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I'm human too: Person-centred counsellors' lived experiences of therapist self-disclosure

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Abstract: Therapist self-disclosure (TSD) is an issue shrouded in debate, risk, and uncertainty. However, it can also serve as a useful therapeutic tool for those who decide to 'take the plunge'. Given the paucity of research on person-centred counsellors' perspectives of TSD, this study sought to explore two person-centred counsellors' lived experiences of self-disclosing personal information to clients during therapy. Semi-structured interviews were conducted, which were recorded and transcribed. A hermeneutic phenomenological approach was adopted to allow an in-depth examination of the counsellors' subjective, pre-reflective lived experiences. Four main themes emerged: 'An internal battle'; 'Levelling the playing field'; 'Normalising experiences'; and 'I'm human too'. Each theme is described in detail with reference to relevant phenomenological concepts. Within the analysis, the implicit power of TSD is revealed - particularly in relation to its potential to 'level the playing field', but also in terms of the position of power held by the practitioner. Potential implications for practitioners are touched upon within the discussion. Also explored within the discussion are the ways in which TSD may serve to facilitate a range of therapeutic goals - including strengthening the therapist-client relationship - which could have direct clinical implications for therapists; particularly, person-centred counsellors.

Keywords: Therapist self-disclosure, TSD, person-centred counselling, hermeneutic phenomenology

Therapist self-disclosure (TSD) refers to therapists' sharing of personal information with clients during therapy. It has been heavily debated as a therapeutic intervention, particularly in terms of its effects on the therapeutic relationship. An increase in empirical attention has led the American Psychological Association (APA) to include TSD under the category of 'promising and probably effective' therapeutic elements (Ackerman et al., 2001, cited in Ziv-Beiman, 2013). There are at least two recognised forms of therapist disclosure: *immediate disclosure* of the therapist's feelings related to the client in the 'here-and-now', and *non-immediate disclosure* of personal information regarding the therapist's life outside the therapeutic encounter (Audet & Everall, 2010). The former is often viewed as the more acceptable form, due to its specific therapeutic function; however, less is known about non-

immediate disclosure - or therapist *self*-disclosure. TSD remains controversial, still being viewed by some as threatening fundamental therapeutic principles (Ziv-Beiman, 2013). However, recent reviews indicate the beginning of a transition within the professional discourse with respect to TSD — the taboo that once ruled clinical practice, is slowly but steadily losing its grip (Ziv-Beiman, 2013).

Quantitative Research

Most researchers have employed quantitative methods to study TSD. This perspective has been particularly useful in providing us with statistical information about the prevalence of TSD; for instance, a review of the literature suggests that

approximately 90% of therapists do self-disclose to clients (Henretty & Levitt, 2010). Henretty and Levitt (2010) carried out a review of the empirical literature on TSD, examining the factors that affect, and are affected by, TSD. This review primarily revealed that: a) frequent therapist self-disclosure appears to encourage more client self-disclosure (if used infrequently and at a relatively low to moderate intimacy level); and b) receiving TSD(s) enhances clients' ratings of therapist warmth (but has no reliable impact on ratings of other therapist qualities, such as trustworthiness and empathy).

Pinto-Coelho, Hill and Kivlighan (2015) carried out a mixed-methods investigation into 185 occurrences of TSD during psychotherapy sessions, with the aim of investigating and describing the occurrence of different types of TSD and revealing whether certain types of TSD were more likely to be judged as higher in intimacy and quality than other types. They were also interested in the relationship between TSD and client-rated 'real relationship' and 'working alliance' scores. The method involved coding TSD by type, intimacy, level and quality, and measuring the frequency of each event. Their findings revealed that clients rated disclosures of feeling and insight as more intimate and higher in quality than disclosures of fact, and that disclosure occurrence was positively related to client-rated working alliance (Pinto-Coelho et al., 2015). A much earlier quantitative investigation by Hill et al. (1988) examined therapist response modes (interventions), e.g. guidance, interpretation, confrontation, open/closed questioning and self-disclosure) in 127 psychotherapy sessions and found that clients rated self-disclosure as the most helpful of all therapist response modes. The authors proposed that clients may have self-disclosures for a variety of reasons, such as providing a glimpse that therapists are also human and have problems or shifting the power balance in the relationship so that clients feel less vulnerable.

While such quantitative research offers the benefit of experimentally controlling variables of interest, it can prove challenging to extrapolate the findings to real-life therapy situations (as opposed to experimental therapy situations), because the natures of self-disclosures are believed to be highly dependent on situational and relational factors and individual differences between therapists (Pinto-Coelho et al., 2015). Furthermore, such findings are correlational rather than causal, leaving directionality unclear. Ultimately, these limitations suggest that quantitative methods alone are insufficient to investigate the complex social phenomenon that is TSD.

Qualitative Research

The majority of the existing qualitative literature on TSD has tended to focus on the client's perspective. Audet and Everall (2010) conducted a phenomenological analysis to obtain an in-depth understanding of how clients experienced receiving TSD during therapy. One of their most interesting findings was that reciprocal disclosure relevance was notably significant to clients. Clients experience disclosure in one of two ways: congruent or incongruent with their needs and expectations. If deemed congruent, the disclosure was experienced as attentiveness and understanding; while if deemed too incongruent, disclosure could be interpreted as a lack of understanding and responsivity by the therapist. Many clients felt that early therapist disclosure unveiled the therapist's 'humanness'; some openly appreciated this coexistence of 'imperfect human' and 'professional with expertise'. Audet and Everall's (2010) findings reveal that TSD can have both facilitative and hindering effects upon the therapeutic relationship. However, therapists' reasons for self-disclosing were not considered.

A more recent study by Berg, Antonsen, & Binder (2017) writing within a Nordic context, looked into psychotherapists' lived experiences of TSD, with the aim of understanding their reasons for doing so. Again, the methodological framework employed was a hermeneutic phenomenological analysis, which allowed the researchers to investigate how therapists attribute meaning to experiences in their practice. Four themes emerged, which captured the rationales behind the therapists' self-disclosures: 1) 'To show care and compassion', as a way of developing a good patient-therapist relationship; 2) To convey that 'you are not that different' as a way of normalising patient experiences; 3) 'To gain credibility' of understanding, i.e. 'I know because I have been there myself'; and 4) 'Objections to self-disclosure', in which therapists described the risks of self-disclosure. The authors propose that the current typology of TSD laid down by Hill and O'Brien (1999) should be updated to include therapists' rationales for self-disclosure, which could have direct clinical implications for therapists if validated by further research (Berg et al, 2017).

