "buy-in" to therapy. Other participants discussed building trust, rapport, and validating the client through the use of therapist self-disclosure. Participants generally used self-disclosure to normalize clients' experiences. One participant talked about using normalizing self-disclosures when working with adolescents who were concerned about the stigma of a diagnosis. This participant discussed using self-disclosure to depathologize an adolescent's situation and convey that the client's experience was a normal part of development. Participants also generally responded that they used therapist self-disclosure to model/teach. As an example, one participant asserted that therapist self-disclosure could demonstrate useful strategies in a concrete way (e.g., sharing that the participant had to adjust to wearing braces as a concrete example of habituation for an anxious client). Generally, participants also shared their reactions and/or feelings about therapy or the adolescent. For example, one participant discussed using therapist self-disclosure to convey happiness and reinforce a client's positive behaviors. Another participant mentioned that he self-disclosed observations and reactions when adolescents made poor choices about relationships or school. Typically, participants used therapist self-disclosure when they felt stuck. One participant discussed

using therapist self-disclosure to shift and move therapy along when the participant or client was feeling frustrated and "couldn't see a way out." Participants also typically used therapist self-disclosure to help an adolescent gain perspective and/or insight. One participant stated that by sharing a self-disclosure with an adolescent who was having difficulty seeing the perspective of another, he could help the client better understand himself and build the adolescent's ability to empathize. Another typical response included a range of other means to facilitate treatment. Examples included using therapist self-disclosure to achieve treatment goals and to encourage adolescents to share more. Finally, participants variantly responded that therapist self-disclosure could facilitate treatment by answering a client's questions. For example, one participant noted that he has self-disclosed by answering questions regarding marital status or children.

Factors Affecting Therapist Self-Disclosure

Participants shared a variety of factors that affected their use of therapist self-disclosure, with client pathology emerging as a general response. More specifically, participants typically used less therapist self-disclosure with clients who demonstrated severe psychopathology (including Axis II diagnoses and boundary issues) than they did with clients who did not demonstrate personality disorder characteristics or boundary issues. For example, one participant stated that she was very hesitant to use therapist self-disclosure with clients who had characteristics of Borderline Personality Disorder because she believed doing so would set the client up for failure or be misinterpreted. Participants variantly responded that they were more likely to use therapist self-disclosure with clients who had Axis I diagnoses. For instance, one participant shared that he was more likely to use therapist self-disclosure with clients who were diagnosed

with adjustment and mood disorders.

Client age/developmental level was another general factor affecting use of therapist self-disclosure, one that included sub-categories. First, participants variantly responded that they used therapist self-disclosure more frequently with older children/adolescents than they did with younger children. For example, a participant discussed increased self-disclosure with adolescents based on his belief that adolescents have identities that are more formed than younger children and can therefore understand and process self-disclosures more easily. Other participants, however, variantly responded that they would be more likely to use therapist self-disclosure with younger children. One participant explained that she was more likely to disclose to a younger child because a younger child needs more concrete, direct modeling (while an adolescent could understand other techniques better and does not need therapist self-disclosure to aid understanding). Participants also variantly stated that the content of their self-disclosure was affected by developmental level/age. One participant indicated that he used self-disclosures that involved advice and direct feedback with clients whose developmental level was lower than their biological age. One participant stated, "I use self-disclosure with adolescents because they are able to think about the self-disclosure more abstractly and make sense of it due to their developmental maturity." Participants variantly reported a range of other demographic variables (gender, SES, culture) that affected their use of therapist self-disclosure. For example, one participant noted that she was more likely to use therapist self-disclosure with adolescents from lower socio-economic backgrounds as they faced more barriers to accessing therapy. Another participant shared that when he works with adolescents or families who hold strong religious convictions, he is very

careful about disclosing his personal religious beliefs.

In addition to client factors, participants also noted that their own characteristics typically affected their use of therapist self-disclosure. For example, one participant discussed using her values and internal "gut test" to determine whether therapist self-disclosure was appropriate. Another participant shared how his behavioral and cognitive-behavioral orientation influenced his use of therapist self-disclosure as reinforcement with adolescents.

Finally, the strength of the therapy relationship also variantly affected participants' use of therapist self-disclosure. For example, one participant indicated that she used therapist self-disclosure more frequently after the therapeutic relationship was established, as that was when she was able to better understand the adolescent's therapeutic needs.

Examples of Therapist Self-Disclosure

Generally, participants self-disclosed previous experiences from their lives to adolescents. One participant indicated that he would share previous personal experiences such as the death of a loved one or transferring schools if an adolescent client had a similar experience. Other participants talked about disclosing situations where they felt anxious or experiences involving their struggle for independence when they were teens. Also, participants generally used self-disclosures of their reactions to clients or to the therapy experience. For instance, one participant stated that she disclosed feelings of sadness when adolescents had difficult experiences. Another participant discussed process disclosures about truthfulness in response to inconsistencies in clients' words and affect. Additionally, participants typically self-disclosed techniques and/or strategies they

had used. One participant shared how she learned to intervene in her thought processes to combat sleep difficulties. Another participant disclosed examples of triggers for anger and the strategies he employed to deal with anger. A final variant category involved self-disclosures of benign autobiographical information (this category differs from self-disclosing prior experiences in that it is simple information about the therapist rather than past life experiences). As illustrations, therapists shared their favorite color or movie, marital/family status, and sports interests.

Table 1. Domains, Categories, and Frequencies of Contextual Findings

Domain	Category	Frequency
1. Training		
a. Was TSD addressed?	Addressed/modeled during clinical training/supervision	Typical
	TSD not/minimally addressed in graduate school	Variant
b. Messages conveyed in training	TSD discouraged in graduate school/training	Variant
	Mixed messages about appropriateness of TSD	Variant
	Use TSD thoughtfully	Variant
b. Perceived Impact of TSD	TSD can be useful/positive	Typical
	TSD can have negative effects	Variant
2. Effects of TSD Training on Use of TSD	Participant is thoughtful about TSD	Variant
	Participant uses less/associates negative feelings with TSD	Variant
	Increased participant's comfort/usage of TSD	Variant
	Participant attributes use of TSD to development rather than specific training	Variant
3. TSD Frequency	Frequently	Variant
	Moderately Frequently	Variant
	Infrequently	Variant
4. TSD Antecedent/Intention	To build/strengthen the therapeutic relationship	General
	To normalize client's experiences	General
	To model/teach	General
	To share participant's reactions/feelings about therapy or the client	General
	As a therapeutic tool to get unstuck	Typical
	To help client gain perspective/insight	Typical
	Other means to facilitate treatment	Typical
	To answer client's questions	Variant

5. Factors affecting TSD	Client pathology	General
	Less TSD with clients with severe psychopathology	Typical
	Participant uses TSD with clients who have Axis I diagnoses	Variant
	Client age/developmental level	General
	Increased frequency of TSD with older children/adolescents	Variant
	Increased frequency of TSD with younger children	Variant
	Content of TSD affected by developmental level (more concrete with lower developmental level)	Variant
	Participant's characteristics	Typical
	Strength of therapeutic relationship	Variant
	Client demographics/needs (race, SES, gender)	Variant
6. Examples of TSD	Previous experiences from participant's life	General
	Participant's reactions to client/therapy	General
	Techniques/strategies therapist used	Typical
	Benign personal/autobiographical information about therapist	Variant

Note. 12 cases total. General = 11-12, Typical = 7-10, Variant = 2-6

Therapist Self-Disclosure Event Findings

Participants were asked to share an example of therapist self-disclosure that occurred in individual therapy (fourth session or later) with an adolescent client. Participants fully described the event including what happened before, during, and after the self-disclosure. The findings based on these questions appear in Table 2 (following this section).

Nature of Therapy

Prior to the therapist self-disclosure event, participants were variantly addressing family-related issues with clients. In one case, the participant worked to improve poor communication between an adolescent and a parent. Participants variantly taught clients techniques, such as relaxation skills and thought challenging. In addition, they variantly worked to build the psychotherapy relationship or educate clients about the therapy process. In efforts to build a comfortable relationship, for example, one participant spent considerable time with an adolescent addressing the client's concerns about social stigma related to attending therapy. Variantly, participants had used therapist self-disclosure with the client prior to this particular therapist self-disclosure event. Finally, clients had variantly talked about prior experiences in therapy and its impact on the current therapeutic environment.

