“AT TIMES I WASN’T QUITE SURE HOW TO POSITION MYSELF IN THE ROOM...AS A TRAINEE OR AS A CLIENT”:

AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF TRAINEE COUNSELLING PSYCHOLOGISTS’ EXPERIENCES OF DISCLOSURE IN PERSONAL THERAPY AND ITS IMPACT ON PERSONAL AND PROFESSIONAL DEVELOPMENT

Masuoodah Yeasmin

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE UNIVERSITY OF EAST LONDON FOR THE DEGREE OF PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY

APRIL 2014

DEDICATION

To my beloved father, who was eager for me to finish. I wish you were here to share this moment with me. I love you and miss you every day.

ACKNOWLEDGMENTS

I would like to express my deepest thanks to the six Trainee Counselling Psychologists who volunteered to participate in this research. Without your willingness to share experiences, this journey would not have been possible. Thank you also to the British Psychological Society who supported me throughout the recruitment process and kindly allowed me to advertise my research on the Doctorate in Counselling Psychology research page and online forum.

I would like to give thanks to my research supervisor, Professor Rachel Tribe, for her time and guidance throughout each stage of the research process. Also, a huge thank you to Dr David Kaposi, who endlessly answered my research queries along this journey. To both of you, I am very grateful. I would also like to extend gratitude to my fellow trainees for their tireless advice and support.

To my parents, family and friends, thank you for listening, for supporting me emotionally and providing me with laughter during moments when I felt incredibly overwhelmed. My nephews, I thank you for your patience in waiting for sleepovers and fun days out together. I love you all.

Finally, and perhaps most importantly, my amazing husband Aziz. I thank you for encouraging me to follow my dreams, your patience, love, invaluable support and for believing in me even when I did not. I could not have done this without you. I love you dearly.

ABSTRACT

Existing literature indicates that individuals experience difficulties with disclosure. Disclosure involves revealing personal information about oneself, both verbally and non-verbally, that may be considered difficult or not disclosed previously, owing to one's own negative feelings about the information, or a fear that others may respond judgmentally. Various research and theoretical models have aimed to provide explanations as to what facilitates and hinders the process of disclosure. However, to date, trainee counselling psychologists' experiences of disclosure in personal therapy is under-represented, particularly within qualitative research.

This research aimed to explore trainee counselling psychologists' experiences of disclosure in personal therapy and its impact on personal and professional development. Semi-structured interviews were conducted with six trainee counselling psychologists in their final year of training and transcripts were analyzed using interpretative phenomenological analysis (IPA). Four master themes emerged from the analytic process: 'Disclosing the self'; 'The therapeutic process and disclosure'; 'Process of disclosure' and 'Impact of disclosure: Personal and professional development'. The themes illustrate how trainee counselling psychologists' initial difficulties with disclosure in therapy stem from their struggle with adopting a client role, their sense of the self as imperfect and a fear of rejection. Moreover, the findings highlight how this struggle results in the development of a divided and false self. The themes further illustrate how other factors within therapy facilitate and hinder disclosure, for instance, the therapist's qualities and responses to disclosures. How and when disclosure takes place was also described by participants, illustrating that this experience is rather subjective. The participants also described how disclosure facilitated understanding of the self and the role of a counselling psychologist, enabling the integration of their dual roles. In light of these findings, suggestions for trainee counselling psychologists, qualified psychologists and training providers are made. These suggestions centre upon trainee counselling psychologists' willingness to disclose, open discussions between therapists, trainees and training providers and additional training for therapists.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

BACP	British Association for Counselling and Psychotherapy
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
CoP	Counselling Psychology
CPA	Comprehensive Process Analysis
DCoP	Division of Counselling Psychology
DDM	Disclosure Decision Model
DPM	Disclosure Process Model
HCPC	Health and Care Professions Council
IPA	Interpretative Phenomenological Analysis
RRM	Revelation Risk Model
TCP(s)	Trainee Counselling Psychologist(s)
UEL	University of East London
UKCP	United Kingdom Council for Psychotherapy

Self-disclosure

“Through my self-disclosure, I let other know my soul.

They can know it, really know it, only as I make it known.

In fact, I am beginning to suspect that I can't even know my own soul

except as I disclose it. I suspect that I will know myself "for real"

at the exact moment that I have succeeded in making it known

through my disclosure to another person”.

Sidney Jourard (cited in Zur, 2004).

INTRODUCTION

A note to the reader: The terms therapy and therapist will be used generically and will refer to a range of psychotherapy professions and therapeutic practice.

The importance of trainee therapists engaging in personal therapy derived from the psychoanalytic tradition whereby Freud (1937/1943) stated it is significant for the development of professional competence (cited in Grimmer, 2005). Freud (1912) further asserted that personal therapy facilitates trainees to develop an understanding of their 'unconscious' (cited in Jacobs, 2011, p.428), which seemingly prevents interference with analysis of their own clients. Subsequently, personal therapy became a requirement in psychoanalytic training (Grimmer, 2005).

The requirement of personal therapy as part of training has changed over the years and varies across training organisations (Dryden and Thorne, 1991, cited in Merry, 2002). This variation seems to be based on the number of hours needed, with some systemic courses (Grimmer, 2005), clinical psychology (Rake, 2009) and cognitive behavioural therapy (CBT) training not insisting on its necessity. However, CBT courses emphasise the importance of personal development through appraisal, supervision and reflective practice (Hope, 2004). The British Association for Counselling and Psychotherapy (BACP) also ceased its minimum requirement of 40 hours of personal therapy in 2005, instead requesting therapists to demonstrate self-awareness (BACP, 2010) through description of experiences, activities and how this applies to clinical practice (Coles, 2008). The BACP change came into place as it was recognised that not all therapeutic modalities perceived personal therapy as a salient component of training (Coles, 2008). Nevertheless, the United Kingdom Council for Psychotherapy (UKCP) continues to promote the need for personal therapy, requiring trainees to undergo the same duration, frequency and therapeutic modality they expect to offer (UKCP, 2013). Similarly, trainee counselling psychologists (TCPs) are required to develop deeper understanding of own life experiences through engaging in a minimum of 40 hours of therapy (The BPS, 2012).

Several authors emphasise that personal therapy is essential as it provides an opportunity to increase self-awareness, explore unresolved difficulties, gain experience of being a client, reflect on work with clients and attain knowledge of various therapeutic approaches (Cross and Papadopoulos, 2001; Dryden and Feltham, 1994; Legg and Donati, 2006; McLeod, 2003; Shillito-Clarke, 2003). The importance of resolving personal issues has also been highlighted so therapists can heal, be congruent with clients (Lum, 2002), cope with the emotional distress of others (Karter, 2002) and ensure that the effectiveness of counselling is not hindered (Cross and Papadopoulos, 2001). Lum (2002) further believed that unresolved issues result in therapists reacting negatively to clients' problems by becoming stuck, avoiding exploration, 'skewing the information, or losing focus' (p.182). Consequently, the therapist is unable to use the self to be 'emotionally available to connect deeply with their clients' inner worlds' (p.182), which is also essential in the development of the therapeutic relationship (Lum, 2002). In her phenomenological research on 9 therapists' lived experiences of the Satir model, which is a brief systemic therapy training program that aims to increase therapists' self-esteem, foster better choice making, increase responsibility and develop congruence, Lum (2002) found that therapists indeed became more congruent, gained greater self-awareness and made better choices, which then impacted positively on their therapeutic relationship with clients. Orlinskly, Schofield, Schroder and Kazantzis (2011) provide support for this as they also found that through understanding one's own conflicts, values and beliefs in personal therapy, therapists were increasingly sensitive and empathic, learnt therapeutic skills and employed greater self-awareness in therapy. Rizq (2010) additionally argued that therapy partially ensured that therapists are not drawn to the idea of exploiting vulnerable clients.

Maintaining one's fitness to practise and to practice ethically is clearly stipulated in guidelines by the Health and Care Professions Council (HCPC, 2012) and the British Psychological Society's (BPS) Division of Counselling Psychology (DCoP, 2005). As counselling psychologists are perceived to be an important part of the therapeutic process, any impairment in the therapist's psychological, emotional and physical wellbeing would inevitably impact on the efficacy of therapy (Shillito-Clarke, 2003). The Standards of Proficiency guidelines for practitioner psychologists thus draw attention to the need for psychologists to sustain their own health and practice effectively within their own scope of

practice (HCPC, 2012). Moreover, it is an ethical requirement for psychologists to be aware of, monitor and inform their supervisor about personal difficulties and limitations, even if temporary, to maintain safe practice (DCoP, 2005). Keeping in mind the importance of practicing ethically ensures psychologists do not persuade themselves to engage in unethical behaviours merely to protect their 'self-image, or esteem', (Page, 1999, cited in Shillito-Clarke, 2003, p.624). In saying this, the HCPC's (2012) requirement for fitness to practice can raise implications for TCPs attending personal therapy. In the early stages of training, uncertainty about the counselling psychologist role, including the concept of fitness to practice and what may be deemed fit might not be clearly understood by TCPs, which can potentially influence TCPs' decisions to disclose in therapy. Disclosure is the process of revealing personal information about oneself to another (Farber, Berano and Capobianco, 2004); accordingly, TCPs may feel at risk of portraying the self as unfit. The concept of disclosure will be discussed further from section 1.3 and onwards.

Although the necessity and importance of personal therapy has been clearly outlined above, literature has since developed, identifying a number of difficulties with requiring trainees to undertake personal therapy (McLeod, 2003), like the process of disclosure, as highlighted above. Further descriptions of these difficulties are underlined in section 1.2. Since personal therapy is mandatory for TCPs, it would be of benefit to further explore and enhance our understanding of the difficulties experienced by TCPs, so that it may be attended to.

CHAPTER ONE

LITERATURE

1.1 Introduction to literature

Throughout this chapter, in the dearth of primary research about TCPs' experiences of disclosure in personal therapy, existing literature relevant to TCPs and disclosure in other settings will be drawn upon. In conjunction with this, literature pertinent to disclosure has been reviewed with the objective of obtaining further understanding on this area generally. An overview of the literature on the impact of personal therapy is also provided to further develop an understanding of the role disclosure plays in personal and professional development. The literature was obtained through a systemic literature review using *PsycINFO and PsycARTICLES*, with multiple search terms entered (see appendix 1).

1.2 Potential difficulties associated with personal therapy

Although the importance of engaging in therapy has been outlined, there remains limited understanding and knowledge regarding the negative experiences of personal therapy, particularly for therapists in training. By implication, it can be assumed exploration of this area may raise questions about the usefulness of therapy whilst training. To date, research has examined the difficulties related to therapy, illustrating that qualified therapists' reasons for not seeking therapy and clients' concerns about therapy may reflect the difficulties encountered by trainee therapists during therapy. Reasons and concerns included limitation of confidentiality (Gilroy, Carroll and Murra, 2001; Mearns, 1997, cited in Atkinson, 2006; Nowell and Spruill, 1993), financial implications (Holzman et al., 1996, cited in Bike, Norcross and Schatz, 2009), fear of exposure (Pope and Tabachnik, 1994, cited in Norcross, Bike, Evans and Shatz, 2008), fear of being disliked and rejected (Farber and Hall, 2002; Kelly and McKillop, 1996), stigma (Corrigan and Rao, 2012; Williams and Healy, 2001), perceived risks and benefits of disclosure (Vogel, Wade and Hackler, 2008; Vogel and

Wester, 2003) and shame (Hook and Andrews, 2005; Macdonald and Morley, 2001). These studies will be reviewed further in the relevant sections.

Studies concerning trainee therapists and psychologists highlight that difficulties indeed exist whilst engaging in personal therapy (Shapiro, 1976, cited in Grimmer, 2005). Thorne and Dryden (1991) specify that personal difficulties are likely to be addressed in personal therapy, which may result in emotional distress, consequently affecting their studies through reduced concentration and participation. Legg and Donati (2006) further reveal that some trainees are reluctant to attend personal therapy as they fear it may be painful. Earlier research usefully brings to attention that attending therapy in the early stages of training can lead to detrimental effects on clinical work (Macaskill, 1988, cited in Gold and Hilsenroth, 2009), with therapists being emotionally unavailable for clients (McLeod, 2003). McLeod (2003) further argues that some trainees may continue with therapy for the purpose of completing a mandatory part of training, even if there is a mismatch between themselves and their therapist, and so do not obtain full benefits of therapy which may be problematic (Thorne and Dryden, 1991). Another difficulty identified by therapists in training is disclosure (McLeod, 2003), which can also impact on therapy. The difficulties associated with disclosure will be reflected upon in section 1.6 and in the remainder of this chapter.

1.3 What is disclosure?

With acknowledgment of the broad range of definitions for disclosure, this research will refer to Jourard's (1971) definition of disclosure as he was one of the first researchers to explore this phenomenon (Forrest, 2010). Jourard (1971) defined disclosure as the 'act of making yourself manifest, showing yourself so others can perceive you' (p.19). The act of disclosure therefore requires the presence of two or more people (Ignatius and Kokkonen, 2007). Research on disclosure within the context of therapy further adds that disclosure also entails revealing personal information about oneself, which may not have been previously disclosed, or is considered challenging and shameful for the individual disclosing. Moreover, disclosure can be refrained from owing to assumed negative responses of the therapist and the impact this may subsequently have on the individual (Farber et al., 2004).

1.4 Types of disclosure

Disclosure often occurs through language, although it can also transpire non-verbally (Stricker, 2003). Farber (2006) asserts that non-verbal disclosures can provide information about what clients are thinking and feeling, for instance, agitation can imply anxiousness, whilst smiling can often be used to hide negative emotions like shame (Bonanno et al., 2002). Therefore, commenting on what can be observed can aid comfort in making verbal disclosures (Farber, 2006). Disclosures can also be unavoidable, voluntary, accidental (Barnett, 2011), mandatory (Stark, 2011) or it can take place either face-to-face, through the telephone or computer (Ignatius and Kokkonen, 2007). The disclosure literature has also examined how disclosure can vary from person to person, as well as from one context to another (McAllister and Bregman, 1985, cited in Ignatius and Kokkonen, 2007). For instance, there are client disclosures in therapy, therapist disclosures to clients, disclosure in supervision and disclosure by therapists attending therapy. TCPs' disclosures in therapy is another context, however, there is limited research within this area. Significant research and literature related to these contexts will be examined further in the relevant sections.

1.5 Models of disclosure

There are several models described throughout the disclosure literature outlining why, when and what factors influence how individuals decide to disclose. The following models of disclosure offer a broader understanding of the intricacies involved in disclosure.

1.5.1 Fever model

Stiles' (1987a) fever model asserts that individuals disclose information in order to relieve distress, which has built up as a result of withholding information that is worrying them (cited in Stiles, Shuster and Harrigan, 1992). Stiles (1987a) likened the build-up of distress to a fever that occurs after a physical infection. The model states that the sensations experienced during distress, such as painful thoughts and emotions, come into awareness and result in a strong urge to disclose what is going on at the time. Furthermore, the level of disclosure increases as distress increases. Findings from Stiles et al.'s (1992) study

provided support to this view. The model also suggests that disclosure is cathartic, enabling individuals to release their distress, which can bring about self-understanding and enhance wellbeing. Moreover, the model states that individuals do not expect benefits from disclosing, but rather come to realise its advantages and so in future seek opportunities to disclose when feeling distressed again.

1.5.2 Disclosure Decision Model (DDM)

Omarzu's (2000) disclosure decision model (DDM) offers another perspective, suggesting that individuals have a choice and go through three stages when deciding to disclose, with decisions being dependent upon the social and personal goals attainable. According to this model, the following five possible goals can be achieved through disclosure: approval, intimacy, relief, identity and control. In the first stage, individuals identify an important goal based on the situation they are in. The second stage involves assessing the appropriateness to disclose and to whom to disclose to. Kelly and McKillop (1996) highlight that sometimes individuals observe responses of the person they will disclose to by making other disclosures. The final stage involves considering how beneficial and risky the disclosure will be. Possible risks entail 'social rejection, betrayal…discomfort for the listener' which influences 'how much, how broadly' and 'intimately' a person will disclose (Omarzu, 2000, p.180-181).

1.5.3 Temporal model

Farber, Berano and Capobianco's (2006) temporal model illustrates that individuals go through the following six stages of disclosure:

1. Therapy begins with a positive attitude about disclosure
2. Hesitance felt prior to disclosing
3. Vulnerability felt whilst disclosing
4. Positive emotions experienced instantly after disclosure
5. Individuals seek and often receive approval from their therapist after disclosure
6. Disclosure increases the chances of disclosing in the future to therapists and others

Strengths of this model are that some of the stages coincide with other findings (Stiles 1987a, cited in Stiles et al., 1992; Omarzu, 2000), for instance, the experience of negative and positive emotions before and after disclosure. Furthermore, this model broadened the literature on disclosure by recognising that six possible stages exist. However, the reliability of this model is arguable as the stages were derived from a relatively small sample and participants knew the researcher, thus possibly resulting in biased responses.

1.5.4 Revelation Risk Model (RRM)

Afifi and Steuber's (2009) revelation risk model (RRM) provides a framework that predicts the likelihood of disclosure, the continuation of concealing secrets and the strategies used to disclose. The RRM focuses specifically on the disclosure of secrets. Secrets are defined as information that is negative and intentionally kept from others owing to the consequences of disclosure (Kelly and McKillop, 1996). The RRM believes individuals' 'readiness' and 'willingness' (p.148) to disclose is reliant on the severity of risk of disclosing. The risks envisaged are the 'risk to the self', 'risk to the relationship' and 'risk to other people', which is distinct from other disclosure models (p.148). Nevertheless, there are three conditions that influence disclosure. Similar to the fever model (Stiles 1987a, cited in Stiles et al., 1992) and the DDM (Omarzu, 2000), the first is catharsis, activated by intolerable distress. The second is the respondent ought to know and is entitled to know, with guilt generating pressure to disclose, and finally, individuals are asked to disclose, whereas in the fever model the pressure comes from the self.

An integral part of this model is communication efficacy, which is individuals' convictions in their capacity to relay information to others (Afifi, Olsen and Armstrong, 2005). The RRM further emphasises that communication efficacy, including risk, predicts the occurrence of disclosure and the types of strategies used (Afifi and Steuber, 2009, see table 1). The following six strategies were identified: preparation and rehearsal, directness, third party revelations, incremental disclosures, entrapment, thus disclosing through an argument or by leaving evidence behind, and indirect mediums like telephone, email or letter. Essentially, when the risk is low, individuals are more ready, willing and believe they have the skills to communicate. However, when the risk is high, individuals' perceptions of their ability to

communicate are lower, resulting in non-disclosure. The limitations of this model, however, are that it does not explain whether the strategies arise in a particular order, whether one is utilised more or if any are effective. In light of this absence, further research is required.

Table 1: When disclosure is likely and the strategies used to disclose

Communication efficacy and risk	Strategies used
Low communication efficacy	Preparation, third party revelations and incremental
High communication efficacy	Direct and entrapment
High risk	Preparations, entrapment and third party revelations
Low risk	Direct and entrapment

1.5.5 Disclosure Process Model (DPM)

Chaudoir and Fisher's (2010) disclosure process model expands previous models of disclosure in three ways. Firstly, it characterises disclosure as a process that also includes decisions to disclose and the outcomes of disclosure itself. Secondly, it implies that two types of goals, approach and avoidance, influence the likelihood of disclosure. The DPM specifies that approach goals move towards disclosure as positive outcomes are expected and avoidance goals move away from disclosure because negative outcomes are envisaged. Chaudoir and Fisher (2010) emphasise that these goals also influence how disclosure occurs, which eventually impinges on outcome. Finally, the distinguishable part of the DPM is that three types of 'mediating processes' emerge concurrently after a disclosure. These are 'alleviation of inhibition', which involves individuals disclosing previous repressed information about a stigmatised identity, 'social support', which alludes to individuals acquiring support, and 'changes in social system' (p.238), which arises when new information about an identity is disclosed and shared with others. Table 2 encapsulates findings from Chaudoir and Fisher's (2010) review of existing research and literature on individuals with various 'concealable stigmatized identities' (p.237), revealing that the mediating processes can result in individual (openness, enhanced wellbeing), dyadic (trust,

intimacy, liking) and social outcomes (reduced stigma and normalisation of disclosure), as well as influence goals further.

Table 2: The impact of mediating processes of disclosure amongst individuals with stigmatised identities

Mediating Processes	Outcomes	Goals influenced
Alleviation of inhibition	Individual	Approach
Social Support	Individual and dyadic	Avoidance
Changes in social system	Individual, dyadic and social	No goals influenced

Chaudoir and Fisher (2010) conclude that the DPM does not simply end with these outcomes, but rather it is an on-going process. They further highlight that the different outcomes can impact on succeeding 'disclosure processes through a feedback loop', (p.240). In essence, positive outcomes lead to more disclosure, whereas negative outcomes lead to reduced disclosure. They further surmise that goals do not influence the mediating processes but do impact greatly on individual, dyadic outcomes and less on social, which explains why disclosure is favourable in some circumstances and not others.

1.6 Issues with disclosure

As mentioned in section 1.2, disclosure has been documented as an issue in therapy, particularly for TCPs in personal therapy. However, thus far, there seems to be no specific research exploring TCPs' experiences of disclosure in therapy and this justifies exploration. Accordingly, research on issues which seemingly hinder and facilitate disclosure within the different contexts identified in section 1.4 will be discussed, with an attempt to provide a premise for understanding the issues surrounding disclosure, as well as shed light on TCPs' difficulties with disclosure in personal therapy. Additional related research on disclosure will also be considered.

1.7 Related research on clients' difficulties with disclosure

1.7.1 Stigma and shame

There is a body of research placing weight on how others' reactions to disclosures or the beliefs held by society about certain problems or illnesses results in individuals experiencing shame, stigma (Bos, Kanner, Muris, Janssen and Mayer, 2009) and internalisation of these views, for instance, that they are incompetent (Corrigan and Rao, 2012). Bos et al.'s (2009) quantitative study of 500 participants with mental illness investigated the relationship between stigma, social support, self-esteem and disclosure. Findings illustrated that owing to stigma and less social support from colleagues, individuals were more likely to disclose to family. This finding certainly supports the DDM's notion that risks of being stigmatised or not receiving support can lead to decisions to not disclose (Omarzu, 2000). Stigma was also found to be negatively related to self-esteem, however, owing to a cross-sectional design, causality could not be determined. This limitation is of interest because if self-esteem were to influence disclosure, it would illuminate literature on the wounded healer further (see section 1.9.1 for further detail). Nevertheless, a quantitative design would not provide insight into how self-esteem impacts on disclosure, thus future researchers may wish to consider a qualitative design.

Although Farber and Hall's (2002) sample of therapy clients did not report shame as impacting on disclosure, Farber's (2003) review of self-disclosure research identified that shame indeed inhibited disclosure. Lewis (1971) defined shame as an emotion which is 'characterised by a sense of the self being flawed', (cited in Candea and Szentagotai, 2013, p.102). Farber (2003) accentuates that individuals who perceived the self as a failure and disliked aspects of the self, experienced high levels of shame and disclosed less about these areas. In their discussion about the implications of shame, Candea and Szentagotai (2013) stress that shame can result in concealment of one's deficiencies, through a withdrawal coping style (Black, Curran and Dyer, 2013), making shame difficult to find and treat (Graff, 2008).

Macdonald and Morley's (2001) study of 34 psychotherapy outpatients provides support for the view that shame is concealed. Their study illustrated that 74% of non-disclosures were due to shame; with 70.4% expressing this was owing to a fear of being viewed negatively by others. Analysis of interviews using grounded theory yielded two categories, concern about the self and concern about others (see table 3), mirroring Gilbert's (1998) concepts of 'internal' and 'external' shame (cited in Candea and Szentagotai, 2013, p.102).

Table 3: Shame associated with the self and other

Shame associated with non-disclosure and the self	**Shame associated with non-disclosure and the other**
Shame and other self-conscious emotions	Upsetting and burdening others
Out of character	Unhelpful positive responses
Inability to justify feeling and experiences	Lack of understanding
Responsibility	Lack of interest or attention
Rejection of one's own feelings	Lack of trust
Reluctance to experience unpleasant emotions or memories	Lack of confidentiality
Isolation	Fear of being disbelieved

However, findings suggest that the relationship between shame and non-disclosure is complex. Besides individuals' non-acceptance of the self impacting on disclosure, their feelings are also projected onto others, resulting in the expectation they would be treated negatively, which inevitably impacts on disclosure too. However, the diary exercise in this research contained closed and somewhat leading questions, which may have led to desired responses, thus contradicting the aim of conducting an 'open-ended inquiry' (p.2). Nevertheless, Glaser's (2003) assertion that grounded theory corresponds with both paradigms, as it is embedded in interpretation, explanation, impact and causes, is well supported. Additionally, Hook and Andrews' (2005) study lends support to these findings as they also found 72% of their participants did not disclose owing to shame. These findings certainly support Omarzu's (2000) DDM as besides feelings of shame, individuals' decisions

to not disclose seemed to be also based on anticipated negative responses from others. Although it can be assumed that the above findings are transferable to TCPs, therapy for TCPs is somewhat different as it is mandatory and they do not typically enter therapy with the primary aim of addressing a specific problem. Accordingly, research exploring TCPs' experiences is warranted.

1.7.2 Confidentiality issues and potential rejection

Younggren and Harris (2008) define confidentiality as 'the duty to protect client privacy' (p.590) that stems from a professional relationship, which also facilitates trust, empathy, the therapeutic relationship, disclosure and successful therapy. Pope and Vasquez (2011), however, stress there are limitations to confidentiality, which ought to be made explicit by practitioners and supervisors (Cobia and Boes, 2000) as not doing so can be risky for clients and therapists (Freeny, 2007). Conversely, the limitations of confidentiality may serve to limit disclosure, although this is less likely if the benefits of disclosure are also provided (Muehleman, Pickens and Robinson, 1985).

Nowell and Spruill (1993) found in their quantitative study that participants indeed made less disclosure when informed of limitations of confidentiality than participants who were given complete confidentiality. Limitations of this study, however, entail the inability to generalise findings to therapy clients as participants had no previous therapy experience and were also asked to envisage how they would respond in such situations. Studies which are analogous in design should generally be treated cautiously. Nevertheless, as concerns about confidentiality were reflected in other findings (Gilroy et al., 2001; Mearns, 1997, cited in Atkinson, 2007; Woods and McNamara, 1980, cited in Nowell and Spruill, 1993), and was the main reason for not seeking therapy (Farber, 2000; Norman and Rosvall, 1994, cited in Norcross et al., 2008), findings are arguably convincing and representative. These findings also appear to challenge the RRM's view that individuals' readiness and willingness to disclose influences the occurrence of disclosure (Afifi and Steuber, 2009). It seems that besides readiness and willingness, the space an individual has also plays a large role in the likelihood of disclosure and being explicit about the limitations of confidentiality is indeed an important aspect of therapy.

Similar to Macdonald and Morley (2001), Farber (2006) specifies that self-rejection is projected onto the therapist, with clients thus expecting the therapist to be rejecting, judgmental and critical, which seemingly hinders disclosure. Leroux, Sperlinger and Worrell's (2007) phenomenological study too revealed that feelings of vulnerability in therapy were linked to a fear of unaccepted parts of the self being visible and rejected, hence leading to uncertainty about disclosure. However, the validity of these findings is limited as only some participants reported this same experience. Conversely, this finding certainly supports the DDM's view that potential risks of disclosure inhibit its occurrence (Omarzu, 2000). The hesitancy and vulnerability described by Leroux et al. (2007) also appears to be consistent with the temporal model (Farber et al., 2006), although, the temporal model did not specify the reasons as to why hesitancy and vulnerability is felt prior to and during disclosure. Rasmussen's (2002) retrospective study further suggests that rejection is related to resistance in therapy. Farber (2006) contends that resistance ought to be attended to as it can resemble non-disclosure by not being completely honest. In essence, these studies indicate that concerns about confidentiality and rejection are prominent issues in therapy as it impacts on disclosure. Thus further exploration is required; particularly with TCPs as research involving them is limited.

1.7.3 Anticipated risks and benefits, including beliefs about disclosure and therapy

Research alerts us that individuals often anticipate the risks and benefits prior to disclosing, which subsequently inhibits or enhances disclosure. Anticipated risks have been generally defined in the literature as the expected danger of being judged, an inability to cope with distress, feeling misunderstood, rejected and ignored following disclosures (Vogel and Wester, 2003). Anticipated benefits on the other hand refer to reduced distress, support, intimacy (Chaudoir and Fisher, 2010) and admiration (Kelly, 2000). This strengthens Omarzu's (2000) DDM, Afifi and Steuber's (2009) RRM and Chaudoir and Fisher's (2010) DPM. Research has typically examined reasons for non-disclosure, revealing that anticipated risks largely hinder disclosure (Kelly and McKillop, 1996). Two studies exploring anticipated risks and benefits of disclosure also examined its relationship to the perception of therapy and usefulness of help seeking (Vogel and Wester, 2003; Vogel et al., 2008),

one's level of psychological distress and willingness to seek help (Vogel et al., 2008). Research in this area has commonly hypothesised that increased anticipation of risk will result in less disclosure and anticipated benefits will lead to increased disclosure. As illustrated by Afifi and Steuber's (2009) RRM, when the risk is perceived as high, individuals' perceptions of their ability to communicate is lower, thus resulting in non-disclosure. Vogel and Wester (2003) too made the same hypothesis, including, those with less favourable views about therapy, which derives from anticipated risks, are less likely to seek help. Vogel et al. (2008) also speculated that one's psychological distress will be linked to willingness to seek help and thus emotional expression.

As expected, findings from Vogel and Wester's (2003) study revealed that anticipated risks and negative perceptions of counselling, such as the fear of being overwhelmed with sadness and being pressured by the therapist to talk influenced one's attitude to seeking help. Non-disclosure was also largely related to how comfortable one felt with disclosing, which impacted on the level of disclosure made. In support of this finding and other research, Vogel et al. (2008) surmise that anticipated risks and difficulties with emotional expression were negatively related to help seeking behaviour. On the contrary, anticipated benefits increased emotional expression. Psychological distress, however, did not contribute to the relationship between emotional expression and willingness to seek therapy, which is dissimilar from other research (Boyd, 1986; Norcross and Prochaska, 1986, cited in Vogel et al., 2008). Nevertheless, these studies suggest that perceiving emotional expression and therapy as beneficial can greatly influence help seeking and disclosure. It is therefore highly recommended that therapists tackle negative preconceptions about disclosure and therapy. As TCPs are required to attend therapy during training, it would be useful to explore whether beliefs about the helpfulness of therapy, including anticipated risks and benefits influence their level of disclosure.

1.7.4 Self-presentation

Kelly's (2000) self-presentation model offers further insight into the issues related to disclosure. This model proposes that individuals intentionally do not disclose in an attempt to portray themselves positively, be liked, gain approval and receive positive feedback,

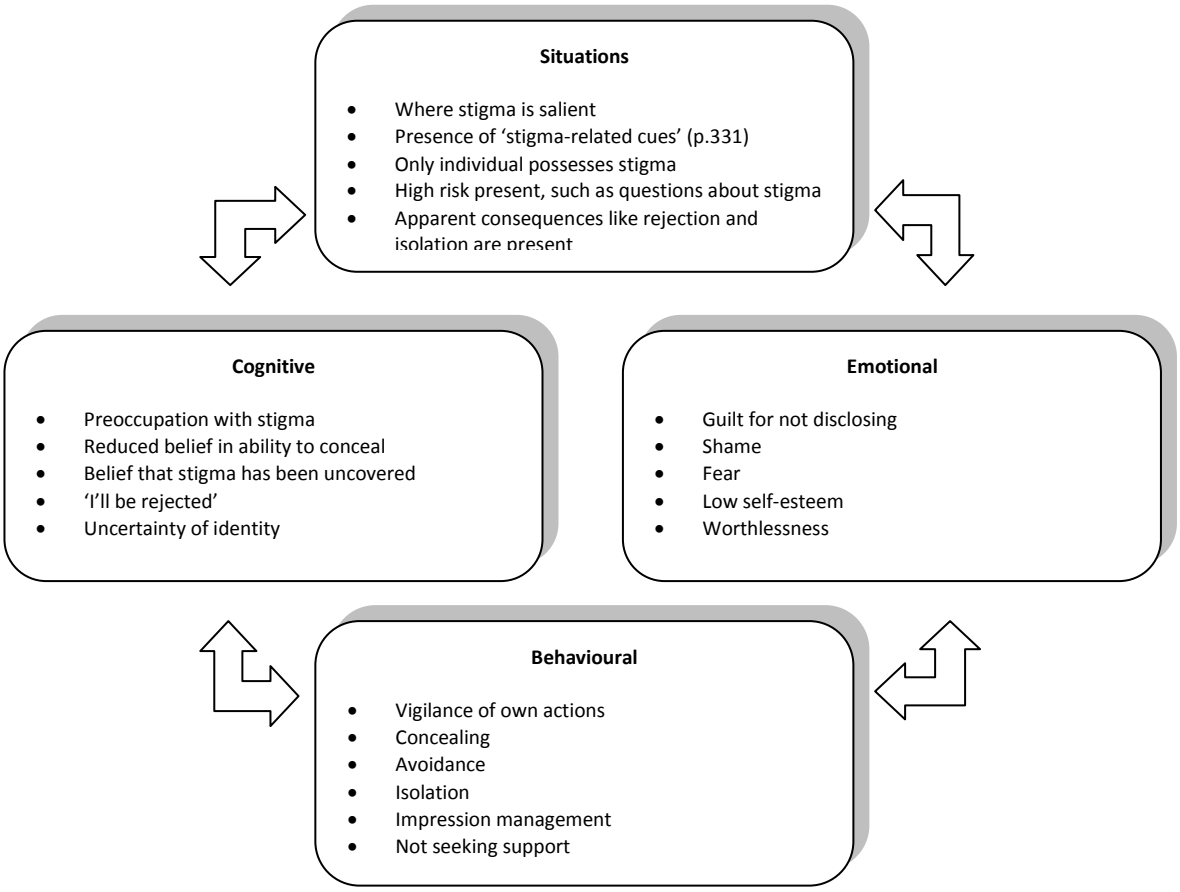
resembling the achievable goals outlined by the DDM (Omarzu, 2000). Kelly (2000) adds that individuals also fear rejection and disclosures are often what the individual aspires to be. She further explains that positive feedback enhances self-esteem as they come to view themselves favourably, whilst negative feedback can result in negative self-perception. This model further postulates that non-disclosure or concealment about negative parts of self leads to better therapy process and outcomes, as the client moves towards being the ideal self they presented. Consistent with Kelly's (2000) argument, Leary and Allen (2011) assert that self-presentation is motivated by a fear of negative evaluations and disapproval, leading individuals to 'distort their answers' (p.893) in a way that will be approving. This model certainly coincides with aspects of the DDM (Omarzu, 2000), the temporal model (Farber et al., 2006) and the RRM (Afifi and Steuber, 2009), for instance, the seeking of approval and fear of negative outcomes following disclosures. Distinctly, the self-presentation model highlights that approval can also be sought through modified disclosures, even when risks are envisaged. Although Kelly's (2000) model sheds light on trainees' potential reasons for non-disclosure, its relevance to TCPs is nevertheless a speculation. Research exploring TCPs' reasons for non-disclosure is therefore undoubtedly required, which will permit difficulties to be understood and resolved. Furthermore, Hill, Gelso and Mohr (2000) argue that Kelly's (2000) findings are inconsistent with other research, that clients do not display less symptoms or simply engage in non-disclosure for reasons of self-presentation. Arkin and Hermann (2000) also disagreed with Kelly (2000), stating that clients' perceptions of the self and self-presentation is largely influential in changing their own self-concept, not therapist feedback. Findings from a more recent research lend support to Kelly (2000) and the above critiques (Hewitt, Habke, Lee-Baggley, Sherry and Flett, 2008). However, as self-presentation of 90 clinical patients was investigated in an interview setting, it limited generalisation to a real clinical setting. Nevertheless, Kawamura and Frost (2004) support Hewitt et al.'s (2008) findings.

1.7.5 Distress and disclosure

Pachankis' (2007) study suggests that individuals selectively disclose and conceal problems as a way of avoiding rejection and stigma, which can subsequently trigger negative cognitive, emotional and behavioural responses in particular situations (see figure 1).

Pachankis (2007) points out that these responses also interact with each other, influencing future decisions about disclosing, concealing and avoidance. This model strengthened Stiles' (1987a, cited in Stiles et al., 1992) fever model, in that distress is experienced owing to non-disclosure. Pachankis (2007), however, implies that distress increases the risk of disclosing, whereas Stiles et al. (1992) maintain that distress results in disclosure.

Figure 1: Psychological impact of non-disclosure and concealing a stigma



Pasupathi, McLean and Weeks (2008) also found that negative emotions predicted everyday disclosures, which appears to be coherent with the fever model's (Stiles, 1987a, cited in Stiles et al., 1992), the temporal model's (Omarzu, 2000) and the RRM's (Afifi and Steuber , 2009) view that distress results in disclosure. However, significant life experiences, although linked to negative emotions, were not disclosed owing to a fear of others' responses and to prevent preoccupation, which perhaps lends support to the RRM's notion that individuals have to be ready, willing and believe in their ability to communicate the disclosure in order

for it to take place (Afifi and Steuber, 2009). Nevertheless, as disclosure enhances wellbeing, like various disclosure models contend (Stiles, 1987a, cited in Stiles et al., 1992; Farber et al., 2006; Chaudoir and Fisher, 2010), Pachankis (2007) specifies that helping individuals consider the benefits of disclosing can help facilitate disclosure. Chaudoir and Quinn's (2010) quantitative study also revealed that positive first disclosure experiences can result in feeling less fearful of disclosing, trust in others, comfort with disclosing, higher self-esteem and future disclosures (Chaudoir and Quinn, 2010). Amongst other limitations, a key limitation of these studies is that mainly students were used and placed in experimental conditions, therefore limiting the applicability of findings to clients, TCPs and disclosure in therapy. By contrast, the following quantitative studies have concluded that keeping a secret, akin to non-disclosure (Farber, 2006), did not result in distress (Kelly, 1998; Kelly and Yip, 2006; Vrij, Nunkoosing, Paterson, Oosterwegel and Soukara, 2002). Rather, the seriousness of the secret (Vrij et al., 2002) and individuals' personalities, like the propensity to conceal and a poor sense of self, are in fact responsible for negative symptoms (Kelly and Yip, 2006). Accordingly, research exploring the degree to which issues related to clients play a role in the process of disclosure would be valuable in understanding disclosure further.

1.7.6 Gender and disclosure

Links have been made between gender and disclosure. In a meta-analysis of 205 studies, Dindia and Allen (1992) found that females disclosed more, although concluded that the recipient's gender can impact greatly on disclosure too. Furthermore, their research underlined that when the recipient was a woman, women disclosed more than men and when the recipient was a man, men disclosed more than women. In contrast, earlier research surmises that males disclose more than females (Kobocow et al., 1983, cited in Ignatius and Kokkonen, 2007), or there is no gender difference (Shapiro and Swensen, 1977, cited in Ignatius and Kokkonen, 2007). A more recent quantitative study by Pattee and Farber (2008) examined the effects of gender and gender role identification on 223 clients' disclosures in therapy. Findings revealed that female clients with female therapists experienced more difficulties with disclosure than male clients with female therapists. Additionally, role identifications like androgyny, whereby individuals have both masculine and feminine characteristics, were more open than those who specifically identified

themselves as masculine or feminine. Jourard (1971) explains that traditional sex roles insist men should be tough, which plays a role in inhibiting men from disclosing. This finding supported earlier research (Fielden, 1982, cited in Hill and Stull, 1987; Shaffer, Pegalis and Cornell, 1992), while other research emphasised that androgynous females were more likely to disclose than androgynous males or vice versa (Fischer, 1981; Rosenfeld et al., 1979, cited in Hill and Stull, 1987). Strengths of these quantitative studies included comparison tests and the use of large samples, therefore allowing findings to be generalised. However, inconsistent findings suggest that results ought to be treated cautiously. Furthermore, there is a lack of clarity as to how gender and gender role influences disclosure, which has also been overlooked by existing disclosure models (see section 1.5). Accordingly, further research may illuminate this area.

1.7.7 The therapeutic frame, boundaries, therapeutic space and disclosure

As disclosure occurs within the context of therapy, research has identified that various elements of the therapeutic process, like the space available to disclose, the therapist's characteristics, skills and responses (Orlinsky et al., 1994, cited in McLeod, 2003) can affect disclosure and therapeutic outcomes (McLeod, 2003).

In psychodynamic practice, a therapeutic frame, or secure frame, denotes the way a therapist and client will work together (Gray, 1994). The therapeutic frame also provides the therapeutic space (Devereux and Coe, 2010), which can be viewed as the 'stage' where change occurs, as well as the room available for disclosure (Cox, 1978, p.40). Langs (1999) identifies that when the frame is attacked, difficulties can arise within the therapeutic relationship (cited in Symons and Wheeler, 2005). The therapeutic frame also outlines boundaries (Symons and Wheeler, 2005), such as a consistent venue, time and fee, typically no therapist disclosures and the therapeutic relationship not moving from professional to personal (Gargiulo, 2007). Gray (1994) points out that when the frame is secure and maintained, therapists are perceived as reliable, trustworthy and consistent, which facilitates feelings of safety and exploration of issues (Symons and Wheeler, 2005).

A quantitative study on 763 psychology students by Cochran, Stewart, Kiklevich, Flentje and Wong (2009) elucidates the importance of the therapeutic frame. Findings revealed that meeting outside of the therapeutic frame resulted in clients feeling concerned about confidentiality, uncomfortable, rejected and confused about how to conduct themselves around the therapist, yet wanting therapists to acknowledge them. Although a relatively large sample was used in this study, along with actual incidental encounters, hypothetical scenarios and students were utilised, thus limiting the extent of generalising findings to therapy clients and real encounters. Nevertheless, this research still highlights the importance of maintaining boundaries to facilitate clients' feelings of safety to disclose. In relation to the disclosure models in section 1.5, these findings inform that besides readiness and willingness, as outlined by the RRM (Afifi and Steuber, 2009), an individual's feeling of safety and level of trust in the recipient is also significant for the occurrence of disclosure. The temporal model (Farber et al., 2006) also seems to have overlooked that feeling safe prior to disclosure is imperative. Conversely, it can be argued that anticipated risks and benefits of disclosure shapes an individual's feeling of safety and level of trust, which disclosure models have certainly drawn attention to (Omarzu, 2000; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010).

1.7.8 The therapeutic relationship and disclosure

The therapeutic relationship is considered vital in producing change in the self (McLeod, 2003) and has been conceptualised in various ways (Bordin, 1979; Rogers, 1957). Rogers (1957) sets out the core conditions of the therapeutic relationship, focussing mainly on the qualities the therapist brings to the relationship. These are empathy, congruence and unconditional positive regard, which he believed help form an authentic relationship whereby clients feel valued and understood. Conversely, Bordin (1979) argued that the relationship comprises of additional conditions, with both the therapist and client impinging on the relationship. He conceptualised this as the therapeutic alliance, or the working alliance to incorporate other theories as each therapeutic model differed in how they worked with change. In essence, the therapeutic alliance is viewed as a component of the therapeutic relationship (Meissner, 2006). However in this chapter, the term therapeutic relationship will include the alliance and vice versa.