Ziv-Beiman (2013), writing in an Israeli context, offers a comprehensive empirical and theorical review plus a single case study. She argues that TSD is such a powerful therapeutic tool that it holds the potential to be used as an integrative intervention. In a literature review, she found that TSD is strongly established as beneficial to the therapeutic alliance and serves to advance a range of therapeutic goals. She proposes the following criteria for successful TSD: low-to-mild frequency of immediate self-disclosures; moderate levels of detail; prompt return of focus to the client; and exploration of patient reactions. Equally relevant was the authors' personal case study of self-disclosing during therapy, which both therapist and client considered to directly facilitate therapeutic change. Ziv-Beiman (2013) emphasised how such interventions address multiple therapeutic goals, hence the term *integrative*. However, further research is required to examine how 'integration' is understood and the extent to

which TSD as an integrative intervention would be effective within different versions of integrative psychotherapy. To this end, Ziv-Beiman followed up this research with writing with Shahar (Ziv-Beiman & Shahar, 2016) drawing on their preferred cognitive-existential-psychodynamic version of integrative psychotherapy. Using clinical examples, they argue that TSD can constitute a clinical error; particularly when patients experience the other as impinging on them.

Contrasting Theoretical Approaches

Finlay (2019) highlights how disclosures tend to be viewed as either beneficial or problematic depending on the nature of the disclosure, the specific relational-social context and the theoretical framework adopted. She suggests that TSD offered with the aim of raising the client's self-awareness occurs more frequently in humanistic-integrative practice, yet less frequently in psychoanalytic contexts where the therapist is more of a 'blank slate', and in cognitive brief therapy, where disclosure is seen as less relevant. In other words, the relational, cultural and theoretical context needs to be foregrounded more – a criticism that applies to most of the research conducted on TSD. Even when that theoretical context is noted in papers, the specific relational context impacts on whether TSD is, or is not, appropriate. The implication of this complexity is that further qualitative and idiographic studies identifying the cultural context are needed to probe therapist decision-making.

Psychoanalysis originally insisted on therapist neutrality enabling clients to express their unconscious feelings and desires and therapists to interpret their meaning (Freud, 1912/1958). However, Ziv-Beiman (2013) indicates that contemporary versions of psychodynamic psychotherapy (e.g. relational approaches) actually encourage some degree of TSD. Some point to the value of explicitly communicating counter-transferential experience. O'Brien and Houston (2007) provide an example of this:

> Therapist: I am feeling some rather uncomfortable pressure on me to please you in our sessions, with what I say and how I say it. It occurs to me that this might be because it is how you are feeling – that there is some pressure on you to be interesting to your colleagues in the office, and an interesting client to me, or we may not want you. (2007, p.160)

Some therapeutic approaches, such as social constructionist family therapy, actively advocate TSD. For example, Freedman and Combs (1996) highlight the work of 'reflecting teams', where clinicians reveal what they have observed in sessions. In other contexts, such as cognitive brief therapy, disclosure is seen as more irrelevant and not a productive use of limited time which is needed for hearing the client's perspective and

offering psycho-educational responses. However, in this context, brief disclosures might be used to normalise a client's distress (Goldfried, Burckell & Eubanks-Carter), and some recent 'third wave' cognitive approaches such as acceptance and commitment therapy (ACT) recommend it can be useful for offering validation, promoting the therapeutic relationship and encouraging self-acceptance (Ruddle & Dilks, 2015). These findings mirror those of Harris (2009) who advocates for using TSD selectively and is most beneficial to the client when interventions are focused on normalization, validation, promoting self-acceptance, or enhancing the therapeutic relationship (Harris, 2009, cited in Ruddle & Dilks, 2015).

In a reflective, theoretical piece, Geller - a psychotherapist - highlights the relevance of both intrapsychic and interpersonal factors, as well as emphasising the significance of temporality (lived time) in TSD; particularly within the context of psychoanalytic-existential therapy (Geller, 2003). Geller openly rejects early Freudian recommendations that therapists should verbally disclose as little personal information as possible and limit their expressivity as far as possible (Freud, 1912/1958). Rather, Geller (2003) advocates for TSD, and in line with more existential teachings, bases his stance on authenticity, transparency, realness and egalitarianism. He argues that the meaning and value of a self-disclosure can only be understood in context; including temporal contexts, such as the beginning and end of therapy. Early in therapy, Geller posits that clients may be too anxious to take in the conceptual meanings of a therapist's communications; thus, he recommends limiting self-disclosures to ones that are intended to convey acceptance, empathy, and encouragement. Towards the end of therapy, he recognises the temptation of self-disclosing to celebrate the achievement of goals, to reciprocate the tender feelings expressed by an appreciative patient, and to say goodbye; to leave a lasting impression of a 'real person' for client to remember and identify with. Tensions peak between spontaneity and restraint, and uncertainties arise about the optimal boundary between the 'professional self' and the 'personal self' (Geller, 2003). While the importance of self-awareness in relation to overstepping ethical boundaries is acknowledged, Geller also argues that therapists should not work too hard to resist the temptation to express loving feelings for technical reasons. While clients usually remember very little of what was actually said during therapy, TSDs tend to be among the few things that can be recalled by clients after therapy is terminated, often having a delayed or continuing influence on clients during their lives after therapy (Wzontek, Geller, & Farber, 1995 cited in Geller, 2003).

Humanistic Approaches to TSD

I was particularly surprised by the paucity of TSD research from humanistic, person-centred perspectives, primarily as the

founder of person-centred therapy, Carl Rogers (1951, 2012) identified congruence – authenticity, genuineness, and the ability of the therapist to be true to his or her feelings – as one of the most fundamental attributes of the therapeutic process. Historically, humanistic-experiential psychotherapists have accentuated the importance of TSD in promoting an authentic therapeutic bond, regarding the therapist's genuineness – which entails self-disclosure when appropriate – as a central tool in facilitating the patient's growth and establishing an effective therapeutic relationship (Bugental, 1987; Rogers, 1957, cited in Ziv-Beiman, 2013). Humanistic scholars maintain that TSD allows the client to feel equal to the therapist and to acknowledge that all human beings suffer from weaknesses and unresolved issues (Stricker & Fisher, 1990; Williams, 1997, cited in Ziv-Beiman, 2013).