Therapy Relationship Prior to Therapist Self-Disclosure Event

Participants typically described the relationship as strong prior to the therapist self-disclosure event. In one case, the participant reported that the adolescent viewed her as reliable and having the adolescent's best interests at heart because the two of them had weathered the crisis of a school expulsion. Another participant described a slowly

forming relationship where the participant and client had built a collaborative and supportive bond. In contrast, participants variantly described a tenuous relationship prior to the self-disclosure event. One participant described a relationship in which the adolescent viewed therapy as a punishment from the parent and prioritized other activities over therapy. In another case, a participant noted that the client was hesitant and distrustful of therapists because she did not want to be perceived as weird or sick.

Timing of Therapist Self-Disclosure Event

In six cases, the therapist self-disclosure event occurred in the 4th through 10th sessions, three cases involved therapist self-disclosure events in the 11th through 20th sessions, and three cases involved events in the 21st session or later. This researcher would have liked to characterize these results as occurring early in therapy, middle of therapy, or end of therapy, but many participants were still working with the clients, making it difficult to classify results in this manner. Within the session in which the therapist self-disclosure occurred, six participants reported self-disclosing in the beginning of the session, four participants reported doing so in the middle of the session, and the final two participants could not remember the timing of the self-disclosure event within the session.

Therapist Self-Disclosure Event Antecedent/Intention

Participants discussed what led to the self-disclosure and their intentions behind delivering the self-disclosure. As mentioned earlier, although participants were asked about these topics separately, significant overlap between antecedent and intention led researchers to combine them into one domain. Typically, participants used the therapist self-disclosure to model or teach adolescents who were struggling with something. For

example, one participant wanted to model the importance of finishing high school and transitioning to college for an adolescent who was the first in her family to pursue a college education. Another participant, who was working with an adolescent struggling to engage in therapy, wanted to demonstrate that techniques taught in therapy were applicable to non-crisis situations and could be used proactively in everyday life. Participants also typically used therapist self-disclosure as a therapeutic tool to get unstuck when therapy felt stagnant. In one case, a participant felt that she had "hit a wall" in helping the adolescent make a connection between self-esteem and relationship choices. In another case, an adolescent was feeling stuck because she had not made progress on her anxiety, and the participant felt that self-disclosure was a way to stop the adolescent from thinking of anxiety as unmanageable and something she must live with forever. In addition, participants typically responded that the self-disclosure was used to help a client gain perspective and/or insight when clients were struggling to make connections in therapy. For instance, one participant used self-disclosure to explore how an adolescent's mental health problems were prohibiting him from getting a job. Another participant wanted to deviate from negative feedback provided by the adolescent's parent, so the participant used self-disclosure to show the client a new, positive perspective. Participants variantly used self-disclosure to convey their understanding to the adolescent client. For example, one participant noted that he wanted to acknowledge the client's opinion and value the client's experience. Another variant intention/antecedent was to normalize when clients were felt alone or stigmatized. In one case, the participant wanted the adolescent, who was feeling that no one else could understand his struggle, to understand that everyone has struggles, challenges, and things to work on. Participants

also variantly used therapist self-disclosure to build and/or strengthen the therapeutic relationship. More specifically, a few participants discussed a desire to increase clients' "buy-in" to therapy through self-disclosure. Finally, participants variantly noted that the disclosure was spurred by the client challenging the participant. In one case, the adolescent client was confronting the therapist, saying therapeutic techniques did not work and that the participant could have no idea what the adolescent was going through.

Content of Therapist Self-Disclosure

Typical therapist self-disclosure content included participants' previous life experiences. One participant self-disclosed a disappointing experience where she was not selected for an advanced soccer team. Another participant disclosed how her time in high school felt boring, mundane, and unchallenging; the same participant also shared how college was freeing because she chose what to study and was able to engage in critical thinking and enlightening discussions. In addition, participants typically shared techniques and/or strategies they used. For instance, one participant disclosed how he thought through his anger response and the techniques he used to handle frustration (deep breathing, walking away, etc.). In another case, a participant disclosed the choices and changes she made to lose weight. Variantly, participants' self-disclosure events involved sharing their reactions to the adolescent client or to therapy. For example, one participant responded to a client's struggle to complete high school by self-disclosing her feelings that the adolescent should look beyond high school. The participant went on to say that she agreed that high school can be boring, but "would hate for [the adolescent] to get stuck in high school and never get to experience college."

Factors Affecting Therapist Self-Disclosure Event

Typically, participants felt that their self-disclosure was appropriate for the adolescents' developmental and functional levels. One participant discussed how the client's understanding of the therapist's role and the client's emotional stability allowed the client to handle the participant's self-disclosure. Another participant felt that the client was developing insight and was therefore an appropriate recipient of the participant's self-disclosure. Participants variantly indicated that a strong psychotherapy relationship and/or appropriate boundaries affected their event. One participant shared that the adolescent had not demonstrated poor boundary issues, so the participant felt it was acceptable to use therapist self-disclosure. Another participant shared her feelings that the therapeutic relationship and rapport were strong enough that she could self-disclose without damaging the relationship. Other participants variantly noted the adolescent's diagnosis/stressors as affecting the disclosure. In one case, the adolescent client had poor social skills and a lack of family and social support, so the participant felt compelled to self-disclose to help the client succeed. The self-disclosure events were also variantly affected by therapy being stuck. One participant discussed how he had "hit a dead end" with the client and needed therapist self-disclosure to get his point across. An additional variant response included participants sensing the need to build the relationship through therapist self-disclosure. For instance, one participant felt that the adolescent client was taking a risk by disclosing her symptoms, so the participant thought it appropriate to share something in return to build trust and rapport. A final variant factor was the presence of a shared experience between the participant and the adolescent. In one case, a participant noted similarities in relationship patterns between his life and the client's life, which swayed him to self-disclose.

Effects of Therapist Self-Disclosure Event

Effects on client. Generally, the therapist self-disclosure seemed to affect the client positively. In all cases, the self-disclosure helped clients achieve treatment goals, increase insight, or change perspective. One participant shared how the self-disclosure event increased the adolescent's ability to draw connections between self-esteem and her relationship choices. In another instance, the client was able to identify thoughts and triggers that contributed to her anxiety and was able to lower anxiety levels. Typically, clients shared more following the therapist self-disclosure. For example, one client became more able to ask for help and support and appeared less guarded following his therapist's self-disclosure. Following one participant's self-disclosure about personal anger issues and techniques used to combat anger, the adolescent client began to explore his own experiences with anger and what he could do in situations when he felt angry. Finally, participants variantly responded that self-disclosure prompted the clients to feel that they were normal, which then promoted relief or hope. In one case, the adolescent moved past feeling overwhelmed by decisions to be made and began to see how she could have unique experiences that were appropriate despite being different from the experiences of others.

Effects on participant. Participants generally reported that they experienced positive effects of the self-disclosure. As a positive sub-category, they typically reported a positive emotional impact. For example, one participant felt more comfortable and appreciated by the client following her self-disclosure. As another sub-category, participants variantly believed that their therapist self-disclosure was a positive intervention, which they felt was useful. For instance, one participant thought that

therapist self-disclosure was the right choice for that moment in therapy. However, participants variantly felt that the self-disclosure event had little or no impact on them. In one case, a participant commented that the event had no positive or negative effect.

Effects on therapy relationship. Participants typically responded that the relationship was strengthened or there was an increased investment in therapy following the therapist self-disclosure. One participant shared that the event helped solidify the therapeutic relationship and took it to the "next level" to become deeper. In another case, the participant felt that the self-disclosure provided an additional therapeutic dimension in which the participant and the adolescent could jump into action and use what they had already accomplished together in therapy. Some participants variantly responded that that the self-disclosure had no effect on the relationship. In those cases, however, the participants noted that the relationship was already solid.