Research illustrates that a strong therapeutic alliance leads to better therapy outcomes and enhances the occurrence of disclosures (Horvath and Bedi, 2002), as does the length of stay in therapy (Farber, 2006) as it allows clients time to delve into their past (Seligman, 1995). In their quantitative study of 147 patients in therapy, Farber and Hall (2002) found the strength of the therapeutic alliance was a strong predictor for disclosure, enabling participants to disclose negative thoughts and feelings about the self, which shame and stigma studies previously identified as difficult. In align with quantitative methods (Willig, 2008), this research indeed measured the degree of disclosure. However, it can be argued that the measures utilised simply found what was sought and different questions may have yielded contrasting results. In instances of non-disclosure, findings discount the possibility that the topic may be insignificant for the person. Consequently, the reliability of these measures and findings are questionable. Nevertheless, akin to the RRM, these findings highlight that the relationship plays an important part in the process of disclosure. Whilst the above studies specify that a strong relationship determines disclosure, the RRM underlines that non-disclosure is a result of protecting a relationship (Afifi and Steuber, 2009). In relation to TCPs' disclosures, the extent of applicability of these findings is unclear. Accordingly, research on TCPs in therapy is essential.

1.7.9 Therapists' characteristics

Therapist qualities have been acknowledged as influencing the strength of the therapeutic relationship, which subsequently impacts on disclosure. Reflecting on 90 studies on the alliance, Horvath (2001) found the following qualities to be desirable in a therapist:

- Empathy
- Honesty and flexibility
- Collaboration and negotiation of goals
- 'Active and enthusiastic engagement' (p.369)
- Experience

Whilst these characteristics resulted in poor alliance:

- Therapist controlling the session
- Hostility and challenging behaviour
- Rigid and 'cold' (p.370)
- Rejecting

Additionally, Ackerman and Hilsenroth (2001) found from their review of 14 studies on the alliance that the following characteristics and techniques hindered the alliance, the therapeutic process and client engagement:

- Appearing unfocused and worn out
- Lacking confidence
- Being inflexible, inaccurate and overusing interpretations
- Therapist disclosure
- Not setting a treatment framework
- Not attending to client resistance or ruptures in the relationship
- Using silence inconsistently
- Rigid use of cognitive interventions and failing to attend to emotions

Findings from these reviews, however, ought to be treated cautiously as client factors were recognised as influencing the likelihood of a positive alliance. Saypol and Farber's (2010) investigation lend support to this as they found that clients with secure attachment styles trusted their therapist and disclosed more and had fewer negative feelings following disclosure. Nevertheless, these reviews demonstrate the significance of the core conditions set out by Rogers (1957), which he asserts facilitates openness. Farber and Doolin (2011) also found in their meta-analysis of 18 studies that positive regard led to client engagement, facilitated difficult disclosures and positive therapy outcomes, which is comparable to the DPM's claims that mediating processes such as social support can lead to openness and wellbeing (Chaudoir and Fisher, 2010). Although the employment of quantitative methodologies in these studies helped establish a relationship between therapists' qualities,

the alliance and client engagement, they do not specifically elucidate how it impacts on client disclosure, which is of interest.

While the following qualitative studies differ in the types of participants recruited, the sample size and methods of analysis utilised (Giorgi and Gallegos, 2005; Knox, 2008; Littauer, Sexton and Wynn, 2005), they generally concluded that the therapist was experienced as accepting, holding, empathic and real, which helped form the alliance and enabled clients to be open. These findings undoubtedly strengthen the temporal model's view that receiving approval following a disclosure increases the likelihood of future disclosures (Farber et al., 2006). Nevertheless, limitations included not using clients as participants (Knox, 2008), participants in long-term therapy (Giorgi and Gallegos, 2005), participants attending only two sessions, sessions being video recorded as part of another quantitative research and researchers knowing participants' therapists (Littauer et al., 2005). A key limitation across these studies is that, once again, they do not directly obtain data on how these positive qualities impinge on clients' disclosures in therapy. The data simply reports that clients are more open. Conversely, Balmforth and Elliott's (2012) comprehensive process analysis (CPA) of a case, along with a post-session questionnaire, illustrates that remaining close to the 'clients' frame of reference' (p.8) is significant for disclosure as it ensured the therapist was neither dismissive nor forceful. This seemingly strengthened the relationship and highlights the importance of the therapist's alertness to what the client brings. However, limitations of this research are that disclosure has not been analysed using CPA before and it was not understood through exploration of the client's experience, thus being open to researcher bias. Nevertheless, the process of what led to disclosure was usefully obtained; stressing this is an area which merits further research as it can inform therapists which qualities to specifically adopt to facilitate disclosure.

1.7.10 Therapists' responses to disclosure

As the process of disclosure expects a response from the recipient, a feature of the recipient taken into account prior to disclosing is they are trustworthy (Ignatius and Kokkonen, 2007). Farber (2006) usefully alerts us that patients in therapy often disclose less distressing issues

in the beginning of therapy before revealing more profound issues, because of feelings of safety with the therapist, which is closely linked to trust. These findings certainly provide support to the second stage of the DDM and the incremental disclosure strategy identified in the RRM, as recipients' responses are assessed prior to making a significant disclosure (Omarzu, 2000; Afifi and Steuber, 2009). Additionally, MacCulloch, (2012) identified that negative reactions to disclosures can inhibit trust from developing, which is pertinent in removing 'masks of pretence' (p.59) and self-acceptance.

In their review of existing literature, Kelly and Mckillop (1996) identified the following responses: rejection (Coates, et al., 1979; Gurtman, 1986), being made to feel useless about their coping strategy (Brickman et al., 1982), unfair comments (Lehman and Hemphill, 1990) and unsupportive advice (Pennebaker, 1993) contributed to further feelings of rejection, shame, negative self-perception, isolation and non-disclosing behaviour. A more recent qualitative research of 21 clients in therapy by Farber et al. (2004) revealed that alongside other factors, disclosure was more likely when the therapist responded with:

- Acceptance by not forcing a disclosure
- Maintained eye contact
- 'Warm expression' (p.342), like smiling
- Understanding and stating the client is normal
- Slow and soft speech

Although this study utilised a fairly small sample, which accordingly limited generalisation, this research indeed fulfilled the aims of a qualitative methodology, which is to facilitate deeper understanding of participants' experiences, including identification of factors which inhibit and enhance disclosure. These factors include anticipated risks and benefits, shame, guilt, fear of one's own response, intolerable distress, the therapeutic relationship, positive and negative feelings following disclosure. A further strength of this study is that findings echo the characteristics desired in therapists to enhance the therapeutic relationship, as highlighted above, suggesting that therapist characteristics do indeed influence disclosure. Farber (2006) therefore proposes that therapists meet disclosures with acceptance, which

will cause clients to feel validated and approved. Furthermore, findings from these studies visibly endorse various disclosure models' views that expected negative responses from the recipient inhibit disclosure, whilst positive responses enhance disclosure (Omarzu, 2000; Farber et al., 2006; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010). However, further qualitative exploration of therapists' responses and disclosure may explicate existing findings.

1.8 Therapist disclosure

1.8.1 Perspectives of varying theoretical orientations

Research on the influence of theoretical orientation on disclosure is limited (Farber, 2006), however, therapist disclosure within different orientations has received much attention, particularly the implication on client disclosures (Barret and Berman, 2001; Hill and Knox, 2001; Burkhard, Knox, Groen, Perez and Hess, 2006; Hanson, 2005). In relation to psychodynamic therapy, Freud (1912) believed that knowledge of the therapist can interfere with patients' freedom of associations and inhibit the development of transferences (cited in Carew, 2009), hence therapist disclosure is discouraged. Within humanistic therapy, Rogers (1961) believed that therapist disclosure was an essential component of the therapeutic relationship as it facilitated therapists to convey their feelings without maintaining a facade. He further believed that disclosure helped establish rapport and create openness between the client and therapist. Goldfried, Burckell and Eubanks-Carter (2003) too believed that therapist disclosure in CBT is helpful as it modelled to clients the comfort in experiencing and expressing emotion, as well as discussion of various permitted subjects. Although other therapies, namely, feminist psychotherapy and rational emotive therapy (RET) do not specify that therapist disclosure leads to client disclosure, they argue that it alters the power dynamics between the client and therapist (Tobal and Walker, 2008) and demonstrates human imperfection, which is indicative of the client and therapist as being equal to one another (Dryden, 1990).

1.8.2 A therapeutic tool or a therapeutic mistake

Research surrounding therapist disclosure illustrates that many psychologists believe disclosure taints the therapeutic process and must not be employed (Goldstein, 1994). However, Hill and Knox (2001) assert that views vary, with some therapists promoting disclosure and others not. A number of quantitative and qualitative researches have been conducted within this area, with findings to date being inconclusive (Peterson, 2002). Hill and Knox's (2001) review of quantitative research found that in 14 of 18 studies, therapist disclosure was viewed positively, with 3 studies reporting negative perceptions and 1 entailing mixed findings. The review concluded that moderate therapist disclosure impacted positively on the therapeutic process and clients disclosed more. Barrett and Berman's (2001) study revealed that reciprocal disclosures enabled clients to feel more comfortable and favour the therapist. More recent research by Myers and Hayes (2006) echoes these findings, highlighting that when the alliance was strong, general disclosures led to perceiving the therapist positively. Even though findings from these studies were consistent with one another and the use of quantitative methods allowed findings to be representative, ascertain the relationship amongst variables and control various factors, 'which would be unethical in a field study' (Horvath and Symonds, 1991, cited in Myers and Hayes, 2006, p.183), they encompassed the following limitations:

- Generalisation to real therapist disclosures as real clients were not used (Barrett and Berman, 2001; Hill and Knox, 2001; Myers and Hayes, 2006)
- Not all variables could be controlled and findings are limited to reciprocal disclosures (Barrett and Berman, 2001)
- Most participants in these studies were white, thus affecting external validity

In contrast, qualitative research obtained mixed findings, with therapists (Burkard et al., 2006) and therapy clients (Hanson, 2005) reporting reciprocal disclosures as beneficial, whilst other therapy clients expressed feeling shocked, hurt and not disclosing to protect the therapist's feelings (Wells, 1994). Hanson's (2005) grounded theory analysis study also revealed that therapist disclosure greatly enhanced the relationship, enabling clients to feel safe and understood. However, unhelpful and non-disclosures led clients to feel insecure,

distrustful and lack connection with their therapists, which subsequently inhibited the level of disclosure made. Audet and Everall (2010) also reported some negative experiences from clients following therapist disclosure: feeling unsure about the therapist's role, feeling misunderstood, perceiving the therapist as unprofessional, unresponsive and questioning the therapist's competency (Audet, 2011). Despite negative reports, all of these studies report that prior to disclosure, the therapist was experienced as rigid, lacking warmth, unemotional and distant. The following limitations of these studies were also noted:

- Participants were mainly from white backgrounds (Audet and Everall, 2010; Burkard et al., 2006; Hanson, 2005), thus limiting applicability to the wider client group
- Participants who view therapist disclosure as important were possibly recruited (Audet and Everall, 2010, Burkard et al., 2006; Hanson, 2005)
- Findings may not be representative of clients who are 'functioning less well' (Hanson, 2005, p.103).
- The impact of disclosure on specific factors could not be obtained, like 'therapeutic boundaries, roles and professional qualities' (Audet, 2011, p.97)

Despite limitations, qualitative methods allowed rich data to materialise (Hanson, 2005) and exploration of actual clients' experiences, consequently enhancing the credibility and authenticity of findings (Audet and Everall, 2010), which may not have been acquired with a quantitative methodology. In saying this, TCPs have not yet been recruited into studies. It is therefore unclear whether therapist disclosure impacts on TCPs' level of disclosure in therapy, which justifies further research. Although the disclosure models do not specifically refer to disclosure by therapists, the DDM (Omarzu, 2000) appears to support the therapist disclosure research with positive outcomes. The related research highlights that therapist disclosure enhanced intimacy with some clients, a goal which the DDM identified as prompting disclosure (Omarzu, 2000). It can therefore be assumed that therapists' disclosures were motivated by this goal. The theoretical orientations which support therapist disclosure also seem to be guided by the assumption that it will result in intimacy, and accordingly client disclosures. Carter (2003) and Dryden's (1990) views that therapist

disclosure normalises the process of disclosure and demonstrates that therapists and clients are equal to one another, thus reduces stigma, also seems to correspond with the DPM's belief that disclosure results in social outcomes (Chaudoir and Fisher, 2010).

1.9 Difficulties with disclosure: Qualified therapists' experiences

1.9.1 Dilemmas of the wounded healer

Research on disclosure brings to light the concept of a 'wounded healer', which Zerubavel and Wright (2012) define as therapists who have encountered painful experiences in the past and can use their wound 'in the service of healing' (p.428) others. The relationship between a wounded healer and effectiveness as a therapist is supported (Gilroy et al., 2001; Gilroy, Murra and Carroll, 2002; Martin, 2011; Miller and Baldwin Jr., 2013). In Zerubavel and Wright's (2012) review of literature on the predicaments experienced by a wounded healer, they reveal that stigma and fear of being judged on professional competence prevent therapists from disclosing personal difficulties, as well as leads to shame and isolation.

Raised in this review are also concerns about a culture of silence within the psychology discipline, with disclosure of personal difficulties being perceived as risky, thus 'some things are better left unsaid' (p.485), indeed supporting the DDM (Omarzu, 2000), RRM (Afifi and Steuber, 2009) and DPM's (Chaudoir and Fisher, 2010) claims that anticipated risks, such as rejection and judgement inhibits disclosure. However, research unearths the risks of not resolving wounds, like a lack of empathy (Graves, 2008; Lum, 2002; Zerubavel and Wright, 2012), negative effects of countertransferance (Gelso and Hayes, 2007) and the misuse of power and projection (Satir, 2013). Zerubavel and Wright (2012) impart that such a culture is detrimental for trainee psychologists, particularly in the early phase of training, as it implies that trainees should not seek support.

1.9.2 To disclose or not to disclose: Fear of rejection

The wounded healer literature argues that resistance of exploration stems from a fear of rejection and being perceived as incompetent to practice (Zerubavel and Wright, 2012). Grimmer and Tribe's (2001) and Barnett and Hillard's (2001) study corroborate these findings. The latter found that psychologists were reluctant to access support and 69% of participants terminated therapy as they feared disclosing mental health problems would result in losing 'the privilege to practice psychology', (p.208). The degree to which these findings are applicable to TCPs is constrained, thus research exploring TCPs' experiences is indispensable. Additionally, a qualitative method would not only identify if rejection is an issue but would also illuminate the reasons already provided, which was not obtainable from Barnett and Hillard's (2001) quantitative research.

The fear of rejection has also been linked with the fear of exploitation (Farber, 2006). Shillito-Clarke (2003) brings to attention that counselling psychologists are perceived to be in a position of power and once difficulties are disclosed there is fear of being exploited; hence vulnerability is felt during disclosure. This echoes the temporal model's (Farber et al., 2006) 3rd stage of disclosure (see section 1.5.3) and various disclosure models' viewpoints that potential risks obstruct disclosure (Omarzu, 2000; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010). Difficulties with being fully open due to power dynamics were identified in Leroux et al.'s (2007) research too, as was the fear of being exposed. Once again, research on TCPs would be useful in understanding how these difficulties can be addressed as disclosure is pertinent for self-development (Karter, 2002).

1.10 Disclosure in supervision

1.10.1 Supervisee shame and misrepresentation

Research on shame and disclosure experienced by supervisees in supervision has been conducted (Ladany, Hill, Corbett and Nutt; 1996; Yourman, 2003; Yourman and Farber, 1996). Research highlights that trainees withhold errors made in clinical work as supervision encompasses an 'element of evaluation' (Graff, 2008, p.81) and such disclosures may

portray the trainee as incompetent. As various disclosure models contend (Omarzu, 2000; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010), non-disclosure certainly seems to be motivated by a fear of negative responses from others. Additionally, it seems that in the context of supervision, supervisees' primary goal is to obtain approval, though with non-disclosure, not with disclosure like the DDM (Omarzu, 2000) and temporal model (Farber et al., 2006) assert.

Yourman's (2003) case illustrations obtained from two trainees and two supervisors depicts four supervisory relationships whereby trainees' shame inhibited disclosure. These are:

1. Accusatory questions about interventions, resulting in disclosure being distorted in a way that would be approving, whilst preventing feelings of incompetence
2. Supervisor's expressed disapproval resulted in minimal disclosure about clinical work
3. Supervisor's attempt to raise issues with the supervisee resulted in shame, manifesting in defensive and aggressive behaviour
4. Supervisee's inability to disclose feelings of dislike was compounded by the risk of shame and fear of breakdown in the relationship

Yourman's (2003) finding also illustrates that non-disclosure does not simply stem from shame but also as a result of what happens in the supervisory relationship. The RRM also specifies that non-disclosure may arise from the decision to protect a relationship from harm (Afifi and Steuber, 2009), thus supporting the view that the strength of the relationship can indeed be a strong predictor of disclosure (Farber and Hall, 2002). Consequently, attending to the relationship may be useful in addressing issues of non-disclosure. Although this research suggests that TCPs may experience similar difficulties, the findings ought to be generalised with caution as it was a small sample, containing only two trainees. Future research directly involving TCPs would therefore shed light on whether non-acceptance of the self is an issue that impacts on disclosure in therapy. Using a qualitative method would further allow deeper understanding of subjective experiences on aspects which previous quantitative research may have missed.

Schwartz's (2008) reflection on self-presentation and supervision identified that the need to portray 'correct descriptions and formulations' (p.56) results in trainees finding it difficult to disclose in supervision. He further highlights that the dual role of supervisors, which is teaching and helping trainees obtain 'full membership in the professional community' (p.58), does not allow trainees to feel free, suggesting that trainees may feel this way in personal therapy too. Omand (2010) reiterates that it is difficult to 'expose your working, if there is uncertainty about how much space you have available' (p.382), therefore research on TCPs' experiences of disclosure would be valuable.

1.10.2 The supervisory relationship

Research on trainees' disclosures in supervision (Gray, Ladany, Walker and Ancis, 2001; Gunn and Pistole, 2012; Ladany et al., 1996; Mehr, Ladany and Caskie, 2010) provides support to Farber and Hall's (2002) assertion that the therapeutic relationship is significant for disclosure. Despite large differences in sample size, the methodology used and different types of trainees, the studies concluded that:

- Dismissal of thoughts and feelings weakened the supervisory relationship, which seemingly hindered disclosure (Gray et al., 2001)
- The supervisory alliance and secure attachment to the supervisor led to disclosure (Gunn and Pistole, 2012)
- More than 90% of trainees did not disclose owing to a weak alliance. Disclosure was also impeded by negative feelings about the supervisor, supervisor incompetence and impression management, which was related to a fear of jeopardising one's own profession (Ladany et al., 1996)
- Alongside the following reasons: the fear of negative consequences, deference and impression management, 84.3% of trainee therapists also did not disclose due to the perception of a weak supervisory alliance (Mehr et al., 2010)

Although the use of quantitative methodologies helped establish a relationship between disclosure and the alliance, these studies do not take into account other factors that may

have played a role in strengthening the therapeutic relationship and therefore disclosure. For instance, client collaboration (Bachelor, Laverdiere, Gamache and Bordeleau, 2007), therapists' personal characteristics (Ackerman and Hilsenroth, 2001; Hodgetts and Wright, 2007; Littauer et al., 2005), the agreement of goals, tasks and bond (Bordin, 1979) and clients' levels of attachment security (Obegi, 2008). By comparison, Gray et al.'s (2001) qualitative research gathered specific supervisor responses that resulted in a weak alliance, which provided insight into unhelpful interactions supervisors could avoid. In contrast, the temporal model (Farber et al., 2006) and the DPM (Chaudoir and Fisher, 2010) accentuate that approval from the recipient, including intimacy, liking and trust ensure that future disclosures will occur. However, once again, narrowing questions were used in Gray et al.'s (2001) study as 19 categories were investigated. This may have led to limited responses, much like quantitative measures. Therefore, interviews containing broader questions would be helpful in obtaining deeper understanding of the connection between the therapeutic relationship and disclosure. Furthermore, research on TCPs in therapy is necessary as the above findings are only applicable to a degree.

1.11 TCPs' disclosures in personal therapy: Probable predicaments

McLeod (2003) points out that some training courses require therapists to report on trainees' progress, which can lead to trainees experiencing problems in disclosing personal and professional difficulties. Grimmer and Tribe (2001) report that participants in their study experienced difficulties in disclosing emotional experiences and felt pressured to attend to difficult experiences despite feeling unready and reluctant. Nevertheless, participants expressed that such experiences taught them to give their own clients more space to talk. Grimmer (2005) too stressed that although therapy allows trainees to make personal disclosures that may be normalised by therapists, trainees could also be recommended to refrain from seeing clients, albeit temporarily, owing to suitability. This implies that trainees may experience distress and avoid future disclosures to remain on the training course. Moreover, the wounded healer literature brought to attention that not disclosing or resolving wounds can impact on clinical work (Gelso and Hayes, 2007; Graves, 2008; Lum, 2002; Zerubavel and Wright, 2012). Research also reveals that early experiences of therapists, particularly difficult relationships with parents, indeed influences decisions to

become therapists, which can serve to fulfil ones' own needs instead of clients' needs (Barnett, 2007; DiCaccavo's, 2002; Halewood and Tribe, 2003). In view of the potential risks to clinical work, trainees are encouraged to take ownership of their problems, particularly if it is unresolved (Szecsody, 2003; Zerubavel and Wright, 2012). Additionally, trainees' willingness to be open to change, exploration of pain (Jung, 1961, cited in Wheeler, 2007; Johns, 2012) and understanding of the motivation to train as therapists is promoted (Wheeler, 2007). As the aforementioned studies (Barnett, 2007; DiCaccavo's, 2002; Halewood and Tribe, 2003) do not provide explanations for therapists' reluctance to explore personal difficulties and research on TCPs' disclosures is scarce, the following sections endeavour to elucidate the difficulties TCPs potentially experience with disclosure in personal therapy.

1.11.1 Ambiguity of role owing to mandatory therapy

Jacob's (2011) reflection on the aims of personal therapy raised interesting points. He identified that having therapy as an educational process whilst expecting trainees to understand their 'own complexes and internal resistances' (p.428) raised the following issues:

- Difficulty in accessing repressed materials as trainees used greater defences
- Prior knowledge of therapy meant trainees intellectualised instead of genuinely having the experience
- Trainees found it difficult to end therapy for reasons of unhelpfulness
- Where therapists are asked to provide a report, trainees disclosed selectively as therapists are perceived to be in a position of power

Consequently, Jacobs (2011) calls for greater clarity on the role of therapy and consideration of the timing of therapy for trainees. He further acknowledges that his own therapy was beneficial as it was not mandatory, allowing him to attend in a less 'defended state' (p.437). Other researchers also raised concerns about mandatory therapy and contended that

trainees ought to be provided with clear rationales about therapy and what they can expect so they can enter it with openness (Legg and Donati, 2006; Thorne and Dryden, 1991).

King (2011) argued for therapy to be separated from training. Her qualitative research on therapists who provide therapy to trainees identified that trust and confidentiality are an issue for trainees owing to therapy being mandatory. King's (2011) content analysis also revealed that the following problems are associated with mandatory therapy:

- The alliance becomes affected
- Therapy is met with resistance, with trainees not allowing themselves to be clients
- Trainees feel under surveillance
- Ambivalence about therapy and simply 'going through the motions' (p.190)
- Controlling the 'nature and depth' of therapy (p.190)
- Confusion because of trainees' internal and external worlds becoming entwined

Although this research provides insight into why TCPs may struggle in therapy and thus disclosure, a limitation of this study includes participants being known to the researcher. This may have resulted in skewed data, thus questioning the validity of findings. Furthermore, this research obtained therapists' perceptions on TCPs' difficulties; it would therefore be more valuable to explore TCPs' experiences directly. Additionally, although content analysis contains elements of interpretative phenomenological analysis (IPA), it does not incorporate interpretation by the researcher. An IPA research on TCPs would therefore allow for a deeper analysis and understanding.

Findings from Rizq and Target's (2008a/2008b) IPA research on nine counselling psychologists' experiences of therapy were comparable to arguments for personal therapy whilst training, including research on the difficulties with adopting a client role and feeling inspected (King, 2011). Mearns (1997) alerted that 'dual relationships (e.g. therapist/assessor)' (cited in Atkinson, p.408), are certainly problematic as they impede on trainees' abilities to be open. Another interesting finding raised by Rizq and Target (2008a)

is the risk of engaging in 'pretend therapy' (p.41), which is when the presentation of the self is reduced, particularly during training. Similar to McLeod (2003) and Jacobs (2011), Rizq and Target (2008a) underlined that the reasons entailed trainees finding the early stages of therapy difficult, unclear understanding of the significance of therapy, therapy being enforced upon them and feeling fearful of being stuck in emotional distress. This seemingly led trainees to proceed through therapy quickly, be resistant and disengage from the 'emotional work and risks' (p.40) comprised in the therapeutic process, echoing findings from King's (2011) study. These findings certainly support the temporal model's view that hesitance and vulnerability are felt before and during disclosure (Farber et al., 2006), as TCPs are unsure how their disclosure will be received.

In more recent research, Rizq and Target (2010a/2010b) employed a mixed methods design to explore how counselling psychologists' attachment status and reflective function overlaps with how they use their experience of therapy in clinical practice. While a positive link between secure attachment and high reflective function was found, more interestingly, findings illustrated that therapy was used primarily for learning therapy skills rather than for self-development, thus further highlighting the reputed difficulty in adopting a client role. Participants reported employing and discarding techniques used by their therapist, highlighting therapy can positively influence clinical work. However, Grimmer and Tribe (2001) argue that reflexivity is often indicative of competency, which is not always true. Rizq and Target (2010a) indeed found this to be correct as one participant had high reflective function yet lacked clinical skills and had unresolved trauma. Particular strengths in both of Rizq and Target's studies (2008a/2008b/2010a/2010b) are that IPA allowed them to go back 'to the things themselves' (Wertz, 2005, p.173), counselling psychologists, whilst a mixed methodology in their later study enhanced validity of findings. However, as participants in these studies were trained more than six years ago, it is possible their accumulated knowledge of psychological theory and research methodologies affected the data. Furthermore, as these studies did not specifically obtain the views of TCPs, they may not represent current experiences of TCPs. Participants in the 2008a study may have also preferred to have therapy as the majority described it as 'special' (p.41). Accordingly, findings should be treated cautiously and this necessitates new research with TCPs.

1.11.2 Is a parallel process at play?

The above studies suggest that trainees experience difficulties with disclosure in therapy as they are unable to disregard their role as a trainee or find it challenging to integrate their two differing roles. It can be deemed that attending therapy for both personal and professional development is responsible for this struggle. Research on parallel processes in supervision (Morrissey and Tribe, 2001; Pearson, 2000; Jacobsen, 2007; Tracey, Bludworth and Glidden-Tracey, 2012) provides some understanding of the dilemmas perhaps experienced by trainees. Parallel processes is typically defined as the 'unconscious replication of the therapeutic relationship in supervision' (Searles, 1955, cited in Tracey et al., 2012, p.330) or the supervisory relationship in therapy (Jacobsen, 2007). Morrissey and Tribe (2001) explain that during training supervisors have the added role of 'assessing and evaluating the supervisee' (p.106), causing the trainee to feel under inspection and incompetent. While research on parallel processes has focussed on supervision and may not directly explain why trainees respond to their therapists with apprehension, it appears to be very relevant to trainees in therapy. Research highlighting that therapy is used as a learning process from the therapist (Rizq and Target, 2010a/2010b), that trainees engage in pretend therapy (Rizq and Target, 2008a/2008b) and feel assessed (King, 2011), implies that trainees may be replicating their supervisory relationship in personal therapy, perceiving their therapist as a supervisor and consequently struggling to make personal disclosures. Hesitance prior to disclosing (Farber et al., 2006), or a fear of rejection or judgement are certainly risks that disclosure models underline as hindering the occurrence of disclosure (Omarzu, 2000; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010). Nevertheless, there is a scarcity of research in this area, therefore further exploration is required. Additionally, Tracey et al. (2012) note that studies on parallel processes have largely used case studies, therefore understanding this process in the context of a wider sample, using TCPs and qualitative analysis would allow greater understanding of the intricacies involved.

1.11.3 Splitting and the false self

Besides parallel processes, Klein's (1946) concept of splitting may provide an explanation as to why trainees experience difficulties with disclosure and in adopting a client role (cited in

Gomez, 1997). Klein (1946) referred to splitting as a defence mechanism that seeks to keep apart two conflicting thoughts and feelings (cited in Lemma, 2003) or good and bad experiences. She identified that relentless control of keeping the bad away from the self influenced 'psychic health' later in life (cited in Lemma, 2003, p.35). Along with splitting, projection, another defence mechanism, is utilised to tolerate the difficulty in keeping apart the good and bad (Frosh, 2002), which will be discussed later in the relevant section.

Non-disclosure from trainees can be understood within this framework. Karter (2002) recognised that during training, trainees can become caught in a tension whereby they feel compelled to discard their old self as it does not fit in with the new self they ought to be. Karter (2002) viewed rejection of the self as perilous; much like Klein (1975) as splitting can prevent integration. Klein (1946) noted that individuals feel fearful of the bad overtaking the good (cited in Lemma, 2003). In this way, non-disclosure keeps materials perceived as bad, intolerable, stigmatising and threatening their ability to practice at a distance. It can further be discerned that splitting allows trainees to manage the internal conflict brought on by the dual role and ambiguity of therapy (Jacobs, 2011; King, 2011).

Winnicott's (1960a) theory of the false self also offers insight into trainees' difficulties with non-disclosure and resistance of being a client (cited in Parker and Davis, 2009). Winnicott (1960a) asserts that the false self arises from a sense of split in the self and from conforming to the demands of others, it therefore seeks to protect the true self from destruction (cited in Parker and Davis, 2009). Karter (2002) usefully adds that self-doubt can lead to the false self, as can 'envious tension', which stems from the discrepancy between the shameful self and the 'other self' (Berke, 1987, cited in Graff, 2008, p.85). Karter (2002) reveals that trainees can present a false self by concealing their 'psychological cracks', modifying their current way of being to conform to the criterion of a competent therapist and by illustrating they are 'academically and clinically 'sorted'' (p.15). This supports Rizq and Target's (2008a/2008b) notion of pretend therapy. Like the risks of splitting, the false self can be destructive (Karter, 2002), causing one to feel unreal (Winnicott, 1954/158, cited in Parker and Davis, 2009) and preventing integration of the self (Winnicott 1958/1965, cited in Milton, Polmear and Fabricius, 2011).

Ekhlar-Hart's (1987) qualitative research on 15 trainees' experiences of becoming therapists found that in order to guard the true self and feelings of failure, trainees developed a therapist self, like a false self. Findings stress that support from supervisors in managing the tension between the true and therapist self can help prevent trainees from developing a false self. While this research is dated, Omand (2010) lends support by acknowledging that trainees are preoccupied with 'the need to get it right' (p.379), particularly in the early stages of training to prevent perceptions of them as incompetent (Karter, 2002). These findings indeed support disclosure models' notion that perceived risks of disclosure hinder disclosure (Omarzu, 2000; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010) and that approval is sought following disclosures (Omarzu, 2000; Farber et al., 2006). The findings additionally exemplify how trainees' struggles in balancing expectations from the self and that of training can bring about splitting, the false self and non-disclosure in therapy. Further exploration of this area is therefore required, particularly with current trainees to ascertain whether such struggles continue to exist and how this can be managed.

1.11.4 Burdening others and projection

Kelly and Mckillop (1996) found that individuals held back from disclosing owing to the apprehension of burdening or causing discomfort in others, a potential risk identified by the DDM (Omarzu, 2000). Participants in Williams and Healy's (2001) research also expressed not wanting to burden others and therefore did not disclose. Whilst concern about burdening others may inhibit disclosure, the psychoanalytic literature suggests that an inability to tolerate discomfort within the self can lead to individuals defending the self against this feeling by rejecting it and projecting it onto others (Frosh, 2002). Klein (1946) coined this notion projection (cited in Lemma, 2003), which possibly explains non-disclosure to a degree. Segal (1973) specifies that individuals may also use projection to 'attack and destroy the object', (cited in Rizq, 2005, p.453). Essentially, one's unconscious self-perception is 'seen' and 'felt actually to be in the other' (Frosh, 2002, p.33). Graff's (2008) retrospective study of shame authenticates this view as she identified that her supervisee's disapproval of her was actually him discarding his shame and displacing it in her. This finding implies that a perception of the therapist as flawed possibly stems from individuals feeling flawed themselves. These findings draw attention to a limitation of existing

disclosure models. The models of disclosure discussed in section 1.5 suggest that probable negative responses of recipients obstruct the occurrence of disclosure, accordingly, excluding the notion that negative self-perceptions can also be a likely cause of non-disclosure. The fever model (Stiles, 1987a, cited in Stiles et al., 1992), temporal model (Farber et al., 2006) and the RRM (Afifi and Steuber, 2009) indeed allude to self-distress as a motivator for disclosure, though not any other aspect of the self as playing a role in the process of disclosure.

Utilising this idea, Rizq (2005) questions to what degree TCPs' therapy helps obtain understanding of this concept or even promotes connecting with difficult parts of the self. Rizq (2005) further underlines that requiring only a minimum number of therapy hours inadvertently encourages TCPs to 'gloss over the possibility that we may have damaged or vulnerable parts of ourselves' (p.461). In this respect, she emphasises the significance of TCPs recognising 'the most painful, unbearable aspects of ourselves' (p.462), to ensure that the conditions their clients are offered for change to occur are not compromised. This assertion indeed supports the argument provided by literature on wounded healers (Zerubavel and Wright, 2012), which is to take ownership of personal difficulties to minimise projection onto clients.

1.11.5 Impression management

Goffman's (1959) theory of impression management provides a premise for understanding non-disclosure by arguing that communication in everyday life is controlled to create approving impressions to others. Using a stage metaphor, Goffman (1959) separates performances in front of an audience (front stage) from a private performance (back stage), where individuals step out of their character. In the back stage, individuals can plan for their performance, prepare for expected problems and rehearse their impression, akin to the disclosure strategy 'preparation and rehearsal' emphasised in the RRM (Afifi and Steuber, 2009). Distinct from Kelly's (2000) model, Goffman (1959) highlights that impression management does not operate in isolation and is considerably influenced by what others may communicate about the individual in other settings. Consequently, individuals use techniques such as avoidance and correction to manage the disruption

others may cause to their performance. Therefore, individuals are not wholly alone in the back stage, rather, a few people considered trustworthy by the individual are present and help manage the individual's impression on the front stage, which can be deemed similar to the 'third party revelation' disclosure strategy identified in the RRM. However, within the RRM, it seems this strategy is used to make genuine disclosures, rather than control or amend disclosures that third parties subsequently reveal, which Goffman's (1959) theory implies. Nevertheless, similar to Kelly (2000), this theory illuminates how an individual's fear of disapproval can lead to them developing a facade and managing the level of disclosure made.

1.11.6 Relevance of the earlier research

Research on disclosure within the different contexts outlined above, including aspects which hinder and facilitate disclosure seem pertinent to the understanding of TCPs' difficulties with disclosure. Research on shame and disclosure, conducted on clients (Farber, 2003; Hook and Andrews, 2005; Macdonald and Morley, 2001) and supervisees (Ladany et al., 1996; Yourman, 2003; Yourman and Farber, 1996) highlight that TCPs may also experience shame, both in the context of therapy and supervision, as disclosure can entail exposing one's flaws. Although research on supervisees' shame and disclosure may be applicable to TCPs in therapy, the findings drawn from supervision research cannot be generalised as the sample consisted of only two trainees (Yourman, 2003). Thus research on TCPs is crucial.

Given TCPs' roles as a client, supervisee and therapist, research on parallel processes, though predominantly conducted in relation to supervision (Jacobsen, 2007; Tracey et al., 2012), certainly notify that such processes may occur in TCPs' therapy, and consequently hinder disclosures. Furthermore, research on counselling psychologists' experiences and perceptions of personal therapy (Rizq and Target, 2008a/2008b; Rizq and Target, 2010a/2010b), and the difficulties with adopting a client role (Jacobs, 2011; King, 2011) indeed support the view that TCPs' varied roles are problematic as it impacts on their ability to disclose. Conversely, these studies obtained the views of qualified counselling psychologists. Although the findings are hugely relevant to TCPs, the perceptions of current TCPs may be considerably different.

Despite the purpose of therapy being somewhat different for clients and TCPs, the context of therapy and the onus to share personal difficulties remains the same. Consequently, research on clients' difficulties with disclosure, particularly the fear of rejection (Farber, 2006; Leroux et al., 2007), concerns about confidentiality (Gilroy et al., 2001; Nowell and Spruill, 1993) and the anticipated risks and benefits (Kelly and McKillop, 1996; Vogel and Wester, 2003; Vogel et al., 2008) of disclosure are incredibly significant. Research on therapeutic boundaries (Stewart et al., 2009), therapist disclosure (Hill and Knox, 2001; Burkhard et al., 2006; Hanson, 2005), therapists' characteristics (Balmforth and Elliott's, 2012; Farber and Doolin, 2011), therapists' responses to disclosures (Kelly and Mckillop, 1996; Farber et al., 2004; Farber, 2006) and the strength of the therapeutic relationship (Farber and Hall. 2002; Horvath and Bedi, 2002) also appears to determine the likelihood of clients' disclosures. This too is relevant for TCPs as these aspects are related to the context of therapy; a context which TCPs are expected to partake in as part of their training. In saying this, research on supervisees' and qualified therapists' difficulties with disclosure highlight that concerns about competency and the fear of dismissal from training also influence decisions to disclose (Barnett and Hillard, 2001; Zerubavel and Wright, 2012), which may not be relevant to clients engaging in therapy. Furthermore, the wounded healer literature and research on the risks of not addressing difficulties (Zerubavel and Wright, 2012) imply that these issues are also relevant to TCPs. Therefore, research focussed on understanding TCPs' difficulties with disclosure may help address issues of reluctance to disclose in therapy.

Portrayal of the self in an approving way and managing others' perceptions seems to be apparent amongst clients (Kelly, 2000), therapists (Rizq and Target, 2008a/2008b) and supervisees (Schwartz 2008), thus may also be relevant to TCPs. Omand (2010) points out that in supervision, the extent a supervisee can openly disclose about clinical work is unclear. It is possible that TCPs in therapy feel this way too, as therapy is intended for both personal and professional development. Accordingly, research on TCPs' experiences of disclosure would be valuable.

1.12 Impact of disclosure on personal and professional development

Karter (2002) argues that disclosure facilitates the therapeutic progress, while Okken, van Rompay and Pruyn (2012) state that it is also essential for the positive outcome of therapy. The following studies therefore demonstrate how therapy, which entails the process of disclosure, impacts on individuals' personal and professional development.

Thus far, research regarding the efficacy of therapy for trainee therapists has been inconclusive, resulting in doubt as to whether therapy ought to remain mandatory (Malikiosi-Loizos, 2013). Research using surveys revealed that following therapy, therapists had fewer symptoms, 'improvements in self-esteem, interpersonal relations, work function and character change', (Buckley, Karasu and Charles, 1981, p.302), high rates of satisfaction (Norcross, Strausser-Kirtland and Missar, 1988; Macaskill and Macaskill, 1992, cited in Grimmer and Tribe, 2001; Mahoney, 1997), change in personal growth, less burnout (Linley and Joseph, 2007), more self-care and experience of therapy from clients' perspectives (Daw and Joseph, 2007). Farber (2006) also identified that disclosure led to the following positive consequences: emotional closeness with confidant, relief, validation that disclosure is acceptable, insight and understanding of self. A more recent study by Bike et al. (2009) helpfully strengthened earlier quantitative research by replicating and extending Norcross et al.'s (1988) study. In support of the 1988 study, findings revealed that more than 90% of therapists experienced improvement in behavioural symptoms, gained cognitive insight and emotional relief. Nevertheless, participants also reported the following issues:

- Isolation, personal and marital difficulties (Buckley et al., 1981)
- 15-40% of therapists feeling that all of their difficulties were not dealt with and the therapist required more skills (Macaskill, 1988, cited in Grimmer and Tribe, 2001)
- 20% of counselling psychologists feeling that they had limited awareness of professional issues and little development of a theoretical orientation (Williams, Coyle and Lyons, 1999)

Specifically investigating the impact of therapy on professional development, findings highlighted that therapy led to a positive therapeutic alliance, including:

- Therapist confidence, agreement on tasks and goals (Gold and Hilsenroth, 2009)
- Being better therapists (Gilroy et al., 2002; Williams et al., 1999)
- Therapist genuineness and empathy (Norcross, 2005)
- Less professional difficulties (Wiseman and Egozi, 2006)

Although the aforementioned studies obtained therapists' views, a limitation, however, is that questionnaires were used so a deeper understanding of the impact of personal therapy could not be established (McLeod, 2003; Lyons and Coyle, 2007). In a review of studies examining the effects of therapy, Macran and Shapiro (1998, cited in Murphy, 2005) also concluded the same limitations and recommended that future research incorporate qualitative methods to obtain a deeper understanding of the impact of therapy. A further limitation in Daw and Joseph's (2007) study is that only 48 of the 220 therapists contacted had participated. Alongside difficulties with generalising these findings, the data raises questions of credibility as arguably only therapists with positive experiences may have responded. In saying this, Daw and Joseph (2007) used IPA to analyse the data collected from open-ended questions, thus sought to understand participants' experiences (Smith, Flowers and Larkin, 2009) of therapy, which was accomplished.

In recognition of methodological limitations, literatures were reviewed (Wigg, Cushway and Neal, 2011) and qualitative studies were conducted with therapists (Bellows, 2007; Macran, Stiles and Smith, 1999; Rake and Paley, 2009), trainee and qualified counselling psychologists (Grimmer and Tribe, 2001) and counsellors (Murphy, 2005). Similar findings were drawn from these studies, lending support to Lum's (2002) rationale for therapists to engage in therapy. The benefits included:

- Increased empathy and insight
- Learning what it feels like to be a client
- Dealing with personal difficulties

- The ability to distinguish between personal and client issues
- Validation of therapy and of psychological interventions
- Knowing the self better and becoming emotionally available to deal with clients' issues

Rake and Paley (2009) additionally reported that disclosing led to understanding the therapeutic process and developing the ability to use the self in the therapeutic process, which participants felt could not have been obtained through academic teaching. Besides physical relief and comfort, participants in Haenish's (2011) IPA study also described learning the significance of the therapeutic relationship, which subsequently impacted on their relationship with clients and others.