One empirical study in this context is notable, although arguably slightly dated now. Reupert (2006) carried out a thematic analysis on interviews with six person-centred therapists (M=3; F=3) practising in Austrialia, to explore person-centred therapists' sense of self. The participants were asked to describe the self that therapists brought to counselling, as well as their involvement of self during therapy. The therapists identified the self that they brought to therapy as multifaceted: defining of who they are (both inside and outside of the professional role); evolving over time with different people and life experiences, yet maintaining a sense of consistency and genuineness across different encounters; and consisting of the therapist's inner experiences. In terms of how the self was used or involved in therapy, one of several aspects explored is self-disclosure. All six therapists talked about sharing themselves in therapy, though there were differences in what, how much, when, and with whom they might do so. Disclosures varied in type (e.g. some discussed disclosing their immediate affective state to clients, while others described providing factual information about themselves), as well as intimacy (e.g. one therapist reported disclosing her divorce experience with a client, while another disclosed less personally revealing information). For these therapists, self-disclosure appears to be a major way in which they involve the 'counselor's self' in therapy. By extension, participants described the self that they bring to therapy as a central entity that plays an important role in the therapeutic alliance, confirming Rogers' (1951, 1957) view that the personhood of the therapist is a key component of the therapeutic endeavour (Reupert, 2006).

Rationale for the Present Study

Relatively little empirical research exists to date which specifically explores *humanistic/person-centred* counsellors' experiences of TSD, and even less exists which explores the topic from a phenomenological perspective. Geller's (2003) paper was a reflective-theoretical piece rather than

systematically investigating therapists' experience. Reupert's (2006) study, offers a sketchy qualitative thematic analysis where TSD is one of many aspects examined. Her findings are interesting and relevant, though lack depth. TSD is seen more as a clinical decision, and what is lacking is the kind of description offered by phenomenological methodologies of the embodied tensions and uncertainties of the lived experience.

Furthermore, the majority of the literature originates from the outside the United Kingdom (UK), calling for further research to help us develop a more nuanced understanding of TSD within the UK milieu. For instance, the (2017) study by Berg et al, took place in a Norwegian psychology context while Ziv-Beiman (2013) and Ziv-Beiman & Shahar (2016) write in an Israeli clinical psychology context. Geller (2003) offers his perspective as a clinical psychologist working in the Department of Psychiatry, Yale University, in the US. Reupert's study worked with therapists (who were either psychologists or social workers) in Australia. Questions are raised about whether person-centred counsellors practicing in the UK would say similar things.

Given that previous research has already illustrated the benefits of adopting a phenomenological approach to investigate the topic (e.g. Audet & Everall, 2010; Berg et al., 2017), it seemed appropriate to carry out a phenomenological analysis of person-centred counsellors' lived experiences of therapist self-disclosure (TSD) within the context of the UK. The aim of the study was to answer the following research question: '*What is the lived experience of therapist self-disclosure for person-centred counsellors*?'

Method

Design

For this qualitative study, I employed a hermeneutic phenomenological methodology. My aim was to capture the pre-reflective experience of TSD in the embodied, relationally meaningful way in which it is lived by person-centred counsellors. Phenomenologists seek to capture lived experience – to connect directly and immediately with the world as we experience it (Finlay, 2011). The focus is on our personal or shared meanings, as distinct from the objective physical world explored by science (Finlay, 2011). Phenomenological hermeneutics (Heidegger, 1927/2010) places emphasis on 'being in the world', the aim of which is to understand experiences from the personal vantage point (Kafle, 2011).

Interviews were used as the method of data collection for this study, as they generate ideas that emerge from and are

grounded in data. According to Patton (1990, cited in Reupert, 2006), interviewing is also regarded an appropriate methodology for gathering insights into ambiguous and personalised concepts such as the self, which is relevant in the context of therapist self-disclosure. A semi-structured interview format was used to allow a combination of open-ended questions (to prompt thick, detailed descriptions of experience) with the opportunity to explore interesting themes or responses further; allowing us to delve deeper and deeper into the lived experience of TSD. Open-ended questions also encourage the follow up discussion to be led not so much by the researcher, but by the participant – the purpose of which is to get at what participants really experienced, from the inside out, not simulations of what they 'thought' they experienced (Laverty, 2003; Geertz, 1973).

Throughout the entire research process, I was guided by hermeneutic phenomenological principles (van Manen, 1990). Above all, I prioritised rich description – which, according to Merleau-Ponty (1962), is the principle aim of phenomenology. Equally, I considered how verbatim accounts do not necessarily capture all of what is 'really said' in interviews; it is also important to look for what is said 'between the lines' (Kvale, 1996, cited in Laverty, 2003). By paying attention to the silence, for instance, we can uncover the self-evident and taken-for-granted; allowing implicit meanings to be brought to the fore. This illustrates the inevitable role of interpretation that is always present within hermeneutic phenomenology (Finlay, 2011). It constitutes an inevitable and foundational structure of our being-in-the-world. Instead of setting my prior knowledge/understandings aside, which I see as not possible, I am following Heidegger's (1927/2010, p. 144) recognition that all understanding has the structure of "something as something" – in other words, it involves prior interpreted understanding. These fore-structures can be seen as part of a circle of understanding, where new understanding arises from what is already understood. So the fore-understandings are used, in part, as a lens to reflect more deeply and to let them inform the inquiry (Churchill, 2018).

I aimed to embrace an appropriately phenomenological attitude (Finlay, 2008), which involved adopting an open, non-judgemental, curious approach while attempting to both suspend or 'bracket' my own prior assumptions in order to apply myself fully and genuinely to my participants' experiences. As with all phenomenological analysis, the focus is on pulling out explicit and hidden meanings through iteratively examining the data (Finlay, 2011). Phenomenologists talk about lived experience in terms of the 'lifeworld', which is 'the world that is subjectively lived' (Finlay, 2011). Thus, I focused on four existential dimensions of the lifeworld during the analysis: the participants' sense of sociality (relationships with others), temporality (lived time), spatiality (lived space/relationships with objects), and embodiment (lived body). These interlinked dimensions acted as a lens through which to view the data, which helped to deepen the narrative (Finlay & Molano-Fisher, 2008).

Participants

The participants consisted of two person-centred counsellors. The first participant, 'Maria' (pseudonyms are used to respect participants' anonymity), is an existing acquaintance of mine who has been practising as a person-centred counsellor since 2007. She runs her own counselling practice from home, and also works for various agencies. The second participant, 'John', was previously unknown to me. He has been practising as a person-centred counsellor since 2004, working with private clients and doing some counselling work in GP surgeries.