Table 2. Domains, Categories, and Frequencies of Therapist Self-Disclosure Event Findings

Domain	Category	Frequency
1. Nature of Psychotherapy		
a. Course Prior to TSD	Addressed family related issues	Variant
	Taught client techniques	Variant
	Relationship building/Education of therapy process	Variant
	Participant used TSD with adolescent prior to TSD event	Variant
	Client had worked with another therapist prior to TSD event	Variant
2. Therapeutic Relationship Prior to TSD Event	Strong relationship	Typical
	Tenuous relationship	Variant
3. Timing of TSD Event		
a. Session Number	Session 4 to 10	Variant
	Session 11 to 20	Variant
	Session 21 or after	Variant
b. Within Session	Beginning of session	Variant
	Middle of session	Variant
	Could not remember	Variant
4. Antecedent/Intention for TSD Event	To model/teach	Typical
	To get unstuck	Typical
	To help client gain perspective/insight	Typical
	To convey participant's understanding	Variant
	To normalize	Variant
	To build/strengthen the therapeutic relationship	Variant
	To respond to client challenging the participant	Variant
5. Content of TSD	Previous experiences from participant's life	Typical
	Techniques/Strategies participant has used	Typical
	Participant's reactions to client/therapy	Variant

Domain	Category	Frequency
6. Factors Affecting TSD Event		
	TSD was appropriate for client's developmental and functional level	Typical
	Strong psychotherapy relationship/appropriate boundaries	Variant
	Client's diagnosis/stressors	Variant
	Therapy was stuck/tried other interventions	Variant
	Shared experience between participant and client	Variant
	Need to build relationship through TSD	Variant
7. Effects of TSD Event		
a. Effects on Client	C moved toward achievement of treatment goals/prompted insight or change in perspective	General
	Client opened up/shared more	Typical
	Client felt more normal, which promoted hope/relief	Variant
b. Effects on Participant	Positive	Typical
	Emotional impact	Typical
	TSD was useful	Variant
	Little/No impact of TSD	Variant
c. Effects on Relationship	Strengthened relationship/increased investment in therapy	Typical
	No effect but relationship already solid	Variant

Note. 12 cases total. General = 11-12, Typical = 7-10, Variant = 2-6

Closing Findings

The closing questions allowed participants to reflect on their experiences and offer any additional information they felt was pertinent to the study. The findings based on these questions appear in Table 3 (following this section).

Effects of Interview on Participant

Participants typically responded that they found the interview helpful and that it stimulated reflection and/or increased their attention to therapist self-disclosure. One participant shared that the interview brought therapist self-disclosure to the forefront of her mind and that she would continue to think about therapist self-disclosure in upcoming sessions and be more aware of her actions. Another participant responded that the interview was helpful because it caused him to reflect and critically evaluate the process of treatment and how he used therapist self-disclosure.

Motivation for Study Participation

Typically, participants stated that they wanted to help the researcher or research. One participant recalled that others had participated in her dissertation, so she felt it was only fair to participate in others' research. Another participant agreed to be interviewed because he wanted to help push the discipline forward and contribute to research. Participants variantly responded that they participated because they thought the topic was interesting or important. For instance, one participant commented that although she personally thought therapist self-disclosure was helpful, she believed it was important to find out how other therapists use self-disclosure. Finally, some participants variantly agreed to be involved in the study because they were asked.

Table 3. Domains, Categories, and Frequencies of Closing Findings

Domain	Category	Frequency
1. Effects of Interview	Helpful, stimulated reflection/increased attention to TSD	Typical
2. Reason for Participation in Study	Wanted to help researcher/research	Typical
	Thought topic was interesting/important	Variant
	Was asked	Variant

Note. 12 cases total. General = 11-12, Typical = 7-10, Variant = 2-6

Illustrative Example of Therapist Self-Disclosure Event

The following content describes one particular participant's experiences of a therapist self-disclosure event. This example was chosen as it illustrates a variety of the general and typical findings presented in the previous sections of this chapter. To maintain the participant's confidentiality, slight changes have been made to demographic information as well as to the experience itself. The participant (Beth) and the client (Carrie) have both been assigned pseudonyms.

Beth was a 31-year-old Caucasian woman with her doctorate in clinical psychology. She was working as a Licensed Practicing Counselor at the time of the event, with 7 years of supervised clinical work with children (2 years as a licensed counselor). She identified her theoretical orientation as integrative with a focus on cognitive behavioral interventions. Her client, Carrie, was a 16-year-old, African American female who presented with social anxiety and depressive symptoms. Beth had been working with Carrie in outpatient, biweekly therapy for three months prior to the self-disclosure event. Therapy had initially focused on building a relationship and providing Carrie with relaxation techniques. Beth described the relationship prior to the self-disclosure event as strong. She felt that appropriate boundaries were in place and that she and Carrie enjoyed good rapport.

As therapy progressed, Carrie began to share more about her anxiety, which was contributing to significant school absences and abdominal pain. Beth recalled a similar experience she had in her childhood and began to think about self-disclosing to Carrie, particularly because it seemed that Carrie was stuck and feeling as though she would never be able to cope with her anxiety. In the therapist self-disclosure event, then, Beth

sought to normalize Carrie's experience and model additional coping strategies. Specifically, Beth wanted Carrie to know that she could make progress on the anxiety and that others (including Beth) have felt similarly.

After considering the implications of disclosing, Beth shared that as an adolescent, she too would get anxious and develop abdominal pain. Beth went on to share a particular example when she felt anxious at the grocery store. She also shared her feelings of embarrassment and racing thoughts related to her anxiety. Beth then described how strategies such as deep breathing and challenging her anxious thoughts helped her overcome her anxiety. When asked about the factors that influenced her decision to self-disclose, Beth stated that she considered the client's diagnosis of anxiety, the strong therapeutic relationship with appropriate boundaries, and Carrie's level of insight.

Following Beth's self-disclosure, she noted that Carrie appeared relieved, opened up other areas of discussion, and disclosed to Beth additional thoughts and fears related to her anxiety. In addition, Carrie made significant progress in treatment as her self-confidence improved and her anxiety decreased. She developed further insight into how her anxiety was related to events that happened in her family. Beth also experienced positive effects from the event: She felt good that the self-disclosure had been useful and felt that she had been able to help Carrie. Finally, Beth indicated that her self-disclosure strengthened the therapeutic relationship and increased Carrie's trust in Beth and in therapy.

V: DISCUSSION

In this chapter, contextual findings (i.e., those related to participants' overall experience with and use of TSD, and thus not related to the specific event they later described) are presented first. These results include information on therapist self-disclosure training, client characteristics that affect use of therapist self-disclosure, and the relationship between therapist motivation and self-disclosure content. These findings are followed by discussion of participants' examples of a specific event in which they used therapist self-disclosure with an adolescent in individual therapy. Results are discussed with respect to the impact of the therapeutic relationship on the motivation for disclosure and the therapist self-disclosure content. Motivation for participation and effects of the interview on participants are briefly addressed. The final sections of this chapter focus on the limitations of this study and the implications for therapy and future research.

Of note, due to the limited empirical literature on therapist self-disclosure with adolescents, the research on therapist self-disclosure with adults and the theoretical literature on therapist self-disclosure with children were used as a reference point for the discussion of this study's findings.

Contextual Findings

Participants discussed their general use of therapist self-disclosure and representative examples of disclosures they use in therapy with adolescents. Participants largely felt that it was important to use therapist self-disclosure carefully and for the benefit of the client. Most participants had some level of training on therapist self-disclosure and felt that the intervention can be beneficial. Participants considered the

pathology and developmental level or age of the client when using therapist self-disclosure, and then disclosed previous life experiences, techniques/strategies, and reactions to clients or therapy in order to normalize, model/teach, build the therapeutic relationship, get unstuck, and share reactions to help the client gain perspective or insight.

Overall, many of these findings are consistent with those from studies on the use of therapist self-disclosure with adults: Therapist self-disclosure has been demonstrated as a way to normalize client experiences (Edwards & Murdock, 1994), teach strategies for coping with stress (Lane, Farber, and Geller, 2001), develop the therapeutic relationship (Derlega, Margulis, & Winstead, 1987), help clients make positive changes in their lives (Knox, Hess, Petersen, & Hill, 1997), and share reactions to a client or the therapeutic process as a way to promote insight (Lane et al., 2001). It seems, then, that these participants' use of therapist self-disclosure with adolescents paralleled the extant literature on therapist self-disclosure with adults. Perhaps the developmental differences between adolescents and adults were not substantial enough to produce differences in the use of the intervention. While research demonstrates vast developmental differences between young children (e.g., a 5-year-old) and adolescents (Erikson, 1959; Piaget, 1972), adolescents possess many of the same cognitive skills as those held by adults (e.g., hypothetical and deductive reasoning, consideration of multiple perspectives). Given such similarities, therapists may have assumed that using therapist self-disclosure with their adolescent clients would have comparable results as it does with adult clients. In addition, the majority of participants indicated that therapist self-disclosure was addressed in their training, but they did not recall training specific to therapist self-disclosure with child and adolescent clients. Perhaps without specialized training or

instruction on using therapist self-disclosure with children, participants were more apt to apply therapist self-disclosure in a general manner or as they would with adult clients. Furthermore, although participants in this study shared experiences using therapist self-disclosure with adolescents that paralleled the adult literature, it is possible that therapists' internal processes (which may not have been fully explicated in the interview process) may be different when disclosing with adolescents versus adults. Thus, although these disclosures may have looked, to an external observer, quite similar to those shared with adult clients, participants' internal processing leading to these disclosures may have been very different. Participants may, for instance, have considered recipients' age or developmental level, considerations less likely to have been present with adult clients. Such factors may not have altered the disclosures themselves, but may indeed have been part of therapists' internal processing prior to delivering the intervention.