Whilst these studies reveal that therapy positively influences personal and professional development, two participants in Rake and Paley's (2009) study shared that the mandatory aspect of therapy, some of the therapists' manners and stances and the length of time required to attend were experienced as imposing and demoralising. Akin to McLeod (2003) and Legg and Donati (2006), these participants also attested that attending therapy whilst training resulted in upsetting emotions and obscured clinical judgements. Nevertheless, they later considered their experience to be helpful as they learnt what they ought to not replicate with clients. Similar to quantitative research, these studies encompassed limitations too, which included:

- The use of small samples, thus making findings more challenging to generalise to therapists on the whole
- The likelihood of only therapists with positive experiences volunteering to participate (Macran et al., 1999)
- The possibility of participants not disclosing fully as many participants reported not disclosing to their therapist (Grimmer and Tribe, 2001) and were known to the researchers (Haenisch, 2011; Rake and Paley, 2009)

- The possibility of participants developing further personally and learning the value of therapy since attending as a trainee, thus resulting in positive responses (Haenish, 2011)

Irrespective of these limitations, the findings overall can be considered highly credible as they were consistent with each other despite using different methods of analysis. Rake and Paley (2009) further posit that in-depth interviews enabled understanding of the intricacies involved in the impact of personal therapy on practice, where such insight may not have been acquired had a quantitative methodology been employed (Smith, 2008). Furthermore, small samples are in concordance with qualitative research, as it does not typically seek to generalise (Willig, 2008) and triangulation was achieved in Grimmer and Tribe's (2001) study. In view of the last listed limitation, it would be useful to explore current trainees' experiences of disclosure in therapy. In relation to the disclosure models, the above findings certainly provide support. Consistent with the fever model (Stiles, 1987a, cited in Stiles et al., 1992), it seems that disclosure indeed leads to relief and self-understanding. A common positive outcome also identified within these studies is closeness with the recipient, which was specified by the DDM (Omarzu, 2000), the temporal model (Farber et al., 2006), the RRM (Afifi and Steuber, 2009) and the DPM (Chaudoir and Fisher, 2010). The DPM also highlighted that disclosure also led to the process of disclosure being normalised, which corresponds with Farber's (2006) findings. The negative aspects noted within these studies, for instance, difficulties not being resolved (Macaskill, 1988, cited in Grimmer and Tribe, 2001) and therapists' negative responses (Rake and Paley, 2009) were also considered to be potential risks identified by disclosure models (Omarzu, 2000; Afifi and Steuber, 2009; Chaudoir and Fisher, 2010).

1.12.1 The true self

Alongside personal and professional development, research informs us that disclosure facilitates development of the true self, which contributes to wellbeing and less perceived stress (Ryan, LaGuardia and Rawsthorne, 2005), like the fever model (Stiles, 1987a, cited in Stiles et al., 1992) and the DPM specify (Chaudoir and Fisher, 2010). Jourard (1971) referred to the true self as an 'authentic being', which he described as 'being oneself, honestly, in

one's relations' and 'dropping pretence, defences, and duplicity' (p.133). He also believed that being authentic could aid authenticity in others. However, Winnicott (1960) believed that in adulthood, the true self, which was initially instigated by the 'good enough mother', (p.18) consisted of parts of the initial true self, the self's experience of interacting with the world and agreement with the world on how to be. Thus, the self can never be wholly true (cited in Bollas, 2008). As mentioned earlier, the false self can result in internal conflict (Berke, 1987, cited in Graff, 2008). Jourard (1971) thus accentuates the value of disclosing. He argues that only when one is their 'real self' and behaves in accordance with their 'real self', the process of 'being' (p.32) can facilitate learning about oneself and growth. While Winnicott (1948/1960) believed that particular surroundings can help the true self emerge (cited in Tuber, 2008), Jourard (1971) pointed out that therapy and the therapist's acceptance can offer clients the experience of disclosing freely and being authentic, as well as accepting themselves without the need to conceal, which can subsequently reduce feelings of deception (Farber, 2006). Bellow's (2007) study of therapists also found that therapist acceptance led to self-acceptance. Farber (2006) additionally specifies that encouraging disclosure of hidden feelings in therapy provides clients with a valuable experience of authenticity, which they can in time endorse in their life outside of therapy, thus with others.

1.13 Summary of literature review

This review of literature outlined the issues related to disclosure within various contexts, for instance, client disclosures in therapy, therapist disclosures to clients, disclosure in supervision and disclosure by therapists attending therapy. The review highlights that disclosure in therapy is significant for positive therapeutic outcome, personal development and professional development where trainees are concerned. It further brings to attention that the issues raised by clients, therapists and supervisees, are incredibly relevant to understanding the difficulties TCPs may experience with disclosure in therapy. Although similar difficulties were identified, such as, the fear of rejection, confidentiality concerns and negative therapist reactions, the context in which disclosure occurs in is somewhat different, as is the purpose of the disclosure and the individual disclosing. Furthermore, the

implication of the disclosure is also likely to differ amongst clients, therapists, supervisees and TCPs.

Disclosure by clients in therapy can be deemed similar to TCPs attending therapy. However, a key difference between them is that clients often enter therapy with a specific problem to work on, whereas TCPs may not. Furthermore, as therapy for TCPs is intended for professional development also, disclosures and non-disclosures may be guided by different reasons. The latter may also be deemed true for qualified therapists entering therapy.

Research also highlights that although risks of disclosures are envisaged by clients, therapists and supervisees, the risk itself differs within these contexts. For instance, in the context of therapy, the risks for clients may entail rejection, confidentiality being broken, shame and so forth. However, for therapists and supervisees, and possibly TCPs, the risks also include questions about competency and the fear of dismissal from training or profession. Though once again, the level of this risk will differ as TCPs and trainee supervisees are still in training, while qualified therapists and qualified supervisees are not.

As this review of literature illustrates that TCPs can experience a number of difficulties with disclosure, research specifically exploring TCPs' experiences of disclosure is necessary. Furthermore, this review illustrates that research on disclosure in relation to clients, therapists and supervisees cannot fully explain TCPs' difficulties with disclosure. Therefore, research with TCPs as participants would help elucidate the assumptions that shame, a fear of rejection and disapproval, vagueness of the TCP role and therapy impact on their ability to disclose in therapy, as well as their personal and professional development.

1.14 Rationale for current research, relevance and contribution to counselling psychology

Although personal therapy is mandatory for TCPs, a number of difficulties are experienced within it. The pressure to continue despite difficulties suggests there is an increased risk of emotional damage, which conflicts with the fundamental rationale for personal therapy (McLeod, 2003). Research on disclosure, a difficulty experienced by many in therapy, has

largely focussed on disclosure from therapists (Mathews', 1988; Ramsdell and Ramsdell, 1993; Hill and Knox, 2002, cited in Farber, 2006), clients (Hill et al., 1993; Pattee and Farber, 2004, cited in Farber, 2006; Hook and Andrews, 2005), supervisors (Ladany and Melinkoff, 1999, cited in Skjerve, 2009; Skjerve et al., 2009), supervisees (Yourman and Farber, 1996; Reichelt et al., 2009) and non-clients (Chaudoir and Quinn, 2010; Slavin-Penny et al., 2010; Sloan and Kahn, 2006). Findings on TCPs' disclosures, however, were incidental, as they derived from research on trainees' experiences of personal therapy. Consequently, these findings do not provide an understanding of TCPs' experiences of disclosure and its impact on personal and professional development. Furthermore, although research has contributed greatly to literature on disclosure, findings were drawn largely from quantitative methods (Farber, 2006) and thus do not provide a deep insight into the experiences of disclosure. Accordingly, exploration of TCPs' experiences of disclosure is warranted.

Given that counselling psychology considers therapy as significant for TCPs' development of self-awareness (Malikiosi-Loizos, 2013) and to deal with emotional difficulties so that it does not impact upon clinical work (McLeod, 2003) and other aspects of training (Thorne and Dryden, 1991, cited in Grimmer and Tribe, 2001), it is essential that they feel safe and less vulnerable in disclosing. Additionally, as therapists may have difficult past experiences (Zerubavel and Wright, 2012), it is vital that they are aware of their difficulty and are able to seek help when needed (McLeod, 2003) without the fear of repercussion, which will subsequently ensure ethical practice. It is therefore hoped that this research will contribute to counselling psychology by:

- Increasing the awareness of TCPs' difficulties with disclosure
- Influence training programs and clinical practice by highlighting how issues related to disclosure can be addressed, so that TCPs are less resistant, can fully engage in therapy and therefore work more effectively with clients
- Contribute to broadening the literature on disclosure by providing TCPs' accounts

1.15 Aims and research questions

Based on the aforementioned gaps in previous literature, this research aims to obtain a deeper understanding of TCPs' experiences of disclosure in therapy and how this experience informs their personal growth and clinical work. The main research question is therefore:

'What are TCPs' experiences of disclosure in personal therapy and its impact on personal and professional development?'

The following sub-questions will also be explored:

- What brings TCPs to disclose and not disclose?
- What facilitates and hinders TCPs' disclosures?
- How do TCPs disclose in therapy?
- How does disclosure impact on TCPs?

CHAPTER TWO

METHODOLOGY

2.1 Overview

This chapter provides the rationale for the chosen research methodology and the research design is presented. An account of how this study met research quality criteria will also be outlined. Personal reflections on conducting this research, including the obstacles experienced, will be integrated throughout this chapter using an italic font and in the first person for ease of the reader.

2.2 Research paradigm: Hermeneutic-phenomenology

Epistemology is concerned with the gaining of knowledge and 'how we come to know,' (Trochim, 2000, cited in Krauss, 2005, p.758). This research will be underpinned by the hermeneutic-phenomenology paradigm, which extends from phenomenology (Langdridge, 2007), though informed by Heidegger (1962). Husserl (1859-1938), the 'founder' of phenomenology, alleged that in order to understand a phenomenon, researchers must go 'back to the things themselves', (cited in Becker, 1992, p.10). However, Husserl's (1927, cited in Smith et al., 2009) proposal of bracketing, that is, putting aside one's pre-understanding of the world can be deemed impossible when 'we are always in the world' (Hein and Austin, 2001, p.6). Likewise, the hermeneutic epistemology can be criticised for moving too much away from participants' experiences (Laverty, 2003), as it believes it is the researcher's interpretation of the experience (Schleiermacher, 1998, cited in Smith et al., 2009), including the time and context the interpretation is made (Gadamer, 1990/1960, cited in Smith et al., 2009), that enhances understanding. Accordingly, Heidegger (1962) rejected bracketing, believing that in order to know, researchers must derive meaning from the experience. Therefore, his approach to phenomenology involved interpretation, which Bryman (2008) argues is a stance 'in its own right' (p.17) and is interested in the way experience has lived. It can be said the hermeneutic-phenomenology paradigm is located in

the middle of realism and relativism as experience results from interpretation. It is thus constructed, though at the same time 'truth' for the person subjected to the experience (Willig, 2008).

Hermeneutic-phenomenology was selected instead of positivism as this research is interested in understanding unique subjective experiences, that is, TCPs' lived experiences of disclosure in personal therapy and its impact on personal and professional development, rather than aiming to discover 'a single truth from the realities of participants', (Ponterotto, 2005, p.130). Also in accordance with the hermeneutic-phenomenology paradigm, this research aims to attend to the structure of experience, how it develops in the consciousness, how previous meanings of experience develop and influence the individual and social levels (Laverty, 2003). However, if the research question aimed to investigate the relationship between therapists' theoretical orientation and disclosure, a positivist paradigm would indeed be appropriate, allowing these two factors to be measured (Lyons and Coyle, 2007). Similarly, a social constructionist paradigm was disregarded as this would have diverged from the aim of this research. Nevertheless, if this research sought to establish how disclosure was constructed through language over time, then this paradigm would be considered suitable (Willig, 2008).

2.3 A qualitative approach

Qualitative research is interested in the meanings participants attribute to events (Willig, 2008), which is consistent with the aims of the hermeneutic-phenomenology paradigm and this research. Further than this, a qualitative methodology is particularly ideal as research in the area of disclosure has largely been drawn from a quantitative methodology (Farber, 2006), inhibiting a deep insight into the experiences of disclosure.

Although quantitative research has proved to be useful in this area, it was discounted owing to incompatibility with the aim of this research, which sought to obtain detailed descriptions of participants' subjective experiences, as opposed to gaining data that will make general claims about a given population (Creswell, 2003). Alternatively, a combination of methods could have been utilised as it can 'elaborate on results' by adding more understanding of

disclosure and providing different perspectives (Hanson et al., 2005, p.226). Nevertheless, a key problem with this approach is the disparity between paradigms, which Buchanan (1992, cited in Wiggins, 2011) argues can lead to methods being used inappropriately.

2.4 Research methodology: Why IPA?

The selection of a research paradigm facilitates researchers in identifying appropriate methods and participants needed for their study (Denzin and Lincoln, 2005). Consequently, a number of methodologies were considered, which will be reflected upon. Nevertheless, as the theoretical philosophies underpinning interpretative phenomenological analysis (IPA), which are phenomenology, hermeneutic and idiography, greatly coincide with the hermeneutic-phenomenology paradigm, it was deemed the most suitable methodology for this research. IPA enables the researcher to capture and explore the personal meanings that participants assign to their experiences. In this way, IPA is phenomenological, as it is concerned with the human experience, particularly in the way that it is lived (Smith et al., 2009. See section 2.2). It is also hermeneutic as it emphasises the social interaction between the researcher and participant, permitting the researcher to bring in their perspectives and interpretations to the analysis (Shinebourne, 2011). IPA therefore allows meanings of experiences to be jointly constructed. Within IPA, this process is described as a double hermeneutic (Smith and Osborn, 2003). Double hermeneutic occurs in a further way in IPA. Ricoeur (1970) recognises that two interpretative stances exist. Firstly, the hermeneutics of empathy, which endeavours to understand the meaning of the text as it is seen (cited in Langdridge, 2007) and secondly, the hermeneutics of suspicion, which seeks to unravel the hidden meaning of the experience by drawing on existing theoretical perspectives to elucidate the phenomenon (cited in Smith et al., 2009). In this way, the use of IPA is appropriate as one of the aims of this research is to broaden current literature on disclosure.

IPA adopts an idiographic approach as it is committed to understanding specific experiences in specific contexts. Consequently, a small sample is employed to allow the unique experience and perception of each participant to be illustrated (Smith et al., 2009). This approach is particularly appropriate for this study as research on TCPs' experiences of

disclosure thus far has stemmed from general research on TCPs' experiences of therapy. Additionally, disclosure research has typically focussed on clients in therapy, supervisees in supervision and therapist disclosure, excluding the experience of TCPs. IPA is therefore well positioned to obtain in-depth understanding of TCPs' experiences of disclosure in therapy.

The DCoP's (2005) professional practice guidelines specify that the chosen methodology, design and the manner research are conducted in, ought to be congruent with the DCoP's values. Central to the hermeneutic-phenomenology paradigm and IPA is making sense of the lived experience, whilst acknowledging the relationship between the knower and known (Laverty, 2003). These viewpoints are consistent with counselling psychology (CoP) values that experiences are unique to individuals. CoP also adopts a pluralistic, relational and curious stance, both in research and in working with clients, attending to meaning-making and process (McAteer, 2010). Copperstone (2009) too likens the CoP stance to a researcher, while Strong, Pyle, deVries, Johnston and Foskett (2008) compare it to the hermeneutic-phenomenology paradigm as they all explore clients' experiences and seek to make sense of them. Furthermore, IPA is being increasingly utilised within the Counselling Psychology discipline as an attempt to move away from nomothetic research (Smith et al., 2009). This approach is therefore incredibly relevant as my research does not seek to make generalisations about a group.

Although IPA is considered appropriate, it is important to be aware of its limitations, which could impact upon this research:

- Language cannot provide a true representation of experience as different words can be used to describe the same experiences
- The differing use of language can implicate the level of data analysis
- Participants' accounts are dependent on the researcher's account of their experiences
- IPA is interested in understanding individuals' thoughts and beliefs about particular topics, which conflicts with the phenomenology aspect of IPA as it aims

to capture the way in which the experience is lived in that moment, thus in the context of the interview.

In relation to the limitation concerning language, an alternative method of analysis to consider instead of IPA is discourse analysis (DA), which is underpinned by the social constructionist paradigm. DA regards language as an essential element in the exploration of meaning and experience. It examines how language is constructed, changes over time, within cultures and shapes experiences (Willig, 2008). In relation to this research, DA would therefore examine the language constructed between the researcher and participant (Lyons and Coyle, 2007) to understand disclosure. In this way, DA may have offered new insights by reflecting on information that was previously not recognised as significant within the area of disclosure. Nevertheless, whilst DA is considered a suitable method of analysis for this phenomenon, this research seeks to develop knowledge around 'what and how people think' about disclosure, including their experience of disclosure (Willig, 2008, p.69). The focus on language would therefore have moved away from this aim and so DA in comparison to IPA was deemed unsuitable.

The rationale behind choosing IPA and not grounded theory (GT), a more established approach, is that the focus is not on explaining 'contextualised social processes', which is exclusive to GT. Instead, the objective is to gain detailed insight and enhanced understanding into participants' experiences (Willig, 2008, p.73). Like post-positivism, GT also aims to develop a theoretical account of particular phenomena rather than to verify theory (Glaser and Strauss, 1967, cited in Carter and Little, 2007), which often requires larger samples in contrast to IPA (Smith et al., 2009). This aspect of GT could have been valuable for this research as it would allow new explanations of disclosure to come to the forefront, which may have otherwise been overlooked. Conversely, GT discourages the use of existing theories in setting objectives and research questions (Carter and Little, 2007), which is incompatible with this research as the aims derived from identifying a gap in current literature. Furthermore, it is anticipated that IPA will allow the findings of this research to broaden current literature (Smith, 2008), which is another feature of IPA. On reflection of GT's features, it was comprehended that it was not appropriate for this research.

2.5 Personal reflections on the conceptual processes of this study

There were various personal and professional reasons which led me to research the phenomenon of disclosure. Willig (2008) accentuated that as the researcher's interpretation is an integral part of the analysis, it is imperative the researcher is reflexive, that is, aware of how their beliefs and ideas influence the research process. Given that this study is about TCPs' experiences of disclosure in personal therapy and I am a TCP who also engaged in personal therapy, it was essential for me to highlight any personal thoughts or biases during the analysis to facilitate the reader to evaluate my interpretation of the data and to ensure findings are indeed embedded in the data obtained (Larkin, Watts and Clifton, 2006).

I became interested in the topic of disclosure in my second year of training when I was asked to critically analyse a research paper concerning clients' deference to the therapist. Rennie (1994) defined deference as 'the submission to the acknowledged superior claims, skill, judgement' of a different person (p.428). He asserted that in a therapeutic relationship whereby the therapist is perceived as more superior, there is potentiality for clients to conform to the therapist's suggestions. Rennie (1994) found that clients were indeed deferent and did not make certain disclosures. Reading this paper and further literature on this topic area led me to reflect on the extent I disclose and comply with my therapist. I also marvelled at how some of my thoughts and feelings went unexpressed owing to a fear of being perceived negatively.

Up to the point of data collection, I had attended therapy for more than three years with the same Counselling Psychologist. During this period, I attended approximately 70 sessions and my level of comfort with disclosure had increased significantly by then. Nevertheless, I acknowledged that in the first 18 months of therapy, I experienced great difficulty with disclosing (see appendix 13 for further reflections). I wondered whether my attitude towards disclosure would have been different if I was not a TCP and if therapy was not mandatory. In light of this awareness, I speculated how many other TCPs experienced difficulties with disclosure and thus the implications I encountered afterwards. I accordingly thought it to be an important area that required further exploration.

Through clinical work, I came to realise that my interpretation of clients' experiences would include both my own and their sense-making (see appendix 13 for further reflections). Therefore, remaining mindful of my own preconceptions and bracketing it as far as possible is imperative, not only for clinical work but for this research too. Consequently throughout this research process, I used a reflective diary to ensure I was continually aware of such issues. Accounts of these reflections will be illustrated in the hope that it provides the reader with an understanding of how my experience shaped the research process.

2.6 Research design

2.6.1 Participants

In align with IPA's idiographic approach, which seeks to understand specific experiences in specific contexts (Smith et al., 2009), the recruitment process ensured the selection of participants that allow exploration of this particular experience. Since IPA is interested in the individual experience, thus quality instead of quantity, a sample of between three and six participants is deemed suitable. For Professional Doctorates and less experienced researchers, Smith et al. (2009) recommend between four and ten interviews, rather than participants. They assert a large amount of data could hinder a deeper level of analysis and reflection.

IPA also calls for a relatively homogenous sample (Landridge, 2007). Homogeneity ensures the likelihood of detecting whether established patterns of similarities or differences relate to individual characteristics or social variables (Smith and Osborn, 2003). Consequently, the age, gender, ethnicity, therapeutic orientation and the number of therapy hours completed were considered. Purposive sampling was utilised, consistent with IPA principles (Smith et al., 2009). To establish homogeneity as much as possible, all the participants were in therapy; they shared the experience of disclosure in therapy and were in their final year of training. The various categories outlined above did not appear to be relevant for this research and were therefore disregarded.

I was aware that not employing a strict criterion in relation to participants' age, ethnicity, gender and so forth would possibly impact on the data. Although these categories would provide further insight into disclosure, after much reflection and discussion with my supervisor, I realised that such a strict criterion may limit access to participants. More importantly, the aim of this research was not to make comparisons between categories but to explore TCPs' individual experience, thus a fixed criterion on every measure is not justifiable.

2.6.2 Inclusion and exclusion criteria

The participants needed to be TCPs in their final year of training and in personal therapy. My rationale for this was that I assumed a TCP in their final year would have sufficient experience of therapy in order to share their experiences of disclosure, to provide insight into what has facilitated and hindered their disclosure, including the impact on their development, both personally and professionally. The research excluded TCPs who were training at the University of East London (UEL) as I attended this university.

2.6.3 Recruitment

I devised an advert which specified that I was looking for TCPs in their final year of training and currently in therapy. As TCPs are members of the BPS' DCoP, initial contact was made with the Chair of the DCoP through email, requesting my advert to be circulated to all TCPs. Agreement was obtained on the basis my supervisor confirmed approval of the advert to the Chair (see appendix 3). Additionally, a flyer was devised (see appendix 4) to distribute to universities that run accredited CoP training (see appendix 5).

Initially, response to the advert was slow, with only one TCP responding. I subsequently contacted universities through telephone to request flyers be distributed. However, many stated they could not email my flyer, which led me to consider disseminating the flyers to TCPs that attended the same clinical placements as me so they may distribute it to their cohort. Following this action, I received interest from a further two participants. However, after five months from the initial recruitment, no further interest was received. In response

to this, I advertised my research on a social networking internet site (see appendix 6), which contains a group for Counselling Psychologists in the UK. This resulted in the recruitment of two additional participants. A reminder was sent six weeks later on the same social networking site which led to interest from three more participants. However, two participants in the last recruitment stage did not respond to further correspondence. Accordingly, I recruited six participants in total.

I felt disappointed with the initial slow response rate and worried that the subject of disclosure may act to deter participation. On reflection, the low uptake may have been owing to the advert not clearly stating that disclosure of personal experiences is not a necessary requirement for participation. This issue was queried by participants who made contact through the social networking site and, seemingly after clarification, they continued to show interest. I was also aware of the possibility that participants may volunteer to assert particular views. It was therefore essential I maintained participants' focus on the phenomena as much as possible. In hindsight, a way of improving the response rate may have been to obtain permission from Universities to attend before CoP lectures and introduce my research, as well as leave flyers for TCPs who wished to participate.

2.6.4 The sample

Participants were requested to complete a brief demographic form (see appendix 7) prior to the interview. The sample contained six TCPs, one male and five females, aged between 21 and 45 years (see table 4 for further information). This sample is deemed appropriate as the aim of the hermeneutic-phenomenology paradigm, including IPA, is to select participants who have lived experience (Laverty, 2003)

I felt dissatisfied that I had only recruited six participants and felt the strain to obtain rich accounts from these participants. Whilst arranging interviews, I noticed that I still awaited response to the adverts. However, I soon realised that my focus on the need to recruit a larger sample was moving me away from the aim of my research and could potentially influence the data obtained. Recalling Smith et al.'s (2009) assertion that a large dataset is not 'indicative of 'better' work' (p.52) and can inhibit the time needed for a successful

analysis; I came to accept that six interviews were sufficient and manageable due to my limited experience in IPA.

Table 4: Participants' characteristics and demographics

For reasons of confidentiality, all names have been changed and anything that could possibly identify a participant has been removed.

Participant	Gender	Age range	Year of training	Completion of more than 40 hours of therapy
Emily	Female	31-35	3	Yes
Eric	Male	26-30	3	Yes
Lara	Female	26-30	3	Yes
Alva	Female	41-45	3	Yes
Ishi	Female	21-25	3	Yes
Adel	Female	26-30	3	Yes

2.6.5 The context

The rationale for therapists to attend therapy as part of professional training includes the development of professional capacity and personal development, such as increased self-awareness and enhanced wellbeing (Norcross, 2005). Orlinksky, Schofield, Schroder and Kazantzis' (2011) international survey on a sample of 3,995 participants found that 87% of this sample attended therapy at least once. Participants included psychologists, counsellors, social workers, psychiatrists and nurses. However, not all training organisations insist on personal therapy as a requirement (see Introduction). TCPs are expected to engage in a minimum of 40 hours of therapy (The BPS, 2012).

2.7 Ethical considerations

An awareness of ethical matters created by qualitative research is essential. Ethical approval for this research was granted from UEL's research committee (see appendix 2).

2.7.1 Informed consent

An information sheet was provided to all participants who expressed interest, which contained a brief description of the nature of this research (see appendix 8). The information sheet enabled potential participants to ask the researcher about areas of the research they were unsure about, for instance, whether disclosure of personal experiences is necessary. Participants were also informed that the data will be accessible to research supervisors, external markers and retained up to five years to allow for publication in books, journals and conferences. Upon meeting with each participant, another opportunity was provided to ensure participants fully understood the information sheet prior to signing the consent form (see appendix 9). Participants were also informed verbally, through the information sheet and consent form of their right to withdraw at any time.

2.7.2 Confidentiality

The participant information sheet outlined the steps that will be taken to ensure confidentiality and anonymity. Participants were informed that although parts of their interview will be used in the write-up of this research, they will be allocated suitable pseudonyms and any information which could identify them will be removed, for instance their place of study. Furthermore, audio recordings and identifiable information will be safely stored under password protected files. If required, participants will have the right to access copies of their interview material and a summary of the findings (Creswell, 2003).

2.7.3 Potential distress

Whilst discussing personal experiences, there was potential for emotional distress to be evoked in participants and this required ethical consideration. Utmost effort was

maintained to ensure the safety, physical and mental well-being of participants in accordance with the guidelines stipulated by the BPS (2009). No participant withdrew consent or stopped midway through the interview. At the end of the interview, participants were debriefed, given the opportunity to share how they found the interview and provided with a written debriefing sheet (see appendix 10). Ethical consideration was also given to the researcher's dual role (researcher/TCP). To ensure psychological interventions were not implemented by the researcher, participants were provided with appropriate contact numbers they could access for support (see appendix 11) should they feel distressed following the interview.

2.8 Data collection

2.8.1 Semi structured interviews

Semi-structured interviews have been identified as the most suitable method to obtain data for IPA as they enable the researcher to probe interesting areas (Smith, 2008). The interview adopted a relatively non-directive stance, guided by an interview schedule (see appendix 12) containing broad questions as suggested by Smith et al. (2009), in order to encourage participants' natural, free flowing meanings of their experiences. Appropriate probes were utilised in order to seek clarification and elaboration of participants' responses. Four of the interviews took place in a meeting room at UEL and two were conducted over the telephone. The interviews lasted between 41 minutes and 1 hour and were audio recorded using a digital device. At the end of each interview, reflective notes (see appendix 13) on the interview process were made by the researcher to lend support to the analysis stage. All the interviews were transcribed verbatim (see appendix 19 on CD). Although this method is regarded as the most appropriate data collection for IPA, it does encompass some limitations which will be considered in the discussion chapter.

I had 9 years experience of working with clients who become emotionally distressed and was therefore more acquainted with working therapeutically than in research. This posed a struggle as I endeavoured to balance the fine line between using my therapeutic skills to conduct the interviews while also making certain that I remained in the role of researcher. I

attended to this by reminding myself of the purpose of this research prior to each interview, though continued to remain sensitive as a researcher. Nevertheless, I found interview 4 particularly challenging (see appendix 13).

Prior to the interviews, participants were aware that I am a TCP and I wondered whether this would impact on how much they shared with me. Participants were also aware this research aimed to inform clinical practice, I was thus mindful of the possibility of the interview process being used as a context to assert particular views and negative experiences of disclosure. However, none of the interviews overtly indicated that participants had another agenda (see appendix 13 for further reflections).

2.8.2 Data Analysis

Data analysis commenced immediately after transcription of the interviews. IPA was utilised to analyse the transcripts, following the steps suggested by Smith et al. (2009). Prior to analysis, a three column table was devised, with the transcript presented in the middle column. A colour code was adopted to distinguish between comments made at the descriptive (blue), rhetoric (brown) and latent level (pink), as proposed by Gee (2011) for ease of distinction. The colour purple was also used for general comments (see appendix 14).

i) Reading, re-reading and listening to audio

Consistent with IPA's idiographic approach, transcripts were analysed individually (Willig, 2008), forming the first stage of the analysis. Through implementing an iterative approach, each transcript was read twice whilst listening to the audio, allowing me to immerse myself in the interview, become familiar with the participant's voice and recall how I felt at the time.

Through listening to the audio, I aimed to connect with the text more closely, follow the participant's story more coherently and listen to how their experience unfolds. Whilst listening to the audios, I felt frustrated with myself as at times I asked leading questions or

did not encourage deeper exploration through further questioning. Noting my thoughts and feelings during this stage helped induce the process of double hermeneutic.

ii) Initial noting

Following the initial stage, I re-read the transcripts twice more alongside the audio and closely engaged with the text. I noted what came to mind in relation to the three levels outlined above (see appendix 14), as the aim was to try and interpret the content and complexity of the meanings contained within the data (Larkin et al., 2006, cited in Smith et al., 2009). Listening to the audio added great depth to the analysis as it provided insight into experiences that would not be explicitly noticeable from looking at the text, for instance, the tone of voice used, pauses in speech or when laughter appeared to derive from nervousness rather than genuine amusement. Without listening to the audio, this would have been overlooked.

Prior to starting this stage, I felt hugely overwhelmed by the large amount of data obtained and felt unsure as to which categories my comments fell into. As a novice researcher, I felt my notes were largely descriptive. However, over time I became familiar with the different levels and this process became easier (see appendix 13 for further reflections).

iii) Developing emergent themes and searching for connections

The third stage of the analysis sought to 'reduce the volume of detail' (Smith et al., 2009, p.91) by working only with the initial notes. This process allowed identification of themes, which aimed to capture what the participant is expressing, as well as the researcher's interpretation. The development of themes involves the hermeneutic circle, whereby the researcher interprets parts of the data 'in relation to the whole' and 'the whole is interpreted in relation to the part' (Smith et al., 2009, p.92). This brings to light the most pertinent parts of the data, including commonalities and differences that emerged within the text. I thus began this stage by first reading through parts of the transcript, reading the notes made beside each segment and thinking about the interview as a whole. This process led me to note potential themes (see appendix 14).

I found the process of identifying themes a struggle at first as I could not identify the few words required to capture particular experiences. However, as I progressed through the transcript, this became easier, particularly when I began thinking about the whole of the interview (see appendix 13 for further reflections).

As recommended by Smith et al. (2009), the themes were then typed up and cut out separately. I then clustered the themes in terms of similarity, leaving some themes to be either discarded and/or merged owing to overlap (see appendix 17). This process was repeated for the remaining interviews, keeping a note of new themes as well as commonalities between the interviews.

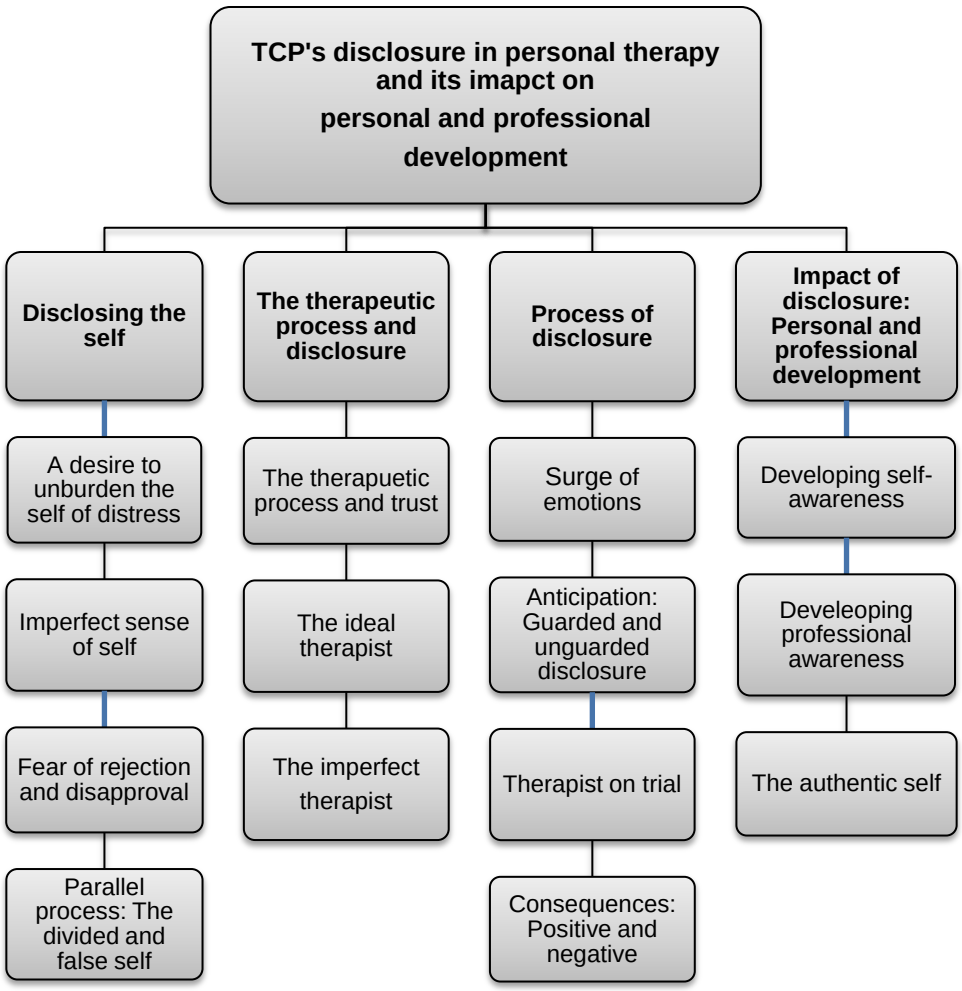
I found the process of grouping themes for each transcript somewhat difficult. However, physically moving around the themes made it easier. Although I was easily able to identify similar themes, I struggled with discarding themes, feeling that I was not doing full justice to participants' accounts. During this period, I met with a peer who helped me think about which themes corresponded. I also went back to the interviews to check if the themes indeed fitted the data, which helped highlight the significance of some themes and not others.

iv) Bringing it all together and identification of master themes

The final stage of the analysis involved a cross analysis of all the interviews, thus looking at all the themes together and noting commonalities and differences between them. I then organised and clustered the themes into subordinate themes, identified master themes for each cluster and devised a provisional structure of what may be a narrative of participants' experiences of disclosure. Over several occasions, this structure was revisited and reorganised, with more themes being discarded and merged until a more coherent structure surfaced (see figure 2). Verbatim quotes to depict each theme have been extracted from all the transcripts and are presented in a table (see appendix 18).

I found this process very exciting, though at the same time challenging. Forming a logical structure was not an easy task as I found that certain themes could easily be placed under another master theme (see appendix 13 for further reflections).

Figure 2: Final structure of data



2.9 Validity and quality

Qualitative research has received much attention pertaining to the importance of maintaining quality. Willig (2008) asserted that questioning the validity of our research ensures it indeed 'describes, measures or explains what it aims to describe, measure or explain' (p.16). Equally significant is the research's contribution to knowledge, which critical reflection of research allows (Tobin and Begley, 2004). However, the guidelines usually used to evaluate quantitative research are not suited to qualitative research, as it includes

'objectivity, reliability and statistical generalizability' (Yardley, 2008: p.236). Consequently a number of criteria have been developed (Henwood and Pidgeon, 1992; Morrow, 2005; Spencer, Ritchie, Lewis, and Dillon, 2003; Tobin and Begley, 2004; Yardley, 2000). In this research, the guidelines set out by Yardley (2000) were utilised as recommended by Smith et al. (2009), along with its proposal of a wide range of approaches to determine validity.

2.9.1 Sensitivity to context

Yardley (2000) proposed researchers should display sensitivity to context through awareness of existing literature on the phenomenon under study, the data obtained from participants and consideration of the socio-cultural setting the research takes place in. Smith et al. (2009) further assert that sensitivity to context ought to be demonstrated from the initial stages, which was met in the following ways:

- Existing literature on disclosure is presented in chapter one, with this research being borne out of the scarcity of literature on TCPs' experiences of disclosure
- Sensitivity to the material obtained and the socio-cultural setting was addressed throughout this chapter by way of reflexivity on the recruitment, data collection and analysis stages; consideration of ethical issues and context of study in section 2.5.6

2.9.2 Commitment and rigour

Yardley (2000) stated that commitment to research is demonstrated by extended involvement in it, for instance, through enhancing research skills and the level of time taken during data collection and analysis. Whereas rigour refers to the extent to which the study achieved what it intended to in regards to the research question, the sample, the quality of data collection and analysis. Thomas and Magilvy (2011) assert that rigour allows 'researchers and their audiences' (p.152) to have conviction in the data obtained as it is anticipated clinical practice will be based on these findings.

This research aimed to achieve commitment and rigour in the following ways:

- Various literatures on research methods were studied to enhance knowledge and understanding
- Discussions with research supervisors, attendance at a research conference and IPA workshops further developed knowledge and skills in analysis
- Deep exploration of the phenomenon of disclosure, including the degree of analysis (as can be observed in the interview example presented in appendix 14)
- The processes carried out at each stage of analysis (as presented in appendices 14-17), reflects the thoroughness and completion of the analysis
- Themes were discussed with research supervisors and a peer. There was agreement that the themes were amply interpretative
- IPA's requirement for 'sufficient idiographic engagement' (Smith et al., 2009, p.181) during the analysis is demonstrated through the provision of quotes from each participant (see appendix 18)

2.9.3 Coherence and transparency

Transparency relates to reflexivity, thus calls for reflections on the research process and in the write-up, while coherence is described as the extent to which the research question, the research paradigm and the methodologies adopted fit together to provide a logical and convincing narrative to the reader (Yardley, 2000). Smith et al. (2009) bring to attention that the write-up ought to demonstrate the principles of IPA, which further establishes coherence. Transparency and coherence were met by:

- Outlining my research paradigm, the chosen methodology and analysis
- Including my reflections on the phenomenon of disclosure
- Providing reflections on each stage of the research process. These reflections depict how the research process may have been influenced
- By adopting a hermeneutic-phenomenological stance, I acknowledged the double hermeneutic element of IPA, in that my interpretations will be influenced

by my experiences and understanding on the phenomenon being researched. Consequently, a reflective diary was kept to remain aware of my thoughts following each interview (see appendix 13), which proved significant during the analysis

2.9.4 Impact and importance

Yardley (2000) emphasises that research is valuable if it is influential on the actions of individuals the research is intended for and if it provides 'new ways of understanding a topic' (p.223). Achievement of impact and importance in research demonstrates 'real validity' (Smith et al., 2009, p.183) and was demonstrated in this research by:

- Outlining in the discussion chapter how findings relate and contribute to the literature on disclosure and inform clinical practice and training programmes for TCPs

2.10 Concluding comments

This chapter provides justification for the chosen research paradigm and how the selected methods of data collection and analysis are suited to this paradigm. Furthermore, the steps taken to select and recruit participants, the ways in which interviews were conducted and the data analysed were outlined. Additionally, reflections upon each stage were provided to demonstrate how my personal and professional experiences may have shaped the research. The analysis is presented in chapter three, whilst chapter four draws upon the implications and limitations of the methodology and analysis.

CHAPTER THREE

ANALYSIS

3.1 Overview

This chapter presents the analysis of six semi-structured interviews with TCPs in their final year of training. Using IPA, the analytic process revealed four master themes and fourteen subordinate themes (see table 5).

Table 5: Master themes and subordinate themes from present study

Master themes	Subordinate themes
Master Theme One: Disclosing the self	A desire to unburden the self from distress
	Imperfect sense of self
	Fear of rejection and disapproval
	Parallel process: The divided and false self
Master Theme Two: The therapeutic process and disclosure	The therapeutic process and trust
	The ideal therapist
	The imperfect therapist
Master Theme Three: Process of disclosure	Surge of emotions
	Anticipation: Guarded and unguarded disclosure
	Therapist on trial
	Consequences: Positive and negative
Master Theme Four: Impact of disclosure: Personal and professional development	Developing self-awareness
	Developing professional awareness
	The authentic self

This chapter will explore the master themes and corresponding subordinate themes, along with verbatim quotes from each participant. Although the four master themes were present in all of the interviews, not all subordinate themes were present, which will be highlighted. Additionally, similarities and disparateness between the interviews will be examined. The data was analysed at three levels:

- Participants' descriptions of their experience, for instance, the phrases used, their assumptions and emotional responses
- The rhetorical devices employed, such as language, repetition of words and tone of voice
- At a conceptual level, thus understanding the overall meaning of what is being conveyed

Each level of analysis will be reflected upon as each subordinate theme is considered, though the conceptual level will be reflected upon in greater depth within the discussion, in relation to psychological theories and concepts.

3.2 Introduction to the themes

The four master themes provide an account of TCPs' experiences of disclosure in personal therapy, with attention to how this phenomenon developed, how it manifested and the impact it had on participants. The first master theme encompasses the tension all the participants experience at a personal level and how this leads to the performance of an 'appropriate' self. The second master theme highlights how various elements of the therapeutic process, including participants' expectations of the therapist and apparent actions of the therapist hinder or facilitate disclosure. The third master theme illustrates the process of disclosure participants go through, reflecting upon the experience prior, during and immediately following disclosure; further highlighting what may hinder and facilitate disclosure. Finally, the fourth master theme depicts the impact of disclosure on the self at a personal and professional level, which subsequently results in a more authentic self.

3.3 MASTER THEME ONE: Disclosing the self

The subordinate themes encapsulated within this master theme depict all of the participants' desires to attend personal therapy from the outset. There is a seeming awareness amongst the participants of the importance of disclosing experiences perceived as either difficult or requiring a level of support, albeit minimal. Though at the same time, participants are faced with feelings of imperfection, vulnerability and fearing condemnation. The subordinate themes further emphasise that all the participants become enmeshed in a parallel process, which is an internal conflict and uncertainty about whether to position the self as a TCP or as a client, resulting in the divided self, as well as portrayal of a 'perfect' or false version of the self.