Recruitment and Consent

The main participant criteria I maintained was British Association for Counselling and Psychotherapy (BACP) accreditation and 5+ years professional experience (based on my assumption that more experienced counsellors would have more experiences of TSD to describe and/or greater confidence in applying them). The method of recruitment used was snowball sampling; Maria was contacted via email to enquire whether she would be interested in participating the study, and upon expressing interest she was asked to recommend other potential participants. John was the first person fitting the criteria to express interest; he was sent details about the study in the same way. Date and location were also set via email. Before the interviews, I went through the participant information sheet collaboratively with each participant to ensure that they understood the details surrounding the nature of the study and their rights to withdraw. When I was confident that they understood these details, they were they invited to sign the document to indicate that they freely gave their informed consent.

Pilot Interview

Prior to embarking on the main interviews, I undertook a pilot interview with one other person-centred counsellor (recruited independently from the main participants). This allowed me to refine the balance between using pre-determined questions and engaging in open conversation, and trial whether the interview schedule would produce data relevant to the research question. Ultimately, this led to the revision of some initial questions, as some interesting and relevant themes were revealed in the pilot interview (e.g. professional vs. personal self-identity, boundaries in the therapeutic relationship and theoretical influences on self-disclosure) – which I wanted to follow up in the main interviews to evoke more introspection and elicit more descriptive responses.

Data Collection and Analysis Procedure

Participants took part individually in separate semi-structured interviews, which each lasted approximately one hour. In accordance with participants' preferences, the interviews took place in their private counselling rooms. Informed consent was obtained: Together, we then went through the instructions, which clarified what was meant by therapist self-disclosure; that it did not refer to the sharing of professional information (e.g. name, credentials, address etc.), but rather the disclosure of personal information, such as experiences, struggles, views and opinions. This process also served to ease participants into the interview process and give them an idea of what was to come. The interviews commenced upon receiving permission to turn on the recording device. An interview schedule was used, but in line with the nature of semi-structured interviews, questions were often adapted in response to participants' discourse. Specifically, participants were invited to reflect upon their experiences of sharing personal information with clients during therapy. Prompts were used to elicit further clarification/elaboration in response to interesting points if deemed necessary. Post-interview, participants were de-briefed in accordance with ethical guidelines and thanked graciously for their participation. In an environment of confidentiality and safety, the audio recordings were transcribed verbatim according to phenomenological conventions as described by Lynden (2017).

A hermeneutic phenomenological analysis was then carried out on the data, during which I tried to follow van Manen's (1990) principles of engaging in iterative reflexive analysis and attuning myself deeply with the research question. This involved 'dwelling' with the data (von Eckartsberg, 1998), examining it, and then progressively deepening understandings as meanings come to light (Finlay, 2011). I attempted to absorb myself into the participants' words and their underlying emotions in order to allow implicit meanings to 'come to the fore' rather than forcing/imposing my own ideas upon the data. As themes began to emerge, a colour-coding technique was used to isolate each theme. This resulted in the identification of four distinct themes, which I felt captured the essence of the participants' experiences to the best of my ability.

Materials

With each interview, two copies of the participant information sheet were used: one to preserve as evidence of informed consent, and one for the participant to keep for future reference. Also used were individual copies of the participant instructions, interview schedule, and debriefing information. An audio recording device (Btopllc Digital Voice Recorder) was used to record the verbatim of the interviews. The resulting audio clips were each approximately 1 hour long in duration, which were analysed alongside the transcripts.

Ethical Considerations

As this study was part of a piece of undergraduate coursework with the Open University (OU), the project went through the required OU ethical approval process. This study also complies with the *Ethical Principles for Conducting Research with Human Participants* (BPS, 2014). Participant recruitment only commenced upon obtaining consent from my module tutor in response to a project proposal and ethical approval form. With researcher safety in mind, I informed a trustee of where, when and with whom I would be conducting the interviews. I gave participants the opportunity to suggest their own pseudonyms to demonstrate my respect for their input and self-determination. I also respected their autonomy by informing them of their right to withdraw and have their data destroyed up until a specific point in time. Participant well-being was also paramount, which is partly reflected in my decision to investigate the experiences of counsellors rather than clients. While I felt that counsellors (as trained professionals) would be more 'mentally robust' participants, I also considered that they may have felt a sense of shame and/or exposure in sharing their deeply personal 'mistakes' with me. With this in mind, I adopted a warm, empathetic attitude, and was sure to reassure them of my absence of judgement.

Reflexivity

A key assumption within phenomenological research, owing to the interpretive nature of the methodology, is that the researcher will inevitably influence the results of their research (van Manen, 1990). The biases and assumptions of the researcher are embedded in, and essential to the interpretive process that is hermeneutic phenomenological analysis (Laverty, 2003). Accordingly, I adopted reflexivity (Finlay, 2017) as a guiding principle throughout the entire research process. I kept a reflexive journal to assist me in the process of reflection and interpretation, which enabled me to keep track of any preconceptions that I felt might have influenced my interpretations. When analysing the data, I attempted to suspend or 'bracket' these prior assumptions; for instance, I had to make a conscious effort to put aside my assumption that experiences of TSD would be largely positive. The purpose of bracketing is not an attempt to be unbiased or objective, but rather to put aside (to the extent that we can) our own expectations in order to attend more actively to the participant's views; the findings should represent the phenomenon being researched, rather than the researcher's beliefs, preferred theories, and/or biases (Finlay, 2017; Morrow, 2005). With regard to transparency, I kept three reflexive questions in mind throughout the research process in

line with Tuval-Maschiach's (2016) model for improving transparency – 'what I did', 'how I did it', and 'why I did it' (Tuval-Maschiach, 2016, cited in Finlay, 2017). In doing so, I hope to make my intentions and reasons for my methodological choices evident to the reader, with hopes of remaining as transparent as possible. However, as this is my first attempt at a piece of phenomenological research, I avoid any claims to be an experienced and/or unbiased researcher, and my interpretations should be considered with these disclaimers in mind.

Results

Four themes emerged from the analysis: 1) An internal battle; 2) Levelling the playing field; 3) Normalising experiences; and 4) I'm human too. The themes will be presented in turn, illustrated with excerpts from the interviews.