Although many of this study's results parallel the research on therapist self-disclosure with adults, closer examination reveals interesting findings regarding therapist training, client psychopathology and age/developmental level, and the connection between the motivation for therapist self-disclosure and what participants disclosed.

Therapist Self-Disclosure Training

With respect to training, most participants reported that therapist self-disclosure was addressed at least to some extent during their training. However, they received inconsistent messages (i.e., some participants were told never to use or were discouraged from using therapist self-disclosure, others were told to use it thoughtfully) regarding the use of therapist self-disclosure. Thus, in spite of research supporting the benefits of therapist self-disclosure (Delega, Margulis, & Winstead, 1987; Edwards & Murdock,

1994; Lane, Farber & Geller, 2001; Knox, Hess, Petersen, & Hill, 1997), none of the participants reported training experiences that specifically encouraged them to use the intervention. Given the conflicting messages regarding the use of therapist self-disclosure, participants seemed to resort to relying on their own experiences and development to determine whether, or when, to use the intervention... and they often found it a useful clinical tool.

One wonders why educators would hesitate discuss the appropriate use of therapist self-disclosure. Perhaps they were concerned that new clinicians would overuse therapist self-disclosure and risk blurring the boundaries between therapy and development of a social relationship. Therapist training focuses on the development of a variety of skills (e.g., reflections, restatements, interpretations, self-disclosures; Hill & O'Brien, 1999), but self-disclosure is something that likely occurs commonly in non-therapeutic conversation. Therefore, perhaps those involved in training clinicians feared that new therapists would have difficulty distinguishing between a social, and a therapeutic relationship. An alternative explanation is that educators may be unaware of literature supporting the use therapist self-disclosure.

The Role of Client Characteristics

Psychopathology. Most participants noted using therapist self-disclosure less frequently with clients who demonstrated severe psychopathology, such as psychosis or boundary issues, but were relatively more comfortable using the intervention with clients who have Axis I diagnoses (e.g., mood disorders, anxiety). Clients with psychosis or boundary issues may more likely misinterpret a therapist's self-disclosure than clients who suffer from milder diagnoses, and thus therapists exhibit more caution using

therapist self-disclosure with more disturbed clients. Similarly, Dryden (1990) warned therapists against disclosing to patients who may use the information to harm themselves or the therapist. For instance, clients who are not able to process ideas in a logical manner or may misinterpret the disclosure (e.g., perceiving disclosure of personal information as a romantic advance) would likely not be suitable candidates to receive a self-disclosure. Therapists have also reported that they avoid therapist self-disclosure with adults if it will confuse the client, blur boundaries, or overstimulate the client (Edwards & Murdock, 1994).

Developmental level/age. In addition to considering the client's psychopathology, all participants felt that a client's age or developmental level influenced their use of therapist self-disclosure. Specifically, they used concrete, skill-based self-disclosures to model/teach strategies to younger children or clients who function at a lower developmental level. With adolescents, they used a variety of self-disclosures (e.g., self-involving disclosures, disclosures of experiences, etc), given their more developed cognitive and interpersonal abilities than younger children.

These findings echo Gaines's (2003) theoretical assertions that therapist self-disclosure should be tailored based on developmental level, as cognitive and emotional abilities vary depending on an individual's developmental stage. Gaines suggested that younger children, for example, receive therapist self-disclosure as a concrete way to learn skills (e.g., gain strategies for how to handle being teased by hearing what worked for the therapist). Adolescents, on the other hand, are in the process of identity development (Erikson, 1959) and have increased ability for hypothetical and deductive reasoning, which allows them to consider possibilities from multiple perspectives (Piaget, 1972).

With adolescents possessing more advanced cognitive abilities, perhaps participants viewed adolescents as more able to process more complex, self-involving self-disclosures (e.g., therapists' reaction to an adolescents' interpersonal style in therapy). When therapists disclose their experience of adolescent clients or the therapy process, adolescents are naturally more likely to be able to consider the therapist's perspective due to their developing cognitive skills.

Relationship Between Motivation and Therapist Self-Disclosure Content

As might be expected, clear connections emerged between therapists' motivation to self-disclose and the actual content of their disclosures. Participants were motivated to self-disclose when they wanted to normalize client struggles, model or teach, build or strengthen the therapeutic relationship, help the client gain insight, provide feedback to the client, or get therapy "unstuck." Participants' self-disclosures themselves fell into three main categories: self-disclosures of past experiences similar to a client's situation, self-disclosures of techniques/strategies participants found helpful, and self-disclosures of reactions to clients or the therapy process. These specific types of therapist self-disclosure appeared to arise directly from participants' motivations or intentions to disclose. This relationship is visually represented in Figure 1. The number of cases fitting into each category is displayed in parentheses. For example, of the twelve cases in which participants discussed being motivated to model or teach through self-disclosure, eight disclosed past helpful coping strategies. Of note, participants could identify multiple motivators and types of disclosure, and thus the numbers across categories exceed the number of participants.

Participants shared previous experiences and techniques or strategies found to be

helpful (the first two of the three types of therapist self-disclosures), for instance, when they wished to normalize client's struggles, model or teach. Perhaps participants felt that disclosing about a specific situation they too had faced would help the client feel as though the struggle was a normal situation that others, their therapists included, experienced. Thus, sharing a clear example of a struggle from the therapist's life, paired with the techniques that s/he found helpful in the situation, was a direct way to model or teach an adolescent client. Similar disclosures with adult clients (i.e., sharing past experiences and strategies for coping with difficult situations) have been identified as particularly effective at advancing treatment (Edwards & Murdock, 1994; Lane, Farber, & Geller, 2001). In addition, the motivation to use self-disclosure to model and teach by sharing strategies may have been driven by participants' predominant theoretical orientation, cognitive-behavioral. As mentioned earlier, Aaron Beck, the father of cognitive-behavioral therapy, viewed therapist self-disclosure as a way to role model and teach problem-solving skills (Beck, Freeman, & Associates, 1990). Additionally, past research indicates that behavioral and cognitive-behavioral clinicians are generally accepting of therapist self-disclosure (Goldfried, Burckell, & Eubanks-Carter, 2003).

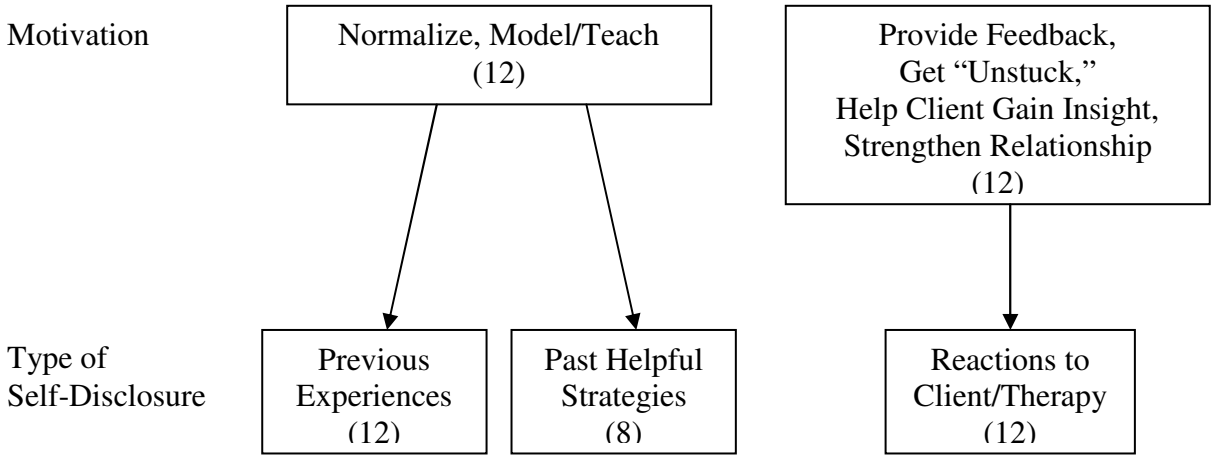
Participants used the third type of self-disclosure, self-involving disclosures (i.e., experiential disclosures related to the client or therapy process; McCarthy & Betz, 1978), to provide feedback, get therapy "unstuck," help the client gain insight, or strengthen the relationship. In fact, such disclosures were the only type used to get "unstuck" in therapy and to provide direct feedback about the client or the therapy process. Such an intention is not surprising, given such disclosures' immediacy and here-and-now nature (these disclosures can be a direct means to comment on current therapy process). In addition,