3.3.1 A desire to unburden the self from distress

This subordinate theme depicts all the participants' willingness to attend therapy as part of their training. It is apparent from all participants' accounts that this readiness to attend is prompted by a previous need for therapy or a need now to possibly work through difficulties. It is further evident from participants' descriptions that there is a longing to relieve the self from a burden they have been holding. The timing of personal therapy thus seems just right. The extracts below are some of many exemplars which illustrate this. This first extract taken from Emily's account summarises her experience prior to attending therapy:

> *"My husband and I had some really difficult things going on in our life [...] I was just at the end of my tether [...] I just needed something for myself but also I was just in a really bad place that's why the therapy was really really helpful"* (Emily: lines 173-184).

Emily's use of the phrase 'end of my tether' illustrates that she reached a point where she felt unable to continue dealing with the difficulties she was experiencing. Her use of the words 'needed something' conveys the desperation she felt to relieve her distress. Prior to expressing her need for 'something', Emily states that her husband was prescribed

antidepressants. It is likely that Emily too wanted the same support. The tone of her voice however then raises and she moves on to telling me quickly that she was 'in a really bad place'. This was perhaps Emily's attempt to justify her need for antidepressants, which she possibly views as negative and fears that I may too perceive it as so. However, it seems Emily felt unable to request this particular support from her GP and thus the timing of therapy was right.

Although Eric's eagerness to attend therapy does not overtly illustrate a strong need for therapy like Emily, his use of the phrase 'on my mind' suggests he may occasionally be preoccupied with recurring troubling thoughts which he desires to unleash:

> *"I was excited about it in a way and… and having somewhere to talk about anything which was on my mind basically"* (Eric: lines 13–16).

This extract further conveys that Eric recognises the value of having allocated space to talk about difficulties and is excited by the prospect of being able to do this himself. The opportunity to attend therapy as part of training is seemingly viewed as desirable.

Like other participants, Adel covertly expresses a need for therapy but perhaps experienced difficulties with accessing it prior to training:

> *"It almost felt like it gave me an excuse to have personal therapy even though I was quite kind of open to that"* (Adel: lines 19-21).

Her description implies that having personal therapy be mandatory was perhaps a blessing in disguise as it ensured she had to access therapy. Additionally, she furtively communicates that having therapy be mandatory enabled her to use this as a reason to tell others why she is attending therapy, rather than that she actually requires it, thus concealing her need for it. Adel's extract indeed highlights she longed to unburden herself from some level of distress.

Each of these extracts reveal that prior to training, there was an apparent need to obtain support for the self. It is further evident from these descriptions that a part of the self is cautious in expressing a *need* for therapy and thus there was openness to attending it as part of training. Beyond these extracts however, participants convey understanding of the need of therapy as a TCP, which also seemed to augment their openness.

3.3.2 Imperfect sense of self

Described by all of the participants was a perception of the self as imperfect (see appendix 18 for exemplars). Participants described feeling ashamed about particular experiences which they felt unable to disclose. Furthermore, the self was perceived as weak, owing to the inability to attend to or cope with their difficulty, thus resulting in the avoidance of disclosure. For some participants, experiencing the self as imperfect also led to self-doubt and feelings of inadequacy in their TCP role. Within their descriptions of this, participants conveyed feeling fearful of being perceived as incompetent by their therapist, which further hindered disclosure. The following extract illustrates Emily's feelings of imperfection:

> *"I think it's more to do with my own perception of myself [...] of not wanting to know the truth maybe or my own perception of not being ready to go near that material. [Okay]. So choosing deliberately to hold back"*
> (Emily: lines 615-621).

Emily describes feeling fearful and unready to attend to what appears to be negative perceptions of her. Perhaps attending to her negative perceptions would mean it is the truth, thus unchangeable and so it is better left unsaid. Additionally, there seems to be an underlying sense of her inability to cope with the admittance of not being entirely perfect. For her, this may be too painful to tolerate. Although Emily expresses her fear is more to do with her own self, it is likely that she fears if her therapist were to know the 'truth', then her professional integrity may be in question, so she actively avoids disclosure.

Alva echoes similar feelings of imperfection and describes her need to be liked by others, which hindered what she disclosed:

"I think what happened in first year was yeah my need to be liked and my need to please everyone and my need to make everyone feel that I do a good job, and and was completely separate from my fitness to practice issue" (Alva: lines 126-130).

Although Alva expresses her desire to be liked was not related to her appearing suitable to practice as a psychologist, she acknowledges that she wanted to be perceived as hardworking, valuable and worth retaining in this profession. This suggests she was indeed concerned about 'fitness to practice'. Her account further highlights that in order to prevent negative perceptions from others, including her therapist; she ensures her disclosures are not offensive or hurtful.

The following extract from Ishi conveys that feelings of shame resulted in fear of disclosing. Ishi's description of feeling 'exposed' and 'vulnerable' also communicates that she feels at a disadvantage in contrast to her therapist, in that her disclosure would mean her therapist has more knowledge of her than she does of him. Consequently, they would no longer be equal to one another and she can no longer hide behind a disguise:

"I was afraid of feeling naked, of of feeling exposed [Yeah] erm, you know, and and vulnerable [...] [Mmm, mmm] I was just afraid that all of a sudden I would feel [pause] ashamed I suppose or embarrassed or [That you said too much?] Yeah, that I said too much and and that I'd lost control maybe of the, of the discussion, in a way" (Ishi: lines 338-351).

This extract also highlights that she did not trust herself to disclose cautiously. There seems to be an ongoing concern of regretting her disclosure afterwards, which is possibly linked to her fear of being perceived as an incompetent psychologist. Ishi's trepidation around disclosure is clearly evident in this extract through her repetitive and hasty use of the words 'and', 'of' and 'of the'.

It would appear from these extracts that the participants entered personal therapy with feelings of imperfection, inadequacy and shame about aspects of themselves. However, this

focus then shifts towards feeling imperfect and inadequate as a psychologist, as well as apprehension about being perceived as such by their therapist. This subordinate theme further conveys that an appraisal of the self as imperfect can lead to disclosure being hindered, particularly in the early stages of therapy. The next subordinate theme is inherently linked with this theme as it illustrates how an imperfect sense of self can be projected onto the therapist.

3.3.3 Fear of rejection and disapproval

A trepidation shared by all of the participants is that revealing imperfect aspects of the self could result in condemnation and/or dismissal from training. Seemingly, disclosure is refrained from, possibly as a way of protecting the self from further negative emotions like shame, and to secure one's position on training. Below, Eric's use of the word 'guarded' conveys how cautious he felt about his disclosures, fearing they may lead to rejection or disapproval:

> *"I was a bit guarded maybe, a bit concerned err, that if I said sort of the wrong thing in in personal therapy, you know, what would happen"*
> (Eric: lines 18-20).

This account further suggests that Eric made assumptions there will be negative repercussions from disclosures that he deemed 'wrong' or perhaps unacceptable from a TCP. His anxiety thus resulted in the protection of the self through withholding certain information. Lara too provides an account of how she was preoccupied with concerns about her therapist's response to her disclosure:

> *"It was the initial sort of what he would think of me as a result of this"*
> (Lara: lines 143-144).

For Lara, there was an apparent fear of the outcome of her disclosure. She perhaps felt her disclosure would be perceived as socially inappropriate or unacceptable and therefore be met with rejection and disapproval. As expected, Lara's feelings of trepidation led to

uncertainty about disclosing. Additionally, given Lara's description of her experiences thus far (see transcript in appendix 19 on CD), it is likely that her own feelings of disapproval have resulted in fearing that her therapist will disapprove of her too.

Alva strongly echoes all participants' fears of rejection and disapproval:

> *"One of my placement erm resonated with one of my issues quite strongly and I actually had a lot of difficulty disclosing it in personal therapy because I didn't want it to reflect on my fitness to practice"* (Alva: lines 30-34).

It seems that for Alva, disclosing her difficulties would lead to being perceived as incapable of practicing as a psychologist. During this account, the intonation of Alva's voice lowers and the pace too becomes slower; illustrating that this contemplation is unbearable. Accordingly, just as the other participants' disclosures were hindered, Alva's trepidation of being told she cannot continue with training made it tremendously hard for her to disclose too.

This subordinate theme highlights that there seems to be much fear of rejection, disapproval and of being dismissed from training, should the therapist identify with TCPs' self-perceptions of imperfection. Accordingly, disclosures of personal difficulties are largely hindered. Furthermore, the trepidation described by participants seems to produce uncertainty about which issues are *safe* to bring to therapy, thus disclosures are given much contemplation.

3.3.4 Parallel process: The divided and false self

This subordinate theme refers to how all the participants became caught in a conflicting situation whereby they experience a divide in the self. Shared by all the participants were descriptions of feelings of tension, struggle, concern and uncertainty as to how to position the self in the therapy room, that is, either as a client or as a TCP. Owing to the requirement that therapy is utilised as a space for personal and professional development, there is an ostensible switching of roles which appears to play a part in the hindrance of disclosure to

an extent. This subordinate theme provides insight into how the divided self results in TCPs experiencing great difficulty in remaining true to the self. It is further apparent from the extracts that entering therapy as a TCP can result in portraying the self in a way that is deemed 'perfect' and suitable for a counselling psychologist profession. Emily's extract provides an understanding of the strain she felt in regards to disclosing personal difficulties:

> *"You know we have to be emotionally robust but also take risks and things [...] you got to be able to kind of work with stuff and not be and not break down"* (Emily: lines 146-154).

Emily's account illustrates that she feels compelled to demonstrate particular characteristics whilst disclosing. Her employment of the words 'we' and you' suggests this strain is felt not only by her but other TCPs too. This extract also conveys a sense of struggle. It highlights that although a TCP may be open to working through difficulties, there appears to be an obligation to portray resilience, perhaps owing to the assumption that it is a required characteristic as the role would entail listening to others' difficulties. Emily also seems to believe that an inability to demonstrate resilience may indicate she is not 'strong enough' to be a psychologist, further making the process of disclosure difficult. This extract brings to awareness that the role of a TCP in therapy is incredibly challenging as there is a requirement to show openness and willingness to explore difficulties, while at the same time ensure fear of exploration and high levels of distress are not observable. Recalling further on her initial experience of therapy, Emily's TCP role led her to be cautious of the way she presented in therapy:

> *"I was very mindful of how much I came across as able to be a good practitioner so I was afraid that you know if I show that I was on the brink of [laughs] of depression then they'd throw me off the course or something"* (Emily: lines 138-142).

Emily describes being vigilant of not demonstrating she is 'on the brink', that is close to the edge of being in a deep level of despair. It seems portraying herself in this state would result in devastating consequences such as being perceived unsuitable for this profession,

which would then result in the incompletion of training. Emily consequently presents herself as 'healthy' and in a positive light by omitting in her disclosure the level of difficulty she is truly experiencing. Although Emily admits to showing a false self in therapy, her laughter suggests she is uncomfortable with sharing this. The laughter also perhaps acts to negate the seriousness of misrepresenting the self, particularly as therapy is for professional development too.

Alva's account further captures the difficulties TCPs face whilst attending therapy as a client:

> *"At the end of the day my college, and have the power to qualify me or not [Mmm mmm] and my therapist has to sign this sheet of paper saying 'fitness to practice'. No! 'Fitness to practice concerns have arisen from personal therapy'. [Mmm mmm] So in a way my therapist, has the power in my training"* (Alva: lines 268-276).

She conveys the vulnerability and powerlessness she experiences in therapy as her therapist is perceived as an assessor of her capabilities to practice. Consequently, Alva appears to be cautious about the extent of her disclosure. Alva's frustration and distress can also be heard as the tone of her voice rises and she loudly states 'no'. Her frustration seems to be related to a loss of control over her future as she believes her therapist ultimately decides whether she can practice or not. Sadness can also be heard as the intonation of her voice begins to lower and soften. Seemingly, Alva's struggle leads to portraying herself favourably to her therapist. This is exemplified in the succeeding quote:

> *"It was a sign of improvement that I can admit this vulnerability blah blah. [Yeah] But with that [chuckles] placement incident it was just such a, erm, it was just so crudely, just present in terms of I am actually not fit to see these patients"* (Alva: lines 722-727).

Here, Alva states that acknowledgement of her difficulties is an indication that she is improving. However, her use of language here, 'blah blah', suggests that she may not truly believe in this, though declares her difficulties to perhaps signify she is getting better and

thus 'fit to practice'. This suggests that Alva's admittance is calculated and she is indeed controlling how she presents herself. Although Alva claims to have decided to admit her difficulty, her use of the words 'crudely present' implies that she did not have a choice but to make the disclosure as her difficulty was apparent. Alva's chuckle in this extract indicates that she felt embarrassed by this experience, particularly as she believed it depicted her as unfit to practice. Chuckling in this way was also perhaps Alva's attempt to not show me the extent of how much she struggled and is continuing to struggle.

Further support is provided by Ishi who describes the struggle she experienced:

> *"I found that since I was doing it as part of my training, at times I wasn't quite sure how to position myself in the room. [Mmm]. As a trainee or as a client. I think there was a slight, erm, discomfort around that"*
> (Ishi: lines 19-24).

Ishi explicitly describes feeling hesitant and uneasy with regards to her role in therapy. This is also observable as she contemplates whether to adopt a TCP role, which for her perhaps means presenting professionally and discussing issues only relating to this, or a client role and simply bringing in personal issues, unrelated to her TCP role. Ishi's description suggests that attending therapy as a TCP prevented her from engaging as a client as she perhaps did not want it to reflect her abilities as a psychologist. The following extract also taken from her account highlights that even when a client role is adopted; there is ongoing conflict and difficulty in balancing the two roles. Ishi's sense of divide indeed impacted on how she presented in therapy:

> *"Looking out for myself in the room as a client well well, sort of made that worse, I think, at times. It probably took me a bit longer to get into the process and then, sort of, engage with it on a, on an, on an emotional level"*
> (Ishi: lines 34-38).

Ishi acknowledges that engaging with her client role, as well as focussing on her TCP role resulted in suppressing of emotions, which subsequently obstructed her ability to connect

with the therapy process. Like other participants, whilst in a TCP role, Ishi may have presented a version of herself that would be considered suitable and professional.

It is evident from all the transcripts that entering therapy as a TCP is indeed complex. There is an apparent sense of divide in the self as participants describe struggling to balance their two differing roles, particularly as they move to and from each role. For instance, reflecting on their experience as a client one moment and in another moment, as a TCP. In this sample, the divided self results in an inability to process and address personal difficulties from the start of therapy. The accounts also bring into awareness that even when participants attempt to take on a client role, it is impossible to move away from their TCP role, which too adds to difficulties with disclosing. It is probable, however, that holding one's TCP role in mind allows distance to be created from the true self as there is palpable fear that sharing one's difficulties can impact negatively on their professional self.

3.3.5 Summary

Overall, this master theme illustrates that although personal therapy is generally viewed positively, TCPs experience great difficulties with engaging in the therapeutic process. There appears to be a sense of discomfort around disclosing the self to the therapist, particularly as these TCPs hold unresolved difficulties, which then result in an imperfect sense of self. This is illustrated by participants' expressions of feeling unready to attend to difficulties, along with feelings of shame and inadequacy as a psychologist. The accounts also illustrate that an imperfect sense of self transforms into a fear of rejection and disapproval from the therapist. However, participants' descriptions depict that this fear may stem from feelings of self-rejection and self-disapproval, which are then projected onto the therapist. It is further evident from participants' descriptions that a divide in the self emerges as two roles are retained whilst in therapy, which subsequently results in moving away from the true self and presenting a self participants' believe befits their TCP role.

3.4 MASTER THEME TWO: The therapeutic process and disclosure

This cluster of subordinate themes demonstrates how the therapeutic process, trust and participants' expectations and experiences of their therapist can influence the occurrence of disclosure, including the level of disclosure made.

3.4.1 The therapeutic process and trust

This subordinate theme uncovers how various aspects of the therapeutic process, such as the context in which therapy occurs, the therapeutic approach adopted by the therapist, the frequency and duration of therapy, the therapeutic relationship, therapist disclosures and so forth, impact on the level of trust obtained with the therapist and the likelihood of disclosure. Emily's account provides understanding of how a lack of consistency, in this instance a change of venue, can generate feelings of anxiety, insecurity and mistrust:

> *"He had to change erm where the therapy was [...] So erm he came to meet me erm for the very first session because I didn't know where the room would be [...] he took me up in the lift and he was kind of explaining that the place used to be like an old hotel [...] When I got into the erm room with him, I felt a real sense of violation! [...] There was a real sense of like boundaries been broken, "I've just gone up in a lift with you, you just told me this was a hotel", all just feels a bit seedy and horrible"* (Emily: lines 368-381).

For Emily, the therapeutic relationship and trust developed in a place which she became familiar with and felt secure in. However, stepping outside of what appears to be a circle of trust that she developed with her therapist resulted in her feeling insecure and uncertain of how to interact. Additionally, the unfamiliarity of the new venue and the therapist's revelation of the venue's history threatened Emily's sense of trust in him. There is an apparent apprehension as Emily's account is filled with several instances of 'erm'. It seems that Emily felt her therapeutic relationship was changing and in that moment it did not feel therapeutic anymore. Instead, the relationship felt as though it turned into a relationship which appears unethical. Emily's use of the word 'violation' and the rise in her tone of voice

highlights that she felt under threat. The language she uses, 'seedy and horrible', further suggests she felt at risk of her therapist wanting an inappropriate relationship with her and thus the situation felt sordid. Emily went on to describe that if this was true (see appendix 19 on CD), it would be devastating as thus far her therapist has been 'perfect' and she did not want this jeopardised. Her description also portrays the significance of keeping the therapeutic context consistent in order to develop and strengthen trust, which is considered essential for disclosure. Below, Eric emphasises trust is a requisite element for disclosure:

> *"I think trust is…is key. I think it's…it's a fundamental part of any disclosure* (Eric: lines 489-490).

Eric also recalls the length of time it took to feel comfortable to disclose in therapy:

> *"It was a gradual process, I think...I think certainly between...certainly between the the summer of year one and year two"* (Eric: lines 783-786).

It is evident from his account that in the first year of therapy he was hesitant about disclosing. Eric's description also highlights that with time trust can develop, which can subsequently aid disclosure.

The following extract taken from Ishi's account is one of many examples (see appendix 18), which conveys how the frequency of sessions can impact on the therapeutic relationship, trust and consequently disclosure:

> *"There's a there's a momentum I find, to to to the therapy and and an intensity and when there's a break [...] that momentum is lost [Mmm] I start doing other things with my life and talking to other people. I mean it's it's, sort of the the the link sort of weakens [...] disclosures take momentum I find"* (Ishi: lines 756-765).

It can be understood from Ishi's account that the regularity of sessions is essential in enabling one to feel secure in the therapeutic process and breaks between sessions can

result in bringing this feeling to a halt, including disclosure. Utilising support from others also suggests that Ishi perhaps perceived her therapist as unreliable and that she did not trust her therapist would be present when needed. Ishi indicates that when sessions are regular a strong relationship and trust is formed, which ostensibly facilitates disclosure. Ishi's repetitive use of words indicates she is somewhat nervous, which may be an indication of how difficult it can be to talk with someone whom a relationship has not been developed with, in this instance the researcher. Trust and consistency is therefore paramount for disclosure.

The above subordinate theme brings to awareness that the therapeutic process plays a salient part in the formation and obstruction of trust, which ultimately impacts on disclosure. Besides consistency of the therapeutic setting, therapy sessions and the length of time in therapy, further references were made about other elements of the therapeutic process and how at times these too play a role in disclosure (see appendix 18).

3.4.2 The ideal therapist

Evident in all the transcripts was this subordinate theme, which comprises of participants' perceptions of a 'perfect' therapist, including the therapist's apparent actions, which were considered impressive and admirable. Participants' favourable descriptions of their therapist illustrates that it largely impacts on the occurrence of disclosure. In the extract below, Eric describes feeling complete acceptance and support from his therapist. He also lays strong emphasis on and elongates the word 'feeling', which implies he truly felt understood and not rejected:

> *"Feeling what I'd read about it. [Laughs]. In regards to therapy of this unconditional positive regard and [Hmm, hmm] and really seeing alot of the…of underlying humanistic principles, which you often hear about and read about and see [...] I think that was influential in…err, in me sharing further things in the future"* (Eric: lines 263-272).

Eric's description and laughter also conveys that observing the therapeutic skills he learns about 'come to life' is an unusual experience because, whilst it aided his learning, it also created feelings of relief and trust. Furthermore, he emphasises how his therapist's reaction enabled him to make future disclosures.

Lara's account further suggests that an apparent positive reaction from the therapist aids disclosure:

> *"He reacted really well erm, [...]. He was, he was just very professional I think, erm [pause] and and he he did handle it, no he handled it really well, erm, which helped I think"* (Lara: lines 205-209).

Lara's repetition of her therapist's ability to manage her disclosure, including her strong emphasis on the word 'really', implies that she is impressed by his professionalism and that such a response from a therapist can facilitate deep disclosure. For Lara, a 'professional' psychologist is perhaps someone who exhibits unconditional positive regard, regardless of the disclosure topic. Her description suggests that her therapist indeed responded in the way she expected a psychologist 'should'. Alva too shared a similar experience (see appendix 18).

Adel's account signifies that a therapist's interest in the disclosure is ideal and paramount in feeling safe to disclose:

> *"To I think be a quite curious about you maybe and to ask you know to ask questions and ask people to say more about certain things and to not be too leading but to be kind of containing and structured enough"* (Adel: lines 798-801).

Adel shares that a therapist's interest materialises through further questioning about the disclosure. However, she also emphasises a need for the therapist to refrain from being overly directive, to allow space for the disclosure and to not be guided in a direction that is suited to the therapist. Adel's use of the word 'containing' also depicts the importance of wanting to feel protected by the therapist during disclosure, perhaps from any feelings of

distress that may arise. It seems having a sufficient amount of structure also allows emotions to be experienced gradually and gently. Overall, this extract communicates there is a desire for the therapist to 'hold' the client through the disclosure, which brings about feelings of safety and subsequently disclosure.

The extracts within this subordinate theme illustrates that therapists' responses can determine the occurrence of disclosure. It is evident from the transcripts that gentle inquisition, demonstrating acceptance, listening, attending to the disclosure and conveying that the disclosure can be worked through seemingly creates feelings of importance, trust and security within the client. This subordinate theme also reveals that displaying the above qualities as a therapist is vital in the encouragement of disclosures.

3.4.3 The imperfect therapist

Shared by all the participants were apparent actions from the therapist that were perceived as inappropriate, unethical and thus imperfect. Participants also provided descriptions of actions that would be viewed as improper should the therapist employ them, which also depicts the therapist as imperfect. Emily's account of her experience is one of many exemplars which highlights that therapist disclosure can act to impede disclosure:

> *"I remember telling talking to her about money and her then then disclosing to me that she would have trouble paying her rent if I stopped paying for therapy! [Right] I felt like she was trying to make me feel a bit guilty"*
> (Emily: lines 295-301).

During Emily's description of her therapist's disclosure, the intonation in her voice rises, exemplifying her disbelief and shock at the therapist's action of putting her own needs before hers. It seems from Emily's account that alongside feelings of guilt, she perhaps also felt unimportant and devalued as her own disclosure was disregarded. It can be further understood from the transcript that the therapist's disclosure is indicative of her inability to keep personal difficulties separate and from being imposed onto clients, leading Emily to view her disclosure as pointless and unsurprisingly discontinue therapy.

Shared by participants was the influence of the therapist's demeanour on disclosure. Alva's extract is an exemplar of this:

> *"I actually did want someone a bit more, warmer and less sort of sort of, sort of strong and resolute, but someone just a bit more human"* (Alva: lines 190-192).

Alva's account suggests that she found it difficult to connect with her therapist and qualities such as warmth, congruence and kindness were not present. The transcript also reveals that Alva's request for a strong therapist was perhaps misinterpreted by her therapist. It is apparent from Alva's account that her need for a strong therapist possibly stems from her fear that the process of disclosure will be difficult, thus a more open and receptive therapist is desirable.

A further action perceived negatively by participants was a lack of response from the therapist. Adel's account captures the impact this has on the therapeutic relationship and thus disclosure:

> *"In my mind I wanted a certain response, I wanted a resp' I wanted a response! I didn't really want no response and that was what I was getting [...] I was wondering you know is this, is she just wanting me to work this out myself with no guidance, you know what what is her role here, what does she think her role is here"* (Adel: lines 461-468).

It is apparent through the language Adel uses that she feels angry with her therapist for not responding to her disclosure. Repetition and accentuation of the word 'response' also suggests she felt let down and rejected. Adel's rejection of the therapist is also clear as the tone of her voice rises whilst referring to the therapist as 'her' and 'she'. These words are also strongly emphasised, eliciting an impoliteness in Adel's tone which further illustrates the intensity of her anger and rejection. From the transcript, it appears that the experience of rejection can result in a rupture in the therapeutic relationship, as well as feeling cautious of further rejection, which seemingly creates avoidance of future disclosures.

The above accounts bring to awareness that various therapists' responses are experienced negatively, which subsequently results in hindering disclosure. Participants' descriptions also brings to light that a therapist's lack of response, non-verbal behaviour and the way in which they conduct themselves is also significant in determining disclosures. This theme was common for all the participants.

3.4.4 Summary

This master theme encapsulates how the therapeutic process is a significant part of disclosure. The accounts illustrate that an amalgamation of the therapeutic process, the level of trust obtained and TCPs' experiences of the therapist results in the facilitation and or hindrance of disclosure. These extracts further exemplify that the process of disclosure is rather subjective and intricate as it is influenced by several entities, thus closer attention to each of these areas are necessary.

3.5 MASTER THEME THREE: Process of disclosure

This master theme attends to the process of disclosure by denoting what leads to the development and obstruction of disclosure. Each subordinate theme also reflects how the event of disclosure varies from individual to individual. From the transcripts it further emerged that the participants utilise particular methods to assess whether it is safe to disclose, resulting in the control of disclosures. Also represented within this theme is the immediate outcome of disclosure.

3.5.1 Surge of emotions

This subordinate theme refers to a gradual or sudden rise of emotion, which appears to also create a strong physical sensation. Evidenced in all but one of the transcripts were descriptions of feeling intense pressure and increasing distress prior to disclosing, which felt uncontainable and intolerable, thus resulting in disclosure. Emily's description overtly provides an understanding of how she came to disclose:

"I was also very aware of how uncomfortable I felt and how that I didn't feel I was able to talk about anything else in therapy unless I just addressed it because the feeling felt so strong" (Emily: lines 488-491).

It would appear that prior to disclosing, Emily experienced strong, forceful sensations which continued to increase in intensity until she attended to it. This account thus gives the impression that disclosure occurred as the emotions experienced felt unbearable, rather than the actual content of the disclosure was distressing.

In contrast, Ishi's strong sensation did not result in actual disclosure. However, her account demonstrates that her decision to disclose was prompted by a strong need to disclose:

"I thought it in advance, "Well, that that is something that I'm, I'm gonna tell him on Monday", [...]. Erm, and and "I want to discuss that with him" or "I want to bring it up now" because I think it's time" (Ishi: lines 206-211).

Furthermore, whilst Ishi describes her experience, the pace of her narrative becomes faster, illustrating the strain she perhaps felt prior to disclosing. Swift repetition of the words 'that', 'I'm', 'and', also display she felt compelled to disclose quickly.

The extracts convey that agitation is perhaps experienced within the body, which provides a sense of urgency and force to disclose. It would also seem that besides the content of disclosure requiring attending to, disclosure is also driven by a surge of intolerable tension which begins to feel uncontainable and possibly arises from concealing a significant issue.

3.5.2 Anticipation: Guarded and unguarded disclosure

This subordinate theme depicts how all of the participants engaged in a process of predicting what the outcome of their disclosure may be. It is evident from the transcripts that participants who envisaged a negative outcome would arise disclosed with reservation. On the contrary, where participants imagined a beneficial outcome, their disclosure was

unguarded. Extracts taken from Eric's account portray how the expectation of reprimand led him to be cautious of his disclosure:

> *"I think maybe to an extent, I may err, at least at times quite guarded"* (Eric: lines 60-61).

Eric's use of the words 'maybe' and 'may' also prevents him from providing a complete picture of his experience of disclosure, which is perhaps a representation of his vigilance in terms of what he disclosed in therapy. Hesitance is also discernible from Eric through the word 'err'. The following extract demonstrates Eric's reasons for controlling his level of disclosure:

> *'Being concerned that if I indicated that I wasn't practicing in a ethical way err, then that…you know, that that might have consequences, that she [...] you know, somehow would contact my err, university"* (Eric: lines 87-92).

It can be understood from this narrative that Eric anticipated that demonstrating improper practice, which would ostensibly arise from disclosing, would subsequently result in negative consequences such as his university being alerted. It also seems that owing to feeling at risk of being eliminated from training, Eric restricted his disclosures to prevent the display of any unethical practice.

Recalling her experience, Lara too provides an understanding of how expecting a negative outcome, in this case a negative reaction from the therapist, can make disclosing challenging:

> *"It was really difficult and quite uncomfortable. Erm, [...], I don't know if I was worried about what he thinks, or not so much what he would think but how he would react. It was it was really uncomfortable and really quite difficult"* (Lara: lines 111-116).

Lara expresses feeling uneasy prior to her disclosure. She describes her experience of disclosing as hard as she was greatly preoccupied with her therapist's perception of her and of what his immediate response would be. It is probable that Lara anticipated a negative reaction and uncertainty about how to manage this may have added to her worry. Lara's repetition of the words 'difficult' and 'uncomfortable' and strong accentuation of the word 'really' certainly indicates that her level of distress was high during this moment. A later account of her experience supports that her anticipation of a negative outcome delayed disclosure:

> *"I'm afraid sometimes it means I censor some things, coz I just feel like we've been over them and over them"* (Lara: lines 283-285).

The intonation of Lara's voice becomes lower as she apathetically reiterates the words 'over them', suggesting that she senses her therapist will become fed up and frustrated with her if she were to disclose material similar to previous disclosures. Lara consequently decides to modify her disclosures.

The following extract taken from Alva's account suggests that she believed her disclosure would be beneficial for her, which seemingly facilitated her in disclosing unguardedly:

> *"I have faith that that's going to be worked through to bring something positive in the end"* (Alva: lines 549-551).

Further than this, Alva trusted her therapist would not be rejecting of her disclosure or treat it meaninglessly. Instead, it would be attended to and worked through, which enabled her to make the disclosure and encouraged future disclosures.

Ishi also echoed Alva's anticipation that disclosure would be valuable rather than detrimental:

> *"I felt very much [pause] I needed to to engage with in order to be a good therapist"* (Ishi: lines 186-188).

From the transcript, it seems that Ishi acknowledges that through engaging in therapy and disclosing she developed personally, which she believed would then enable her to become a competent psychologist. Also, Ishi seemingly accepts that she is not entirely equipped with the skills necessary to become an effective psychologist and thus needs to work towards it. The pause in her description further indicates that she is reflecting deeply on the issues related to disclosure and keeps hold of the benefits of disclosing.

This subordinate theme reveals that participants evaluate the outcome of a disclosure prior to disclosing, which indeed influences the level of disclosure. Additionally, it is evident from the transcripts that expecting a negative outcome results in participants guarding their disclosure or refraining from disclosure altogether. In contrast, it is apparent when the outcome is not perceived as risky; disclosures are uninhibited.

3.5.3 Therapist on trial

A mutual subordinate theme amongst five of the participants was the employment of a strategy to assess whether it is safe to disclose and if the therapist meets the necessary requirements for disclosure. It would appear this strategy entails examining the therapist's demeanour whilst making a partial and or implicit disclosure. Although Lara was the only participant who did not explicitly state that she assesses her therapist's response, the previous subordinate theme indicates that her partial disclosure perhaps alerted her as to whether she should make a full disclosure. Nevertheless, below is one of many examples that summarises this subordinate theme succinctly:

> *"I think what's been helpful [...], testing out times when I've disclosed maybe something small and the reaction to that"* (Emily: lines 1043-1046).

It is evident from Emily's extract that a small disclosure allows one to test whether a disclosure will be beneficial by observing the therapist's response. It is likely that this strategy enabled Emily to then postulate that a similar response may be obtained from her therapist if she were to make further disclosures about the same or a different topic.
Eric recalls his experience, which appears to be similar to Emily's:

"I was paying a lot more attention to everything, to sort of facial expressions, behaviour and everything [...] I was searching you know am I being judged" (Eric: lines 742-748).

This extract illustrates that Eric indeed searched for signs of disapproval through being vigilant of his therapist's response. It is probable that when the response appeared negative, Eric assumed he said something inappropriate, which then prevented further disclosure. It can be further understood from Eric's transcript that his strategy of testing the therapist is perhaps related to his position as a TCP as the therapist is perceived as someone in authority, reviewing his suitability for the counselling psychology profession.

Consistent with other participants, Ishi too tests her therapist's response. These extracts illustrate that she specifically checks if her therapist is listening and shares the same understanding as her:

"I was on the lookout for signs that he would not get it. That he would not be sufficiently attuned (Ishi: lines 249-251)

"There was there was a lot of, erm, [pause] a lot of, vigilance. There was alertness to his responses" (Ishi: lines 259-260).

It is further evident from the transcript that prior to disclosing, Ishi assesses her therapist's verbal response to general disclosures, as well as his attendance of her non-verbal responses. It seems that for Ishi, attending to all her responses signifies he is connecting with her deeply, which then enables her to disclose. However, the language Ishi uses, for instance, 'lookout', 'sufficiently attuned', 'vigilance' and 'alertness', gives the impression that she was continually seeking moments when she did not feel understood and of when he makes mistakes. This illustrates that Ishi did not trust her therapist would be non-judgemental of her disclosures. This extract additionally conveys that finding flaws in her therapist perhaps provided her with permission to not disclose, which may be related to her fear that disclosing carries a risk. Furthermore, perceiving her therapist as inadequate possibly authorises her to reject him before he can reject her. Nevertheless, it is likely that

Ishi's relentless surveillance can result in misinterpreting interventions with the intention of not disclosing.

This subordinate theme brings to awareness that TCPs engage in a process whereby they assess the therapist's manner through partial disclosures to draw on the possible outcome of disclosure. It would seem that when participants feel heard, disclosure is likely. Also of significance is the therapist's non-verbal behaviour, which acts to inform participants of the therapist's availability to listen. Overall, this subordinate theme encapsulates that therapist reactions strongly determine the incident of disclosure, strongly echoing the previous subordinate themes.

3.5.4 Consequences: Positive and negative

This subordinate theme refers to the immediate experience following a disclosure. It emerged from the transcripts that all of the participants experienced some form of positive and or negative feeling, which in turn shaped future disclosures. In the following extract, Emily describes feelings of liberation directly after disclosing:

> *"Working through, material that's really suppressed, erm, about being able to, just feel a sense of release, I've lessened some anxiety"* (Emily: lines 724-726).

Emily's use of the word 'release' also indicates that through the disclosure she was able to physically let go of not only the issue she has been withholding, but also the negative emotions attached to it. It can be further understood from this extract that owing to no longer using tremendous energy to conceal her difficulties and through disclosing, her body felt a sense of relief. The intonation of Emily's voice lowers and softens whilst she describes this, giving the impression she indeed feels a sense of peace having disclosed. Eric too expressed such relief

On the contrary, Ishi describes what appears to be an undesired outcome:

"Unless he really worked with it, I, in later sessions and took it forwards, I I I felt a little bit disappointed, a little bit deflated" (Ishi: lines 409-411).

Referring to an experience when her disclosure was not given more time to reflect on, or attended to in subsequent sessions, Ishi expresses feeling let down. There is also a sense of dissatisfaction with her therapist and perhaps herself for having disclosed. By her account, there was a desire to delve deeper into the disclosure, particularly as the experience leading up to it is challenging. It is likely that Ishi expected her disclosure to be explored and dealt with; instead it was regarded as insignificant and irrelevant, leaving her feeling dejected. Ishi's repetition of the word 'I' emphasises that her disclosure had a significant negative impact on her.

Adel's account resembles Ishi's negative experience:

"I didn't really feel like I was in control almost that it was my thought, my Feeling but I didn't own it 'coz it was out there now, [...] it was between us and nothing was being done with it" (Adel: lines 481-485).

Adel's description demonstrates that by disclosing, she felt she had given up some of the power she retained, perhaps in anticipation of being consoled, along with understanding of her difficulties. However, it would seem that Adel's expectation was not met, which left her feeling insecure and powerless. It is also apparent from Adel's description that she and her disclosure were not attended to, creating further feelings of helplessness.

This subordinate theme illustrates that the immediate experience after disclosing varies from person to person. More importantly, the transcripts demonstrate that besides the therapist's immediate response, as illustrated in the previous subordinate theme, TCPs' immediate thoughts and feelings following disclosures are equally significant as they act to hinder or facilitate future disclosures. Essentially, it can be understood that feelings of contentment following a disclosure is likely to enhance trust and future disclosures, whilst feelings of regret can ostensibly lead to cautiousness about potential disclosures.

3.5.5 Summary

This master theme outlines various processes which can occur prior to disclosing. It is evident from the illustrated extracts that for some participants emotion can be experienced as overwhelming, leading to strong physical sensations and urges to disclose in order to relieve the body. Whilst for others, it appears that reflecting on the likely outcome of disclosure determines its occurrence. This is also apparent when therapists' responses to partial disclosures are tested. Additionally, the immediate outcome of disclosure plays a role in the probability of future disclosures. In summary, this master theme depicts that the process of disclosure is not identical for individuals and any one of these subordinate themes can be experienced at any time.

3.6 MASTER THEME FOUR: Impact of disclosure: Personal and professional development

This final master theme reveals that over the course of therapy, disclosing aspects of the self that participants' view as 'imperfect' steadily led to self-understanding, as well as development of a more coherent sense of self. Additionally, it outlines that disclosing contributed to TCPs' professional development, including recognition of therapeutic elements that can aid disclosure. More significantly, it draws attention to how the internal conflict experienced by participants at the beginning of therapy, which emerged from the divided self, seemingly resolves, leading to a more authentic self.

3.6.1 Developing self-awareness

This subordinate theme refers to how disclosure aids insight into one's own difficulties. It is apparent from the transcripts that through this insight participants are able to move towards resolving them and recognise the impact their difficulty is having on them and significant others. The following extract illustrates how disclosing facilitated Lara:

> *"Understand why I feel certain emotions more. But I think if, if any way it's it's made me sort of [pause] if not manage my emotions a bit better [...] I'm I'm not so erratic and all over the place as perhaps I was before and I'm much more self aware"* (Lara: lines 458-464).

It can be understood from Lara's account that disclosing enabled recognition and understanding of her emotions, including feeling less overpowered by emotions. Prior to disclosing, there was an apparent turmoil and struggle with negative cognitions, which resulted in Lara feeling fragile. However, this account indicates that disclosing brought about a sense of stability within the self. Furthermore, the soft intonation of her voice is indicative of the calmness she feels at present owing to disclosing. The following extract is a further example, one of many, which demonstrates how disclosure facilitates awareness of the whole self:

> *"It was quite important for me, erm, in in challenging some of my beliefs about others, about myself and and in in helping me connect with erm parts of me that I had not really connected with before"* (Ishi: lines 183-186).

Ishi's extract depicts that disclosing resulted in the identification of unhelpful perceptions she held about herself and others, which consequently enabled her to test their accuracy. Her account further highlights that disclosing facilitates confrontation of suppressed parts of the self, which ostensibly helps diminish a sense of disconnection from the self. Although Ishi's description imparts that disclosing leads to a positive impact on the self, there is a seeming hesitance in her voice. This is illustrated by her repetition of the words 'and', 'in' and 'erm'. While Ishi's hesitance is not explicitly stated, closer analysis of her account gives the impression that the reported impact of disclosure may not be entirely true.

Even though this subordinate theme communicates that disclosure enhances self-awareness and thus positive changes, participants' accounts appear to be somewhat predictable. It is probable that this is related to training programmes' expectations to develop personally, therefore TCPs feel compelled to express this change has transpired.

3.6.2 Developing professional awareness

Shared by all of the participants is awareness of the counselling psychologist role, including learning of therapeutic models and interventions. This subordinate theme also renders that participants' experiences of disclosing resulted in TCPs' reviewing and altering their own therapeutic styles to facilitate their own clients' disclosures. Eric's reflection on his therapist's disclosure demonstrates that impetuous disclosures can result in clients feeling unimportant:

> *"I think it's very important to to be very selective in that process and to er to only share things on a few occasions because at the end of the day the therapy is not for me er it's not for me to get my soapbox and start sort of preaching er it's... it's the client's time"* (Eric: lines 951-956).

It can be discerned from the transcript that Eric valued his therapist's genuineness. However for Eric, being genuine did not necessarily equate to the therapist disclosing personal views, but rather, the therapist presenting themselves without a disguise. It is apparent from this extract that Eric recognises the need to limit disclosing as a therapist. His use of the metaphors 'soapbox' and 'preaching' additionally suggests that therapist disclosures can result in clients feeling their space is being invaded and used as a platform to voice their views. Furthermore, it seems that therapist disclosure can cause clients to feel compelled to agree with the therapist, thus hindering their own disclosure.

Lara's account illustrates that her experience of disclosing led her to pay attention to the way she interacts with clients and how the therapeutic process enhances clients' disclosures:

> *"Made me think about even things like chair positions and the way I respond and the way perhaps that, that I expect people to change at my pace instead of their own pace"* (Lara: lines 682-685).

It is evident from the transcript that Lara's feelings of powerlessness in the therapy room, which stemmed from sitting on a lower chair to that of her therapist, has resulted in her being mindful of the therapy room setting and how that might impact on disclosure. This extract also emphasises the importance of following a client's pace and as a therapist to refrain from being exceedingly directive or coercive in bringing about disclosure. It would appear that in this way, Lara adopted her therapist's approach as she did not feel pressured to disclose. Lara's account also exemplifies that providing clients with space and allowing them to control the extent of their disclosure helps form a strong and trusting therapeutic relationship, which ostensibly leads to disclosure.

Adel's description of her experience underlines the importance of remaining with clients' experiences of disclosing as an alternative to immediately offering a viewpoint:

> *"Acknowledging difficulties and erm exploring rather than kind of being more interpretive, [...] it's more about kind of treading carefully, treading lightly and you know not going in with a sledgehammer"* (Adel: lines 970-975).

This extract conveys that offering explanations at the point of disclosure can be detrimental for the client rather than helpful. Adel identifies that interpretations offered by therapists can feel confrontational. Furthermore, Adel's use of a metaphor, 'going in with a sledgehammer', denotes that interpretations can be experienced as a weapon being utilised to destroy the disclosure to pieces. It can be comprehended from Adel's narrative that she too felt this way when her therapist offered instant interpretations to her disclosure, thus the timing of interpretations is imperative. It also seems from the language Adel uses that the therapist ought to employ a gentle approach, as an overly active stance can lead clients to feel unheard, rejected, perceive their disclosure as insignificant and possibly resisting further disclosures. Furthermore, like Lara, providing space is viewed as vital in aiding disclosure.