An Internal Battle

For these participants, the lived experience of TSD is ambivalent and appears to consist of conflicting emotions. Upon feeling the urge to self-disclose, both counsellors described 'wrestling' with the dilemma of whether or not it would be appropriate to do so in each given context. John illustrated a powerful, almost irresistible desire to self-disclose in relation to his own experiences of depression: "I'm sitting there with the client, thinking, 'oh God, she's depressed, that sounds just like me... do I say anything?'". This compelling urge to self-disclose was also expressed by Maria, who related feeling a deep connection with clients who - like her - had strained relationships with their mothers: "Often a lot of things that they're saying I'm thinking, 'oh wow, I've been through that as well'... And I'm thinking, 'oh gosh, this is uncanny'... I felt almost like I couldn't sit on it for long".

I refer to this process as an 'internal battle' as the participants' desire to self-disclose often clashed with their awareness of the potential risks involved. John related his reluctance to self-disclose back to his initial training:

> In training, there's a degree of objectivity, and there's a tradition within therapy of therapist non-disclosure... One of the other counsellors said to me, "I think you need to look at how it serves your interests to self-disclose". (John)

Maria also described her training coming to mind upon feeling the urge to self-disclose:

> In my training, they told us that if we've had a similar experience to a client, we should always evaluate whether it's gonna be useful for them to hear or whether you just wanna get it off your chest. (Maria)

In this sense, the participants' reluctance to self-disclose appears to root from their initial counselling training, in which TSD is often discouraged. While this may suggest an implicit fear of judgement/reprimand from colleagues or superiors, it also demonstrates their appreciation for the theoretical values that have been instilled within them, which appear to have stayed with them over time.

Maria did recount one negative experience of self-disclosing:

> There was one that didn't go so good... This one time, [a client] was talking about her mother... So I said... I do know what it's like to be a daughter and feel like you haven't got a mother. And then the questions came... And it was like, question, question, question... until I felt very uncomfortable. (Maria)

The memories of Maria's negative experiences of TSD appeared to have stayed with her over time, contributing to her internal battle. Participants' ultimate decisions surrounding self-disclosures appeared to be underpinned by a kind of internal assessment process, in which they described 'evaluating' the context of each client's situation. John explained:

> It's all about context... To me, the whole point of counselling is to be monitoring and very carefully evaluating what I think is going on... so if I thought that they had come into the situation thinking they were consulting an expert that would tell them what to do... then I'd be much more wary about telling them the answer, than if we'd been through half a dozen sessions. (John)

As illustrated here, it often takes time to gather an understanding of the context of clients' situations, which may change the intended meaning and potential consequences of self-disclosures. Maria also emphasised the importance of 'assessing the bigger picture':

> This one [client] was very open right from the very start... so very quickly I got quite a clear picture of what she'd been through. But other clients are... a lot slower with their pace... I just need to gain a better picture, before I do share anything personal... I think you need time to assess the client's situation. (Maria)

Here, Maria channelled the importance of time as it is lived; time is relative to how it is experienced with each particular client.

The emphasis on assessing *context* also illustrates the intersubjective nature of TSD. For instance, John explained that he'd be more reticent to self-disclose to a client who seemed "really lonely or emotionally needy", compared with a

client "who you know is solidly embedded in social networks". This assessment process demonstrates the participants' intentionality to only divulge information which they believe will be potentially useful for the client to hear but the decision-making process is layered and can involve weighing competing intentions.

Levelling the Playing Field

The participants often described their TSDs in relation to 'levelling the playing field' or 'correcting the power imbalance'. John described this perceived power imbalance as follows:

> A lot of clients tend to put therapists on a bit of a pedestal, because the experiences can be quite similar to visiting a doctor... there can be a kind of power imbalance. A lot come with the presupposition that counsellors come across as superior, cold and clinical. (John)

Maria also acknowledged the existence of this imbalance:

> People need to know that there's a human being sat opposite them, and not this perfect, all worked out professional... because we want to be equal, we want to be mutual. But I suppose there always is that power that the counsellor holds as having the professional position, and I think anything you can sort of do to try and level it out in any way is helpful. (Maria)

These excerpts also capture the intentionality underlying the participants' self-disclosures; the purpose of their attempts to address clients' presuppositions appeared to be to correct the power imbalance; in this sense, 'levelling the playing field' also emerged as a rationale.

The environment also appeared to have an influence on participants' decisions surrounding self-disclosure; for example, John described how the 'power imbalance' can be consolidated when the counselling is taking place in a GP environment, as a lot of his work has: "The environment is basically set up around the GP. The GP's chair is a big chair, and the patient's chair is a small, hard chair... and again, it's like a power imbalance."

For John, the physicality of the GP environment "contributes to this sense of you wanting to correct that imbalance... to level the playing field". Interestingly, he related his attempts to do so by changing the physical dynamics of the therapeutic encounter:

> I've even tried to get the client to sit in the big chair, on the grounds of saying, "you're more important than I am here"... I will do what I can to try and make it feel more equal, and less doctor-patient. (John)

This theme illustrates how the participants often experienced TSD as a useful tool in helping to serve a range of therapeutic goals; for instance, putting the client at ease in the foreign counselling environment and encouraging the development of an equal therapist-client relationship.

Normalising Experiences

The participants also described using TSDs as a way of 'normalising' clients' experiences, which was often described in relation to communicating absence of judgement over potentially embarrassing, humiliating or shameful experiences. John related utilizing his own personal struggles in attempt to normalise a client's similar experiences:

> It's desperately painful if, you know, your child has been sectioned. And it's like, if your therapist can say "yeah, mine too"... then, instead of being this terribly shameful thing... it helps to normalise it, and it's a thing that you're then talking about rather than confessing to. It just enables it to be discussed in a different light I think. (John)

The intentionality of normalising was also illustrated by Maria in relation to working with a client who was worried that she was judging her about her self-injury problems:

> She was worried that I was judging her, she was saying things that, in her words, were f***ed up, and things about when you see the blood, and things like that, and other things. And some of it, I was thinking, well, that **is** a bit f***ed up, but I know what you mean 'cause I've been there. (Maria)

Maria appeared to relate to the bodily sensations and vivid images described by this client, such as 'seeing the blood'. It appeared to be Maria's actual embodiment of the physical descriptions of self-harm that she related to the most, and which urged her to make the following very compelling, moving and heartfelt self-disclosure:

> So I did say to her, "I'm not judging you. At all. And don't worry about 'weirding me out' – you're not, and you will not weird me out. Whatever you tell me, I can hold it, and I can listen to it... and I've been there myself - I used to do that too." And then it was like something completely changed, and her whole body just went ((exhales deeply)) relaxed, you know? Because she panics quite a lot, and previously she would often look for something to fiddle with. But after I disclosed, she seemed to be more relaxed. (Maria)