given the developmental changes adolescents experience (i.e., burgeoning self-awareness and growing ability for perspective taking; Piaget, 1972), therapists may have used these disclosures to help clients make insightful connections in their lives via reflecting on their interactions. These kinds of self-disclosures may guide clients to become more aware of how they communicate with their therapist and, by extension, other people in their lives. Additionally, participants may have felt that discussing their feelings toward clients or the therapy process would bring an underlying topic (e.g., feeling stuck in therapy or noting the client's hesitance to addressing a particular topic) to the surface so that the therapist and adolescent could address it. Clients may feel uncomfortable or uncertain about how to talk about what they experience in the therapy, or could be unaware of what is actually transpiring between themselves and their therapists. If the therapist offers a disclosure focusing on the therapeutic process, the client may then feel more comfortable discussing his or her feelings about the treatment process. Therapists, then, likely needed to make the first move for such conversations to occur. In doing so, perhaps therapists hope that their self-involving disclosure moves the treatment forward by fostering a conversation about the here-and-now therapy process occurring between the client and therapist, and thereby facilitating client insight. Overall, these findings demonstrate that the content of participants' disclosures was driven by specific intentions.

Self-disclosure with adolescents, then, does not appear to be something that these participants take lightly or use without significant forethought. Additionally, it seems that certain types of self-disclosure are viewed as more helpful than others when therapists are driven by specific intentions. Specifically, disclosures of therapists' past experiences and helpful strategies may be used when a therapist is trying to model/teach or normalize an

adolescent's experiences, while disclosing reactions to the client or therapy may be more effective when the therapist wants to get "unstuck" in therapy or provide direct feedback to the client.

Figure 1 Pathway for Motivation and Type of Self-disclosure.



Therapist Self-Disclosure Event Findings

Next, participants each shared a specific example of a therapist self-disclosure event that occurred in individual therapy with an adolescent. While they addressed some areas similar to those discussed in the contextual information section (above), additional patterns emerged within these findings.

These participants largely enjoyed strong therapy relationships with their adolescent clients prior to the therapist self-disclosure, revelations in which they shared previous life experiences or coping strategies used in times of difficulty. In using the intervention, participants weighed their clients' level of functioning, and then disclosed for appropriate therapeutic purposes (e.g., to teach, to build the relationship, to get unstuck, to promote insight), efforts that yielded beneficial effects for their clients, themselves, and the therapy itself.

Similar to the contextual results, many of these findings are consistent with those from studies on the use of therapist self-disclosure with adults (Delega, Margulis, & Winstead, 1987; Lane, Farber & Geller, 2001; Knox, Hess, Petersen, & Hill, 1997). As explained earlier in the discussion and further substantiated here, then, it appears that therapist self-disclosure is used quite similarly with adolescent and adult clients. Nevertheless, a deeper examination of these findings yields some unifying themes regarding the impact of the therapy relationship on why and what participants disclosed. Figure 2 visually depicts the pattern that emerged, with the number of cases in falling into each category displayed in parentheses. For example, of the nine cases in which a strong initial relationship was identified, six of those mentioned being motivated to use therapist self-disclosure to model or teach. Of note, participants could identify multiple motivators

and types of disclosure, and thus the numbers across categories may exceed the number of participants.

The Role of the Therapy Relationship

Strong therapy relationships. As noted above, the majority of participants initially identified strong relationships with their adolescent clients, and they shared their prior experiences or coping strategies to model or teach. In addition, and more intriguingly, they also shared their reactions to clients or to the therapy process in an effort to help clients gain perspective or insight. It may be, then, that once they were confident in the foundation of a strong relationship, they felt comfortable self-disclosing such personal information (i.e., their reaction to the client). Relatedly, the majority of the participants who identified having a strong relationship with their clients actually noted the strength of that relationship as one of the factors that affected their willingness to self-disclose. Such self-involving disclosures suggest that these participants felt safe sharing more here-and-now information than the participants who identified tenuous relationships with their clients (who disclosed only an experience similar to the adolescent's; see below). Some have suggested that such disclosures of immediacy (i.e., therapists' in-the-moment reactions to what is happening in therapy) may be more intense for therapists and clients, as these disclosures bring provocative and potentially more vulnerable topics (e.g., impact of clients' interactional patterns on therapy process) to the forefront for further discussion (Knox & Hill, 2003; Teyber, 2000). However, it is also possible that despite self-report of a strong relationship, participants may have disclosed personal reactions for other reasons that were left unstated. Therapists could have shared a reaction to meet their own emotional needs (e.g., sharing feeling of being stuck because the therapist was

frustrated and wanted to vent that feeling). For example, if the therapist was feeling frustrated with lack of progress in therapy or a client's unwillingness to address a certain issue, s/he may use a self-involving disclosure such as "I feel stuck" or "I feel as though you are avoiding an important topic," a disclosure potentially motivated more by the therapist's negative emotional reaction (e.g., frustration, anger) than by reasons in service of the client (e.g,, to increase client insight). If internal negative emotions were driving the self-disclosure, participants may have been hesitant to disclose such motivators, as they may have felt that such comments would reflect poorly on them.

In the adult therapy literature, self-involving disclosures or disclosures of immediacy may reassure clients (Hoffman-Graff, 1977), may be helpful in examining interactional patterns in therapy (Knox & Hill, 2003), and may stimulate more client self-referent statements, including those that attend to clients' role and behavior in therapy (Hendrick, 1987; McCarthy & Betz, 1978). However, not all research supports the idea that self-involving disclosures are useful. For instance, Knox et al. (1997) found that adult clients did not report self-involving disclosures as helpful, and Hill, Mahalik, and Thompson (1989) found that self-involving disclosures are only helpful when they are perceived by the client as reassuring and supportive.

Despite such mixed findings on the effects of self-involving disclosures, the participants' reports of effects in this study were largely positive. Participants indicated that clients became more open and achieved goals/insight, and therapists experienced positive feelings (optimism, comfort, appreciation). Perhaps because these disclosures occurred in the self-reported context of a strong relationship, the effects were more likely to be positive, rather than mixed as the literature suggests. In addition, the actual

language that participants used in their self-involving statements was also quite affirming: Therapists stated that they liked something the client was doing and seemed focused on helping clients understand an important issue (e.g., commenting supportively about a topic that the client had been avoiding). Perhaps, then, the very manner in which participants disclosed was received as supportive and genuine, and therefore also contributed to positive effects. Another possible explanation, of course, is that participants only shared examples in which they perceived that such disclosures had positive effects.

Tenuous therapy relationships. For the three participants who noted difficult relationships with their clients, those relationships had a substantial influence on the motivation to self-disclose, and also then on the content of the disclosure. Unlike the earlier group of participants who identified strong relationships with their clients, participants who disclosed in the midst of a tenuous relationship did so hoping that their self-disclosure would build or strengthen the relationship. Furthermore, they all disclosed a life event similar to what the adolescent client was experiencing. Effects of the self-disclosures were reported to be positive for both the participant and the relationship: The participants felt more "comfortable," "appreciated," "satisfied," and "optimistic" following their self-disclosure; they also reported that the relationship was strengthened as a result of the self-disclosure. Thus, the participants appeared to self-disclose about a prior experience similar to the adolescent's current experience in order to foster a stronger connection between themselves and their client, thus strengthening the tenuous therapy relationship.