It can be discerned from this subordinate theme that regardless of negative and positive experiences of therapeutic interventions and disclosure, the experience as a whole greatly enhanced the stance TCPs adopt with their own clients. It is further apparent from the

extracts that TCPs developed insight into unhelpful therapy styles, which they subsequently avoided to ensure clients do not feel hesitant to disclose.

3.6.3 The authentic self

A central subordinate theme which occurred in all the transcripts is 'The authentic self', which captures how TCPs move from the false self that derived from the divided self, to a more connected and true version of the self. It is evident from transcripts that the tension TCPs initially experienced seemingly begins to subside. Further than this, TCPs begin to accept both good and bad aspects of the self, enabling them to feel comfortable within themselves, with the therapist and other relations. The following extract taken from Alva's account captures how disclosing aided her to not conceal herself anymore:

> *"Now I've had a different experience [Yeah] It's actually slowly filtering onto my other relationships, [...] I don't have to hold it any more just to keep the peace, as you say negative things"* (Alva: lines 740-748).

It is apparent that Alva's positive experience enabled her to be more expressive, irrespective of it being good or bad. It seems that owing to her experience of disclosing, she makes fewer attempts to escape discussions that may cause her to feel uncomfortable and negative. Until now, Alva's disclosure of her true emotions has been constrained to protect others' feelings. However, her account gives the impression that she is now less inclined to seek approval and no longer feels compelled to suppress negative feelings. This further suggests that Alva does not feel apprehensive about others' reactions, instead there's a sense of hope that others' responses will mirror her therapist's response to a degree, consequently allowing her true self to emerge.

Just as others expressed being able to display their true self (see appendix 18), Ishi reports feeling courageous in showing the whole of her, including aspects which she considered disgraceful and concealed from others:

"I feel [pause] more able to to show different sides of me to others, much more able than I was before and I think that has to do, also with the disclosure thing" (Ishi: lines 923-926).

It seems from Ishi's extract that perhaps owing to her therapist's acceptance of her, she too came to accept parts of herself which she had previously used tremendous energy to avoid. Furthermore, it is palpable from the transcript that Ishi detached from aspects of herself as she felt frightened to confront them. This provides understanding into why therapy initially felt difficult for her, including her struggle with adopting a client role. It is likely that Ishi's comfort with presenting different parts of herself is also related to her feeling less preoccupied with others reacting with horror if they were to know the 'real' her, as her therapist did not respond in this way. She seems more at ease with presenting her authentic self and less obliged to portray a false self. Conversely, the inflection in Ishi's voice becomes monotonous as she utters the words 'the disclosure thing', which suggests a sense of disinterest. Ishi's reference to disclosure as a 'thing' further implies that she possibly perceives it as inconsequential, though feels obliged to communicate change has occurred within her, as after all, this is one of the reasons for attending therapy. It could therefore be discerned that Ishi is continuing to present herself untruly to an extent.

3.6.4 Summary

This final master theme captures the impact TCPs' disclosures had on their personal and professional development. The subordinate themes also clearly illuminate that in spite of the difficulties initially experienced with disclosing, as well as during therapy, it nevertheless results in a positive impact. It is evident from transcripts and the extracts outlined above that disclosing helped bring about awareness of difficulties, together with working towards resolving such difficulties. Furthermore, the changes reflected within these accounts shed further light on the parallel processes described by participants in the first master theme. It is clear from participants' descriptions that a change in the self also influenced a change in their TCP role in some way, for instance, developing the capacity to put aside one's difficulties, which then acted to maintain focus on clients. Finally, the last subordinate theme indicates that disclosing ultimately leads TCPs to feel less perturbed by their dual

role, feel more connected with the self and less fearful of showing their authentic self. Nevertheless, in light of training programmes' requisites for TCPs to undergo a process of thorough self-development, participants' alleged changes are rather unsurprising. Consequently, the authenticity of this apparent change is questionable.

CHAPTER FOUR

DISCUSSION

4.1 Overview

This chapter will reflect upon the findings of this research in relation to the research questions and how they correspond with existing literature outlined in chapter one. A critical evaluation of this research, the researcher's reflection on the research process, and the implications for future practice and theory are discussed. Additionally, suggestions for future research will be considered.

Semi-structured interviews were conducted with six TCPs with the aim of exploring this main research question:

'What are TCPs' experiences of disclosure in personal therapy and its impact on personal and professional development?'

Alongside this question, the following areas were investigated:

- What brings TCPs to disclose and not disclose?
- What facilitates and hinders TCPs' disclosures?
- How do TCPs disclose in therapy?
- How does disclosure impact on TCPs?

IPA was utilised to analyse participants' accounts, yielding four master themes. Collectively, these master themes provided a narrative of TCPs' experiences of disclosure in personal therapy, including its impact on their personal and professional development.

4.2 Reflections on findings

Most themes which emerged in this research have been explored in the existing literature, namely, the processes individuals go through when disclosing (Afifi and Steuber, 2009; Chaudoir and Fisher, 2010; Farber et al., 2006; Omarzu, 2000; Stiles, 1987a, cited in Stiles et al., 1992), consideration of the anticipated risks and benefits of disclosure (Kelly and McKillop, 1996; Vogel and Wester, 2003; Vogel et al., 2008), consequences of disclosure (Farber, 2000; Gilroy et al., 2002; Kelly and McKillop, 1996; King, 2011; Leroux et al., 2007; Mearns, 1997, cited in Atkinson, 2006; Shillito-Clarke, 2003) and non-disclosure owing to shame (Farber, 2003; Hook and Andrews, 2005; Ladany et al., 1996; Macdonald and Morley, 2001; Yourman and Farber, 1996; Yourman, 2003). However, this research also revealed new insight into disclosure, particularly TCPs' motivations to disclose and not disclose; a group of participants which has not yet been investigated in regard to disclosure in therapy. Furthermore, therapist characteristics which appear to influence disclosure were identified. Previously, research on therapists' characteristics has largely focussed on how it impacts on the therapeutic relationship and less on disclosure, which is what this research fulfils. The following section will illustrate each master theme and recapitulate what appear to be the most interesting insights yielded from the interviews.

4.2.1 Disclosing the self

Participants' reflections on therapy as part of training were on the whole perceived to be a valuable component of training. For all the participants, there was a sense of wanting to engage in therapy, for personal issues and to understand the therapy experience from a client's perspective (see appendix 18), which seemingly resonates with arguments for mandatory therapy within the existing literature (McLeod, 2003; Shillito-Clarke, 2003; Legg and Donati, 2006). Zerubavel and Wright's (2012) assertion that therapists have had difficult past experiences are also supported by current findings as the majority of the participants expressed a *"neediness to have personal therapy"* (Adel, lines 96-97). However, the culture of silence, as discussed by Zerubavel and Wright (2012), is also evident in this current research, which gave rise to and perpetuated feelings of imperfection, as described by all the participants.

Conveyed across participants' descriptions was also a sense of struggle with disclosing, particularly about aspects of themselves which they perceived as imperfect and shameful. Participants described feeling apprehensive that such disclosures would portray them as an incompetent psychologist. This finding is consistent with Corrigan and Rao's (2012) paper on stigma and Zerubavel's and Wright's (2012) assertion that the wounded healer fears being judged on professional competency and thus resorts to non-disclosure or prevents deeper exploration of difficulties, especially in the early stages of training. Current findings were also consistent with existing literature regarding concerns about confidentiality (Farber, 2000; Gilroy et al., 2001) and a sense of feeling under inspection (King, 2011), including the risk of disclosures being misused and exposed by the therapist (Leroux et al., 2007; Shillito-Clarke, 2003). The majority of participants reported being watchful of the depth of their disclosure as they felt disclosures deemed inappropriate by their therapist may be communicated to training providers, resulting in negative repercussions.

Analysis of participants' accounts also revealed that their sense of imperfection and self-rejection activated fears of rejection and dismissal from training, consequently reducing the likelihood of disclosing. This finding strongly links to research on shame (Hook and Andrews, 2005), particularly Macdonald and Morley's (2001) research as they too found that non-acceptance of the self resulted in expecting the therapist to be non-accepting and hindered their participants' disclosures. Existing research on trainees and shame further highlights that disclosure is inhibited due to the trepidation of being viewed as incompetent (Graff, 2008; Yourman, 2003), which resonates with findings of this current research.

All of the participants' concerns about certain disclosures impacting on their ability to practice suggest that they perceived their therapists as an assessor or supervisor, thus supporting the concept of parallel processes identified within supervision research (Jacobsen, 2007; Tracey et al., 2012). However, present findings appear to extend current understanding of parallel processes as it illustrates that TCPs can experience this process in their own therapy too. Current research findings and the existing literature highlight the importance of disclosing feelings of failure to lessen increased feelings of failure and shame and reduce their perception of the therapist as rejecting. It seems addressing negative perceptions of the self early in therapy may provide a way of reducing fear of making

further disclosures too. More importantly, this finding supports several researchers' contentions about the significance of trainees taking responsibility in attending to and resolving personal issues (Johns, 2012; Wheeler, 2007), together with the awareness of their motives to become therapists (Barnett, 2007; Halewood and Tribe, 2003) to minimise negative impact on clinical work.

Within the existing literature, Jacobs (2011) and King (2011) bring to light the dilemmas in attending therapy as a trainee. Both researchers assert that the mandatory nature of therapy, including utilisation of therapy as a learning process, hindered trainees' abilities to adopt a client role. In the current study, participants described a tension, uncertainty of their role in therapy, a struggle with maintaining a coherent sense of self and a sense of division within the self, mainly owing to having two differing roles. The title of this thesis, a quote taken from Ishi's account, is understood to be emblematic of this division and uneasiness within the self. The analysis of interviews also yielded that whilst in the role of a TCP, participants' assumptions about how a psychologist ought to be led to them possibly portraying a false version of the self. This can be likened to Rizq and Target's (2008a/2008b) finding on 'pretend' therapy. Keeping apart negative aspects of the self from the positive appears to be supported by Klein's (1946, cited in Gomez, 1997) notion of splitting too. Also in accordance with current findings are theories of the false self (Winnicott, 1960a, cited in Parker and Davis, 2009), self-presentation (Kelly, 2000) and impression management (Goffman, 1959), as seen in Alva's account of her experience of disclosure. Her comment, *"I think I pretty much knew what I was going to say to you",* (lines 873-874) further highlights that impressions can be planned and rehearsed, as stipulated by Goffman (1959). Interpretation of Alva's account, *"It was a sign of improvement that I can admit this vulnerability"* (lines 721-722), further suggested that she may have displayed a false self, that is, as a favourable TCP. However, as Grimmer and Tribe (2001) supportively posit, reflexivity is not necessarily an indication of competence.

In line with research questions, this master theme begins to explain that a need to resolve existing or past difficulties, together with learning about therapy facilitated disclosure. Though at the same time, feelings of inadequacy, trepidation of rejection and presenting the self as a 'suitable' TCP acted to hinder disclosure. This research also broadened existing

research by offering potential explanations as to why pretend therapy, splitting, the false self, self-presentation and impression management occurs in TCPs and how it impacts on their disclosure in therapy. An avenue for future research may be to explore the relationship between past difficult experiences and TCPs' disclosures in therapy, which may offer further insight into whether difficulties with disclosure is indeed related to negative self-perceptions.

4.2.2 The therapeutic process and disclosure

This master theme offers insight into what facilitates and hinders TCPs' disclosures; addressing one of the research questions. As illustrated in the analysis chapter and appendix 18, the likelihood of disclosure is determined not only by the self but also by several elements of the therapeutic process. These include maintenance of therapeutic boundaries, consistency of sessions, trust, the length of time in therapy, the therapist's characteristics, therapist disclosure and the therapist's initial responses to disclosures. Research exploring therapists' characteristics (Balmforth and Elliott's, 2012; Farber and Doolin, 2011; Horvath, 2001) have mainly underlined their significance in developing the therapeutic relationship and facilitating client engagement. Despite acknowledging that client openness is likely when positive qualities are exhibited by the therapist (Giorgi and Gallegos, 2005; Knox, 2008; Littauer et al., 2005), these studies, besides Balmforth and Elliott's (2012) and Farber et al.'s (2006) research, overlook specifically which characteristics aid and inhibit disclosure and how. Furthermore, limitations of Balmforth's and Elliot's (2012) study are that disclosure was understood only through the analysis of one case and not through the participant's accounts, thus findings were not grounded in the participant's words. Farber et al. (2006) also obtained quantitative data, therefore limiting deeper understanding on how particular characteristics aid disclosure. In regards to therapist disclosure, present findings were similar to existing research (Hill and Knox, 2001; Peterson, 2002), as participants reported finding it both helpful and unhelpful. Nevertheless, research on therapist disclosure to date (Audet and Everall, 2010; Audet, 2011; Burkard et al., 2006; Myers and Hayes, 2006) has not obtained data on how it impacts on TCPs' disclosures in therapy. Current findings from this study, the utilisation of IPA and recruitment of TCPs, surmount some of these identified gaps in the existing literature.

Consistent with previous research (Gargiulo, 2007; Cochran et al., 2009), current findings also emphasise the importance of maintaining boundaries within the therapeutic frame for the development of trust and feelings of safety. However, current findings extend existing research by explicitly highlighting that this aids disclosure too (see appendix 18). Research regarding the strength of the therapeutic relationship in enhancing disclosure (Gunn and Pistole, 2012; Horvath and Bedi, 2006; Mehr et al., 2010) is also in line with findings from the current study. Also similar to existing research is the identification of specific therapist characteristics which hindered TCPs' relationships with their therapist and thus disclosures. However, employing a qualitative methodology in the current study usefully revealed that additional factors, such as individuals' negative self-perceptions, the fear of rejection, the therapist's gender and defences like projection, which may have been employed by TCPs in this study, also contributed to disclosure. Previous studies were unable to gather this data owing to employing quantitative methods. Deeper analysis of the accounts further revealed that some participants rejected their therapist because they themselves feared rejection. Additionally, finding therapist flaws provided participants with the permission to not disclose, thus colluding with their attempt to present a 'perfect' TCP.

In summary, these new findings highlight that elements of the therapeutic process are pertinent for disclosure. However, it is further apparent from the data obtained that these elements vary in degree of importance to TCPs, with some elements not considered essential at all. It would therefore be useful for future research to explore further the relationship between different elements of the therapeutic process and disclosure in therapy.

4.2.3 Process of disclosure

A number of models within the existing literature have put forward what influences the occurrence of disclosure and how it may take place. Some models also propose that a number of phases arise sequentially before disclosure (Farber et al., 2006; Omarzu, 2000), whilst others have suggested they occur simultaneously (Afifi and Steuber, 2009; Chaudoir and Fisher, 2010), or there is only one phase (Stiles, 1987a, cited in Stiles et al., 1992). In accordance with Stiles' (1987a) fever model (cited in Stiles et al., 1992), participants in the

present study indeed reported an urge to disclose and did so to reduce tension. Pachankis' (2007) assertion that non-disclosure can result in distress and preoccupation with the disclosure topic is also apparent in the present study.

In contrast to the DDM (Omarzu, 2000), it is evident from the analysis chapter that participants in the present study seemed to want to gain approval mainly through non-disclosure, particularly as an adept TCP. Nevertheless, with disclosure they aimed to lessen their distress, gain insight into difficulties, work on them and be a reflective psychologist. An interesting finding which emerged from the analysis of the present study is the subordinate theme *'Therapist on trial'*. Although making small disclosures to observe the responses of others is not a new finding, the present study extends existing literature by outlining specifically what is monitored within the therapist, for instance:

- Smiling
- Therapist presence, thus appropriate response
- Interest through acknowledgment
- Exploration through questioning
- Therapist comfort

Data analysis also highlights that therapists are tested with small disclosures throughout the course of therapy. The therapist on trial is therefore an ongoing process.

All the six stages in Farber et al.'s (2006) temporal model were apparent in the present study. Although participants revealed that negative emotions and physical symptoms such as emotional fatigue, anxiety, embarrassment, physical exhaustion, sadness, regret, physical discomfort and tension were additionally experienced immediately following disclosure. Furthermore, unlike this model, the current study illustrated that the process of disclosure does not end with disclosure increasing the chances of future disclosures. This study revealed that negative emotions following a disclosure persisted in between sessions, with TCPs worrying about the subsequent session, whether the disclosure will be followed up and how. It seems from current findings that the outcome of disclosure, in particular the

therapist's response, influences the likelihood of future disclosures. This is evident in existing literature (Chaudoir and Quinn, 2010; Farber et al., 2004).

Afifi and Steuber's (2009) RRM posits that individuals' readiness and willingness to disclose is determined by the risks of disclosing. Participants in the present study engaged in a process whereby they assessed the benefits and risks of disclosing, which consequently led to selective or unguarded disclosure. This finding is also similar to Chaudoir and Fisher's (2010) avoidance and approach goals specified in the DPM, as positive and negative outcomes determined the occurrence of disclosure. Participants also expressed that believing that the disclosure will and can be worked through facilitates disclosure. On the contrary, if it is thought the disclosure issue cannot be resolved, disclosure is then obstructed. This finding, alongside other findings outlined in the analysis chapter, certainly supports existing research on anticipated risks, benefits, beliefs about helpfulness and help seeking (Vogel and Wester, 2003; Vogel et al., 2008). However, as underlined by this model and seen in all participants' accounts, a cost and benefit analysis is not as straightforward as it seems as factors like intolerable distress can influence readiness and willingness to disclose.

Distinct from this model, the present study identified additional factors which influence disclosure. For instance, the therapeutic relationship, the therapist's characteristic, therapist's gender, TCPs' negative sense of self, TCPs' tendencies to be a reserved character and the significance of the topic of disclosure. These are evident in the analysis chapter and participants' transcripts. In accordance with Kelly and Yip's (2006) and Vrij et al.'s (2002) findings, it can be understood from the data analysis of this study that participants' sense of self and the seriousness of their disclosure topic determined whether they disclosed or not. However, unlike several other studies, which assert that the act of non-disclosure does not lead to distress (Kelly, 1998; Kelly and Yip, 2006; Vrij et al., 2002), this present study identified that it does, even when the disclosure topic was not considered hugely significant.

A further interesting insight which emerged from the analysis is the therapist's willingness to explore disclosures further, the therapist's readiness to listen and ability to tolerate disclosures. Emily speaks in length about this and how if her therapist is perceived to be not

strong enough, then she is less likely to disclose (see appendix 18), whilst Alva describes not wanting to *'overburden'* (line 688) her therapist, particularly when she appeared tired, similar to Kelly and Mckillop's (1996) and Williams and Healy's (2001) findings. Conversely, existing literature (Graff, 2008; Rizq, 2005), together with findings from the present study highlight that therapists' perceived imperfections, or the inability to tolerate distress, may be a reflection or projection of TCPs' imperfections and difficulties. As this was not explored further in the current study, future research may want to explore to what degree participants' negative sense of self influences their perception of their therapist as well as their disclosure in therapy, to obtain even greater understanding of the process of disclosure.

In relation to the research question about how TCPs disclose, participants utilised similar strategies as outlined in the RRM, for instance incremental and preparation. Though as noted earlier, some disclosures were unplanned and occurred spontaneously. This seemed to be the case when the disclosure topic was not hugely significant or owing to trust and unstructured therapeutic models, which was not identified in previous existing models. Furthermore, in the current study, Alva seemed to prime the therapist before disclosing in order to prepare her therapist for a disclosure. This is described under the subordinate theme *'Therapist on trial'* in the analysis chapter. This strategy can be viewed as similar to incremental disclosure and preparation, however priming, as employed by Alva, did not include disclosing actual details of the disclosure topic or practising the disclosure beforehand, as specified in the RRM.

Similarities between present findings and the DPM (Chaudoir and Fisher, 2010) were also identified. The DPM views disclosure as an ongoing process, with different outcomes occurring concomitantly. Findings from this study also revealed that a particular process of disclosure does not exist; the process is not the same for all individuals, but rather it is subjective as any one of the subordinate themes under master theme three can be experienced at any time. Furthermore, as already highlighted, a number of elements can influence the process. The process of disclosure is therefore rather complex. In order to further understand each process, future research is required.

4.2.4 Impact of disclosure: Personal and professional development

Participants' reflections on the impact of their disclosures on personal and professional development were largely positive. The analysis engendered insight into how TCPs made sense of their own self, the self in relation to others, their role as a TCP and clinical work, thus responding to the research question, 'How does disclosure impact on TCPs'. Furthermore, where negative aspects of disclosure were reported in the current study, for instance, a lack of therapist response, this perception did not remain negative, much like Rake and Paley's (2009) findings. Participants' accounts suggest that negative experiences were considered to be a helpful process as they learnt how to 'be' and 'not be' with their own clients. Deeper understanding of this negative experience was obtained owing to employing a qualitative methodology. The use of questionnaires would have obtained a limited response.

In comparison to research that investigated the impact of therapy on personal and professional development (Bike et al., 2009; Daw and Joseph, 2007; Gold and Hilsenroth, 2009), current findings were similar. This may be owing to disclosure being perceived as part of the whole therapy process. Within the realm of professional development, this study extended existing literature by highlighting the aspects TCPs consider important for clinical work and disclosure. These are the therapeutic space, the therapy room setting and the significance of forming and maintaining boundaries. Additionally, through disclosure and therapy, participants described developing an understanding of the counselling psychologist role and discovering the approach they would like to undertake.

The sense of division within the self owing to differing roles is reflected substantially in this final master theme as all the participants spoke about how disclosure aided their personal and professional development simultaneously. This is disparate from Rizq and Target's (2010a/2010b) findings as their participants mainly reported professional development. Although the dual role seemed problematic early on in therapy for participants in the present study, reflection on their development suggests that this felt sense of division is not as distressing as it initially was. It can be also understood from interpretative analysis of the data that through disclosing over time, participants began to feel more comfortable with

disclosing and more connected with the self. Furthermore, positive experiences of disclosure resulted in TCPs feeling less fearful of disclosing, not only to their therapist, but to others too. It would further appear that where acceptance was demonstrated by the therapist, TCPs' assumptions about how a 'perfect' psychologist ought to be were also challenged, consequently resulting in self-acceptance and the ability to show their authentic self. This final subordinate theme indeed supports previous studies' assertions that disclosure leads to self-understanding, growth, self-acceptance (Jourard, 1971), authenticity (Winnicott, 1948/1960, cited in Tuber, 2008) and authenticity with others (Farber, 2006). Distinct from existing findings, however, the present study provides TCPs' accounts of the experiences of disclosure in therapy and highlights that if therapy is to remain mandatory, then authenticity is significant for personal and professional development too.

4.3 Implications from current study

4.3.1 Key findings

Personal therapy was overall viewed as a positive experience by all TCPs. However, initially, there was a seeming struggle with engaging in personal therapy. The TCPs described experiencing the self as imperfect and inadequate as a psychologist, which subsequently resulted in the fear of rejection and disapproval from the therapist. The data further suggested that TCPs' fears may have derived from self-rejection and disapproval, which was then projected onto the therapist. The TCPs also described a sense of division within the self owing to uncertainty of their role in therapy, which consequently led to them distorting their disclosures and portraying the self as 'fit'. Aside from this struggle influencing disclosure, the findings highlighted that the therapeutic process, trust, maintaining boundaries within the therapeutic frame, the strength of therapeutic relationship, therapists' qualities, TCPs' expectations of the therapist and therapists' responses to disclosures also influenced the occurrence and hindrance of disclosures. Conversely, the level of influence of these factors varied between all the participants, thus illustrating that the process of disclosure is subjective. Furthermore, this study revealed that therapists' perceived imperfections may be a reflection of TCPs' imperfections, thus endorsing TCPs' decisions to not disclose and conspire with their presentation of a false self. This too

demonstrates that disclosure is a complex process. TCPs' descriptions of how they come to disclose further brings to light that the process of disclosure is dissimilar for individuals and that these processes do not occur sequentially. The findings suggest that some disclosures stemmed from heightened emotion. Accordingly, disclosures helped relieve the self from distress. For others, disclosure and non-disclosure appeared to derive from consideration of the potential risks and benefits of disclosure, as well as the therapist's potential response, which TCPs test out by making small disclosures or though informing the therapist a disclosure will be made. Moreover, TCPs search for the therapist's presence, comfort, smile and interest. This immediate response subsequently acts to influence the occurrence of present and future disclosures. TCPs' reflections on the impact of disclosure suggest that it indeed facilitated personal and professional development. The data reveals that feelings of imperfection and experience of the self as divided gradually subsided over the course of therapy, leading to greater self-awareness, self-understanding and self-acceptance. Moreover, TCPs reported developing an understanding of the TCP role, recognising the skills required as a therapist to aid disclosure in clients and the ability to attend to clients' difficulties, whilst setting aside one's own difficulties. Finally, the findings highlight that personal and professional development enabled integration of TCPs' dual roles and accordingly, presentation of a more authentic self.

4.3.2 Clinical practice and training implications

The present research contributes largely to the understanding of the phenomenon of disclosure by providing the accounts of TCPs, a population yet not investigated. An extensive literature search revealed that exploration of TCPs' experiences of disclosure is scarce, thus findings from this IPA study ought to be treated with caution. Nevertheless, alongside new findings, some of the themes identified were consistent with previous research, thus provide further indication of how the process of disclosure can be facilitated in TCPs attending mandatory therapy and for successful outcomes, such as personal and professional development.

In accordance with literature on the wounded healer (Zerubavel and Wright, 2012), TCPs in this study certainly indicate that they required some level of support and thus personal

therapy was welcomed. Ronnestad and Skovholt (2003) also found from their study on therapists' professional development that at the beginning of training, own issues can sometimes be used as a motivation to train, resulting in over-identification with clients, sympathy and the risk of advice giving as solutions to problems are often based on personal experiences. However, Ronnestad and Skovholt (2003) bring to attention that as therapists progress through training, they realise that their way of helping is no longer sufficient and recognise the significance of professional training. Furthermore, they experience pressure to fulfil the needs of training as they near the ending of training and start to demonstrate 'eagerness and, commitment to learn, and an attitude of openness', (p.17). This subsequently incites professional development.

The above findings certainly correspond with findings from the current research as TCPs too showed a process of development. TCPs in this research further described finding the process of therapy, including disclosure, easier as they progressed through therapy. Furthermore, from the early stages of therapy, there is a seeming shift for TCPs by the final stage as they showed eagerness and commitment in wanting to develop personally, professionally, and demonstrated greater openness to disclosure. Moreover, TCPs' understanding of the counselling psychologist role over time enabled them to relate to their therapist more easily. Findings from the current research, in particular the difficulties experienced in the early stages of therapy, can raise questions about the effectiveness of mandatory therapy for TCPs. Nevertheless, in spite of these difficulties, including concerns about disclosure, this research highlights the significance of mandatory personal therapy for TCPs. It is evident from the current research on TCPs that over the course of therapy, difficulties indeed lessened and TCPs developed both personally and professionally, which is essentially the aim of mandatory therapy.

In light of current and existing findings, an important implication is that TCPs take responsibility for acknowledging their own difficulties and be willing to allow exploration. Furthermore, it is vital that TCPs are attentive of any processes that may hinder their ability to engage and disclose when they first attend therapy, for instance negative self-perceptions, the fear of rejection, the need to portray the self as 'healthy' and the risk of projection. It can be assumed that TCPs are already aware of this; however a possible way

of facilitating and ensuring insight is through incorporating it in training. Through discussions in lectures, the importance of self-care, openness and willing of self-exploration can be emphasised. Furthermore, normalising the initial difficult process of therapy, particularly their dual role, and helping TCPs to understand that this process can change and become easier as time goes on would be another valuable discussion to have with TCPs before they attend personal therapy. This would subsequently facilitate the process of disclosure and ensure that the therapy process is useful and valuable from the onset.

The first master theme in the analysis, in particular the subordinate theme *'Parallel process: The divided and false self',* suggests that TCPs' reluctance and difficulties with disclosing is related to uncertainty of their role in therapy. It is further apparent that when the role of a TCP is adopted in therapy, disclosure of difficulties is hindered to a degree. An implication of this is that more clarity on the aims of personal therapy is required in therapy and in training to prevent the self from struggling with this division, to allow TCPs to adopt the client role more easily and accordingly resolve difficulties. These findings also signify the need for psychologists offering therapy to TCPs to recognise that the TCP role is complex owing to uncertainty about the role they ought to adopt whilst in therapy. Additional training for psychologists wishing to provide therapy for TCPs may therefore be useful in raising awareness of the dilemmas that exist. A discussion in the early stages of therapy about being a TCP, along with exploration of how this dual role can be managed may also be of benefit for the TCP, particularly as clinical work can sometimes relate to personal difficulties. Williams et al.'s (1999) findings certainly support this recommendation as clarity on the aims of therapy led to participants being able to explore personal issues early in therapy. A further suggestion in managing conflict of roles may be to attend personal therapy for the duration of one year prior to attending formal training as participants' accounts demonstrate that difficulties with disclosure mainly occurred in the first year of therapy.

Hill et al. (2000) suggest that individuals sometimes conceal the self as they are unaware of what is appropriate to discuss in therapy. Rarely therapists educate clients about what can be discussed in therapy, other than informing them about the limitations of confidentiality. However, owing to TCPs' conflict in managing their dual role, which subsequently hinders

the level of disclosure made, a discussion around what can be bought to therapy may challenge TCPs' assumptions about not being good enough because they possess difficulties. This may then act to enhance TCPs' disclosures and their self-development. Alongside this, the encouragement of self-care, even when training ends, ought to be promoted in training courses by lecturers.

Findings highlight that participants' presentation of a false self may have been guided by what TCPs construed to be an ideal psychologist. Although this vision may differ across TCPs, a recommendation from this study would be to have a discussion about this perception. Although this may already be supposed, psychologists working with TCPs can perhaps specify that psychologists are human too and can therefore have problems. It is also vital to emphasise that attending to difficulties and reflecting on clinical practice in relation to difficulties is what deems a 'skilled' counselling psychologist. Participants in this study certainly found that a positive response to their disclosure enabled them to recognise their experience is *"human"* and *"nothing shameful"* (Ishi: line 452 and 455).

The master theme *'The therapeutic process and disclosure'* usefully highlights that therapists ought to demonstrate particular characteristics for the facilitation of disclosure and authenticity, which are significant for personal and professional development. Additional training for psychologists wishing to provide therapy to TCPs may subsequently benefit from awareness of the mediums that specifically facilitate disclosure. Furthermore, as found in the analysis, such skills can reduce negative responses to disclosures, enhance the development of trust, which can reduce anxiety about disclosing, decrease the need to test the therapist's response, lessen anticipation of the risk of disclosing and diminish the occurrence of negative feelings following disclosure. Besides additional training for qualified psychologists, exploration of TCPs' beliefs surrounding disclosure would be an indispensable discussion to have at the start of therapy, as it may help eradicate negative assumptions that seem to be hindering disclosure. Highlighting the benefits of disclosure in therapy, including its benefit on personal and professional development, as suggested by Zerubavel and Wright (2012) previously, including a discussion in lectures, is also highly recommended.

Findings of this study verify that the process of disclosure is relatively complex as a number of facets influence its occurrence. Furthermore, findings exemplify that the experience of disclosure is subjective and therefore current findings must not be taken at face value. These findings do, however, stress the importance of therapists exploring the facets which appear to be hindering disclosure, such as, TCPs' negative self-perceptions, fear of rejection from the therapist, TCPs' need to portray the self as 'perfect', anticipated risks and benefits, distress, the therapist's gender, therapeutic boundaries, trust, the therapist's characteristics, therapist disclosure, the therapist's initial response to disclosures and the therapeutic relationship. Moreover, the current findings suggest that discounting these issues can result in the risk of TCPs' authenticity diminishing, which is detrimental for present disclosures, future disclosures and personal and professional development.

4.4 Reflexivity

It is important to reflect upon the researcher's position within this study. Smith et al. (2009) assert that a 'certain amount of reflection is a helpful and necessary part of phenomenological and hermeneutic enquiry', which subsequently serves to remain with 'sense-making', (p.149). As outlined in the methodology chapter, my interest in conducting this study partly derived from my own difficulties with disclosure in therapy. It was therefore imperative that I remained continually reflective of the research process and did so by keeping a reflective dairy. Nevertheless, an ongoing challenge for me was managing the balance between my role as a researcher and that of a therapist. There were times when participants expressed feeling upset and I naturally provided an empathic response. Remaining with this stance could have easily led the interview to a different direction, potentially away from the topic under study. I therefore attempted to stay in the researcher role by reminding myself of the purpose of the interviews and noting down areas of particular interest in my reflections. On reflection however, my hesitance about slipping into a therapist role at times led me to rigidly remain with the structure of the interview schedule, which consequently resulted in less exploration. This occurred particularly with the first few interviews I conducted. In awareness of this and as I became more skilled as a researcher, I asked questions in a different order with different participants which allowed for a more natural exploration.

A further challenge I faced was being entwined in a parallel process, owing to my role as a researcher and a TCP. As a TCP, I was mindful of the difficulties in disclosing sensitive information to an unknown person, especially as I did not know how the information I disclosed would be used. As a fellow TCP, I found myself drawn into participants' experiences, particularly as some of the difficulties expressed echoed my own experiences, to which at times I inadvertently responded with subtle agreements. Participants' awareness of my role as a TCP may have provided them with a sense of comfort that I would understand the difficulties which can arise in therapy, therefore, enabling them to disclose more openly. In saying this, I was very much aware of my researcher role and often moved back into this position. My probing of interesting areas indeed reflects this shift. As a researcher, whilst understanding participants' experiences of disclosure in therapy, I wanted them to feel safe to share. However, given my knowledge that therapy is an important aspect of a TCP's training, including fitness to practice; it is possible that participants may have felt apprehensive about disclosing to me. Participants certainly described feeling uneasy about their therapist's potential disapproval. Perhaps in this way, participants anticipated disapproval from me. My dual role in this context certainly was a predicament. However, in order to prevent disruption to the interview process, I attempted to maintain a consistent role by reminding myself that I am a researcher within this context. This also ensured my reflections were grounded in the data gathered rather than my assumptions about participants' experiences, which possibly stemmed from my own experiences as a TCP.

4.5 Critique of the research

As outlined in chapter two, IPA seeks to explore the personal meanings that participants assign to their experiences; particularly in the way that it is lived (Smith et al., 2009). In this way, the utilisation of a small sample was indeed appropriate. Furthermore, this study aimed to obtain in-depth understanding of participants' experiences of disclosure and employing a larger sample would have impeded this aim. Nevertheless, it is important to note that a small sample size does denote a limitation, particularly in regards to generalisation. Additionally, an extensive literature search revealed that this research appears to be the first to specifically explore TCPs' experiences of disclosure in therapy;

therefore generalisation of current findings ought to be done with prudence. Despite this limitation, the strength of this research is that it offers insight into a domain which is currently dearth within the disclosure literature.

Although this research sought to recruit participants in their final year of training, it could be argued that by this point, participants have developed a strong therapeutic relationship with their therapist, thus were more likely to disclose and have attained an overall positive view of their experience of disclosure. This is evident in participants' transcripts, where the difficulty of disclosing subsides as they progressed through therapy. The recall of early experiences of disclosure also posed a difficulty for some of the participants, which may be reflective of using final year TCPs. It is likely that this may have led to recall of more recent positive experiences and possibly explains why unhelpful experiences came to be later viewed as helpful. A possible further limitation in recruiting final year TCPs is that they would have developed wide knowledge of therapy, therapeutic models and interventions. It is probable that this knowledge could have shaped their responses, consequently affecting the validity of the data gathered. This limitation is indeed observable in participants' accounts as some of the TCPs used language drawn from psychodynamic theory, for instance, transference and counter-transference to imply self-awareness. Furthermore, they described that being contained by the therapist led to disclosure, but also that disclosure led to feeling contained. It seems by this stage, TCPs' knowledge of theory and particular use of language can also demonstrate something that may not be there, for instance, that they feel "*more resolved"* (Alva: lines 816-817), or that disclosure indeed impacted on their personal and professional development positively. However, it is the use of language that is distinctive to therapeutic models which implies that their responses may not be wholly authentic. It is further noteworthy that one of the participants only just disclosed difficulties to her therapist, that is, after two years of attending therapy. This raises the question of what else may have been left undisclosed by participants during the interview process. IPA also considers language to be a limitation during analysis as individuals vary in how they employ language to describe their experiences. In light of this limitation, future research may consider recruiting participants in the second year of training, to obtain more accurate reflections and deeper insight into the initial difficulties that occur. Nevertheless, a key strength of employing this inclusion criterion is that

exploration of what hindered and helped facilitate disclosure over time was obtainable. This finding may not have been obtainable had less experienced TCPs been recruited.

In relation to recruitment, it is important to reflect on why participants volunteered to participate. This will seemingly have an impact on the data gathered and consequently the analytic process. It is evident from the analysis that all the participants experienced some level of difficulty with disclosure, with some not being able to share this difficulty with their therapist. Through TCPs' descriptions of their experiences of disclosure, frustration with the therapist at times was noted, as seen in the data analysis. It is therefore probable that participants volunteered with the intention of using the interview process as a way of venting their frustration and sharing the struggle they experienced with disclosing; a struggle not previously disclosed and perhaps still bothersome. Alva's disclosure of having planned what she was going to say in the interview (lines 873-874) indeed suggests that much thought had been given to the research prior to taking part, which certainly questions the validity of the data gathered.

Problems with recruitment were also experienced, as highlighted in chapter two. Existing research highlights that confidentiality concerns are linked to disclosure (Nowell and Spruill, 1993; Younggren and Harris, 2008), perhaps the same reason impacted on TCPs' decisions to participate in this research. Many of the themes which emerged in the current study, for instance an imperfect sense of self and the fear of being perceived as incompetent, may also help explicate why several attempts were made to recruit. This presents a challenge for future research, though exemplifies the significance of this research. In contrast to the recruitment strategies employed in this research, future research may want to consider attending various universities which accredit the course to provide flyers and brief information about the research to help facilitate an easier and quicker recruitment process. This strategy was considered in the present research however was later discarded as a sufficient number of participants were recruited.

In regards to homogeneity, the sample recruited was homogenous to a degree, as all the participants were TCPs in their final year of training and shared the experience of personal therapy, therefore, the experience of disclosure. As this research aimed to specifically

explore disclosure experiences of TCPs, this sample was deemed appropriate. Nevertheless, to exclude information, such as the therapist's orientation, the specific number of therapy hours TCPs engaged in, the number of therapists a TCP had, or different training programmes requirements for fitness to practice, this sample can be viewed as a limitation, particularly as these categories may have impacted on the data gathered. For instance, it is evident from one of the participant's descriptions that they had two therapists during their training, which undoubtedly impinged on the number of hours they completed with each therapist. Initially, the decision to include TCPs in their final year of training was to ensure that TCPs had sufficient therapy experience to enable them to reflect on their experience. Although this participant may have had sufficient experience of therapy and disclosure, their experience with each therapist may have been different, thus impacting on their disclosure experience. A further limitation of this sample is that the manner TCPs' completed therapy hours were verified appeared to differ. For instance, a participant reported that her therapist was requested to state whether the TCP is also fit to practice. It is evident from this TCP's transcript that such a procedure influenced their decision to disclose. Nevertheless, at the time of recruiting, these categories were not considered to be relevant and were accordingly discarded. Furthermore, it seemed that restricting the inclusion criteria to include such specifics could have led to difficulties with recruiting and may not have provided the in-depth understanding of TCPs' disclosure experiences that was obtained. Additionally, establishing patterns and relationships between these categories were not the aim of this research and may have led to the consideration of a different methodology. Conversely, these limitations draw attention to the significance of these categories. As a way of managing the difficulties that may have risen from a strict inclusion criterion, simply gathering this information following participants' consent to participate would have illuminated current findings. This information would have further shed light on the complexity of disclosure and accentuate that the experience is indeed subjective.

It is of further importance to acknowledge that the sample recruited was not representative of gender, age or ethnicity as this study specifically sought to gain insight into TCPs' experiences of disclosure. However, as three participants made references to their therapist's gender as possibly influencing their disclosure, which was not be explored in-depth, future research may wish to explore this further. Furthermore, gender research

implies that males (Dindia and Allen, 1992), including individuals who identify specifically with masculinity, are less likely to disclose (Patee and Farber, 2008). As only one male participated in this research, future research is encouraged to explore male TCPs' experiences of disclosure in therapy too. Although representativeness appears to be a limitation, this study did not seek to make generalisations as the aim of IPA is to delve deeply into the individual experience to obtain rich insight. With this mind, even if this research recruited a much stricter homogeneous sample (all women, all men, same age or ethnic background), different themes may have still been yielded as from a phenomenological viewpoint, truth is not fixed, but rather fluid and subjective to the experiences of the observer, as illustrated in participants' accounts.

During the interview process, participants were provided as far as possible with a safe environment to allow for deep exploration. Nevertheless, it is worth acknowledging that the use of a tape recorder, including the researcher's role as a TCP, may have influenced TCPs' responses to a degree, for instance presenting themselves as a 'fitting' TCP, like they did in therapy. For instance, at the end of Alva's interview, she added: *"I think I would have eventually disclosed to my therapist"* (lines 891-892). This may be an indication of her worry that the researcher as a TCP may think negatively of her as she did not disclose her difficulties for a long period of time, despite it affecting clinical work. The doctoral training programme also requires TCPs to submit the self to a process of self-development through the attendance of personal therapy. In this sense, including knowledge that the researcher is a TCP, thus aware of the significance of personal and professional development, means participants' assertions about having reached a great level of awareness is somewhat predictable. This seeming progression is thus contentious. Telephone disclosure has also been documented to be easier (Ignatius and Kokkonen, 2007). However, the two telephone interviews conducted in this research were in fact shorter, suggesting that the role of the researcher may have been the main issue. Despite these limitations, as highlighted earlier, this research seems to be the first study to explore TCPs' disclosures, thus broadening existing disclosure literature. Further research into this phenomenon is nevertheless championed to discern the validity of findings.

The utilisation of semi-structured interviews were a strength of this study as it allowed for exploration of areas not anticipated, for example, the sense of the self as imperfect and possibly projecting this onto the therapist to avoid disclosure. However, it is likely that the interview schedule may have influenced the direction of the interview to a degree and consequently the themes identified. Conducting a pilot interview, however, did allow for the questions to be revised slightly, to ensure questions were more open and not leading. Furthermore, as this interview sought to explore TCPs' experiences of disclosure and its impact on personal and professional development, it is not unordinary that the interview will be steered towards exploring these issues, together with unexpected areas.

A further important note to consider is that the analytic process is reliant upon the researcher's understanding of the way participants made sense of their experiences. The findings therefore will undoubtedly be influenced by the researcher's experiences. This is especially true as the researcher is also a TCP, with experience of disclosure in personal therapy. A different researcher may have therefore produced different themes. While this may be viewed as a limitation, qualitative research is recognised as a collaborative process. The researcher also acknowledged her part in the analytic process by bracketing her assumptions as much as possible through reflexivity to identify prominent themes of TCPs' experiences, thus surmounting possible researcher bias. Additionally, the hermeneutic-phenomenology paradigm emphasises the importance of staying close to participants' experiences (Wertz, 2005). The presentation of participants' accounts in the analysis chapter certainly accomplishes this, thus further prevails the limitations identified.