There is clearly much implicit bodily emotion underlying this self-disclosure. Maria explained her rationale for self-

disclosing as a way of normalising her client's experience, and also reassuring her that she was not judging her, which she believed to be a preconception of self-harm clients. She also related her desire to reassure the client that it was possible to overcome her problems, because she herself had:

> I think because I myself have overcome my problems, I can kind of show her that over time, it got better for me. And that you'll figure out a way to stop - even if you don't know how you're gonna do it right now, you will do it. (Maria)

Maria felt this self-disclosure had a very positive impact on both the therapeutic relationship and the therapeutic outcome. She described the impact on the client as "really, really positive", and believes that she became more confident and "opened up" a lot more as a result. She also related feeling "safe" with this client, feeling a 'connection', which makes her feel comfortable in "giving a little bit more away" – highlighting the inevitable intersubjectivity of TSD.

I'm Human Too

The participants described using TSDs to communicate their 'humanness'; to mitigate the "perfect, all worked out professional" preconception, and demonstrate that they too were mentally and morally imperfect and vulnerable. Maria described TSD as a "very human thing", and stated that "people need to know that there's a human being sat opposite them". She linked it to Carl Rogers' concept of congruence:

> Congruence is about being honest with yourself about your emotions and how you're feeling. We always work on a basis of honesty... And in person-centred counselling, it's humanistic. The principles underlying the approach, like empathy, and the communication of empathy. (Maria)

Similarly, John emphasised the importance of a "warm, compassionate and understanding" therapist attitude, which he also linked to the founding principles of person-centred counselling:

> This is the genius of Carl Rogers, because he identified what it is about counselling that works – empathy, congruence, unconditional positive regard, and so on. And in terms of congruence, that's where to me, self-disclosure is appropriate, because that is congruent. (John)

John channelled his self-disclosures as a way of 'emphasising the commonalities' between himself and his clients: "we're both human, and we both struggle – we've got more in common than there is different". He also connected his identity roles as a father and a parent to his self-disclosures. In terms of self-identity, both participants described themselves

as people before counsellors; which again, was intrinsically linked to their humanistic values.

> This is why Carl is the man, you know, because it's person-centred therapy, isn't it? So first and fore-most I'm a person. Human first, therapist second... and then after that, you're whatever it says on the certificate in the drawer. (John)

This again demonstrates the persisting dominance of the participants' humanistic values. John also divulged one of his favourites quotes from Carl Rogers: "What is most personal is most universal", which he felt said something really profound about TSD:

> [Rogers] said that on the basis of his own experience...this probably hasn't happened to you, and if it has, you probably won't feel how I feel about it. But what he found was it was precisely that which was the most potent for other people. It's those very personal things which people relate to and find helpful. (John)

This encapsulates the intentionality underlying the participants' self-disclosures: the very human desire to share their personal experiences and struggles with those they see suffering hopelessly with the same thing they have; to communicate that it is possible to overcome it – because 'I myself have'.

Discussion

To reiterate, four themes emerged from the analysis: 1) An internal battle; 2) Levelling the playing field; 3) Normalising experiences; and 4) I'm human too. Theme 1 arose as an overarching theme of sorts, in that participants described going through what I call an 'internal evaluation process' before self-disclosing, during which they appeared to weigh up the potential risks and/or benefits of self-disclosing within each client's specific context. More than a cognitive exercise, the process was often experienced with some bodily tension.

The latter themes emerged as rationales for actually self-disclosing. There was a sense that the participants were striving to 'be' a certain way – one that was consistent with their humanistic values. In this regard, they appeared to employ TSDs as sort of therapeutic tool, conducive to: a) communicate that therapist and client are equal; b) normalise experiences and convey lack of judgement; and c) demonstrate their 'humanness' despite being the professional in the working relationship. The themes, and their underlying rationales, were often interconnected; therapists might intend to convey all three things at once within one self-disclosure, or at other times rationales might be standalone and individually sufficient. Again, as described in Theme 1, this is all heavily

dependent on context. Ultimately, these themes serve to offer supplementary and nuanced insights into the meaning and experience of TSD.

As expected, the lived experience of TSD emerged as a heavily complex process for the participants involved; as therapeutic professionals, they were very aware of the degree of risk involved in self-disclosing to a client, and so their recollections were often drenched in conflicting emotions – some of which they experienced bodily in the moment. However, participants were very much in favour of TSD. While the negative side of TSD was touched on briefly by Maria, the majority of the experiences described by both participants were positive. These could also be described as 'successful' TSDs, in that the self-disclosures in themselves were perceived positively by both therapist and client, and they were described as having a positive impact on therapeutic relationship, the therapeutic process and the therapeutic outcome respectively.

Lifeworld Analysis

Each of the four lifeworld dimensions I chose to focus on - sociality (relationships with others), temporality (lived time), spatiality (lived space/relationships with objects), and embodiment (lived body) – emerged as relevant to the participants' experiences of TSD, although some were more prominent and salient than others. I was particularly surprised that the lifeworld dimension of spatiality emerged as such a critical element of the participants' experiences of TSD, with otherwise mundane objects like chairs and desks suddenly assuming much greater importance. For instance, John described the physical dynamics of the GP environment (e.g. the counsellor sitting in the GP's big comfy chair vs. the client sitting in the small hard chair) as contributory factors to his decision-making process surrounding his TSDs, particularly in relation to 'levelling the playing field'.

Temporality also emerged as important, in that it often took the participants time to a) gather an understanding of clients' situation and b) develop a strong therapist-client relationship over multiple sessions. This substantiates Geller's (2003) aforementioned claims that context (including temporal context) is contingent and key to understanding the meaning and value behind self-disclosures (p.546).

I was not surprised to find the lifeworld dimension of sociality relevant to the participants' experiences, as therapy in general is a highly intense social experience based upon the communication of very personal feelings and meanings between people. Nevertheless, for the participants, a strong therapeutic relationship based on trust emerged as a kind of prerequisite for TSD, and the act of self-disclosing itself appeared to strengthen the relationship even further. Again, this demonstrates the inescapable, intense intersubjectivity of

the therapist-client relationship, which appears to play a fundamental role in the lived experience of TSD for both the participants.