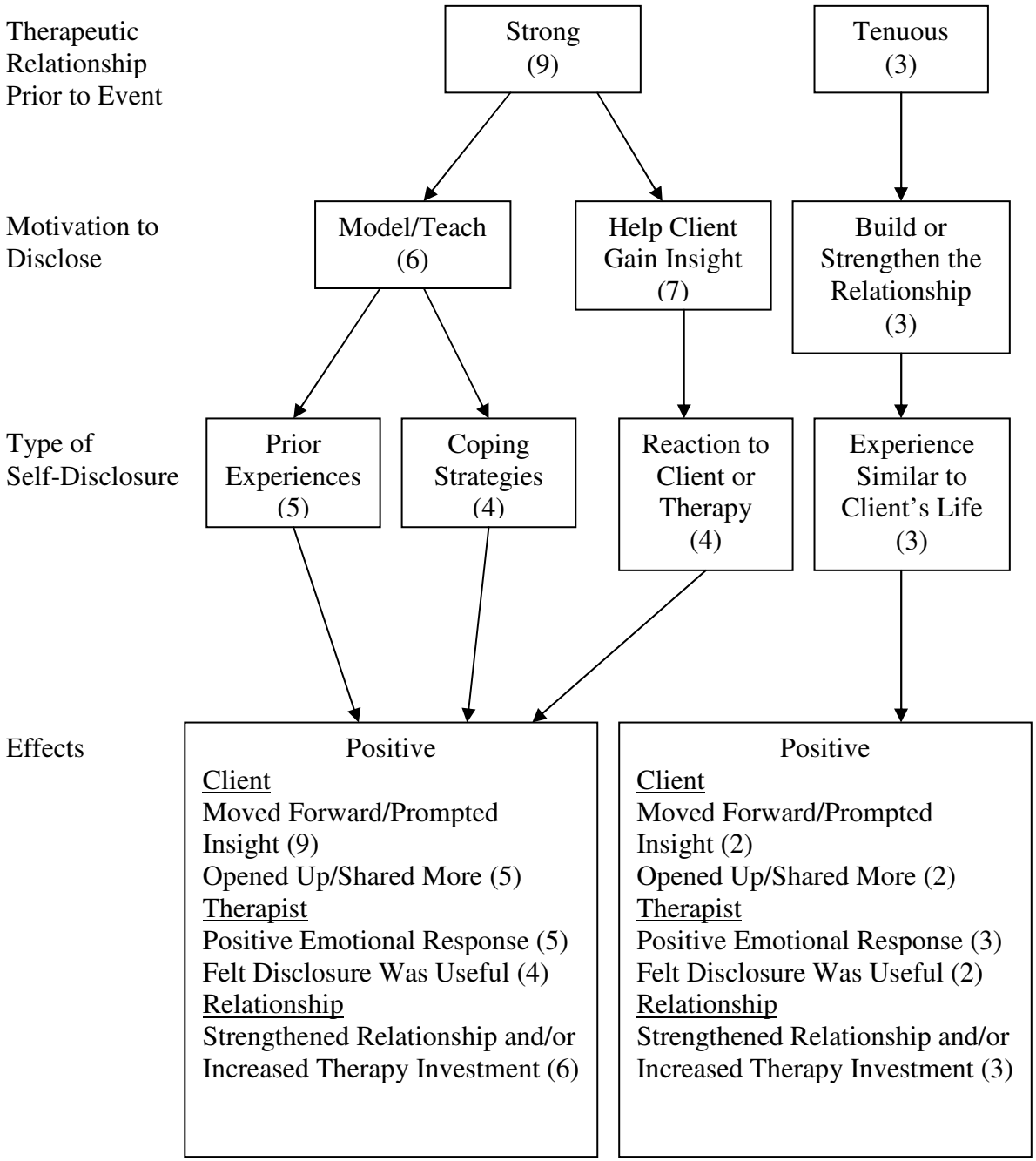
Sharing an experience similar to something in the adolescent's life is a personal

way to increase the perceived similarity between therapist and client, and may also enable clients to see the therapist as a whole person and not just as the "professional" therapist (Knox et al., 1997). In addition, such disclosures may enhance clients' belief that their therapists truly understand them, for they, too, have faced similar life events (Derlega et al., 1987). Intriguingly, the data also suggested that some participants felt a sense of urgency in self-disclosing, as if they feared jeopardizing the therapeutic relationship even more if they did not do something to quickly re-engage the client (Barish, 2004; Gaines, 2003). For example, one participant mentioned needing to "pry open the relationship" and join the client quickly because the client wasn't open to therapy. In such circumstances, the self-disclosure may have served as an expedient technique to save the already tenuous relationship.

Summary. Thus, all participants identified positive effects of their therapist self-disclosures, but their paths to achieve these effects were different. Participants who initially had strong relationships with their clients shared experiences and strategies, and more intriguingly, shared their reactions to clients or the therapy to "get unstuck," model or teach, or help the client achieve goals and insight. Participants who began with a tenuous therapy relationship disclosed previous life events to build or strengthen the relationship with their adolescent clients. Thus, both groups of participants felt they achieved what they set out to do (e.g., foster client insight, build the relationship), but did so by different means and with different intentions. It appears, then, that the initial relationship between client and therapist may influence the intention behind therapist self-disclosures, as well as the actual content of the disclosures. In relationships that are strongly established, therapists may be able to delve deeper into the here-and-now of

therapy by self-disclosing direct feedback to the clients about the interactional patterns occurring in therapy. When the relationship is on rocky footing, it may be beneficial for therapists to share prior experiences that are similar to the adolescent's experiences to bring the therapist and client closer together.

Figure 2 Pathway for specific event results based on relationship.



Closing Findings

In the final portion of the interview, participants reflected on their experience of the interview and shared their reasons for participating.

Experience of Interview

Participants found the interview helpful, with the majority commenting, as might be expected, that their participation stimulated reflection or increased their attention to therapist self-disclosure. Being interviewed about a skill used in therapy is a direct way to engage in vital reflection on one's practice. Participants' positive responses to the interview suggest that CQR can yield intriguing findings while also stimulating participant reflection.

Motivation for Study Participation

Participants' reasons for participating in this study were also unsurprising. Most participants wanted to help the researcher or research, and they often mentioned their own prior experiences recruiting participants. Others appeared to participate because they view research as a way to inform practice. Participants were also interested in the topic, likely stemming from their own experiences with therapist self-disclosure. Some of these reasons (e.g., desire to help another, interest in topic) are congruent with findings of past CQR studies (Knox, Burkard, Edwards, Smith, & Schlosser, 2008; Knox, Hess, Petersen, and Hill, 1997).

Limitations

This study is limited in that it is based purely on self-report (Schwarz, 1999). It only includes the retrospective account of the therapist, and participants were able to select the event they shared during the interview. Perhaps relatedly, participants shared

only events with positive or no effects. Thus, we do not know whether these participants never experienced negative effects of therapist self-disclosure with adolescents, or whether they just chose not to describe such events. Given the in-depth nature of the interview, perhaps participants would have felt uncomfortable talking about an event in which self-disclosure did not go well. It is also possible that participants' responses may have been influenced by social desirability (Haynes & Heiby, 2003): One can imagine that it would be easier to share positive than negative events when being interviewed. This researcher attempted to address this possibility by creating a comfortable interview environment in which all participants were reassured that results would be kept confidential. In addition, since participants were interviewed about a past experience, their responses were subject to retrospective recall errors. However, this researcher did attempt to minimize recall error by requesting that participants share an event that happened within the last two years. Results were also limited to the therapist's perspective. Perhaps clients would have a different recollection of the event shared by his/her therapist. In particular, the effects on the client were based solely on the therapist's perception. A client could outwardly receive a therapist's self-disclosure positively but could have had a different internal response. This limitation presents an area for future research.

Another limitation relates to the complexity of therapy. Therapy is an intricate web of conversation and therapeutic techniques that are continuously influenced by the personalities and experiences of the client and the therapist. Therefore, it is difficult to fully determine the effects of any one specific intervention. For example, a participant may believe that a client became more invested in therapy as a result of the participant's

self-disclosure, but it is possible that another intervention (such as teaching a helpful coping strategy) sparked the client's investment. The researcher attempted to address this limitation by asking a series of detailed questions about the event in order to gather significant background information about the therapist, adolescent, and their therapeutic history. In addition, this researcher focused data collection on the more immediate effects of the event rather than long-term effects, which are logically more likely influenced by additional therapeutic interventions and participant/client variables.

The results of this study may also be applicable only to therapist samples similar to those who participated (e.g., female, Caucasian, cognitive-behavioral, seeing clients in outpatient therapy), and thus should be applied more broadly with caution. For example, the majority of participants identified their theoretical orientation as cognitive-behavioral, which may have influenced the results. Past research indicates that behavioral and cognitive-behavioral clinicians are generally accepting of therapist self-disclosure when used to strengthen the therapeutic relationship and effect client change (Goldfried, Burckell, & Eubanks-Carter, 2003). However, other orientations, such as psychoanalytic, use significantly less self-disclosure than practitioners from other theoretical orientations (Edwards & Murdock, 1994; Goldstein, 1997; Lane & Hull, 1990). If the sample had represented a more heterogeneous group of theoretical orientations, the results may have been different.