4.5.1 Was qualitative rigour achieved?

Willig (2008) asserts that the validity of research is attained if it 'describes, measures or explains what it aims to describe, measure or explain', (p.16). In this way, IPA was in congruence with the researcher's epistemological position and the design of this study certainly addressed the questions it sought to answer. As discussed in the methodology chapter, the quality of this research was further assessed using the guidelines stipulated by Yardley (2000). The steps to ensure sensitivity to context, commitment, rigour, coherence and transparency were also outlined. With regards to impact and importance, it is hoped

that this discussion has highlighted how this study provides novel insight into the experiences of disclosure, questions and extends existing literature. Perhaps more significantly, this study appears to be the first to explore TCPs' experiences of disclosure in therapy and its impact on personal and professional development, therefore contributing to the clinical practice and training programmes for counselling psychologists.

4.6 Suggestions for future research

In addition to suggestions made above about avenues for future research, other areas may benefit from further exploration as a way of enhancing disclosure amongst TCPs. An area of interest is TCPs' perceptions of what a competent counselling psychologist is and how this fits with the way they may present and disclose in personal therapy. The current study did not probe TCPs' perceptions further as it may have slightly moved away from exploring the experience of disclosure. A criterion not considered during recruitment is the therapist's profession and therapeutic model employed by TCPs' therapists. In the present research, four of the participants made reference to their therapist's profession, though not all in relation to disclosure. As not all DCoP training requires therapy to be provided by psychologists, it would be interesting to explore whether it impacts on TCPs' disclosures in therapy. It was also evident in the current research that participants had sound understanding of therapeutic models and were able to specify which psychological interventions and models enhanced disclosure. A thorough exploration of therapeutic approaches and disclosure can help pinpoint these interventions further. Recruiting a sample of TCPs can also offer a more refined insight, which lay persons may not be able to provide. Outcomes from such a study would be useful for clients, qualified therapists and TCPs in therapy.

CONCLUSION

To date, the majority of the disclosure research has been dominated by positivism. Though in recognition of methodological limitations, more recent research has attempted to provide a deeper understanding of disclosure through qualitative methodologies. In keeping with this, the hermeneutic-phenomenology stance taken in this research sought to obtain deeper understanding of TCPs' lived experiences of disclosure in personal therapy and its impact on personal and professional development. IPA was also selected as the preferred research methodology to allow idiographic exploration and further understanding of the structure of participants' disclosure experiences.

In addition to the main research question, semi-structured interviews with six TCPs also explored the following areas: 'What brings TCPs to disclose and not disclose?'; 'What facilitates and hinders TCPs' disclosures?'; 'How do TCPs disclose in therapy?' and 'How does disclosure impact on TCPs?' The analysis yielded four master themes: 'Disclosing the self'; 'The therapeutic process and disclosure'; 'Process of disclosure' and 'The impact of disclosure: Personal and professional development'. The findings were somewhat consistent with existing theory and literature, although the amalgamation of all the themes provided a novel insight into the experience of disclosure, particularly to that of TCPs, a group yet not investigated within this context. Findings which seem distinctive to this research relate to TCPs' struggles with adopting a client role and becoming enmeshed in a parallel process owing to their dual roles. It is further apparent from findings that TCPs' sense of the self as imperfect augments this struggle, resulting in TCPs portraying a false self to negate the possibility of being rejected and dismissed from training. Maintaining therapeutic boundaries and consistency of the therapeutic space was highlighted as pertinent in developing trust, which subsequently aids disclosure. Although the importance of encompassing positive therapist qualities for positive therapeutic outcomes is not a new finding, this research indeed specifies characteristics that are essential in aiding disclosure in therapy. Furthermore, findings suggest that the negative qualities identified within therapists may be a projection of TCPs' own imperfections, thus allowing TCPs to continue maintaining a false self through guarded and unguarded disclosure. The process of

disclosure mirrored existing disclosure models, however, findings from this study elucidate that the process of disclosure is rather complex and subjective, as the decisions to disclose and how disclosure occurred varied between individuals. While testing therapists' responses through selective disclosures is not an exclusive finding, the qualities which the TCPS' sought through testing are unique in the realm of disclosure research. Additionally, this study brings to light that besides selective disclosures, therapists are also tested through priming, by letting the therapist know a disclosure will be occurring. The impact disclosures had on TCPs' personal and professional development was unsurprising. However, findings from this research accentuate the significance of authenticity during disclosures, as it is authenticity that facilitates development. Furthermore, authenticity enabled TCPs to resolve the conflict they initially experienced in therapy, accordingly allowing them to integrate their dual roles, be true to themselves and others. Taking into consideration the paucity of research exploring TCPs' perspectives on disclosure, it is hoped that this study has been valuable and contributed to broadening existing literature and influenced the DCoP training programme, TCPs' personal and professional development and qualified psychologists' clinical practice.

RESEARCHER'S AFTERWORD

Through disclosing,

I came to learn that the 'bad' part of me,

my long-term condition,

is not the whole of me, but a part of me,

which in time,

I came to integrate within my being

And reveal my authentic self.

REFERENCES

Ackerman, S. J. & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy, 38* (2), 171-185.

Afifi, T. & Steuber, K. (2009). The Revelation Risk odel (RRM): Factors that predict the revelation of secrets and the strategies used to reveal them. *Communication Monographs, 76* (2), 144-176.

Afifi, T., Olsen, L. & Armstrong, C. (2005). The chilling effect and family secrets examining the role of self protection, other protection, and communication efficacy. *Human Communication Research, 31* (4), 564-598.

Arkin, R. M. & Hermann, A. D. (2000). Constructing desirable identities - Self-presentation in psychotherapy and daily life: Comment on Kelly (2000). *Psychological Bulletin, 126* (4), 501-504.

Atkinson, P. (2006). Personal therapy in the training of therapists. *European Journal of Psychotherapy and Counselling, 8* (4), 407-410.

Audet, C. T. & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance and Counselling, 38* (3), 327-342.

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly, 24* (2), 85-100.

Bachelor, A., Laverdiere, O., Gamache, D. & Bordeleau, V. (2007). Clients' collaboration in therapy: Self-perceptions and relationships with client psychological functioning, interpersonal relations, and motivations. *Psychotherapy: Theory, Research, Practice Training, 44* (2), 175-192.

Balmforth, J. & Elliott, R. (2012). 'I never talked about, ever': A comprehensive process analysis of a significant client disclosure event in therapy. *Counselling and Psychotherapy Research, 12* (1), 2-12.

Barnett, J. E. & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistnce programs for psychologists. *Professional Psychology: Research and Practice, 32* (2), 205-210.

Barnett, J. E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. *Psychotherapy, 48* (4), 315-321.

Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic practice, 13* (3), 257-274.

Barrett, M. S. & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves. *Journal of Consulting and Clinical Psychology, 69* (4), 597-603.

Becker, C. S. (1992). *Living and relating: An introduction to phenomenology.* USA: Sage Publications, Inc.

Bellows, K. F. (2007). Psychotherapists' personal psychotherapy and its perceived influence on clinical practice. *Bulletin of the Menninger Clinic, 71* (3), 204-226.

Bike, D. H., Norcross, J. C. & Schatz, D. M. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy Theory, Research, Practice, Training, 46* (1), 19-31.

Black, R. S. A., Curran, D. & Dyer, K. F. W. (2013). The impact of shame on the therapeutic alliance and intimate reltionships. *Journal of Clinical Psychology, 69* (6), 646-654.

Bollas, C. (2008). A theory for the true self. In L. Caldwell, *Winnicott and the psychoanalytic tradition* (pp. 8-23). London: Karnac Books Ltd.

Bonanno, G. A., Noll, J. G., Trickett, P. K., Keltner, D., Putman, F. W., LeJeune, J. & Anderson, C. (2002). When the Face Reveals What Words Do Not: Facial Expressions of emotion, smiling, and the willingness to disclose childhood sexual abuse. *Journal of Personality and Social Psychology, 83* (1), 94-110.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16* (3).

Bos, A. E. R., Kanner, D., Muris, P., Janssen, B. & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in mental health nursing, 30* (8), 509-513.

British Association for Counselling & Psychotherapy [BACP]. (2010). *BACP: Student pages - FAQS.* Retrieved May 29, 2013, from http://www.bacp.co.uk/student/faq.php

Bryman, A. (2008). *Social Research Methods: 3rd Edition.* Oxford: Oxford University Press.

Buckley, P., Karasu, T. B. & Charles, E. (1981). Psychotherapists view their personal therapy. *Psychotherapy: Theory, Research and Practice, 18* (3), 299-305.

Burkard, A. W., Knox, S., Groen, M., Perez, M. & Hess, S. A. (2006). European American therapist self-disclosure in cross-cultural counselling. *Journal of Counselling Psychology, 53* (1), 15-25.

Candea D. & Szentagotai, A. (2013). Shame and psychopathology: From research to clinical practice. *Journal of Cognitive and Behavioural Psychotherapies, 13* (1), 101-113.

Carew, L. (2009). Does theoretical background influence therapists' attitudes to therapist self-disclosure? A qualitative study. *Counselling and Psychotherapy Research, 9* (4), 266-272.

Carter, S. M. & Little, M. (2007). Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research. *Qualitative Health Research, 17* (No. 10), 1316-1328.

Chaudoir, S. & Quinn, D. M. (2010). Revealing concealable stigmatized identities: The impact of disclosure motivations and positive first-disclosure experiences on fear of disclosure and well-being. *Journal of Social Issues, 66* (3), 570-584.

Chaudoir, S. R. & Fisher, J. D. (2010). The disclosures processes Model: Understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin, 136* (2), 236-256.

Cobia, D. C. & Boes, S. R. (2000). Professional disclosure statements and formal plans for supervision: Two strategies for minimising the risk of ethical conflicts in post-master's supervision. *Journal of Counseling & Development, 78* (3), 293-296.

Cochran, B. N., Stewart, A., Kiklevich, A. M., Flentje, A. & Wong, C. C. (2009). The impact of extratherapeutic encounters: Individual reactions to both hypothetical and actual incidental contact with the therapist. *Professional Psychology: Research and Practice, 40* (5), 510-517.

Coles, H. (2008). *Personal development criteria.* Retrieved May 25, 2013, from Therapy Today: http://www.therapytoday.net/article/show/872/

Copperstone, J. A. (2009). Doing Counselling Psychology the Heideggerian Way. *Existential Analysis, 20* (No. 2), 329-341.

Corrigan, P. W. & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure and strategies for change. *The Canadian Journal of Psychiatry, 57* (8), 464-469.

Cox, M. (1978). *Structuring the therapeutic process: Compromise with chaos.* London: Jessica Kingsley Publishers.

Cross, M. C. & Papadopoulos, L. (2001). *Becoming a therapist: A manual for personal and professional development.* London: Brunner-Routledge.

Daw, B. & Joseph, S. (2007). Qualified therapists' experience of personal therapy. *Counselling and Psychotherapy Research, 7* (4), 227-232.

Denzin, N. K. & Lincoln, Y. S. (2005). Introduction: The Discipline and Practice of Qualitative Research. In N. K. Denzin, *The Sage Handbook of Qualitative Research, Third Edition* (pp. 1-32). USA: Sage Publications, Inc.

Devereux, D. & Coe, J. (2010). *A need to protect the therapeutic space.* Retrieved November 20, 2013, from Therapy Today: http://www.therapytoday.net/article/show/2200/

DiCaccavo, A. (2002). Investigating individuals' motivations to become counselling psychologists: The influence of early caretaking roles within the family. *Psychology and Psychotherapy: Theory, Research and Practice, 75* (4), 463-472.

Dindia, K. & Allen, M. (1992). Sex differences in self-disclosure: A meta-analysis. *Psychology Bulletin, 112* (1), 106-124.

Division of Counselling Psychology [DCoP]. (2005). *Professional practice guidelines - Division of Counselling Psychology.* Leicester: British Psychological Society.

Dryden, W & Feltham, C. (1994). *Developing Counsellor training.* London: Sage Publications Ltd.

Dryden, W. (1990). Self-disclosure in rational-emotive therapy. In G. S. Fisher, *Self disclosure in the therapeutic relationship* (pp. 61-74). New York: Plenum Press.

Ekhlar-Hart, A. H. (1987). True and False self in the development of the psychotherapist. *Psychotherapy, 24* (4), 683-692.

Farber, B. A. & Doolin, E. M. (2011). Positive regard. *Psychotherapy, 48* (1), 58-64.

Farber, B. A. & Hall, D. (2002). Disclosure to therapists: What is and is not discussed in psychotherapy. *Journal of Clinical Psychology, 58* (4), 359-370.

Farber, B. A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology, 59* (No. 5), 589-600.

Farber, B. A. (2006). *Self-disclosure in psychotherapy.* New York: The Guilford Press.

Farber, B. A., Berano, K. C. & Capobianco, J. A. (2006). A temporal model of patient disclosure in psychotherapy. *Psychotherapy Research, 16* (4), 463-469.

Farber, B. A., Berano, K. C. and Capobianco, J. A. (2004). Clients' Perceptions of the Process and Consequences of Self-Disclosure in Psychotherapy. *Journal of Counselling Psychology, 51* (3), pp. 340-346.

Farber, N. K. (2000). Trainees' attitudes toward seeking psychotherapy scale: Development and validation of a research instrument. *Psychotherapy: Theory, Research, Practice, Training, 37* (4), 341-353.

Forrest, G. G. (2010). *Self-disclosure in psychotherapy and recovery.* UK: Jason Aronson.

Freeny, M. (2007). Whatever happened to clinical privacy? *Annals of the American Psychotherapy Association, 10* (2), 12-17.

Frosh, S. (2002). *Key concepts in psychoanalysis.* London: The British Library.

Gargiulo, G. J. (2007). Framing the question: Psychoanalytic process, the unconscious, and home offices - An alternate perspective. *Psychoanalytic Psychology, 24* (4), 715-719.

Gee, P. (2011). 'Approach and sensibility': A personal reflection on analysis and writing using interpretative phenomenological analysis. *Qualitative Methods in Psychology Bulletin, 11*, 8-22.

Gelso, C.J. & Hayes, J. A. (2007). *Countertransferance and the therapist's inner experience: Perils and possibilities.* New Jersey: Lawrence Erlbaum Associates, Inc.

Gilroy, P. J., Carroll, L. & Murra J. (2001). Does depression affect clinical practice? A survey of women psychotherapists. *Women and Therapy, 23* (4), 13-30.

Gilroy, P. J., Murra, J. & Carroll, L. (2002). A preliminary survey of counselling psychologists' personal experiences with depression and treatment. *Professional Psychology Research and Practice, 33* (4), 402-407.

Giorgi, A. & Gallegos, N. (2005). Living through some positive experiences of psychotherapy. *Journal of Phenomenological Psychology, 36* (2), 195-218.

Glaser, B. G. (2003). *The grounded theory perspective II: Description's remodeling of grounded theory methodology.* Mill Valley, CA: Sociology Press.

Goffman, E. (1959). *The presentation of self in everyday life.* USA: Anchor Books.

Gold, S. H. & Hilsenroth, M. J. (2009). Effects of graduate clinicians' personal therapy on therapeutic allince. *Clinical Psychology and Psychotherapy, 16* (3), 159-171.

Goldfried, M. R., Burckell, L. A. & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behavior therapy. *Journal of Clinical Psychology/In session, 59* (5), 555-568.

Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal, 22* (4), 417-433.

Gomez, L. (1997). *An Introduction to Object Relations.* London: Free Association Books.

Graff, G. (2008). Shame in supervision. *Issues in Psychoanalytic Psychology, 30* (1), 79-94.

Graves, L. (2008). Teaching the wounded healer. *Medical teacher, 20* (2), 217-219.

Gray, A. (1994). *An introduction to the therapeutic frame.* London: Routledge.

Gray, L. A., Ladany, N., Walker, J. A. & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counselling Psychology, 48* (4), 371-383.

Grimmer, A. & Tribe, R. (2001). Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development - an exploratory study. *Counselling Psychology Quarterly, 14* (4), 287-301.

Grimmer, A. (2005). Mandatory personal therapy for therapist: Professional and ethical issues. In R. Tribe, & J. Morrissey, *The handbook of professional and ethical practice for psychologists, psychotherapists and counsellors* (pp. 277-290). London: Brunner-Routledge.

Gunn, J. E. & Pistole, M. C. (2012). Trainee supervisor attachment: Explaining the alliance and disclosure in supervision. *Training and Education in Professional Psychology, 6* (4), 229-237.

Haenisch, C. von. (2011). How did compulsory personal therapy during counselling training influence personal and professional development? *Counselling and Psychotherapy Research, 11* (2), 148-155.

Halewood, A. & Tribe, R. (2003). What is the prevalence of narcissistic injury among trainee counselling psychologists? *Psychology and Psychotherapy: Theory, research and practice, 76* (1), 87-102.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling and Psychotherapy Research, 5* (2), 96-104.

Hanson, W. E., Creswell, J.W., Creswell, J. D., CVlark, V. L. P. & Petska, K. S. (2005). Mixed Methods Research Designs in Counselling Psychology. *Journal of Counselling Psychology, 52* (No. 2), 224-235.

Health & Care Professions Council [HCPC]. (2012). *Standards of proficiency: Practitioner psychologists.* London: Health & Care Professions Council [HCPC].

Heidegger, M. (1962). *Being and time.* USA: Blackwell Publishing.

Hein, S.F. & Austin, W. J. (2001). Empirical and Hermeneutic Approaches to Phenomenological Research in Psychology: A Comparison. *Psychological Methods, 6* (No. 1), 3-17.

Henwood, L. L. & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology, 83* (1), 97-111.

Hewitt, P. L., Habke, A . M., Lee-Baggley, D. L., Sherry, S. B. & Flett, G. L. (2008). The impact of perfectionistic self-presentation on the cognitive, affective, and physiological experience of a clinical interview. *Psychiatry, 71* (2), 93-122.

Hill, C. E. & Knox, S. (2001). Self-disclosure. *Psychotherapy, 38* (4), 413-417.

Hill, C. E., Gelso, C. J. & Mohr, J. J. (2000). Client concealment and self-presentation in therapy: Comment on Kelly (2000). *Psychology Bulletin, 126* (4), 505-511.

Hill, C. T. & Stull, D. E. (1987). Gender & self-disclosure: Strategies for exploring the issue. In V. J. Derlega, & J. H. Berg, *Self-disclosure: Theory, research and therapy* (pp. 81-100). New York: Plenum Press.

Hodgetts, A. & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology and Psychotherapy, 14* (3), 157-163.

Hook, A. & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *British Journal of clinical Psychology, 44* (3), 425-438.

Hope, R. (2004). *The Ten Essential Shared Capabilities: A framework for the whole of the mental health workers.* Retrieved May 29, 2013, from http://www.iapt.nhs.uk/silo/files/10-essential-shared-capabilities.pdf

Horvath, A. O. & Bedi, R. P. (2002). The alliance. In J. C. Norcross, *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-70). New York: Oxford University Press, Inc.

Horvath, A. O. (2001). The alliance. *Psychotherapy, 38* (4), 365-372.

Ignatius, E. & Kokkonen, M. (2007). Factors contributing to verbal self-disclosure. *Nordic Psychology, 59* (4), 362-391.

Jacobs, M. (2011). The aims of personal therapy in training. *Psychodynamic Practice, 17* (4), 427-439.

Jacobsen, C. H. (2007). A qualitative single case study of parallel processes. *Counselling and Psychotherapy Research, 7* (1), 26-33.

Johns, H. (2012). *Personal development in counsellor training* (Second ed.). London: Sage Publications Ltd.

Jourard, S. M. (1971). *The transparent self.* USA: Litton Educational Publishing, Inc.

Karter, J. (2002). *On training to be a therapist: The long and winding road to qualification.* England: Open University Press.

Kawamura, K. Y. & Frost, R. O. (2004). Self-concealment as a mediator in the relationship between perfectionism and psychological distress. *Cognitive Therapy and Research, 28* (2), 183-191.

Kelly, A. E. & McKillop, K. J. (1996). Consequences of revealing personal secrets. *Psychological Bulletin, 120* (3), 450-465.

Kelly, A. E. & Yip, J. (2006). Is keeping a secret or being a secretive person linked to psychological symptoms. *Journal of Personality, 74* (5), 1349-1369.

Kelly, A. E. (1998). Clients' secret keeping in outpatient therapy. *Journal of Counseling Psychology, 45* (1), 50-57.

Kelly, A. E. (2000). Helping construct desirable identities: A self-presentational view of psychotherapy. *Psychological Bulletin, 126* (4), 475-494.

King, G. (2011). Psychodynamic therapists' dilemmas in providing personal therapy to therapists in training: An exploratory study. *Counselling and Psychotherapy Research, 11* (3), 186-195.

Klein, M. (1975). *Envy and gratitude and other works (1946-1963).* London: The Hogarth Press Ltd.

Knox, R. (2008). Clients' experiences of relational depth in person-centred counselling. *Counselling and Psychotherapy Research, 8* (3), 182-188.

Krauss, S. E. (2005). Research Paradigms and Meaning Making: A Primer. *The Qualitative Report, 10* (4), 758-770.

Ladany, N., Hill, C. E., Corbett, M. M. & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counselling Psychology, 43* (1), 10-24.

Langdridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method.* England: Pearson Education Limited.

Larkin, M., Watts, S. & Clifton, E. (2006). *Giving Voice and Making Sense in Interpreting Phenomenological Analysis.* Edward Arnold (Publishers) ltd.

Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods, 2* (3).

Leary, M. R. & Allen, A . B. (2011). Personality and persona: Personality processes in self-presentation. *Journal of Personality, 79* (6), 889-916.

Legg, C. & Donati, M. (2006). Getting the most out of persoanl therapy. In R. &. Bor, *The trainee handbook, a guide for counselling and psychotherapy trainees* (2nd ed., pp. 217-231). London: Sage Publications Ltd.

Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy.* England: John Wiley & Sons Ltd.

Leroux, P., Sperlinger, D. & Worrell, M. (2007). Experiencing vulnerability in psychotherapy. *Existential Analysis, 18* (2), 315-328.

Linley, P. A. & Joseph S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology, 26* (3), 385-403.

Littauer, H., Sexton, H. & Wynn, R. (2005). Qualities clients wish for in their therapists. *Scandinavian Journal of Caring Sciences, 19* (1), 28-31.

Lum, W. (2002). The use of self of the therapist. *Contemporary family therapy, 24* (1), 181-197.

Lyons, E. & Coyle, A. (2007). *Analysing qualitative data in psychology.* London: Sage Publications Ltd.

MacCulloch, T. (2012). Reflections on trust and self-disclosure. *Issues in Mental Health Nursing, 33* (1), 59-60.

Macdonald, J. & Morley, I. (2001). Shame and non-disclosure: A study of the emotional isolation of people referred for psychotherapy. *Journal of Medical Psychology, 74* (1), 1-21.

Macran, S., Stiles, W. B. & Smith, J. A. (1999). How does personal therapy affect therapists' practice. *Journal of Counselling Psychology, 46* (4), 419-431.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28* (1), 14-16.

Malikiosi-Loizos, M. (2013). Personal therapy for future therapists: Reflections on a still debated issue. *The European Journal of Counselling Psychology, 2* (1), 33-50.

Martin, M. (2011). Celebrating the wounded healer. *Counselling Psychology Review, 26* (1), 10-19.

McAteer, D. (2010). Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton, *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 5-20). UK: John Wiley & Sons Ltd.

McConnell-Henry, T., Chapman, Y. & Francis, K. (2009). Husserl and Heidegger: Exploring the Disparity. *International Journal of Nursing Practice, 15*, 7-15.

McLeod, J. (2003). *An introduction to counselling.* Berkshire: Open University Press.

Mehr, K. E., Ladany, N. & Caskie, G. I. L. (2010). Trainee non-disclosure in supervision: What are they not telling you? *Counselling and Psychotherapy Research, 10* (2), 103-113.

Meissner, W. W. (2006). The therapeutic alliance - A proteus in disguise. *Psychotherapy: Theory, Research, Practice, Training, 43* (3), 264–270.

Merry, T. (2002). *Learning and being in person-centred counselling* (2nd ed.). UK: PCCS Books Ltd.

Miller, G. D. & Baldwin Jr. D. C. (2013). The implications of the wounded-healer archetype for the use of self in psychotherapy. In M. Baldwin, *The use of self in therapy* (Third ed., pp. 81-96). UK: Taylor & Francis.

Milton, J., Polmear, C. & Fabricius, J. (2011). *A short introduction to psychoanalysis* (Second ed.). London: Sage Publications Ltd.

Morrissey, J. & Tribe, R. (2001). Parallel process in supervision. *Counselling Psychology Quarterly, 14* (2), 103-110.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52* (2), 250-260.

Muehleman, T., Pickens, B. K. & Robinson, F. (1985). Informing clients about the limits to confidentiality, risks, and their rights: Is self-disclosure inhibited? *Professional Psychology: Research anfd Practice, 16* (3), 385-397.

Murphy, D. (2005). A qulitatative study into the experiences of mandatory personal therapy during training. *Counselling and Psychotherapy Research, 5* (1), 27-32.

Myers, D. & Hayes, J. A. (2006). Effects of therapist general self-disclosure and countertransferance disclosure on ratings of the therapist and session. *Psychotherapy: Theory, Research, Practice and Training, 43* (2), 173-185.

Norcross, J. C. (2005). The psychotherapist's own psychotherapy: Educating and developing psychologists. *American Psychologist, 60* (8), 840-850.

Norcross, J. C., Bike, D. H., Evans, K. L. & Shatz, D. M. (2008). Psychotherapists who abstain from personal therapy: Do they practice what they preach? *Journal of Clinical Psychology, 64* (12), 1368-1376.

Norcross, J. C., Strausser-Kirtland, D. & Missar, C. D. (1988). The processes and outcomes of psychotherapists' personal treatment experiences. *Psychotherapy, 25* (1), 36-43.

Nowell, D. and Spruill, J. (1993). If it's not absolutely confidential, will information be disclosed? *Professional Psychology: Research and Practice, 24* (3), 367-369.

Obegi, J. H. (2008). The development of the client-therapist bond through the lens of attachment theory. *Psychotherapy: Theory, Research, Practice, Training, 45* (4), 431-446.

Okken, V. Rompay, T. van & Pruyn, A. (2012). Exploring space in the consultation Room: Environmental influences during patient-physician interaction. *Journal of Health Communication, 17* (4), 397-412.

Omand, L. (2010). What makes for good supervision and whose responsibility is it anyway? *Psychodynamic Practice, 16* (4), 377-392.

Omarzu, J. (2000). A Disclosure Decision Model: Determining how and when individuals will self-disclose. *Personality and Social Psychology Review, 4* (2), 174-185.

Orlinsky, D. E. (2005). Outcomes and impacts of the psychotherapists' own psychotherapy: A research review. In J. D. Geller, J. C. Norcross, & D. E. Orlinsky, *The psychotherapist's own psychotherapy: Patient and clinician perspectives* (pp. 214-234). New York: Oxford University Press.

Orlinsky, D. E., Schofield, M. J., Schroder, T. & Kazantzis, N. (2011). Utlization of personal therapy by psychotherapists: A practice-friendly review and a new study. *Journal of Clinical Psychology: In session, 67* (8), 828-842.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioural model. *Psychological Bulletin, 133* (2), 328-345.

Parker, S. & Davis, E. (2009). The false self in Christian contexts: A Winnicottian perspective. *Journal of Psychology and Christianity, 28* (4), 315-325.

Pasupathi, M., McLean, K. C. & Weeks, T. (2008). To tell or not to tell: Disclosure and the narrative self. *Journal of Personality, 77* (1), 89-124.

Pattee, D. & Farber, B. A. (2008). Patients' experiences of self-disclosure in psychotherapy: The effects of gender and gender role identification. *Psychotherapy research, 18* (3), 306-315.

Pearson, Q. M. (2000). Opportunities and challenges in the supervisory relationship: Implications for counsellor supervision. *Journal of Mental Health Counselling, 22* (4), 283-294.

Peterson, Z. D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory/Research/Practice/Training, 39* (1), 21-31.

Ponterotto, J. G. (2005). Qualitative Research in Counselling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counselling Psychology, 52* (2), 126-136.

Pope, K.S. & Vasquez, M. T. (2011). *Ethics in psychotherapy and counseling: A practical guide* (Fourth ed.). New Jersey: John Wiley and Sons.

Rake, C. (2009). Therapy and personal development. In J. &. Hughes, *Personal development and clinical psychology* (pp. 108-123). Oxford: Blackwell Publishing Ltd.

Rake, C. & Paley, G. (2009). Personal therapy for psychotherapists: The impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis. *Psychodynamic Practice, 15* (3), 275-294.

Rasmussen, P. R. (2002). Resistance: The fear behind it and tactics for reducing it. *The Journal of Individual Psychology, 58* (2), 148-159.

Reichelt, S., Gullestad, S. E., Hansen, B. R., Ronnestad, M. H., Torgersen, A. M., Jacobsen, C. H., Nielsen, G. H. & Skjerve, J. (2009). Nondisclosure in psychotherapy group supervision: The supervisee perspective. *Nordic Psychology, 61* (4), 5-27.

Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counselling Psychology, 41* (No. 4), 427-437.

Rizq, R. & Target, M. (2010a). 'If that's what I need, it could be what someone else needs'. Exploring the role of attachment and reflective function in counselling psychologists' accounts of how they use personal therapy in clinical practice: a mixed methods study. *British Journal od Guidance & Counselling, 38* (4), 459-481.

Rizq, R. & Target, M. (2008a). "Not a little mickey mouse thing": How experienced counselling psychologists desribe the significance of personal therapy in clinical practice and training. Some results from an interpretative phenomenological analysis. *Counselling Psychology Quarterly, 21* (1), 29-48.

Rizq, R. & Target, M. (2010b). ‘‘We had a constant battle’’. The role of attachment status in counselling psychologists’ experiences of personal therapy: Some results from a mixed-methods study. *Counselling Psychology Quarterly, 23* (4), 343-369.

Rizq, R. & Target, M. (2008b). 'The power of being seen': An interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. *British Journal of Guidance & Counselling, 36* (2), 131-153.

Rizq, R. (2010). Personal Development. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden, *Handbook of counselling psychology* (Third ed., pp. 569-589). London: Sage Publications Ltd.

Rizq, R. (2005). Ripley's game: Projective identification, emotional engagement, and the counselling psychologist. *Psychology and Psychotherapy: Theory, Research and Practice, 78* (4), 449-464.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy.* Boston: Houghton Mifflin Company.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21* (2), 95-103.

Ronnestad, M. H. & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30* (1), 5-44.

Ryan, R. M., La Guardia, J. G. & Rawsthorne, L. J. (2005). Self-complexity and the authenticity of self-aspects: Effects on wellbeing and resilience to stressful events. *North American Journal of Psychology, 7* (3), 431-448.

Satir, V. (2013). The therapist story. In M. Baldwin, *The use of the self in therapy* (Third ed., pp. 19-27). UK: Taylor & Francis.

Saypol, E. & Farber, B. A. (2010). Attachment style and patient disclosure in psychotherapy. *Psychotherapy Research, 20* (4), 462-471.

Schwartz, W. (2008). Presentations of self and the status dynamics of psychotherapy and supervison. *American Journal of Psychotherapy, 62* (1), 51-65.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50* (12), 965-974.

Shaffer, D. R., Pegalis, L.J. & Cornell, D.P. (1992). Gender and self-disclosure revisited: Personal and contextual variations in self-disclosure to same-sex acquaintances. *The Journal of Social Psychology, 132* (3), 307-315.

Shillito-Clarke, C. (2003). Ethical issues in counselling psychology. In R. Woolfe, W. Dryden, & S. Strawbridge, *Handbook of counselling psychology* (2nd ed., pp. 615-636). London: Sage Publications Ltd.

Shinebourne, P. (2011). The Theoretical Underpinnings of Interpretive Phenomenological Analysis (IPA). *Existential Analysis, 22* (No. 1), 16-31.

Skjerve, J., Nielsen, G. H., Jacobsen, C. H., Gullestad, S. E., Hansen, B. R., Reichelt, S., Ronnestad, M. H. & Torgersen, A. M. (2009). Nondisclosure in psychotherapy group supervision: The supervisor perspective. *A. M. Nordic Psychology, 61* (4), 28-48.

Slavin-Penny, O. M., Cohen, J. L., Oberleitner, L. M. & Lumley, M. A. (2010). The effects of different methods of emotional disclosure: Differentiating post-traumatic growth from stress symptoms. *Journal of Clinical Psychology, 67* (10), 993-1007.

Sloan, A. E. & Kahn, J. H. (2005). Client self-disclosure as a predictor of short-term outcome in brief psychotherapy. *Journal of College Student Psychotherapy, 19* (3), 25-39.

Smith, J. A. (2008). *Qualitative psychology: A practical guide to research methods, 2nd Edition.* London: Sage Publications Ltd.

Smith, J. A. & Osborne, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith, *Qualitative Psychology: A practical guide to methods* (pp. 51-80). London: Sage Publications Ltd.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage Publications Ltd.

Spencer, L., Ritchie, J., Lewis, J. & Dillon, L. (2003). *Quality in qualitative evaluation: A framework for assessing research evidence.* Retrieved July 14, 2013, from http://www.civilservice.gov.uk/wp-content/uploads/2011/09/a_quality_framework_tcm6-38740.pdf

Stark, C. (2011). The application of the Canadian Code of Ethics for Psychologists to Teaching: Mandatory self-disclosure and alternatives in psychology courses. *Canadian Psychology, 52* (3), 192-197.

Stiles, W., Shuster, P. L. & Harrigan, J. A. (1992). Disclosure and Anxiety: A test of the fever model. *Journal of Personality and Social Psychology, 63* (6), 980-988.

Stricker, G. (2003). The many faces of self-disclosure. *Journal of Clinical Psychology, 59* (5), 623-630.

Strong, T., Pyle, N. R., deVries, C., Johnston, D.N. & Foskett, A. J. (2008). Meaning-making lenses in counselling: Discursive, hermeneutical-phenomenological and autoethnographic perspectives. *Canadian Journal of Counselling, 42* (No. 2), 117-131.

Symons, C. & Wheeler, S. (2005). Counsellor conflict in managing the frame: Dilemmas and decisions. *Counselling and Psychotherapy Research, 5* (1), 19-26.

Szecsody, I. (2003). To become or be made a psychoanalyst. *The Scandinavian Psychoanalytic Review, 26* (2), 141-150.

The British Psychological Society [BPS]. (2009). *Ethical Principles for Conducting Research with Human Participants.* Retrieved April 7th, 2010, from http://www.bps.org.uk/document-download-area/document-download$.cfm?file_uuid=F1C8E142-E935-EC00-75FD-519F1FDDEA5D&ext=pdf#

The British Psychological Society [The BPS]. (2012). *Qualification in Counselling Psychology: Candidate Handbook.* Leicester: The British Psychological Society.

Thomas, E. & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specifics in pediatric nursing, 16* (2), 151-155.

Thorne, B. and Dryden, W. (1991). Key issues in the training of counsellors. In B. Thorne, & W. Dryden, *Training and supervision for counselling in action* (pp. 1-14). London: Sage Publications Ltd.

Tobal, C. & Walker, G. (2008). The practice of psychotherapy: Application. In M. Ballou, M. Hill, & C. West, *Feminist therapy, theory and practice: A contemporary perspective* (pp. 87-108). New York: Springer Publishing Company.

Tobin, G. A. & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48* (No. 4), 388-396.

Tracey, T. J. G., Bludworth, J. & Glidden-Tracey, C. E. (2012). Are there parallel processes in psychotherapy supervision? An empirical examination. *Psychotherapy, 49* (3), 330-343.

Tuber, S. (2008). *Attachment, play, and authenticity: A Winnicott primer.* Lanham: Jason Aronson, Inc.

United Kingdom Council for Psychotherapy [UKCP]. (2013). *What makes a psychotherapist?* Retrieved May 29, 2013, from http://www.psychotherapy.org.uk/article425.html

Vogel, D. L. & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counselling Psychology, 50* (3), 351-361.

Vogel, D. L., Wade, N. G. & Hackler, A. H. (2008). Emotional expression and the decision to seek therapy: The mediating role of the anticipated benefits and risks. *Journal of Social and Clinical Psychology, 27* (3), 254-278.

Vrij, A., Nunkoosing, K., Paterson, B., Oosterwegel, A. & Soukara, S. (2002). Characteristics of secrets and the frequency, reasons and effects of secrets keeping and disclosure. *Journal of Community and Applied Social Psychology, 12* (1), 56-70.

Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work, 65* (1), 23-41.

Wertz, F. J. (2005). Phenomenological Research Methods for Counselling Psychology. *Journal of Counselling Psychology, 52* (2), 167-177.

Wheeler, S. (2007). What shall we do with the wounded healer? The supervisor's dilemma. *Psychodynamic Practice, 13* (3), 245-256.

Wigg, R., Cushway, D. & Neal, A. (2011). Personal therapy for therapists and trainees: a theory of reflective practice from a review of the literature. *Reflective Practice, 12* (3), 347-359.

Wiggins, B. J. (2011). Confronting the dilemma of mixed methods. *Journal of Theoretical and Philosophical Psychology, 31* (1), 44-60.

Williams, B. & Healy, D. (2001). Disclosure of minor mental health problems: An exploratory theoretical study. *Journal of advanced nursing, 35* (1), 108-116.

Williams, F., Coyle, A. & Lyons, E. (1999). How counselling psychologists view their personal therapy. *British Journal of Medical Psychology, 72* (4), 545-555.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). England: Open Univeristy Press.

Wiseman, H. & Egozi, S. (2006). Personal therapy for Israeli school counsellors: Prevalence, parameters, and professional difficulties and burnout. *Psychotherapy research, 16* (3), 332-347.

Yardley, L. (2008). Demonstrating Validity in Qualitative Psychology. In J. A. Smith, *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 235-251). London: Sage Publications Ltd.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

Younggren, J. N. & Harris, E. A. (2008). Can you keep a secret? Confidentiality in psychotherapy. *Journal of Clinical Psychology, 64* (5), 589-600.

Yourman, D. B. & Farber, B. A. (1996). Nondisclosure and distortion in psychotherapy supervision. *Psychotherapy, 33* (4).

Yourman, D. B. (2003). Trainee Disclosure in Psychotherapy Supervision: The Impact of Shame. *Journal of Clinical Psychology, 59* (5), 601-609.

Zerubavel, N. & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy, 49* (4), 482-491.

Appendix 1: Search terms for literature review

Therapy disclosure	Self-disclosure	Types of disclosure
Disclosure and trainee psychologists	Psychologists' distress	Psychologist impairment
Trainee psychologists' impairment	Trainee psychologists' distress	Disclosure and trainee counselling psychologists
Trainee counselling psychologists and approval	Trainee counselling psychologist's parallel process	Personal therapy and trainee counselling psychologists
Theories and disclosure	Theoretical models and disclosure	Disclosure and negative impact
Disclosure and positive impact	Emotions and disclosure	Gender and disclosure
Supervision and disclosure	Non-disclosure and supervision	Therapy models and disclosure
Trainees' need for approval	Personal therapy and disclosure	Parallel process
Disclosure and its effectiveness	Parallel process in therapy	Parallel process in psychology training
Assessing the therapist	Therapist's qualities	Therapist's qualities and disclosure
Therapeutic process and disclosure	Therapeutic process and non-disclosure	Therapeutic relationship and disclosure
Therapist on trial	Testing the therapist	Idealised therapist
Wounded healer	Therapeutic factors and disclosure	Ideal therapist and disclosure
Perfect therapist and disclosure	Imperfect therapist and disclosure	Fever model
Good therapist	Bad therapist	Notions of the self
Authentic self	Different selves of the therapist	Development of the self
The integrated trainee therapist	Trainee therapists fear disapproval	Rejection and trainee psychologists

Counselling psychology training	Counselling psychology training and personal therapy	Dilemmas in counselling psychology training
Difficulties in counselling psychology training	Issues in counselling psychology training	Split in the trainee counselling psychologist
The fragmented trainee counselling psychologist	Challenges faced by trainee counselling psychologists	The divided self in trainee counselling psychologist
The divided self in personal therapy	The integrated trainee counselling psychologist	The integrated trainee counsellor
Splitting	The split self	The false self
The true and false self	The true self	Hiding the true self
Censoring the self	Presentation of false Self	Presentation of self
Trainee counselling psychologist's fear of disapproval	Trainee counselling psychologists' professional development	Trainee counselling psychologist's fear of rejection
Trust and disclosure	Trainee counselling psychologist's fear of failure	Disclosure in therapy
Non-disclosure in therapy	Clients' non-disclosure in therapy	Clients' disclosure in therapy
Trainees' disclosure in therapy	Trainees' non-disclosure in therapy	Trainees' fear of rejection
Trainees' fear of disapproval	Jourard	Jourard disclosure
Goffman	Goffman self-presentation	Goffman impression management
Trainee psychologists' history of mental illness	Trust and non-disclosure	Trainee counselling psychologists' personal development
Benefits of disclosure	Benefits of non-disclosure	Risks of disclosure
Risks of non-disclosure	Guarded disclosure	Planned disclosure

Unguarded disclosure	Fitness to practice in psychology	Self-presentation in therapy
Impact of disclosure in therapy	Impact of non-disclosure in therapy	Conflicts in trainee counselling psychologists
Trainee psychologists' motivation to become therapists	Trainee counselling psychologists' feeling of shame in therapy	How therapists change: personal and professional reflections
Trainee counselling psychologists' shame in therapy	Trainees' vulnerability	Shame in therapy
Self-concealment in therapy	Trainee counselling psychologist's vulnerability	Trainee counselling psychologist's conscious concealment
Disclosure theories	Disclosure models	Theories of disclosure
Trainee therapist's self-doubt	Selective disclosure	Partial disclosure
Trainee counselling psychologist's self-doubt	Conflicts in trainee therapists	Conflicts in counselling psychology training
Self-presentation	Disclosure process	Therapist factors and non-disclosure
Therapist factors and disclosure	Therapist characteristics and non-disclosure	Therapist characteristics and disclosure
Therapist techniques and non-disclosure	Therapist techniques and disclosure	Factors affecting disclosure
Impact of therapeutic process of on disclosure	Impact of training psychologist on disclosure	Influence of trainee psychologist on disclosure
Relationship between trainee psychologist and client	Therapist's actions in therapy and disclosure	What hinders disclosure in therapy
Therapy setting and disclosure	Factors facilitate and hinder disclosure	What facilitates disclosure in therapy
Therapist, mistrust and disclosure	Therapist, trust and disclosure	Facial expressions and disclosure
Therapists facial reactions to disclosure	Trainee counselling psychologist's disapproval and disclosure	Trainee counselling psychologist's rejection and disclosure

Disapproval and disclosure	Rejection and disclosure	Outcome of disclosure
Therapy duration and disclosure	Length of therapy and disclosure	Therapist, reliability and disclosure
Therapist, security and disclosure	Therapist, consistency and disclosure	The teaching therapist
Therapists' skills	Competence and disclosure	Anticipated risks
What clients want in a therapist	Dilemmas in personal therapy	Unethical therapist
Ethical therapist	Trainee counselling psychologist's early history	Counselling trainee counsellors
The person of the therapist	Therapists' past problems	Why trainees choose to train as a therapist
Therapists' history	Power imbalance	Wounded therapist
Reasons for training as a therapist	Imperfect trainee psychologists	Therapists' mental illness
Trainee counselling psychologist's psychological factors	Trainee counselling psychologist's dilemmas	Trainee counselling psychologist's problems
Therapists' dilemmas	Trainee counselling psychologist's well-being	Therapists' personal life
Disclosure strategies	Trainee counselling psychologist's mental health problems	Trainee counselling psychologist's self-concept
Trainee counselling psychologist's professional competence	Trainee counselling psychologist perfectionism	Trainee counselling psychologist secret keeping

Appendix 2: University of East London ethical approval

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Rachel Tribe **ASSESSOR:** Amanda Roberts

STUDENT: Masuoodah Yeasmin **DATE (sent to assessor):** 05/10/11

Proposed research topic: 'An exploration of trainee counselling psychologist's experience of disclosure in personal therapy and its impact on personal and professional development'.