Finally, the lifeworld dimension of embodiment became apparent with regard to Maria's desire to self-disclose to the client struggling with self-injury problems, in that she seemed to relate to (or 'embody') the bodily sensations and vivid images described by this client, such as "seeing the blood". However, embodiment appeared to be the least salient lifeworld dimension across both of the participants' experiences. I recognise that my interviews tended to focus on more reflective rather than pre-reflective experience, and that this may have led to more cognitive and less embodied explications.

Revisiting the Literature

In many ways, the findings echo and extend those discussed in the existing literature. Firstly, the analysis provided supporting evidence for Audet & Everall's (2010) concept of 'reciprocal disclosure relevance'. For instance, the participants acknowledged the importance of their TSDs being congruent with the clients' needs and expectations; this was reflected in the theme 'An internal battle', in which the participants described evaluating whether or not self-disclosing would be appropriate in each given client's situation and context. This suggests that clients and therapists have similar perceptions, if not a fundamental agreement, with regards to at least one facet of TSD that makes it successful. Additionally, both the participants in this study and the therapy clients studied by Audet and Everall (2010) described their experiences of TSD as conveying/unveiling the therapist's 'humanness'. In light of this correlation, the communication of 'humanness' appears to be perceived as beneficial to the therapeutic process by both clients and therapists. This emphasis on humanness often emerged in relation to the participants' humanistic background, which appeared to have a significant holding on their decisions surrounding TSD. Both participants felt that person-centred values and principles, particularly congruence, contributed significantly to their TSDs; John even described the act of self-disclosure as congruent in itself, in that it serves to communicate the authenticity and genuineness of the therapist.

Secondly, the analysis revealed remarkably similar rationales underlying TSDs to those identified by Berg et al. (2017). Their first theme, 'To show care and compassion', was reflected throughout my analysis, and the participants similarly described using self-disclosures as a way of developing a good patient-therapist relationship. Their second theme, 'To convey – you are not that different' - in which self-disclosures were presented as a way of normalising patient experiences - also arose as one of my themes ('Normalising experiences'). Like

the therapists interviewed by Berg et al. (2017), my participants reported using self-disclosures to reduce the client's sense of stigma or embarrassment and validating that they were not alone in having this problem. Their third theme, 'As a way to gain credibility; I know because I have been there myself', was reflected in my fourth theme, 'I'm human too', in which self-disclosures were regarded as a way for the counsellor to reassure the patient that he/she could understand the patient's difficulties because they had been through similar experiences (Berg et al., 2017). And finally, their fourth theme, 'Objections to self-disclosure', was reflected in my first theme, 'An internal battle', in which the participants similarly described evaluating the possible detrimental effects of self-disclosure. I was taken back by the outstanding similarities between the themes revealed by Berg et al. (2017) and those revealed in my own study. While Berg et al. (2017) focused explicitly on psychotherapists' lived experiences of TSD, the present study revealed that the lived experience of TSD seems to be very similar for person-centred counsellors. Thus, the findings of my study appear to be of relevance to therapists from a broader range of theoretical stances than initially expected.

Thirdly, the analysis provides additional support for much of Ziv-Beiman's (2013) research into TSD. For instance, the participants' positive experiences of TSD (e.g. Maria's self-disclosure regarding her experiences of self-injury) appeared to resonate with Ziv-Beiman's (2013) criteria for successful TSD: low-to-mild frequency of immediate self-disclosures, moderate levels of detail, prompt return of focus to the client and exploration of patient reactions. By extension, in providing further evidence that TSD can serve to to simultaneously suspend or address a variety of therapeutic goals - including strengthening the therapeutic alliance and resulting in largely positive therapeutic outcomes - the present findings lend more support to Ziv-Beiman's (2013) proposition that TSD holds the potential to be conceptualised as an integrative therapeutic intervention. Therefore, I second Ziv-Beiman's (2013) motion that TSD should be considered as a candidate with regards to Stricker's (2010) proposal of refining the classification and conceptualisation of models of psychotherapy integration.

Strengths of the Study

While my research mostly affirms previous research, what makes this piece of research of interest is that it explored person-centred counsellors' experiences of TSD; a fresh and contemporary perspective which hitherto far been neglected in the literature, particularly within the UK milieu. It also reveals more of the phenomenological lifeworld dimensions of spatiality (lived space) and temporality (lived time) as particularly fundamental to the lived experience of TSD for

therapists – something Geller (2003) touched on but I have tried to develop.

This study meets the criteria for a reasonably good study when judged according to the evaluative criteria of Yardley (2000), and I believe that a sufficient density of evidence is demonstrated for each theme. I have strived to ensure that the analysis is coherent, logical, and insightful, and thus as credible as possible. While the participants in this study indeed only represent an extremely small sample - which may present challenges to the generally accepted norms of transferability - phenomenological research does not require large samples, as it is not about making quantitative claims that allow researchers to generalise from samples to populations. Rather, phenomenology is about experiential/theoretical generalisation; the detail in the analysis should allow the reader to make speculative inferences about broader applicability (Lynden, 2017). Furthermore, in following Tuval-Maschiach's (2016) proposed method for improving transparency (demonstrating my intentions and explaining the whys and hows of my methodology), I believe that I have embraced an acceptable degree of transparent reflexivity. In doing so, I hope I have strengthened the study's trustworthiness and demonstrated a certain degree of rigour to those quantitative critics who are committed to systematized methods (Tuval-Maschiach, 2016, cited in Finlay, 2017).

While quantitative methodologies have been used to investigate TSD in the past, I argue that such approaches are far too reductionist to do justice to the complex and often emotionally ambivalent nature of TSD, which the present study has further demonstrated. Based on the present findings, as well as those of the previous literature, it appears that TSD is also an inescapably intersubjective phenomenon, and thus immeasurable by quantitative standards.

Furthermore, the present study further exemplifies the advantages of adopting a phenomenological methodology to investigate TSD, in that it proved useful in fulfilling its purpose – to provide us with an exclusive insight into how person-centred counsellors actually experience self-disclosing to clients during therapy. Here my study builds upon the existing qualitative research, such as the work of Reupert (2006), and phenomenological studies by the likes of Berg et al (2017). According to van Manen (1997), a good phenomenological text 'has the effect of making us suddenly see something in a manner that enriches our understanding of everyday life experience'. In this respect, I consider my study to have done phenomenology reasonably well, for all that there is room to deepen the analysis of pre-reflective experience.