The first author also conducted and transcribed all of the interviews, potentially giving her disproportionate influence over the data collection. However, efforts were made in data analysis to ensure more evenly distributed control over results. The responsibilities for developing domains, core ideas, and cross analysis, for example, were

rotated among the three primary research team members. Additionally, and consistent with the CQR method, all three primary research team members examined the data until consensus was reached. Additionally, the first author was a graduate student interviewing licensed master's- and doctoral-level therapists, reflecting an inherent discrepancy in power. It is possible that the information participants disclosed was influenced by the fact they were sharing this information with a graduate student, someone early in her career and still forming her identity as a therapist. Perhaps participants felt a sense of obligation to share a positive self-disclosure event and impart knowledge to the interviewer. On the other hand, some participants may have been more willing to discuss these events with a graduate student because they may have thought of her as someone outside their peer group.

Implications

Training

An interesting finding emerged with respect to training about therapist self-disclosure. Despite research supporting the benefits of therapist self-disclosure (Delega, Margulis, & Winstead, 1987; Edwards & Murdock, 1994; Lane, Farber & Geller, 2001; Knox, Hess, Petersen, & Hill, 1997), none of the participants reported training experiences that specifically encouraged them to use the intervention. Instead, many participants relied on their own experiences and development to determine their use of therapist self-disclosure. Given that many training programs strive to educate their students based on a scientist-practitioner model, it is surprising that participants were not instructed as to the benefits, pitfalls, and appropriate uses of therapist self-disclosure in therapy. Although those involved in training clinicians may worry that trainees could

overuse therapist self-disclosure, surely it would be better to educate trainees about the research on therapist self-disclosure than leave them to develop the skill on their own, as was the case for many participants in this study. Specifically, trainees should be taught about appropriate intentions for and types of self-disclosure and how self-disclosure, informed by scientific research, may be effectively applied to clinical work.

Therapy

In keeping with the literature on therapist self-disclosure with adult clients, it appears that therapist self-disclosure may also a useful therapeutic tool with adolescents. The majority of effects reported here on the client, therapist, and the relationship were positive, thus contradicting an earlier study where therapists said, "therapist self-disclosure with children is almost never helpful" (Capobianco & Farber, 2005). This study included all types of disclosure (e.g., self-involving, disclosures of experience, etc.) while the study by Capobianco and Farber only addressed disclosures of biographical information and prior experiences. Perhaps when all types of self-disclosure are examined together, therapists' views of the intervention are more helpful. Or, perhaps because all participants shared positive experiences of therapist self-disclosure, they were inherently more likely to consider therapist self-disclosure to be a helpful intervention. Additionally, this study focused solely on therapists' experiences. Greater exploration of the client's experience of therapist self-disclosure may further substantiate or refute these findings.

Of course, as participants noted early in the interview, it is important to use therapist self-disclosure carefully and with appropriate intentions (i.e., for the client's, not the therapist's, needs). Specific to work with children (birth to age 18), the results of this

study with adolescents also supported theoretical assertions. Gaines (2003) and Gardner (1993), for instance, hypothesized that therapist self-disclosure with children/adolescents could increase client comfort and willingness to engage in therapy, model effective strategies, and achieve therapeutic gains; all of these claims were confirmed by participants' responses in this study. Furthermore, this study's findings strengthened prior theoretical arguments that therapist self-disclosure can strengthen the therapeutic relationship, facilitate engagement in therapy, and encourage child and adolescent clients to self-disclose (Barish, 2004; Gaines, 2003; Leichtentrett & Schechtman, 1998). Thus, it appears that therapist self-disclosure with adolescents, when done with thoughtful consideration and purpose, can in fact be a helpful intervention, at least from the perspective of the therapist.

When considering disclosing with adolescents, therapists should also bear in mind other factors that may influence use of the intervention. Specifically, the therapist should likely refrain from using therapist self-disclosure with adolescents demonstrating severe psychopathology (e.g., significant boundary issues, psychosis, danger to self or others). Therapists may also wish to consider the client's developmental level or age. As the current findings suggest, concrete, skill-based self-disclosures worked well to model/teach strategies to younger children or clients who function at a lower developmental level, whereas more varied disclosures (e.g., self-involving disclosures, disclosures of experiences, etc) may be useful with adolescents, given their more developed cognitive and interpersonal abilities.

Interestingly, therapists may also wish to select specific types of self-disclosure based on their intentions. In particular, disclosures of therapists' past experiences and

helpful strategies may be helpful when a therapist is trying to model/teach or normalize an adolescent's experiences. Self-involving disclosures (i.e., such as reactions to the client or therapy) may be more useful when the therapist wants to get "unstuck" in therapy or provide direct feedback to the client.

In addition, the therapeutic relationship appears to influence both the motivation for therapist self-disclosure as well as the specific content of the disclosure. When relationships are strong, therapists may self-disclose direct feedback to the clients as a way to delve deeper into interactional patterns and the therapeutic process. However, when the relationship is tenuous, therapists may wisely refrain from providing such feedback and instead share prior experiences that are similar to the adolescent's experiences as a way to forge a closer bond between therapist and adolescent.

Future Research

While this study attempted to address the gap in literature on therapist self-disclosure with adolescents, the findings cultivate many areas for future research. First, this study only addressed the therapist self-disclosure with adolescents from the therapist's perspective. It is entirely possible that the clients may have felt differently about the therapist's self-disclosure in the events shared. Future studies should thus examine the client perspective. In addition, it would be helpful to have a third party collect observational data, so that one could remove some of the error inherent to self-report (e.g., bias, subjective experience). Efforts should be made in future studies to have larger, more diverse samples (including individuals from a variety of training backgrounds, theoretical orientations, and cultural backgrounds). Furthermore, one wonders if different types of therapist self-disclosure elicit different effects. Does sharing

a here-and-now reaction to an adolescent cause the adolescent to open up more or would another type of disclosure be more likely to do so? While this study sought to understand the process of therapist self-disclosure with adolescents, it did not specifically examine the effects of different types of disclosure. Perhaps future research could address this question by surveying a larger group of child therapists and having them identify the types of self-disclosures they utilize with adolescent patients and the effects of each type of disclosure.

Additionally, future research should examine therapist characteristics and their impact on the use of therapist self-disclosure with adolescents. Throughout the interviews, participants mentioned that their use of therapist self-disclosure had been affected by their career and personal development, theoretical orientation, etc., yet no significant patterns formed in these findings. It is possible that with a larger participant pool and more directed questions, greater clarity regarding the impact of a therapist's characteristics on his/her use of therapist self-disclosure would emerge.

Finally, additional research with respect to negative experiences with therapist self-disclosure is also necessary to more fully understand therapist self-disclosure with adolescents as a whole. Researchers may need to specifically request that participants share information about negative therapist self-disclosure events, as it appears from this study that participants may not readily share these experiences.

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APPENDIX A
LETTER TO POTENTIAL PARTICIPANTS

Dear <Name of Participant>:

My name is Jacquelyn Smith, and I am a fifth-year doctoral student in counseling psychology at Marquette University. I am currently seeking volunteers to participate in my doctoral dissertation research examining psychologists' experiences of using therapist self-disclosure in individual therapy with adolescent clients.

As a child psychologist, you have the unique opportunity to engage in therapy with children, and I am hoping that you will be able to give about an hour of your time to share some of your expertise in this area. The study has been reviewed and approved by Marquette University's Institutional Review Board. Participation in this study involves 2 audiotaped, telephone interviews. The first interview will take about 45 to 60 minutes. The second interview will be scheduled for approximately 2 weeks after the first and will take about 15 minutes.

The focus of the interviews will be on your training related to therapist self-disclosure, your thoughts regarding the appropriateness of therapist self-disclosure in therapy with adolescents, and your experience delivering self-disclosure(s) to your adolescent clients. I am particularly interested in your describing one specific incident of self-disclosure in individual therapy with an adolescent client. Tapes, as well as the resulting transcripts and data, will be assigned a code number. After transcription, tapes will be erased.

Participants must be licensed, child-focused (as determined by at least two classes, workshops, or continuing education credits in child psychology, current caseload of 50% or more child clients, and supervised clinical experience working with children), clinical and counseling psychologists or Master's level clinicians. In addition, you must be able to identify and be willing to talk about a specific event in which you used therapist self-disclosure in an individual therapy session with an adolescent client (i.e., individual between 14 and 18 years of age). Therapist self-disclosure is defined as occurring when the therapist reveals information about her-/himself, and/or reveals reactions and responses to the client as they arise in therapy. In the event, you may have disclosed just one statement or a series of related self-disclosure statements. The event must have taken place in individual therapy within the last two years, and it must have occurred during or after the fourth therapy session. At the time of the event, you must have been a licensed clinical or counseling psychologist.