Course: Prof Doc Counselling

1. Will free and informed consent of participants be obtained? YES

2. If there is any deception is it justified? N/A

3. Will information obtained remain confidential? To some extent

4. Will participants be made aware of their right to withdraw at any time? YES

5. Will participants be adequately debriefed? YES

6. If this study involves observation does it respect participants' privacy? NA

7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? NA

8. Is procedure that might cause distress to participants ethical? YES

9. If there are inducements to take part in the project is this ethical? NA

10. If there are any other ethical issues involved, are they a problem? NO

APPROVED

YES

MINOR CONDITIONS: NB. If research questions are redrafted after the pilot study, please put these past the chair of the ethics committee.

REASONS FOR NON APPROVAL:

Assessor initials: AR Date: 11/10/11

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Rachel Tribe **ASSESSOR:** Amanda Roberts

STUDENT: Masuoodah Yeasmin **DATE (sent to assessor):** 05/10/11

Proposed research topic: 'An exploration of trainee counselling psychologist's experience of disclosure in personal therapy and its impact on personal and professional development'.

Course: Prof Doc Counselling

Would the proposed project expose the researcher to any of the following kinds of hazard?

1	Emotional	YES
2.	Physical	NO
3.	Other (e.g. health & safety issues)	NO

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: LOW

APPROVED

YES

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: **AR** Date: 11/10/11

Appendix 3: Email correspondence with BPS' DCoP regarding advertising

- Participants required

Masuoodah Yeasmin

12/12/2011

Documents
To: hcnpsychology@gmail.com

Cc: Rachel Tribe

From: **Masuoodah Yeasmin** (m.yeasmin@hotmail.co.uk)
Sent: 12 December 2011 18:13:55
To: hcnpsychology@gmail.com
Cc: Rachel Tribe (r.tribe@uel.ac.uk)
Outlook Active View

1 attachment (20.0 KB)

Research participants required.docx
View online
Download as zip

Dear Helen,

I am a trainee Counselling psychologist recruiting participants for my doctoral research. I have attached information about my research. Are you able to publicise it across the counselling psychology division?

Kind regards,

Masuoodah Yeasmin
Trainee Counselling Psychologist
University of east London

- Re: Participants required

Dr Helen Nicholas (hcnpsychology@gmail.com)
Add to contacts
13/12/2011

To: Masuoodah Yeasmin

From:**Dr Helen Nicholas** (hcnpsychology@gmail.com)
Sent: 13 December 2011 08:58:34
To: Masuoodah Yeasmin (m.yeasmin@hotmail.co.uk)

Dear Masuoodah,

Thank you for your email. Please could you ask your supervisor to send me an email approving the advert. The advert will then be placed on our website and will go out in the next e-letter due on 9th January.

We wish you all the best with your research,

Helen

- RE: Participants required

To see messages related to this one, group messages by conversation.

Masuoodah Yeasmin

18/12/2011

To: Rachel Tribe

From:**Masuoodah Yeasmin** (m.yeasmin@hotmail.co.uk)
Sent: 18 December 2011 12:31:09
To: Rachel Tribe (r.tribe@uel.ac.uk)
Outlook Active View

1 attachment (67.4 KB)

Research participants required - PDF.pdf
View online
Download as zip

Dear Rachel,

I have emailed Dr Helen Nicholas, at the BPS, my advert for recruiting participants, the one I showed you when we last met. That is the document I attached but unfortunately you were unable to view it. I have converted it into a PDF document and hope that you are able to view this. Please let me know if you are still unable to view it. Dr Nicholas has requested that you send her an email on hcnpsychology@gmail.com approving my advert, which she hopes will be advertised on 9th of January's 2012 e-newsletter.

Many thanks,

Masuoodah

- FW: Participants required

To see messages related to this one, group messages by conversation.

Rachel Tribe

18/12/2011

To: hcnpsychology@gmail.com

Cc: m.yeasmin@hotmail.co.uk

From:**Rachel Tribe** (R.Tribe@uel.ac.uk) This sender is in your contact list.

Sent: 18 December 2011 12:52:18

To: hcnpsychology@gmail.com

Cc: m.yeasmin@hotmail.co.uk

Outlook Active View

1 attachment (67.4 KB)

Research participants required - PDF.pdf

View online

Download as zip

Appendix 4: Recruitment flyer

WHAT IS YOUR EXPERIENCE OF DISCLOSURE IN PERSONAL THERAPY?

ARE YOU A TRAINEE COUNSELLING PSYCHOLOGIST?

ARE YOU IN YOUR FINAL YEAR OF TRAINING?

ARE YOU IN PERSONAL THERAPY?

IF YES, THEN PLEASE READ ON…

My name is Masuoodah Yeasmin and I am a Trainee Counselling Psychologist studying towards a Professional Doctorate in Counselling Psychology at the University of East London.

I am conducting a research, which aims to explore trainee counselling psychologists' experience of disclosure in personal therapy and its impact on personal and professional development. Your participation in this study would mean having a conversation with me lasting approximately an hour where you would be asked to share your experiences of personal therapy. This research will be supervised by Professor Rachel Tribe (r.tribe@uel.ac.uk). If you are interested in participating and would like to know more about this research, please contact me at u0204706@uel.ac.uk.

THANK YOU FOR TAKING THE TIME TO READ THIS ADVERT

Appendix 5: List of accredited DCoP training

The British Psychological Society

Promoting excellence in psychology

- **City University**

Department of Psychology

LONDON

> www.city.ac.uk

Course Title:

Doctorate in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2005/06**.

From the **2005/06** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

- **Glasgow Caledonian University**

Department of Psychology

GLASGOW

> www.caledonian.ac.uk

Course Title:

Doctorate in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2007/08**.
From the **2007/08** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **London Metropolitan University**

Department of Psychology
LONDON
> www.londonmet.ac.uk
Course Title:
Professional Doctorate in Counselling Psychology
Professional category:
Counselling
Offered as Distance / Blended Learning:
No
Accreditation Status:
This programme is accredited for all intakes from **2004/05**.
From the **2004/05** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **University of Manchester**

School of Education
MANCHESTER
> www.manchester.ac.uk
Course Title:
Counselling Psychology
Professional category:
Counselling
Offered as Distance / Blended Learning:
No

Accreditation Status:

This programme is accredited for all intakes from **2010/11**.
For all accredited cohorts Completion of this suite of postgraduate programmes offered a route to Chartered Membership of the Society and full membership of the Division of Counselling Psychology that is no longer open.

❖ **Metanoia Institute**

Psychology
LONDON
> www.metanoia.ac.uk
Course Title:
Counselling Psyc & Psychotherapy by Prof Studies
Professional category:
Counselling
Offered as Distance / Blended Learning:
No
Accreditation Status:
This programme is accredited for all intakes from **2001/02**.
From the **2001/02** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **New School of Psychotherapy and Counselling**

Decca Building, 254-6 Belsize Road
LONDON NW6 4BT
> www.nspc.org.uk
Course Title:
Existential Counselling Psychology & Psychotherapy
Professional category:
Counselling
Offered as Distance / Blended Learning:
No
Accreditation Status:
This programme is accredited for all intakes from **2006/07**.
From the **2006/07** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling

Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **Regent's College**

School of Psychotherapy & Counselling

LONDON

> www.regents.ac.uk

Course Title:

Existential Phenomenological Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2011/12**.

From the **2011/12** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **Roehampton University**

School of Human & Life Sciences

LONDON

> www.roehampton.ac.uk

Course Title:

PsychD in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2007/08**.

From the **2007/08** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of

your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **University of Strathclyde**

Department of Psychology

GLASGOW

> www.strath.ac.uk

Course Title:

Doctorate in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2007/08**.

From the **2007/08** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **University of Surrey**

Department of Psychology

GUILDFORD

> www.surrey.ac.uk

Course Title:

PsychD Psychotherapeutic and Counselling Psych.

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **1994/95**.

From the **1994/95** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of

your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **University of Teeside**

Psychology Section

MIDDLESBOROUGH

> www.tees.ac.uk

Course Title:

Doctorate in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2002/03**.

From the **2002/03** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details)

❖ **University of the West of England**

School of Psychology

BRISTOL

> www.uwe.ac.uk

Course Title:

Professional Doctorate in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2006/07**.

From the **2006/07** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of

your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details).

❖ **University of Wolverhampton**

School of Applied Sciences

WOLVERHAMPTON

> www.wlv.ac.uk

Course Title:

Practitioner Doctorate in Counselling Psychology

Professional category:

Counselling

Offered as Distance / Blended Learning:

No

Accreditation Status:

This programme is accredited for all intakes from **2004/05**.

From the **2004/05** intake successful completion of this programme confers eligibility for Chartered Membership of the Society and full membership of the Division of Counselling Psychology. If you wish to be eligible to practise as a counselling psychologist on completion of your studies, you are advised to check that the Health Professions Council has approved this programme (see **www.hpc-uk.org** for further details)

Appendix 6: Advert on social networking site for CoP

28 May

RESEARCH PARTICIPANTS REQUIRED.

Hi everyone,

I am a trainee counselling psychologist in my third year of a professional doctorate course at the University of East London. As part of my Doctoral thesis, I am conducting research which aims to explore final year trainee counselling psychologists' experience of disclosure in personal therapy and its impact on personal and professional development.

Masuoodah posted

in Counselling Psychologists UK

17:34

Your participation in this study would mean attending an interview either at University of East London or perhaps at your University, at a time convenient for you and me. The interview will last approximately an hour where you would be asked about your experience of disclosure in personal therapy, the impact your experience had on you and what facilitated your disclosure or prevented you from disclosing, therefore you must currently be in personal therapy. I would really appreciate it if you could take the time to participate in what I hope will be an interesting and valuable piece of research. This research has been granted ethical approval by the University of East London's Ethics Committee and is under the supervision of Professor Rachel Tribe.

Please feel free to send me a message through this should you require any further information about this research. I look forward to hearing your response and am grateful for your time.

14 July

Hi everyone,

I am still looking for participants for my research.

I am a trainee counselling psychologist in my third year of a professional doctorate course at the University of East London. I am conducting research which aims to explore final year trainee counselling psychologists' experience of disclosure in personal therapy and its impact on personal and professional development.

Masuoodah posted in

Counselling Psychologists UK

13:13

Your participation in this study would mean attending an interview either at University of East London or perhaps at your University, at a time convenient for you and me. The interview will last approximately an hour where you will be asked about your experience of disclosure in personal therapy, the impact your experience had on you and what facilitated your disclosure or prevented you from disclosing, therefore you must currently be in personal therapy. I would really appreciate it if you could take the time to participate in what I hope will be an interesting and valuable piece of research. This research has been granted ethical approval by the University of East London's Ethics Committee and is under the supervision of Professor Rachel Tribe.

Please feel free to send me a message through this should you require any further information about this research. I look forward to hearing your response and am grateful for your time.

Appendix 7: Participant demographic form

Initials: _____

Please circle your gender: Male Female

Please circle your age group:

21-25 26-30 31-35 36-40 41-45 46-50

51-55 56-60 61-65 66-70 71+

Please tick the appropriate box to indicate your ethnicity:

(a) **WHITE**
British ☐
Irish ☐
Any other White background ☐
please write below

……

(b) **BLACK or BLACK BRITISH**
Caribbean ☐
African ☐
Any other Black background ☐
please write below

……..

(c) **ASIAN or ASIAN BRITISH**
Indian ☐
Pakistani ☐
Bangladeshi ☐
Any other Asian background ☐
please write below

……..

(d) **MIXED**
White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other Mixed background ☐
please write below

……

(e) **CHINESE or OTHER ETHNIC GROUP**
Chinese ☐
Any other ethnic background ☐
please write below

……..

Name of University you are training with?
(Or please state if you are training through the BPS Independent Route).

_____

Which year of Counselling Psychology training are you in? _____

Have you had more than 40 hours of personal therapy? Please circle: Yes No

Appendix 8: Participant information sheet

You are being invited to participate in a research study. However, before deciding whether you would like to take part or not, it is important that you understand why the research is being carried out and what it will involve. Please take time to read the following information carefully. If you are unclear about any information or require more details, please do not hesitate to contact me (contact details are provided below). Please take your time in deciding whether you would like to take part or not.

Purpose of the study:

This research is being carried out as part of a Professional Doctorate Course in Counselling Psychology. The intention of the study is to explore trainee counselling psychologists' experience of disclosure in personal therapy and its impact on personal and professional development. You will be asked about your experience of disclosure in personal therapy, the impact your experience had on you and what facilitated your disclosure or prevented you from disclosing. The results of the study will help increase knowledge on disclosure, identify what facilitates disclosure and thus enable trainee counselling psychologists to gain maximum benefit of therapy to work effectively with their clients.

Why am I being approached for this study?

You are being approached for this study as you are a trainee counselling psychologist in your final year of training and in personal therapy. As a final year trainee, you have had sufficient experience of personal therapy and thus can contribute largely to this research by sharing your experience.

Am I obliged to take part in the study?

It is entirely up to you if you decide to take part or not. In case you agree, you have the right to withdraw from the study any time during and following the interview, this will not have any adverse implications for you. This means that what you say during the interview will not be used in the research.

What happens after I decide to take part in the study?

You will be requested to complete the attached consent form. I will contact you to arrange a time that is convenient for you to talk about your experiences. The research will involve an interview with me lasting approximately an hour. This means that I will ask you a series of general questions in relation to your experience of disclosure in personal therapy.

What about confidentiality?

With your permission, the interview will be audio-recorded, transcribed and segments of this may be incorporated into a report that will be accessible to other individuals such as the research supervisor, examiners and other academic staff who will be formally assessing the report. However, you will remain completely anonymous, that is, your name and identity will not at any point be made available and will be kept separate from the findings of the

interview. No one will have access to this information except for me and my supervisor.

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

What about the findings of the study?

If you wish to obtain a copy of a summary of the findings, please provide your contact details. These details will be kept separate from the material that you provide me during the interview. The results of the study may be published in a journal. However, no information identifying you as a participant will be included.

Risks

Given the personal nature of the issues you will be discussing in the interview, it is possible that this may evoke difficult thoughts and feelings. If you wish, you may also take small breaks during this period to help you feel more relaxed about discussing your experiences. Both you and the researcher will have the right to put an end to the interview if at any point you become unduly distressed whilst talking about your experiences. This is to ensure that your well-being is safeguarded at all times.

It is possible that taking part in this research may bring about some upsetting feelings in you as you are being requested to share your experiences of personal therapy. In this case, information will be provided to you on general support services that you can access.

Making a complaint

If you wish to make a complaint about any aspects of the study, please feel free to contact the researcher (contact details are provided below) or the Research Supervisor (Professor Rachel Tribe) at the University of East London on 020 8223 3000.

Thank you

Masuoodah Yeasmin
Trainee Counselling Psychologist
Email: u0204706@uel.ac.uk

Appendix 9: Informed consent form

This consent form is to ensure that you are happy with the information you have received about the study. Please read carefully and sign below.

I have read and fully understood the information sheet. I understand that I will remain completely anonymous and all information I reveal will be kept confidential. However, confidentiality will have to be broken if the information I disclose is illegal or likely to cause harm to self or another. I understand that I have the right to withdraw from this research at any time. I also understand that the results of the study may be published in a journal.

I agree to take part in the research conducted by Masuoodah Yeasmin who will explore trainee counselling psychologists' experience of disclosure in personal therapy and its impact on personal and professional development.

Participant Name: _____

Participant Signature: _____

Researcher Name: _____

Researcher Signature: _____

Date: _____

Appendix 10: Written debriefing sheet

TITLE: An Exploration of Trainee Counselling Psychologists' experience of disclosure in personal therapy and its impact on personal and professional development

Thank you for your participation in this study. This debriefing is given as an opportunity for you to learn more about this research study, how your participation plays a part in this research and why this research may be important.

The purpose of this study is to explore trainee counselling psychologists' experience of disclosure in personal therapy and the impact it has on their personal and professional development. This means exploring how you experience disclosure, what led you to disclose, or not disclose, how you felt before and after disclosure. I am also interested in finding out your views and feelings as to how helpful or unhelpful you found disclosing and the impact it had on you personally and professionally.

As personal therapy is mandatory for many trainee therapists, research has examined its effectiveness on personal and professional development. Research has found that although personal therapy can be useful for trainees to address personal difficulties so that they can work effectively with clients, some difficulties in attending personal therapy has been identified. There is a lot of research demonstrating that due to various reasons, such as concerns of confidentiality, feelings of embarrassment and sadness or fear of being perceived as an incompetent therapist, many therapists find it difficult to disclose to their therapists. Given that personal therapy is important for trainee counselling psychologists' to deal with emotional difficulties so that it does not impact upon clinical work, it is important for them to feel safe and less vulnerable in disclosing. Hence, obtaining your views and experience on disclosure and what helps or prevents you from disclosing is important in this matter.

I am hoping that this research will contribute to the practice of counselling psychology by increasing the awareness of qualified counselling psychologists of trainees' difficulties with disclosure. It is hoped that this awareness will lead to addressing issues of disclosure early in therapy so that trainees feel more comfortable in disclosing, are able to fully engage in therapy and thus effectively work with clients.

I understand that it may be difficult at times to answer the questions as part of this research and your generosity and willingness to participate in this study are greatly appreciated. I do however request that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of the research conclusions.

Sometimes people find the subject matter of these interviews difficult. If answering any of these questions has resulted in any distress or concern and you would like to speak to someone about it, I am enclosing contact numbers for services which you may find useful.

As stated before, the information that you provide will be kept anonymous except for me, my supervisor and those formally assessing the report. Thus there will be no information that will identify you, so pseudonyms will be used. It may be possible that the results of this study are presented at academic conferences or published as an article in a journal. If you would like to receive a summary of the findings of this study or have any additional questions, you may contact me or my research supervisor at the University of East London.

Contact details are:

Masuoodah Yeasmin: u0204706@uel.ac.uk

Research Supervisor: Professor Rachel Tribe

Email: r.tribe@uel.ac.uk

Contact No: 020 8223 3000

Appendix 11: Useful contact numbers for support

It is recognised that sometimes sharing experiences of personal therapy can be difficult. If answering any of these questions have resulted in any distress and you would like to talk to someone, below are contact numbers for support services you may find useful.

- **MIND (Mental health charity for England and Wales)**

MIND offers a confidential telephone information line. Local MIND associations provide services such as counselling, advocacy and support.

Tel: 0845 766 0163
Email: info@mind.org.uk
Web: http://www.mind.org.uk

- **SANEline**

SANEline offers a confidential telephone helpline for people experiencing emotional distress. Telephone line is open between 6pm and 11pm, 7 days a week, including public holidays.

Tel: 0845 767 8000
Web: www.sane.org.uk

- **Samaritans**

Samaritans is a **confidential** service which provides non-judgemental emotional support for people who are experiencing feelings of distress or despair, including those which could lead to suicide. Telephone line is open 24 hours a day.

Tel: 08457 90 90 90
Email: jo@samaritans.org

Appendix 12: Interview schedule

Opening the interview

- How do you feel about having personal therapy as part of your training?
- Prior to starting therapy, were there any concerns?
- How would you describe your experience of personal therapy?

Experience of disclosure

- How would you describe your experience of disclosure?
- How did you feel prior to disclosing?
- How did you feel after disclosing?
- How did you come to decide that you will disclose/not disclose?
- Have you experienced any difficulties with disclosure?
- What aspects of your disclosure did you find helpful?
- What aspects of your disclosure did you find unhelpful?
- What aspects of personal therapy was helpful in facilitating your disclosure
- What aspects of personal therapy would you say made it difficult to disclose

Closing the interview

- How did your disclosure impact on your personal development?
- How did your disclosure impact on your professional development?

Appendix 13: Extracts from reflective diary

2.5 Personal reflections on the conceptual processes of this study

In therapy, I found it difficult to disclose what I perceived to be negative aspects of myself. Although after a short while of attending therapy I was able to disclose I have a long-term health condition, I believed making a disclosure of the degree it impacts on me would influence my therapist's judgement of my ability to practice. In essence, I was frightened of being told I am unfit and cannot continue training. Throughout the first year and parts of the second year in therapy, I battled with the expectation to develop personally and professionally. Although I understood how the two are concomitant, the experience of this development process was arduous. It felt difficult to develop in both of these areas at the same time. I felt increasing pressure from myself to develop professionally, though knew that in order for me to achieve this I must develop personally too. Motivated by my desire to be a counselling psychologist, I began to make further disclosures, which after much reflection enabled me to acknowledge that my long-term health condition is a part of me and did not define the whole of me. However, I was mindful of the length of time it took me to reach a point of comfort in disclosing and regretted that much time was wasted in therapy, including financially. This sparked my interest in disclosure as an area to research.

Through clinical work, I observed how my own experiences influenced the way I worked with clients and at times it was difficult to put aside my preconceptions about what the client was saying. This awareness led me to take into account that my understanding of others' experiences can never be fully understood as my experiences, values and beliefs may obscure what their stories mean, as well as my practice. I subsequently recognised that my understanding of clients' experiences would consist of both of our experiences. In this way, I perceived myself as a reflective scientist-practitioner as outlined by Lane & Corrie (2006). Further than this, being a reflective scientist-practitioner for me is about being in the world with others, understanding that my presence would influence others whilst they influence me, my view of the world, my work, and about knowledge and truth being co-created. I also acknowledge that it is impossible to look at other things in another way and I

can only conduct myself in the world from my own perspective, though still significant to be aware of the views I held.

2.8 Reflections on data collection

2.8.1 Semi-structured interviews

I was generally pleased with participants' level of openness and honesty and felt I had indeed obtained rich data. From participants' responses following the interview, it seemed they found the interview process useful, in that they became aware of elements significant for disclosure, which they had not previously considered. This led me to feel more content with my decision to utilise semi-structured interviews as participants were not restricted by a rigid interview schedule and it allowed unexpected areas to be explored.

I opted to conduct two of the interviews through telephone as the participants experienced difficulty with providing a date to meet. Having had two participants drop out, I was worried about not being able to retain these participants too and consequently agreed to one of the participant's suggestion of a telephone interview. I then proposed this to the second interviewee who was in agreement with this plan. Although participants were quite open to answering questions, I was mindful of the implications that could arise with conducting interviews through the telephone. I was aware that there was potential for rich data to not be obtained as interaction would be much limited, which would subsequently impede on developing rapport with the participant. I was also aware that non-verbal behaviours could not be taken into account, which may have illuminated the data obtained. Unsurprisingly, the two telephone interviews were shorter in length.

Reflections on interview 4 - Alva

I got the sense from Alva that talking about her experiences of disclosing triggered the distress she felt prior to disclosing in therapy. Alva's description, the heightened tone of her voice and the speed of her narrative communicated to me that she felt anxious about the implications of not disclosing her difficulties sooner in therapy. I felt the urge to attend to

her struggle through demonstrating empathy; however, I had to remain focussed on the purpose of the research and thought about the implications of adopting a practitioner role. Unusually, at the same time, I tussled with the familiarity of the topic of disclosure in personal therapy. I was mindful of my assumptions and endeavoured to not let it influence my approach in interviewing. I addressed this by adopting a naive stance, clarifying what Alva shared and by asking further questions to obtain a deeper level of understanding.

In comparison to other interviews, Alva's interview stood out to me the most. I wondered whether she was a little apprehensive after sharing with me that she had not disclosed her difficulties until recently, that is, in the final year of training. Although Alva's distress with this experience was apparent, as she progressed through the interview, the tone of her voice changed. It seemed to me that she later became concerned with portraying herself as a 'fitting' TCP, one that has attended to her difficulties, reflected on it and is now resolving it. Although this may be true, Alva's admittance of having a particular interest in this research made me question her motives for participating. She also stated that reflection signifies improvement and wanted to reassure me at the end of the interview that she would not have continued to conceal her difficulties. Alva's desperation to resolve her difficulties makes me wonder whether the interview essentially acted as a process for reflection, which would then indicate to Alva that she is a 'fitting' TCP.

2.8.2 Reflections on data analysis

ii) Initial noting

As I progressed through the analysis, I was surprised by how much I was enjoying it and the initial stress I felt during recruitment and worry about the richness of data seemed to subside. I found the data interesting as there were areas I did not expect, though at the same time, I was mindful that some experiences mirrored my own. In awareness of this, I put aside my thoughts and decided to analyse each transcript over a few days and by going through it twice to ensure notes were grounded in the actual data obtained. Additionally, a peer was provided with a transcript to ensure my interpretations remained grounded in participants' experiences.

iii) Developing emergent themes and searching for connections

Whilst working through latter transcripts, I endeavoured to ensure preceding interviews did not influence the themes, which developed in new accounts. I did this by leaving a few days in between analysis of each interview. Adopting this approach enabled me to approach the data with 'fresh eyes', thus remaining true to participants' experiences and not seek evidence of experiences, which reflected other interviews or my own.

iv) Bringing it all together and identification of master themes

Whilst organising the themes, I felt I was moving away from each participants' account as the data was becoming fragmented and did not represent their entire account. This subsequently led to difficulty with discarding particular themes. In order to help form a logical structure, I met with research supervisors on three occasions and was helped to question the value of themes, whether some themes coincided, how they were different to one another, eventually allowing me to form a more robust structure. This structure was held in this particular position as it provided the best fit for the data, though I am aware that not all the data will fit as it is an imposed interpretation. This part of the process indeed involved a double hermeneutic whereby I sought to make sense of participants who were making sense of their experience of disclosure.

Appendix 14: Transcript, analysis and themes for interview 6

Emerging Themes	Interview 6 transcript - Adel	Comments (impressions, initial notes, descriptive, linguistic, conceptual/psychological)
Portrayal of the 'perfect trainee'/The false self (1) Parallel process/The divided self (2) and (1) A desire to unburden the self of distress (3) Imperfect sense of self (4) (2)	I: Thank you for agreeing to participate in my research. As you know it's about your experience of disclosing to your own therapist and your experiences of that so I thought maybe before we start maybe you can tell me about erm how you felt about having personal therapy as part of your training really when you kind of first found out that's that's what it entails. Adel: Okay, erm well I've never had personal therapy before, I started the course but I think I felt quite open to having personal therapy to be honest with you when I first started erm because I thought you know I was really interested in what it would be like, I thought it was important for when I saw clients myself to kind of know what it was like to be in the position of having therapy and also that it would be useful as well for me to kind of learn more about myself so that maybe didn't influence the therapy and that the therapy wasn't as much about me and to focus on them. Erm yeah it was interesting because I think... it almost felt like it gave me an excuse to have personal therapy even though I was quite kind of open to that therapy before it's kind of taking the first step and going for therapy was something that scared me a bit, and because I was almost you know it was mandatory for the course because I had to do it and it kind of helped me to to have that first step I think. I: So you were quite accepting of it?	Open to having therapy – felt interested in the experience of it. Important to experience it from a client's position "to kind of know" – to have some level of understanding of what it's like for clients. Therapy will enable her to learn about herself so she can separate her own issues from that of clients. Feels personal therapy will be helpful in not letting her own issues influence how she works with clients and also enable her to concentrate more on clients. Similar reasons as to why personal therapy is mandatory for trainees – sounds clichéd. She sounds like the 'perfect trainee'. Sounds like maybe she was in need of therapy too but found it difficult to access it. Having personal therapy be mandatory was like a blessing in disguise – it ensured she had to take that step to access it. She perhaps felt scared about what therapy may bring for her, scared about facing her issues and not being able to cope. "Gave me an excuse" – she could use the fact that personal therapy is mandatory rather than that she actually required it.

Appendix 14: Transcript, analysis and themes for interview 6

	Adel: Yeah….!	
	I: You kind of mentioned about erm you know kind of being in the position of a client and how that might help erm with your client work, how did you think it might kind of help with that?	Strong emphasis on word "yeah" – suggests she was keen and wanted/needed to attend rather than had to attend.
(2) and (1) Fear of rejection/ disapproval (5) (2) and (1)	Adel: Erm I thought it would help because... I think you know when just to kind of see what it's like the different dynamics and how you might feel like how you know for example when I started my first session of therapy you know you feel quite vulnerable because you are talking about quite personal things to someone you've never met before and that it would be quite helpful to kind of be aware of the emotions that clients potentially could have so that erm you were just kind of mindful of that and how that might affect the therapy and be sensitive to the tone of the therapy at the beginning and maybe you not bringing up too much right at the beginning that kind of thing, erm so that's how I thought it might be useful.	She wanted to experience the position of a trainee and understand the various processes that may go on. She felt vulnerable in her initial session. – The thought of exposing herself to someone she does not know was perhaps quite daunting – She feared the response she may get. It would have been interesting to explore her vulnerability. For instance, does being a trainee contribute to her feelings of vulnerability? The experience of knowing the level of emotions that may be experienced when meeting someone has been useful for clinical work – it has enabled her to be aware of how this may influence the first session.
	I: Okay. And erm you you mentioned that erm well before maybe you weren't quite you know wouldn't of maybe kind of gone gone for personal therapy but having the course kind of saying it's mandatory was quite erm quite a good thing really, did you ever think about having personal therapy before?	Knowing how to be gentle at the beginning and not putting pressure onto clients to disclose a lot in little time. From the start of therapy she is positioning herself as a trainee rather than a client. She entered therapy with a view to learn. – She presents herself as a trainee that is willing and open to therapy, thus 'perfect'.
	Adel: Erm no I didn't, I think it never really kind of came, it was never really a time when I thought "yes I should go and have some	I wanted to obtain understanding of whether she was experiencing difficulties beforehand. This may inform her openness to therapy.

Appendix 14: Transcript, analysis and themes for interview 6

(3) Therapeutic process (6)	personal therapy", but looking back I think there were times in my life where it would have been really useful to have had personal therapy and I think when I decided to go onto the course erm I think that was a time in my life where I thought that it would be really helpful because my my dad had just died and I thought that'd be useful to kind of talk about some of the emotions that were kind of being brought up for me in that. I: So you really welcomed the idea of having personal therapy when you started? Adel: Yeah! I: What about kind of the idea of self-disclosure you know to the therapist and whilst you're training, you know how did you kind of feel about that idea? Adel: About what telling the therapist about disclosing any' anything? I: Yeah yeah. Adel: Erm... Well it's interesting because I think first of all it's kind of changed you know the more that I've kind of developed on the course and different therapists and so, coz I've had two different therapists. I: Okay.	Reflects on moments when it may have been useful for her to attend therapy – outside of training. When she reached a decision to attend the course, her dad had passed away. Attending therapy therefore felt like good timing – this explains openness to having therapy. During this period – a number of emotions experienced and she was keen to reflect on them and deal with them – Perhaps in addition to fulfilling course requirement, this was one of her goals too/her motivation to attend. – She wanted to unburden herself from the emotions she has been carrying. Strong emphasis on word "yeah" – it seems it was much needed at that time. My question could have been clearer. I could have perhaps said 'How did you feel about disclosing to your therapist whilst being in training?'

Appendix 14: Transcript, analysis and themes for interview 6

The imperfect therapist (7) (3) Self-awareness/ development (8) (3) (8)	Adel: So the first one that I had in the first year was erm, well, we I thought we were doing cognitive analytical therapy that's kind of what she advertised but then it turned out to not really be that was more just kind of personal development and some psychodynamic work as well and so erm... I think, my minds gone blank I can't remember the question, what was your question, sorry? I: About self-disclosure and how you felt about that. Adel: At first I think because I was so kind of confused and that there was so many things going on at first with the course and kind of emotionally I felt quite kind of able to disclose more emotions rather than actually what what was kind of going on and I think that maybe... that maybe fitted with the time in my life that I was at that maybe you know I did need personal therapy at that time and maybe I needed to kind of make sense of that a bit more and so I think that maybe neediness or neediness to have personal therapy erm actually made me it quite easy for me to self-disclose at first erm and now I do still find it easy to self-disclose but I feel like now I'm a lot more contained. Erm the kind of I I disclosed different things you know I disclosed emotions but it's more I built the awareness of where those emotions are coming from and things and so I almost don't feel like I'm just spilling out and needing to kind of disclose everything, it's more, I'm just a bit more together maybe when I go in for my therapy.	She informs me her thoughts about self-disclosure has changed as time has gone on. This is common as the relationship with therapist develops and becomes stronger over time. She also informed having two different therapists has also influenced her perception of self-disclosure. – Thus a change in the process. It seems her first therapist was selected on her expectation to have CAT however, she was misinformed. She felt annoyed when she realised she had been misinformed and even now I can hear annoyance. "Just kind of" – referring to some of the work the therapist did. The way she describes this sounds like the therapist's work was insignificant for her at that time as she wanted something else. Feelings of annoyance were strong at this point whilst describing her experiences. Her feelings took over and took her focus away from the question I asked. She realised she was talking about her disappointment as opposed to answering my question which made her stop for a moment and ask me to repeat my question. At the point of attending therapy – lots going on for her, practically and emotionally. This was difficult to keep together at first and perhaps the build up of different emotions inside of her made her "able" to disclose. It was needed, she needed to get it out of her, release it, and thus no difficulties were experienced with disclosing. (Fever model). She talks about disclosing emotions rather than content – this illustrates she was perhaps in turmoil and felt overwhelmed by what she was feeling and thus felt compelled to disclose this.

Appendix 14: Transcript, analysis and themes for interview 6

(7)	I: You mentioned erm that your well you initially thought your therapist was a CAT therapist and then then the fact that they weren't, you sounded a bit, were you kind of disappointed with that?	Disclosure is still easy but she is more together now – She feels as one, rather than parts of her are in different directions, which was difficult to take hold of and manage. Emotions now do not take over. She's not "spilling" – telling all, not stopping. She is able to separate her emotions now, think about them individually and can now use therapy time to disclose content as well as emotions. Whilst she describes her experiences, her pace is slow – she is very thoughtful when she speaks – takes her time.
	Adel: Well I was a bit confused because I I went in there and then after my 8th session or something I said "Oh do you have a formulation?" and she said "Oh we haven't been doing CAT because it hasn't really felt like it suited you", and... I did feel a bit, kind of unsure about the therapist at that time because she wasn't really being that transparent with me I don't think and she was very erm she wasn't a very kind of active therapist and because I didn't really know at that time because I started personal therapy before I started any of my placements or anything so I wasn't really sure you know what therapy was about, obviously I knew different therapies would be different but I wasn't sure kind of what was going on in her mind, it almost felt like maybe I was disclosing some things and then she wouldn't really respond that much...	She felt hesitant about the therapist when she realised she was not attending CAT therapy. She seemed unsure as to whether she could trust her as the therapist was not honest and open with her. "Transparent" – therapist did not seem genuine – led her to feel cautious. Due to her lack of knowledge about different therapeutic models, she was unsure of whether this is the way a therapist should be. When she later realised the therapist she was not engaging in CAT therapy – she perhaps felt cheated/lied to by the therapist which resulted in her feeling somewhat distrustful of her.
	I: Mmm mmm.	The therapist's lack of response led her to be curious about what the therapist is thinking.
(7)	Adel: ...And then I was thinking oh maybe something's going on in her mind maybe she's going to kind of bring up some interpretations, she's going to reflect on what I've said and maybe offer some insight but she she never really did and I think that's why I brought up 'is there a formulation?' because I didn't maybe feel like I was getting that much from her at the time.	She assumed the therapist's silence was because she was going to offer her insight into her difficulties. She perhaps felt let down when this was not the case, her expectations were not met. Knowing the 'truth' as it was after the 8th session explains her uncertainty about the therapist and the process up until then.

Appendix 14: Transcript, analysis and themes for interview 6

Surge of emotions (9) (2) (7)	I: Right. Adel: But I think in retrospect as well that maybe because when I did first go in I was kind of spilling spilling out a bit and... spilling out a bit but then at the same time because I didn't go with a specific problem apart from when I first went we did do some bereavement type counselling for the first two sessions but because after I felt like I processed that and we were more kind of dealing with everyday kind of issues it was probably, I can imagine now as a therapist how that could be quite how that could be quite challenging with dealing with what's just coming up day to day... I: Mmm mmm. Adel: ...apart whereas you know if a client comes to you with you know depression or a relationship problem or something you have a point of focus so I wonder if that was maybe quite overwhelming for her. I: Right, so at the time you know it wasn't something specifically you were bringing, but rather the kind of, the various things that were going on in that moment, at that time. Adel: And that maybe I would feel certain emotions but I didn't really feel like I was able to reflect on them that well and and because of that maybe accept accept them? Or I think maybe I was quite resistant even though I was experiencing lots of feeling I wasn't really open	The therapist's continued silence made her question the therapeutic approach. Her feeling of "needing" therapy at the time was also strong. The energy she was putting into therapy was not being mirrored – "she wasn't a very kind of active therapist," which perhaps made her feel let down by the therapist. She wanted to make sense of her emotions and she did not receive this. She reflects on how she first presented in therapy. She describes her disclosures as uncontainable, possible owing to uncontainable emotions. There was a strong emphasis on the words "a bit" when she said it the second time – She perhaps felt that although she was disclosing a lot, it was not that much for her therapist to respond with silence. It seems like she struggles to understand whether her therapist's lacks of response was because of her or because the therapist is this way. She almost takes full responsibility for her therapist's lack of response and evidences this with her experiences of working with clients. She describes herself as a difficult client when she first attended as she did not have a specific problem to work with. She tries to understand the position the therapist was put in when she first went to see her. – She tries to make sense of why the therapist did not respond much to her. She describes the therapist as feeling overwhelmed. – She perhaps was feeling overwhelmed with emotions

Appendix 14: Transcript, analysis and themes for interview 6

(4)	to change maybe? I: Mmm mmm. Adel: Erm and I think that's that's something that I realised maybe after I finished personal therapy with her and actually I didn't have any personal therapy until, again until erm about May time this year and I think in that year I had undergone a lot of personal kind of development changes and I think for me actually doing therapy really really helped erm me to kind of develop and erm to kind of you know be a bit kind of better in that relationship so that when I came back into it, it was erm, it was a bit easier for me to kind of use therapy and easier for me to disclose and maybe be a bit more structured and to kind of be more open to changes, open to feedback and things like that I think.	which then resulted in her "spilling out". She feels because she did not have a specific issue to focus on – it explains the therapist's lack of response to her. She reflects on the way she presented in therapy initially and tries to make sense of that. She said she was unable to think about her emotions – it was overwhelming. A lot of uncertainty and a lot of questions she has been left with about her initial experience of therapy. Repetitive use of "maybe" and also enquiringly states what was going on for her at the time. Even now she is unsure as to what exactly happened with her therapist. Her therapist's imperfection makes her wonder whether she contributed to it.
(4)	I: So I I know you've kind of said you had two therapists erm, what was your kind of experience like with your first therapist. Your general experience of therapy with her? Adel: That was the therapy the CAT therapist? I: Yes, yeah. Adel: Erm so my general experience *[pause]* well I think like I said I think it was a difficult, I think it was quite difficult for her to work with me maybe because I didn't have a point of focus and things and because maybe I wasn't that ready to change and maybe a bit	She had a long gap after leaving first therapist She feels the time between seeing therapists was significant. – It seems like she reflected on her relationship with her first therapist a lot and concluded that she needed to improve so the relationship could be better and work when she next went. She feels she has done wrong and needed to make changes in herself. This awareness came after she left therapy rather than in therapy. It seems there was no discussion about how she or the therapist presented as she was inquisitive about what happened. She describes how therapy helped her develop "kind of" – so a little perhaps, in the areas she described.

Appendix 14: Transcript, analysis and themes for interview 6

(7)	resistant to change. But I think that my experience wasn't that positive because I think even so even though those were challenges I don't think maybe she was that good at containing me...	Reflecting on her experiences perhaps made her realise how therapy should feel, she was more in tune with her expectations, learnt what it is about and perhaps what it should be and feel like. Also what she needs to be like. Her first experience prepared her for the next therapist. She felt more in control and could plan for each session. It's interesting how she talks about having to being open to change and open to feedback which is not in consistent with what she said earlier. She expected and awaited feedback from previous therapist but did not receive any. She seems to have been left feeling responsible for her initial therapy experience not going as she expected.
	I: Mmm mmm.	
(7)	Adel: ...And sometimes I would feel like I was going for therapy and I was just talking [laughs] and just saying stuff and there was nothing really, there was no real kind of response or there wasn't really, yeah I didn't feel contained so I'd kind of come out of therapy feeling worse than when I'd gone in in the first place...	Pause – trying to reflect on her experiences, but I also think perhaps she wants to ensure it is heard clearly. So she thinks about the words to use. She initially said it was "a difficult" – she was perhaps going to say it was a difficult experience for her. However she then says it was difficult for the therapist to be with her. Perhaps she is saying it was in fact difficult for her to be with the therapist. She recognises she is not wholly responsible for the therapist's lack of response and the therapist was not skilled at keeping her together, as she describes herself as somewhat being all over the place at the beginning of therapy.
	I: Yeah.	
(7)	Adel: ...And that didn't change as we kind of developed, I had twenty sessions with her! And still even towards the end I know that that can happen at the beginning where it could be quite overwhelming but then usually things do kind of get better but...	
	I: That didn't change.	She felt unheard. She perhaps felt as though she was talking to herself – "there was nothing really" – she did not getting anything back from what she was putting in. She repeats in different ways there was no one on the other side that she was connecting with. - It was just her in the room. It was perhaps the cold response from the therapist which made her feel worse than when she first went in. Tone of voice much stronger and louder when she said "twenty sessions with her!"
	Adel: That didn't really happen for me.	
(7)	I: So you know whenever you kind of bought things to her it sounds like she was not able to kind of offer anything back to you whether it was kind of in terms of responding to you or giving you insight into what kind of might be going on helping you to make sense of it.	