Limitations of the Study

While the aim of phenomenological research is to better understand a particular phenomenon, I should acknowledge that any analysis is always partial and tentative; there will always be more to be uncovered and open to further description/interpretation. The language used to describe a phenomenon can never fully capture the experience as it is lived in its entirety (Finlay, 2011; van Manen, 2014). Equally, I recognise the influence of my own subjectivity on the interpretations made. In retrospect, I may have embedded some of my subjective assumptions within the design of the study itself; for instance, I recruited more experienced therapists under the assumption that a) as trained professionals, therapists would be more mentally 'robust' participants than clients, and b) more experienced therapists would have more experiences of TSD to discuss and/or more confidence in applying TSDs. As a student, I am still less clear about how the complex layers of TSD emerge in practice over time with clients. This may have led me to view the phenomenon in more simplistic terms.

Another important issue is to what extent the themes are a product of my preconceptions and to what extent they reflect the beliefs held by the participants. I strived to ensure that my interpretations emulated what the participants described during the interviews as closely as possible; however, the themes were chosen from among several possibilities. I also recognise that my general interest in counselling and self-disclosure may have influenced my interpretations; for instance, my experience of being on the receiving end of a self-disclosure by a therapist before (which I personally found extremely beneficial) may have inclined me to unintentionally overemphasise the positive side of TSD and underemphasise the negative side. Further, it seems likely that my analysis was influenced by the research that I read. Thus, I could have made a better job of embracing a phenomenological attitude and 'bracketing' my prior assumptions and expectations to one side.

By extension, I remain aware that even in humanistic (and integrative) contexts, there are robust critiques that have been made against TSD and greater attention could be paid to weighing when disclosures are helpful or problematic both in the interviews and during analysis.

Implications for Future Research

The findings of the present study may have direct clinical implications for therapists - particularly person-centred counsellors - in demonstrating the therapeutic potential of TSD and endeavouring to reduce the surrounding stigma. Future research should build on the present study by evaluating the effectiveness of TSD as an intervention (as suggested by Ziv-

Beiman, 2013) within a range of different therapeutic contexts. This, in turn, raises the issue of how such an intervention would be conceptualised; perhaps, as suggested by Berg et al. (2017), the current typology of TSD should be updated to include therapists' rationales for self-disclosing. Although the participants in my study echoed some of the rationales identified in previous TSD literature (e.g. Berg et al., 2017), further research should investigate the extent to which therapists from different theoretical and cultural backgrounds agree with these conceptualisations. It might also be interesting to compare and contrast the findings with wider international findings on the subject. Such research could have direct implications for therapists, as well theory, research and training. These implications may also extend to clients, given that previous research has indicated that many clients perceive TSD as highly beneficial (Pinto-Coelho et al., 2015; Berg et al., 2017). By extension, the findings may even extend to inform our understanding of interpersonal relations in the wider social world, such as altruistic behaviour, attitudes and relationships.

Another fruitful avenue of research might be to study actual therapist-client interactions in order to explore the complexity of the relational, discursive context in which TSD is embedded. Further research is particularly needed on the relational ethical implications of TSD, including when it may be perceived as destructive and invasive. For instance, further attention could be given to Ziv-Beiman and Shahar's (2016) argument regarding the dangers that clients may feel impinged upon. Also, focusing on the ethical context, Finlay (2019) argues that TSD has the potential to create relational rupture, for instance, if clients feel the focus of therapy is no longer on them sufficiently, or that they are needed to care for the therapist (perhaps replaying their own care-taking history). As Clarkson (2003) points out, excessive self-disclosure is abusive and a form of acting out of the therapist's "need for display, hostility or seductiveness" (p.17).

More conceptual discussion could help draw out insights into the practice of TSD. Finlay (2019) draws on transactional analysis in suggesting that TSD may work best in Adult-Adult transactions between therapist and client, and that they are more problematic if the therapist comes from a vulnerable Child place or when working developmentally/reparatively with the client's Child. Given that the relational dynamics of TSD have thus far been under-researched, perhaps Finlay's (2019) ideas could be drawn upon in order to elucidate what makes a 'successful' or 'problematic' TSD as well as considering the impact of TSD across work with clients at different ages.

Finally, there is room to explicate further the lived bodily dimension of therapists' experience, both in relation to TSD and more generally. More phenomenological explication of how therapists experience and manage their internal conflicts

and layered subjective responses in the moment-to-moment of living their therapeutic relationships may also prove worthwhile.

Considerations for Practitioners

It may also be worth touching on the poignant theme of power which implicitly underlies the majority of this paper. The theme of power is implicit both in terms of the potential power of TSD within itself (as a therapeutic 'tool'/'technique'), as well as the power held by the counsellors themselves as the 'professional with expertise' within the therapeutic relationship. The essence of this theme of power - or rather, power imbalance - was captured under Theme 2, 'Levelling the Playing Field'. Given the current discourse in wider Western society about the problematic nature of power - and potential abuse of power - it may be worth reminding practitioners to think critically about their use of TSD within their practice. Although the participants in this study were generally in favour of TSD, they also appeared to remain very aware of the potential risks involved, as illustrated in Theme 1, 'An Internal Battle'. Therefore, my findings offer a caution to practitioners to probe if there is any intention to manipulate. They might useful ask themselves: 'Whose interests am I serving?' and 'Am I self-disclosing to benefit myself or the client?', as well as considering the factors discussed (e.g. context/time), upon feeling the urge to self-disclose.

As part of deepening the dialogue about the topic, practitioners might also do more to reflect on the socio-cultural context of their own practices (or not) of TSD. It is important to recognise different attitudes exist towards privacy, professional boundaries, modesty, intimacy across different generations and (sub-)countries. With the increase in social media use where personal self-disclosure has become an accepted norm, norms within the therapy context may also be changing, arguably will impact particularly on work with younger people. Continuing research is needed to plot any such changes in social attitudes.

Conclusion

The present study has provided insight into the key debates around TSD and has demonstrated how phenomenological enquiry can bring a new perspective to the topic. By investigating TSD from a different theoretical perspective, it has provided us with a more nuanced understanding of the various ways in which TSD can be experienced. In line with much of the previous literature, the findings suggest that TSD can have multiple and far-reaching effects, from strengthening the therapist-client relationship to expediting a positive

therapeutic outcome. It would seem that these findings may have direct clinical implications for therapists - particularly, person-centred counsellors – and I have proposed several possible avenues for future research which may be conducive in developing our understanding of TSD even further. Given that self-disclosure seems to be routinely practised by many therapists, it seems vital that counsellors and psychotherapists take the risk to share and more openly self-disclose their professional practices.

Acknowledgements

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