I recognize there is a slight chance that talking about your experience of therapist self-disclosure may be uncomfortable, and I am grateful for your willingness to do so. Participation in this project is strictly voluntary, and you may withdraw your consent at any time without penalty. Additionally, the purpose of this research is NOT to evaluate you or your therapy experience; instead, my goal is to understand how therapists experience use self-disclosure in therapy with adolescents and the effects of this

intervention. Thus, I am grateful for the experience and expertise you will share should you participate in this study.

If you choose to participate, please complete and return the enclosed Consent and Demographic forms as soon as possible (using the provided envelope). I will then contact you to set up a time for an initial interview. I have also included the interview protocol so that you may make fully informed consent. Please take a look at these questions prior to your first interview so that you have had a chance to think about your responses. If you do not meet the criteria for participation, I would be grateful if you would pass this packet along to a colleague who might be interested in participating.

Your comments and questions regarding this study are welcomed, so please feel free to contact me. I look forward to your response.

Appreciatively,

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APPENDIX B

INFORMED CONSENT

Marquette University Agreement of Consent for Research Participants

When I sign this statement, I am giving consent to the following considerations:
I understand the purpose of this study titled, "Therapist Self-disclosure with Adolescents: A Consensual Qualitative Research Study," is to gain a deep, contextual understanding of the antecedents, effects, and use of therapist self-disclosure in individual therapy with children under age 18.

I understand that the study involves 2 audiotaped phone interviews, with the first interview lasing 45-60 minutes. The second interview, scheduled for approximately 2 weeks after the first, will take an additional 10-15 minutes. I also understand that there will be approximately 10-15 participants in this study. I understand that the interviews involve a discussion of my experience of therapist self-disclosure to adolescent clients (see enclosed interview protocol) and that I will also be asked to complete a brief demographic form.

I understand that all information I share in this study will be kept confidential. Data associated with me will be assigned a code number rather than using my name or any other identifying information. When the results of the study are written, I will not be identified by name. I recognize that the data will be destroyed by shredding paper documents and deleting electronic files three years after the completion of the study. Furthermore, I understand that my interviews will be audiotaped and that the tapes will later be transcribed and erased after three years.

I understand that the risks associated with participation in this study are minimal, but may include minor discomfort when talking about my experience of therapist self-disclosure with adolescents. I also understand that the only benefit of my participation is to help improve my profession's understanding of the use and effects of this intervention. I understand that study participation is completely voluntary and that I may withdraw from participating in this study at any time. If I do choose to withdraw, I understand that I may do so without penalty or loss of benefits to which I am otherwise entitled. In the event that I withdraw, I understand that all data collected prior to my terminating participation in the study will be destroyed.

All of my questions about this study have been answered to my satisfaction. I understand that if I later have additional questions concerning this project, I can contact Jacquelyn Smith, M.A. at (608)235-3907 (Jacquelyn.smith@marquette.edu) or Sarah Knox (Dissertation Advisor) at (414)288-5942 (sarah.knox@marquette.edu). Additional information about my rights as a research participant can be obtained from Marquette University's Office of Research Compliance at 414/288-1479.

_____ Date:_____
(signature of subject giving consent)

_____ Location:_____
(signature of researcher)

APPENDIX C

DEMOGRAPHIC FORM

Code Number (to be completed by researcher): _____

Age: _____

Sex: _____ Race/Ethnicity:_____

Are you licensed clinician (check one): ___ Yes
___ No

Type of Degree Obtained (please specify whether M.A., M.S., M.S.W., Ph.D., Psy.D., Clinical, Counseling, etc.): _____

Please list at least two classes, workshops, or continuing education credits in child psychology that you have taken:
_____

Is your caseload at least 50% child clients? ___ Yes
___ No

# of years of supervised clinical experience with children: _____
# of years of clinical experience post-licensure: _____
# of years of clinical experience with child clients post-licensure: _____

What is your theoretical orientation?
_____

How often do you use therapist self-disclosure in therapy with adolescents?
_____

For the purposes of being able to contact you regarding participation in this study, please fill out the following information.

Name:_____ Phone number:_____

Mailing Address:
_____

Email Address:
_____

Best possible times to schedule interview:
_____

APPENDIX D

INTERVIEW PROTOCOL

First, let me thank you for agreeing to participate in this study. This interview should take about an hour, and it will be tape recorded. However, code numbers will be assigned to your data to ensure confidentiality from this point forward. Also, if you hear pauses on my end, I'll be taking back-up notes just in case something happens to the recording.

For this study, I'll be using a variation of the definition of therapist self-disclosure that was used in a previous study (Knox, Burkard, Edwards, Smith, & Schlosser, 2008): When verbally self-disclosing, a therapist shares information about him/herself and/or his/her reactions and responses to the adolescent as they arise in therapy. I'd like to begin by asking you a few general questions, followed by some questions about a specific self-disclosure event, and then I have just a few closing questions. As a reminder, this study is looking at therapist self-disclosure with clients ages 14 to 18, so please answer questions with that age group in mind. Do you have any questions for me before we begin?

<u>Opening Questions:</u>

1. In general, please describe your use of therapist self-disclosure with adolescents.
    a. How do you use therapist self-disclosure with adolescents?
    b. What factors or contextual issues (e.g., client characteristics, developmental level, etc.) affect your use of therapist self-disclosure?
    c. What elicits or stimulates these self-disclosures?
    d. Please describe some representative examples of therapist self-disclosures you use with adolescents.
2. What did you learn from your training about therapist self-disclosure with adolescents and how does this affect your use of therapist self-disclosure?

<u>Self-Disclosure Event Questions:</u>

Now I'd like you to talk about a specific event in which you, as a therapist, self-disclosed to an adolescent client (ages 14-18) in session. The event must have taken place in individual therapy within the last two years, and it must have occurred in the fourth therapy session or later. At the time of the event, you must have been a licensed, masters- or doctoral-level clinician. In the event, your disclosure may have consisted of just one statement or may have included a series of related self-disclosure statements.

3. The self-disclosure event:
    a. Please tell me about the nature of this therapy and your relationship with this client prior to the disclosure.
    b. Describe the self-disclosure itself.
    c. What factors or contextual issues (e.g., client characteristics, developmental level, etc.) influenced your use of this therapist self-disclosure?
    d. What were the perceived effects (e.g., on client, therapist, relationship, outcome of treatment) of the self-disclosure?

4. Please provide some basic demographics of your client and the therapy (e.g., age, sex, race/ethnicity, clinical issue(s) being addressed at time of self-disclosure, when in course of therapy TSD occurred, total length of therapy, frequency of sessions, setting [hospital, private practice, clinic, etc]).

Closing Questions

5. Is there anything else you wish to say regarding the event you described, or about therapist self-disclosure with adolescents in general?
6. Why did you participate in this research?
7. How has this interview affected you?

Thank you again for taking the time to participate in this study. If you don't have anything additional to add at this point, I'd like to set up a time for a brief follow-up interview. The purpose of this 10-15 minute interview is to allow you an opportunity to share any thoughts you've had since the first interview, and also for me to review my notes to see if I need any further information from you. I try to schedule the follow-up interview approximately 2 weeks from the first interview, but I can be flexible. When would work best for you?

APPENDIX E

EMAIL TO PARTICIPANTS REGARDING RESULTS

Dear <Participant>,

Some time ago, as part of my dissertation research, I interviewed you regarding your use of therapist self-disclosure with adolescents. Thank you again for your willingness to participate. As you may recall, as part of your participation in my study "Therapist Self-disclosure with Adolescents: A Consensual Qualitative Research Study," you have the option to provide feedback on the results

Attached you will find a copy of the Results and Discussion sections of my dissertation. This has been sent so that you may comment on the degree to which the collective results match your individual experience(s). It is also sent to assure you that your confidentiality has been maintained. If you have comments or feel that your confidentiality has not been protected, please respond to this email and let me know which portions of the write-up need to be altered. I would be grateful for your response by [two weeks from date of email]. If I do not hear from you, I will assume that you have no additional feedback. If you have any questions, please do not hesitate to contact me. Alternatively, you may contact my advisor, Dr. Sarah Knox. Thank you again for your participation.

Appreciatively,

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