Appendix 14: Transcript, analysis and themes for interview 6

(7) and (4) (7) (7) Non-verbal disclosure (10) (9) (4)	Adel: Mmm. And actually in my last session was the only time that she did offer any reflections and I took them quite kind of negatively erm and, I remember my last session she made me cry and it was my last ever session and I was thinking, "Why did you bring this up in the last session?" *[Laughs]*... I: Yeah. Adel: ...If you were going to say something could you not have bought it up in in other sessions and then we would of had time to erm we'd have time to kind of work on the rupture or you know process of what had just been said. I: Mmm mmm, and did you feel able to disclose that to her the fact how you felt about that session and you know how kind of when she, whatever reflection she did make, did you, were you able to express to her that you felt that was quite late and... Adel: Erm I didn't tell her that it was late but I think she must've known because it was quite you know, she kind of said something and then I I kind of broke down in tears and, I'm not really sure I don't know if I said it was late but I said I wasn't really sure if it was that helpful you know her saying that, I don't know erm although I felt upset that she had said that and I think that it was the fact you know I was upset about it, it wasn't like it was a release and that you know that would kind of help me.	This seemed sufficient time for their relationship to have developed but it didn't. She sounded angry and upset – perhaps by the length of time she attended and for change to still not occur. But also for having opened up to her so much and not get anything in return, no validation of her feelings or any fulfilment. She needed therapy because she wanted to make sense of her emotions and she did not get this. She describes how this type of difficulty can be expected at the beginning but it was unusual after 20 sessions. - Strong emphasis on "do" - An expectation of an act, for something to happen, expected things to become better but it did not. Reflecting back what she had expressed. I wanted to also clarify if I understood what she had been expressing about her initial experience of therapy so far. Therapist was open in the last session however the therapist's comments resulted in her crying. The therapist perhaps reflected on how she's been throughout therapy which left her feeling upset and bad. Perhaps it was the therapist's comments in the last session that resulted in her having a long gap between therapists, making her feeling responsible for whatever was going on between them and making her feel like she needed to change for future therapeutic relationships to work. Even though she laughed. I felt quite upset. I could hear how upset she was. She perhaps laughed to reduce how upset she is feeling whilst recalling this. It perhaps still feels quite raw to her. Unfinished. You can hear in her voice how much she wanted the chance to have addressed process issues with the therapist. She had been waiting so long for the therapist

Appendix 14: Transcript, analysis and themes for interview 6

	I: Mm mm mm.	to give her some feedback and having to hear it in the last session left her with no room or space in the session to reflect on the issues or work through them. It feels like it was a cruel way to end the session.
(7)	Adel: Erm subsequently it was more kind of you've opened something up here and we're finishing today so it kind of ended on a rupture which I think was a shame.	
	I: Mmm, so in some ways even though you weren't able to kind of verbally kind of say that to her she was able to see perhaps, you know you were able to let her know in that way the fact that maybe what she had done was not helpful for you.	She's unsure whether she verbally disclosed to her therapist that her intervention was not helpful.
	Adel: Mmm, yeah.	"Broke down" – she could not hold the hurt and upset she felt, not only because of therapist's comments more so because the opportunity to talk about this had been taken away from her. She knew there was no coming back to talk about this.
	I: Erm can you, can you think back to a time when you did kind of disclose something to her, you know erm I was just wondering kind of so you know whether it was something personal or something difficult, I was just wondering how you came to the decision to disclose to her?	She expressed her tears weren't a release of upset emotion. – She felt upset with herself for being upset; she did not want this to show.
(4)	Adel: Erm, *[pause]*. I think, *[pause]* I think I remember having some kind of relationship problems at the time erm and I remember, *[pause]* I remember, *[pause]* certain kind of like feelings that I was having about the relationship I wasn't I didn't really feel like I wanted to kind of admit, or, to myself or really say out loud erm, and I think it was just the decision for it to come out was more because, it was a bit like you know in the sessions, it was a bit like free associations *[laughs]*, your just kind of talking and and it just kind of you know came out that I was maybe having some doubts about my	I wonder about her bereavement and whether it was a sudden loss. Just as the last session with the therapist had been taken away, had her time with her father also been taken away suddenly and there was no chance of going back to complete what is unfinished. It ended during this bad moment – no closure. "Shame" – it was sad for her in the way that it ended. She was made to feel bad, rejected and meaningless.

Appendix 14: Transcript, analysis and themes for interview 6

(6)	relationship at that time and yeah so it was more just like the general process of the therapy that made that come out.	She was in agreement with my reflection about being able to disclose nonverbally through tears how upset she felt with the therapist's intervention – even if she could not disclose her feelings fully to her.
	I: So it was not something you've been you had been thinking about for a while and whether to kind of bring that up in session or not?	
	Adel: No no.	
	I: And what about kind of, what was it about the session itself, kind of what was going on or what was the process like for it to kind of help facilitate that?	Long pauses – she is trying to recall her experiences but it also sounds like she is thinking carefully about her choice of words. I wonder whether she is cautious about giving too much away as she describes her disclosures as "spilling out."
(3)	Adel: I think it was probably bought on by maybe stuff happening outside of the session, that's maybe you know why I was talking about it in the session but I think what maybe did facilitate it was just the fact that I came in and I was talking about this this problem in kind of general and then just through talking about it and talking about it you could kind of see that there were patterns in what I was saying although what I was saying was kind of hinting at some feelings I was having thoughts I was having and it was kind of almost becoming kind of the elephant, 'the elephant in the room' if you know what I mean?	She perhaps felt guilty about having particular thoughts about her relationship and did not want me to think negatively of her. She cannot identify whether she actively made a decision to disclose but refers to the actual process of the therapy session that may have led to the disclosure. Free association led to unconscious, accidental disclosure about difficulties at the time.
Guarded disclosure (11)		She describes it "just kind of you know came out". The therapeutic process/therapeutic model aided her disclosure.
(10)	I: Yeah, because you mentioned that you know it was something that you really did not want to acknowledge or say out loud to yourself.	I clarified whether she had been thinking about disclosing this issue prior to disclosure.
	Adel: Yeah but I felt like it was becoming kind of obvious maybe to me or obvious to her, that you know I had a like a certain like doubt or	

Appendix 14: Transcript, analysis and themes for interview 6

(3)	whatever about the relationship at that time and I think that just kind of made it come out me just talking and talking and talking and it becoming more and more obvious and more and more like I maybe that I just wanted to tell the therapist that I I I was aware that this was you know.	I asked too many questions. I should have kept it simple and asked if there was anything that helped facilitate that particular disclosure.
(9)	I: Mmm, so in terms of kind of how you disclosed it to her do you feel that you were kind of giving her bit by bit then eventually being able to say the whole thing, is that how that kind of disclosure came about?	Difficulties outside of session perhaps led to disclosure – Maybe thoughts and feelings about the difficulties reached a point where it was bothering her, which then resulted in her disclosing it (fever model).
	Adel: Yeah.	Through 'free association' she became aware of what she is talking about and also that she has been avoiding talking about it as she felt unready, thus she talked around the actual issue. She was speaking very fast here, going from one bit to another. "Spilling" – she sounded breathless. – She was perhaps re-experiencing that moment in the interview – there was a rise of emotions before disclosing.
	I: And kind of, what's your experience of disclosure like? I know you say that it kind of suddenly came out rather than you were thinking about it, do you recall what you were feeling like before it was about to come out?	It was overwhelming at the time and overwhelming now while she remembers. Interestingly she was not completing her sentences, which illustrates how she may have presented in the therapy session – she avoided saying what she was truly thinking and feeling. "Elephant in the room" – she uses this metaphor to describe an obvious issue she had which she was ignoring and not addressing openly.
	Adel: Erm, it was feeling like, I need to say this but I don't really know how erm...	
(3)	I: You talk about the elephant in the room, was that kind of the feeling?	"Obvious" – the elephant in the room. There was a clear issue to talk about and they both knew this.
	Adel: Yeah! I felt like there was some pressure almost that I needed to say something erm, and then once I'd said something it was a bit *[pause]*, I kind of felt like I wanted to be reassured, that it was fine erm what I had said at the time.	Doubt – the uncertainty she felt about her relationship was quite strong, perhaps this was causing the feelings of urge – She was feeling the tension of knowing and not wanting to know. – Difficult to say out loud because if she were to acknowledge it then she would need to attend to it. Repetition of "talking and talking and talking" and the word "more". – Her description was mirroring the way she was presenting – She talked quite fast. The urge was
(9)		

Appendix 14: Transcript, analysis and themes for interview 6

(7)	I: And did, were you thinking that before you were saying it?	building up so much she had to let it out (similar to fever model).
Anticipated benefits of disclosing (12) (7)	Adel: Mmm, I was kind of hoping that if I said something it would maybe make it better or then we could kind of work on that but erm *[pause]*, and, I can't really remember what the therapist said, I think, I'm not really sure if she said anything but she kind of nodded in like 'yes' and she would ask me kind of some probing questions but then she didn't really offer any interpretation, she didn't really offer any any kind of summary or anything. Like I said before it wasn't really that containing so it maybe wasn't in that, I think maybe in that situation it's not, I don't think it was that helpful for me really.	Disclosure was gradual – bit by bit. She said it came out suddenly and there were no prior thoughts about it. There were probably thoughts; she was just perhaps not allowing herself to acknowledge it. She does describe however an urge - so perhaps what was being experienced before the disclosure is a physical sensation which she was aware of instead of thoughts. "Need to say this" – there is urgency in her voice/a feeling of urge. A physical feeling inside that was being pushed upwards from her stomach to come out. She had to let it out (similar to fever model).
	I: It sounded like you said you wanted kind of reassurance from her that it would be okay. You mentioned that she nodded to you, was that nodding that she's listening or nodding that she's agreeing with you?	I'm referring to feelings of discomfort. – My question could have been clearer because this metaphor may be accompanied with different feelings for people. I could have asked, "what did it feel like having this 'elephant in the room'?
The ideal therapist (13) (7) (4)	Adel: Yes, I felt like it was nodding like she understood what I was saying and that it was like a significant thing that I was saying, but nothing really came afterwards and I'm not really sure like I said to you that I felt like I wanted reassurance. I think that maybe was part to do with me not being open to change at that time or open to reflection at that time and that maybe I wanted to say what was bothering me but I don't want to do anything about it and "I'm going to give this to you therapist *[laughs]* and then you can deal with that!" and maybe	Words "yeah" and "pressure" were strongly emphasised. She felt a pressure, a heavy weight and force inside of her to make this disclosure. Pause – after saying it was a "bit". Recalling the therapist's response was not what she expected/wanted. She wanted something from the therapist that she did not get. She talks about wanting to be "reassured" – maybe comforted, to be let known that what she's thinking is not bad or wrong. It seems she could not make the disclosure earlier because she was feeling guilty for having these thoughts. The limited response from her therapist perhaps reinforced this guilt.

Appendix 14: Transcript, analysis and themes for interview 6

	she was trying to stay with me in that way.	There was a build-up to let it all out and she was hoping, was ready and now willing to address it, she wanted and needed guidance. A lot of energy forcing this disclosure, but just as the therapist's response was almost empty – she too at this point in the interview paused/there was a blank, nothing to follow, she said she cannot remember. This perhaps mirrors her experience after disclosure.
	I: So I mean before you kind of disclosed you talked about kind of feeling the pressure, certain pressure to kind of say this thing that you've been thinking about for a while and erm and I guess you were hoping that there would be some reassurance and you know to help you kind of think about it maybe and to say "actually it's okay that you've been feeling like this". It sounds like after you had disclosed what it was like that you didn't kind of receive that, so perhaps you kind of somewhat felt disappointed during your disclosure. Is that right?	Emphasis on word "anything" and repetition of "any" – so nothing was said, not even a little something was given back to her after disclosure.
	Adel: Mmm, yeah.	She did not feel comforted after disclosure, it was unhelpful. – Her thoughts, emotions and disclosure were everywhere and this was not held together by the therapist. The therapist did not help her 'keep it together'/prevent her emotions from escalating beyond control.
	I: And what about kind of, you know, what else did feel kind of during the disclosure when you were sitting there, saying and seeing that actually she is not really responding how you wanted her to respond?	I should have asked what it felt like to not have just a nod – should have explored the experience after disclosure further.
	Adel: I just felt, I felt quite exposed really I think, because even though you know I maybe wanted reassurance and I I didn't get reassurance I didn't really get anything as I didn't get much containment like, you know, even though I think that reassurance would have been unhelpful at that time to have maybe you know reassured the feeling of worry but not reassured the situation that I was talking about and to kind of be a bit a little bit more active, I think I wanted her to be a bit more active I think if you, I mean it wasn't like a huge thing that I was talking about, it wasn't it wasn't a	She felt the therapist could hear her disclosure and felt the therapist could understand this was important to her but she did not meet her expectations. She hoped the disclosing would lead to feeling better, to be able to deal with it – she anticipated these benefits; however the actual experience was different.
(4) (12) (7) (8)		She now reflects that maybe she just wanted to get it out in the open and not really address or explore it. She wonders whether the therapist recognised this and that's why she did not respond. It seems her negative experience with this therapist left her with many questions and uncertainty about what happened and so she brings it back onto herself; she feels responsible for her therapist's lack of response to disclosures. She sounds angry at first when she says "I'm going to give this to you therapist" but then laughs. – It's likely that there was a build-up of annoyance/anger at the

Appendix 14: Transcript, analysis and themes for interview 6

(13) (2) (2) (4) (13) (12) (7)	massive thing but I do remember it, but I think if you are a client and there is something big that is going on that you don't feel comfortable talking to your therapist about... I: Mm mm mm. Adel: ...if you then go and tell them then it's a big step and you want some response! You don't want to just be left kind of open and exposed! And I think quite often it is because you do feel like you feel negative and you feel bad about having those feelings or you feel ashamed or you feel something negative, some strong negative emotions. There is some stigma around what you are saying and I think that it is important maybe for the therapist to be quite active in that and to contain to say you know "seems like maybe your worried or ashamed about this, this is right, its normal for you to maybe feel like this, it's natural for you to feel this way and you know, thank you for disclosing this"... I: Yeah. Adel: ...And then to work with with the issue rather than just you know not doing anything and thinking, "well I can't reassure, I can't reassure". I: Yeah, yeah. So at the time you felt not only disappointed but really, you mention about feeling exposed, you also talk about kind of just generally when someone you know makes the decision to tell the therapist something big, you know feelings of kind of shame or just	therapist's lack of response until this point and so she wanted to give the therapist/ throw at her the difficulties she was experiencing. It seems her attitude to not want to reflect on it was intentional and that's why she laughs. She perhaps wanted the therapist to find it difficult as much as she has all this time. The therapist had not been responsive and so she too won't now after disclosure – thus hands over her problems to her. She was made to feel unimportant. She also talks about wanting to say what was bothering her – I don't think it was only the relationship outside of therapy that was bothering but also the therapeutic relationship was bothering her. Exposed – showing the therapist parts of herself that was hidden before and to not have anything in return can feel like the therapist has some power over her. Therapist has information about her and this can feel threatening – the information is in the therapist's 'hands' and her lack of response adds to the fear and uncertainty of what's is going on. She expressed she wanted to feel comforted by the therapist because of the intensity of emotions she was feeling. She wanted her to be active – to respond. The actually disclosure was not significant but the therapist's response was. – This is why she recalls this. She reflects from a trainee's position how a client would feel about this. She is angry whilst talking about this – she raises her voice. She describes how some disclosures are very significant and the courage and action to disclose is a huge thing to do, it is therefore imperative disclosures are then met with a response from the therapist. She detaches herself from this situation and talks about what it could feel like for clients. She uses the word "you"

Appendix 14: Transcript, analysis and themes for interview 6

Negative consequences (14) (5) Anticipated risks of Disclosing (15)	negative feelings of feeling bad and guilty might be attached to that, are these feelings that you felt when you were telling her... Adel: Yeah. I: ...And you know when she didn't respond to you are these some of the feelings that you were feeling? Adel: Yeah, yeah, I think so and I think I felt panic, I felt *[pause]*, I felt nervous about what she might say as well, that erm... I: What before she responded they way she did? Adel: Mmm, before she responded, yeah. I: What did you, how did you think she might have responded? Adel: Well I think I think at the time what it was basically about was about my relationship and being worried that certain feelings that I was having about my relationship meant that I should end the relationship, that the relationship wasn't right and I think I was worried that when I disclosed that sometimes you know I was having doubts or whatever or that I wasn't happy with a certain thing that she would say to me "oh yes" you know and kind of not say explicitly but that I might feel like it was implied "yes you should end this relationship" and that scared me.	instead of "I", - however she is describing how she felt. It's almost as though because therapy is a reason to experience what it's like from the client's perspective; she is hypothesising what it may be like for clients. She is in some ways narrowing down her experience of disclosure/therapy as a process to learn about clients rather than also using it to actually address personal issues. – Avoidance of reality and fear of admitting her negative thoughts and feelings about herself. Feelings of guilt and shame attached to content of disclosure. Numerous negative emotions are felt prior to disclosure. She acknowledges that clients may be perceived negatively because of what they're about to disclose. – Stigma - Interestingly she separates herself from this experience. – She describes how others may feel like prior to disclosure. Perhaps as a trainee she has to feel somewhat stronger to be able to manage this negative experience and not be bothered by it as much, as after all this is meant to be a learning experience, to understand what it's like for clients. She also entered therapy at the beginning with this in mind. It's seems difficult as a trainee to hold all of this in mind at once – to reflect on therapy experiences as a client one moment and in another moment as a trainee/therapist. – This somehow limits authentic processing and addressing of difficulties. She wanted the therapist to respond, to take notice of her negative feelings, to comfort her from these negative emotions and have it normalised. – She wanted the therapist to be verbally responsive. Repetition and emphasis on words "I can't reassure" – you can hear annoyance in her voice as her tone rises. She is annoyed at the therapist's lack of response.

Appendix 14: Transcript, analysis and themes for interview 6

	I: It sounded like that's not what you really wanted to hear as well.	
(12)	Adel: I wanted reassurance that the way that I was feeling was maybe you know natural given the circumstances of the relationship or whatever, and to kind of I think at the time I wanted to think it was me, so because it being me and it being my problem was easier because then maybe I could fix it whereas if it was the relationship or you know something, that was kind of doomed *[laughs]*, I don't know I was worried that that's what she might say and then what would I do with that?	She confirms she herself felt bad, ashamed and guilty about the topic of disclosure.
(15)	I: Yeah, yeah. When you talk about not ready to change it sounds like if she had said that that would have felt like a huge change, on not just your part but on your partner's part as well.	She felt anxious after disclosure. She also dreaded what was going to happen after the disclosure. Frightened of the outcome – perhaps worried about being judged/disapproved of or not being helped in the way that she wants. Dread/fear before disclosure, about the therapist's response.
	Adel: Mmm.	
	I: And what about kind of after the disclosure when she just kind of nodded and didn't give you what you were hoping she would give you, what were you left feeling like? I know you said feeling exposed; did you have any other feelings, whether it was about yourself or even towards your therapist?	She feared her therapist would respond unhelpfully by telling her what she did not want to hear. She did not want the therapist to advise her but rather acknowledge her difficult at first, normalise negative feelings and comfort her.
	Adel: *[Pause]*, I think I felt, *[pause]* I think I regretted saying anything to her to be honest and I was kind of wondering what she was thinking about and I felt a bit frustrated I think with her and a bit, like even though in my mind I wanted a certain response, I wanted a	She anticipated the risks of disclosure which contributed to her fear and delay of disclosing. Not just about the therapist's response but also what the disclosure will lead to – what will become of it. – The unknown is frightening.

Appendix 14: Transcript, analysis and themes for interview 6

(14)	resp' I wanted a response! I didn't really want no response and that was what I was getting.	I was referring to her not wanting to hear the suggestion as well as not wanting the therapist to make a suggestion. I felt she was fearful of acknowledging she is having relationship difficulties and what that may mean. I feel I adopted my role as a therapist here. I was mindful of almost moving away from my role as a researcher.
(7)	I: Mmm mmm.	
(7)	Adel: Erm, so I kind of wondered, I was wondering you know is this, is she just wanting me to work this out myself with no guidance, you know what what is her role here, what does she think her role is here and maybe these are things that I should have brought up with her at the time but and I think I noticed that I do have kind of problems maybe with doing that, you know that's getting better now but at the time you know we have problems of kind of being transparent and saying "this is what is happening, I feel that maybe you as a therapist, this is what I want from you and you are not giving this to me" and then maybe we could of had a conversation about it.	She emphasises and is clear that her initial expectation from the therapist is that her feelings about the content of disclosure are only attended to and not the content of disclosure itself. She was worried the disclosure may result in being made into something bigger than what she expected and this may mean it is more difficult to sort or is even unfixable. Fear of being told the problem is much worse than she thought and also it is unlikely to be resolved. – It's "doomed" – only bad will come out of that issue Feared she may be left with uncertainty – not knowing how to manage the problem after disclosing.
(1)	I: Mm mm mm.	I tried to acknowledge her fear – that the disclosure would not only impact her but her partner also. – Thus resulting in something bigger than what she expects or wants.
(8)	Adel: I think I'd maybe feel easier about doing that now but then I also think that if you have just exposed yourself you're not feeling like you're really, I didn't really feel like I was in control almost that it was my thought, my feeling but I didn't own it 'coz it was out there now, it had almost kind of like I'd passed like it was between us and nothing was being done with it and I felt like I'd done my part and I needed something from her.	My question should have remained more open and not be leading – I assumed and insinuated she felt something towards her therapist because she did not respond to the disclosure verbally.
(14)	I: Yeah you did talk about wanting to hand it over to her and you know her not taking that it felt like it just left you hanging in some	

(7) (4)	ways. Adel: Yeah. I: It sound like that was quite a difficult experience that you had you know with that kind of particular disclosure. Adel: Yeah. I: And you know, what about your other therapist, you know have you, can you think of any, a time when you did disclose to that therapist, you know I just wondered kind of what that was like? Adel: Erm *[pause]*. Oh yes, there was a time when I disclosed something. That was again, that was again around kind of feelings of like being ashamed about what I was, what I was thinking what I was feeling and erm, yeah and that was actually a positive experience, and I remember kind of before I said what I said to her or told her what I what I said, you know what I wanted to say to her, I remember sitting there and feeling... I: In the session? Adel: Yeah, yeah in the session, feeling kind of embarrassed feeling kind of like, I was like smiling kind of not giggling, but almost kind of like 'oh this is, this is embarrassing' type thing. I: Mm mm mm. And is it just in the session that you thought about	She feels disappointed and ashamed at having disclosed because she can't take it back. Curious about therapist's thoughts about her and her situation. – She feels bothered with not knowing what the therapist was thinking and also angry with her for not responding. Repetitive use of words – "I wanted a response" and strong emphasis on "no response" illustrates how much she wanted a response and explains why she is feeling angry. The word "a" was also emphasised strong, - she wanted "a response" so any response, something, even if a little. She felt angry about not receiving any kind of response. Questioning therapist's position. Not only is she confused with her lack of response but also confused about her role. Therapist is referred to as "her" or "she" – and these words are strongly emphasised. There is an impoliteness in her tone when referring to her therapist in this way, illustrating how angry she feels with her. Therapist is not considered as part of the therapeutic process but someone who is outside of it and not fully participating in it. Also feels regretful about not raising process issues with therapist. Recognises she has difficulties with being open to the therapist about process, about feeling unhappy about the therapy process and therapeutic relationship. Refers to herself as "we". - Unsure whether she is referring to "we" as clients or as trainees. She also says "at the time" – it seems in that moment it is extremely difficult to be open and honest with the therapist. Disclosing leads to feelings of vulnerability, powerlessness as nothing is received from the other/the therapist.

Appendix 14: Transcript, analysis and themes for interview 6

(4) Therapist on trial (16) (3) (5)	disclosing it to your therapist or is that something you were thinking about for a while? Adel: Erm... I: And how did you make the decision to disclose about that particular thought? Adel: ...I think that it was it was something that you know it was related to that specific thing I hadn't thought about disclosing but it's part of a like wider issue erm that I had thought of disclosing. And I wasn't really sure if I was ready to and whatever, but then I think because things had come up for me in that week that were affecting me in that kind of area that's why I bought it up I think and I think the fear for me of bringing it up was being ashamed, being erm afraid of being judged negatively for what I was about to say by the therapist... I: Mmm mmm. Adel: Because even though I tried not to I had an idea about what type of person the therapist was and you know my mind like kind of fantasies about of what they what they would be like and what they would think about what I was going to say and... I: Mmm mm, and you being a trainee did that kind of influence your decision about disclosing because you thought that she might be viewing you negatively in some way?	Any power she had was handed over to the therapist but with the expectation of there being a return so it would be equal and balanced. She said she "done my part", so she gave herself and engaged in the process but the therapist did not – her thoughts and feelings were left hanging in the middle – "in between us". The therapist did not absorb it and return it to her in a way that she could comprehend and manage it. Thus she felt out of control, exposed and unprotected. She agrees her expectations of disclosure were not met and she was left holding what she disclosed. – Left bare and open. Experience of disclosure with first therapist was a difficult experience. Pause – indicates she is trying to recall her experience. She experienced feelings of shame prior to disclosure owing to the content of what she was about to disclosure. It seems she felt embarrassed and uncomfortable beforehand.

Appendix 14: Transcript, analysis and themes for interview 6

(12)	Adel: Yeah! Maybe, maybe, yeah, I mean I do sometimes feel like that in therapy as well that being a trainee erm I mean I think I don't really know but I imagine that other trainees use personal therapy a lot as kind of support just for their pers' their their professional training but I kind of use therapy really as just kind of for me and it helps my professional development as well but when I go, I'm not talking about the course all the time I'm talking about other issues, sometimes I'm talking about the course but it's not the erm,	She was quite hesitant whilst describing her experience to me. She was jumpy in her response. She perhaps felt similarly when she made this disclosure to her second therapist – restless, as she was uncertain of the response she was going to get, particularly as she already felt humiliated by it and perhaps thought it is something to feel disgraced about.
	I: The only thing?	She recalled feeling uncomfortable prior to the disclosure. Her smile prior to the disclosure also suggests that she perhaps tried to minimise the embarrassment she felt.
(2)	Adel: ...The only thing and because of that, that worries me sometimes that maybe she, you know I might be judged for "Oh you know well she has these issues and maybe she shouldn't be a therapist if she is thinking in this way or if she is you know not developed in this way very much" or whatever.	
	I: Mmm mmm, yeah.	I asked this second question before the first one was answered. I should have waited for her response.
(5)	Adel: Erm I think there has been a lot more development now and I was certainly weary quite weary of that with my first therapist as well. I was very worried that she was thinking because she wasn't really saying anything that she was thinking "oh this girl, she can't be a therapist because she's got too many problems of her own" or whatever.	Again, disclosing a little/partially/gradually – perhaps to test therapist's response. She was disclosing parts of something else which she had been thinking about disclosing. She felt unsure about the disclosure, unprepared perhaps because the response she could receive from the therapist could be varied and greatly unexpected.
	I: And and your worry about being perceived negatively because	Decision to disclose instigated by the intensity of the issue – it was more bothersome during time of disclosure.

Appendix 14: Transcript, analysis and themes for interview 6

	you're a trainee, did that kind of influence your decisions about what you might disclose and how much you would disclose?	Although she wanted to disclose, she felt uncertain and was frightened perhaps about re-experiencing shame, or even viewed negatively, like she has said or done something wrong.
(5)	Adel: Well I think that made me in the thing that I disclosed to my second therapist it made me more weary of disclosing it because erm it was something that related to I think that kind of related to kind of influences in culture and how I felt maybe I should be and what I should be doing. Whereas I, I felt like I was kind of slipping into that whereas as a Counselling Psychologist I should maybe you know not be so kind of buying into those types of discourses and I should be able to be more open and more kind of judging myself by my own wants and needs as opposed to wants and needs of society and things and I think that's why I kind of felt like giggly and almost ashamed about it because I was like "oh I do sometimes suffer from worrying about this issue", erm...	Imagining and predicting the therapist's response. Imagining the therapist's non-verbal response How she would respond – it sounds like the disclosure itself was role played/rehearsed in her mind as a way of preparing herself. "Fantasies" – it seems she also imagined a desired response from the therapist and that too may have enabled her to disclose.
(5)	I: Yeah, yeah.	My question should have been more open and explored how she thought she was going to be perceived. Rather than assume her fear of disclosure or decision to disclose was related to her being a trainee.
	Adel: ...And so that's what worried me about it I think.	Strong emphasis on "yeah" – being in the position of a trainee influences her decisions about disclosure to an extent Personal therapy is used for personal issues as well as professional development. There's an assumption that other trainees use personal therapy only for professional development.
	I: So how did you kind of come to the decision to disclose that?	She uses the therapeutic space to talk about various issues in her life, things that do not relate to her course but positively impacts on her professional development.
	Adel: I think because it was something in the week that had kind of come up a lot for me and I think as well because in my personal therapy now, I right at the moment in my life I'm very kind of content with my life and sometimes I go to therapy thinking "oh what am I going to talk about today?" you know I don't know I'm not I can't really	Perhaps due to the assumption that personal therapy is used for professional development, she feels concerned about addressing pertinent issues that are not course related. She fears attending to other issues may reflect on her badly, in that she would be viewed as incompetent. It sounds like disclosing her thoughts or ideas about things

Appendix 14: Transcript, analysis and themes for interview 6

(3)	think of things to talk about today and I have to kind of reflect and really kind of dig deep, but obviously there are always things to talk about but maybe just not at the surface at the moment because the things on the surface are good. Erm, so yeah I think it was to do with kind of yeah what was going on like the thing that was maybe affecting me at that moment the most.	can also be used as an indicator that she has not developed adequately as a professional. To hold this in mind whilst attending therapy must cause feelings of uncertainty and require either decisions to be made quickly in that moment or to be thought about over a long period – i.e., whether it is safe to disclose and also weigh up the risks and benefits of disclosing. There seems to be preoccupation with this – "that worries me".
(8)	I: So made it feel like the right, the right time?	
	Adel: Right time to talk about it.	Also fearing she will be "judged" – the therapist then is also viewed as an assessor and not just a therapist.
(3)	I: Mmm. And kind of what was it, did it feel like when you were disclosing? I know you talked about feeling a bit giggly and feeling quite embarrassed but what else were you feeling or thinking at the time?	She was particularly cautious about disclosures with the first therapist. The therapist's lack of response led the trainee to assume she was being perceived negatively and judged on a professional capacity.
(3)	Adel: Well the thing about the therapist judgement and "Oh I can't be thinking this, I'm a counselling, trainee Counselling Psychologist".	
	I: Okay.	Decisions to disclose were influenced by her position as a trainee. She was worried about not portraying herself in a way a psychologist ought to be.
	Adel: Erm, worrying what the therapist's response would be, but then erm she responded you know in a way that was helpful I thought to me.	Feeling cautious owing to content of disclosure.
(5) and (1)	I: Okay. What about during the disclosure, you know how did you kind of disclose it to her?	In this case, it was about cultural influences and her thoughts around how she manages this, perhaps with clients as she talks about it in a professional capacity.
	Adel: I think I said something like, oh well you know there is this thing but	She was aware of the position she was taking, in regards to cultural influences, and this differed with how she

Appendix 14: Transcript, analysis and themes for interview 6

(5) (13)	erm I dunno I feel really silly about it and she was saying "Silly, really, why why do you feel silly?" and you know kind of like helping me along erm and I was like "okay, okay, oh well you know it's this and..."	thought she ought to be as a psychologist. Owing to this distinction in viewpoints – she perhaps felt open to criticism. It seems she feels there is an expectation of her to be more open, to have the ability to be more reflective and attentive to personal needs and to not become consumed with worries about particular things. – As a psychologist she should be in this way. – Attempting to adhere/live up to this expectation at all times, in particular during therapy, may inhibit certain disclosures or lead to disclosures being conveyed in a certain way so that the response of the therapist can be gauged before further disclosure is made.
	I: So kind of telling her your feelings about whatev' about what you're about to say, she sounds like she was kind of encouraging you to kind of say a bit more.	
(16)	Adel: Mmm mmm.	
(13)	I: And then during it, did you kind of what what was the feeling like when you were saying it? Was there any difficulties or what was that experience like?	Decision to disclose was based on an issue which felt pressing in that moment – the issue is recurring often in a short space of time and being bothersome. It also seems towards the end of training when personal issues have been dealt with and trainees feel they have reached a sufficient level of understanding from a client's perspective, personal therapy feels unnecessary and like a chore perhaps. At this stage, towards the end of training, there's a pressure to continue attending, an effort to think and perhaps force/convey a topic as an issue – even when it may not be so bothersome.
	Adel: Erm, there were difficulties I mean it wasn't as intense as when as before I said I think when I was actually saying it it was a bit easier, it felt a bit easier for me when I was actually saying it. Erm *[pause]*. I think maybe I felt a bit of a relief as well maybe.	
	I: Okay. And what about afterwards when, how did your therapist respond?	
(15) Positive consequences (17)	Adel: She erm she said you know thankfully "I can see that that was difficult for you', she said 'I'm really pleased that you felt like you were able to tell me and thank you for telling me' and then yeah we talked about it more and she was kind of more active and erm you know expressed her understanding, that it was significant for me to	It seems there is an expectation for her to attend therapy and only talk about troubling issues – thus the need for deep reflection and search for a topic – "dig deep". It questions how helpful therapy at this stage is? She describes how she feels content now and thus there are no serious issues to disclose. There is no longer an urge as "on the surface are good". Surface being on top – there is nothing emerging or needing to come out. She therefore talks about an issue that is not as troublesome.

Appendix 14: Transcript, analysis and themes for interview 6

	say it which I think was different to the first therapist.	Disclosure was due to timing – issue was more apparent during that time, more pressing.
(13)	I: Yeah, yeah, and kind of thinking about erm their responses, how know how your first and second therapist responded, you know what is it about the way that the second therapist responded to you that made you feel like, actually this is what I wanted, this is what it should've been like?	Struggles with thoughts she has and what she ought to be having as she is a trainee counselling psychologist. There is a pressure/expectation to be or think in a certain way. If the therapist does not perceive this or hears something which does not reflect an adequate 'typical' psychologist. – During disclosure there, it seems there is a risk of being criticised and thought negatively of. Also perhaps a fear of repercussion on ability to continue training.
(13) (7) (8) (13)	Adel: Mmm, erm, I just think it felt supportive, I think with the other therapist, even though she just nodded I felt like there was quite a lot of judgement and even though with the first therapist I did kind of want to go like this and say 'you do it, you deal with my problem'. The second therapist I think because of my own development I I didn't feel like I wanted to do that anymore, I felt like I wanted to kind of understand and work on it myself and so I felt like but I also think with her that there was less of a judgement and it was more collaborative and erm and more that not feeling like the therapist was the expert I think personally, I mean it was her as well but I think it's more the way that I look at things now, that you know the therapist isn't the expert of your life and the therapist doesn't have the power to like tell you or you know that this is right or that's wrong whatever, and I think just having that knowledge which made it easier for me to feel more comfortable but also erm I just think that the way she was supportive with it made me feel less afraid of the judgement, I think.	There is concern about the therapist's response during disclosure. The second therapist's response was positive and helpful. Her disclosure begins with her disclosing how she is feeling prior about disclosing. This enables her to set the scene and perhaps also warn the therapist she is about to make a disclosure. She also lets the therapist know she is feeling foolish about it– again warning her she is perhaps about to say something which may be considered undesirable as she is a trainee. In a way, disclosing like this, that is informing the therapist about her negative feelings, tells the therapist to not add to this and enables her to gauge what the response would be. She reports feeling aided to make the disclosure by being perhaps being informed she does not need to feel worried about making the disclosure.
	I: Mmm mmm. So kind of relieved as well as kind of you know not feeling like you've kind of done something bad and not being made	I could have explored what made her disclose her feelings first?

Appendix 14: Transcript, analysis and themes for interview 6

Professional awareness/ development (18) (13) (18)	to feel in that way. Adel: Mmm. I: Okay, so what about if you think about both of your experiences, you know with the first and second therapist how what did you find would you say, what was helpful in disclosing or did you find it helpful at all? Adel: With the first therapist? I: Yeah. I mean not just specific specific to that one but in general kind of any disclosures you made to you first therapist, would you say there was anything that was helpful about it? Adel: Mmm *[pause]* not really *[laughs]*. Apart from being aware of how maybe other clients might be feeling, you know my own clients might be feeling in therapy. I: If you weren't to respond? Adel: Yeah or just like how how it's difficult to disclose something so obviously you know but if you don't have the experience of doing having the experience of doing it and feeling that emotion I think that could make you more sensitive. I: Like the whole build up you mean?	"Wasn't as intense" – this disclosure differed from the other one. Not as many emotions attached to it and also did not come out suddenly. She was unprepared for the other disclosure whereas in this one, she anticipated the risks and was prepared to respond to various responses. She also disclosed gradually – tested the therapist's response. Preparation made the disclosure easy. She felt relieved during the disclosure – to finally get it out and talk about it. It was a release as it had been bothering her a lot at that time. This disclosure was "easier" – more straightforward as she had planned and rehearsed what she was going to say and how she would manage the response. The therapist acknowledged her difficulty with making the disclosure. She attended to her feelings about the disclosure topic and not straight to the content of the disclosure. This therapist's response was more considerate. She was told the disclosure was important which made her feel accepted and not ashamed, bad, guilty for having such thoughts. Negative feelings were not enhanced owing to the way the therapist handled the disclosure. Thus relief was felt.

Appendix 14: Transcript, analysis and themes for interview 6

	Adel: Yeah! Make you more sensitive to it and reflect on what you could do differently and that kind of thing if you were the therapist.	Second therapist was kind, more caring of her feelings. She felt scrutinised by the first therapist – like she was saying, thinking or doing wrong.
(2)	I: And what about with your other therapist what was helpful about disclosing?	She feels this disclosure was also different not just because of the therapist's response but she has come to own her issues and views herself as equal to the therapist. She does not consider herself to be weaker than the therapist.
(18)	Adel: I think it was helpful because I think I had some like preconceptions about what she might how she might respond and how other people might respond and I think through speaking to her about it, it made it less of a stigma for me if you see what I mean, and I think making it less of a kind of 'no no no I'm not going think about that, I'm going to avoid that' actually made it more acceptable and easier to kind of work work with really.	She was also more committed now to learning and understanding her problems. She did not feel under inspection with this therapist and the therapist treated her as significantly and equally important in the process. There was an exchange between them – she too had control in this relationship and the power was not just in the therapist's hands so to speak.
(12)	I: Mmm mm mm. What about kind of future disclosures did it help with that as well you know her response of being so supportive and open, did it kind of influence future disclosures?	At the beginning, she entered therapy with a lack of knowledge about therapies. Therapy is a part of training, for learning purposes and for her to attend to difficulties so she could be an 'adequate' psychologist. Keeping this in mind may have led her to focus on the therapist's role and also hand herself over to the therapist to be fixed so she can be a suitable psychologist. Responsibility is given to the therapist. She may have come with the view to be adjusted and moulded into what her therapist thought was best – she is the "expert" and after all this is part of her training.
True self (19)	Adel: Yeah I think so yeah. I think it definitely strengthens the relationship, the therapeutic relationship when you feel like you can tell your therapist something that's uncomfortable and it's accepted and you know you work with it you talk about it. You know she just explored it with me, she just asked me more questions and that and allowed me to explore how I felt about about the thing I was avoiding bringing up.	Having knowledge about her own position as well as in relation to the therapist enabled her to be more open and take an equal part in the therapeutic process. Therapist response should ensure client is not feeling bad and that they've done something very inappropriate. – As relief will then be experienced after disclosure.
	I: Right. Mmm, so what about kind of, if you think about, if there was	

Appendix 14: Transcript, analysis and themes for interview 6

	anything unhelpful you know about disclosing to your therapist, you know what would that be?	
(6)	Adel: In general?	I asked a leading question – assumed there was something that helped facilitate the disclosure.
(13)	I: Yeah. If you just think about kind of your whole experience with both your therapists	
	Adel: Erm, I think it's unhelpful for the therapist not to acknowledge the difficulty of what you're of what you're saying. I think it's unhelpful not to, contain you in that way erm and to maybe just like make a like a nod or something that can is so open to interpretation when you're very hyper' hypersensitive to...	
	I: Mmm mmm yeah	Pause and laughter – She recalled her initial experiences of disclosure were unhelpful. Laughter perhaps because it is as bad as she described and also perhaps disbelief that her initial experience was very awful considering she saw a psychologist whom she first viewed as an expert. Although first experience was negative – she learnt what it felt like to receive this response from a client's perspective.
(7)	P: ..."I don't feel good about this" and then they don't say anything and you know what does that what does that mean? Erm, I think it's yeah important obviously not to make a judgement on what somebody has disclosed as well because obviously if it's a big if it's a really big deal I thinks it's better if it's a big deal then they're obviously very kind of open to suggestion and client's are very open to suggestion and sensitive to reading into something and any kind of anything negative maybe. This is how I'm thinking a bit. Erm and, yeah I think that's it really.	Strong emphasis on "difficult". – It is hard to utter the words. She experienced the difficulties attached to making disclosures, she experiencing the worrying thoughts about making disclosures and the negative emotions which are felt in that moment. – She experienced the rise and intensity of these emotions. Without this experience – you may not understand what it is like for a client in that position. She is more understanding and attentive owing to her own personal experiences of disclosure in therapy. She is more aware
	I: So kind of other than them being responsive, responding to what you're saying it sounds like you know with your first therapist you	

Appendix 14: Transcript, analysis and themes for interview 6

(7) (2) (13) (2) 'Do unto others what has	know she seemed like maybe she was thinking about things and but not saying them to you, so for them to be quite transparent about you know transparent about what they're thinking, it sounds like that's quite important for you as well. Adel: Yeah, yeah definitely, yeah definitely it is. I mean with my second therapist I don't know what she is thinking all the time but because she does say things you know you and you're not gonna know what someone's thinking they can tell you they're thinking something and they're not thinking that or whatever. I know as a therapist sometimes I think things that I don't say to the clients because you know for a number of reasons erm... I: Yeah. Adel: But I think to have some kind of congruence really, I think yeah that's it really, that she wasn't being very congruent with me. She thinks psychodynamic she wasn't picking up on any kind of transference counter-transference she wasn't saying "Oh it feels like you want me to say something and I wonder what it feels like that I'm not saying anything", it was just very kind of blank and yeah. I: Mmm, and quite a reserved position that she's taken. Adel: Yeah, yeah. Maybe she was thinking 'oh, what do I do? *[Laughs]* what do I, what do I do now?' *[Laughs].* Maybe she wasn't very experienced, I don't know.	of what the experience may be like for clients and not just concerned with the topic of disclosure itself – she thus responds to the experience of disclosure. Her experiences have led her to reflect on her own interventions with clients and also taught her how and what to do differently from her therapists / not the same way. Preconceptions – ideas and thoughts beforehand about the therapist's likely response made it less hard to disclose. – She perhaps thought about positive responses which aided her disclosure. She perceived she would not be made to feel humiliated and her experience during the disclosure confirmed her ideas which also reduce feelings of shame and embarrassment. She no longer felt the need to push away her thoughts and feelings because they were not rejected by the therapist. The therapist took them from her so they could think about it together. There is no divide between them, they are not disconnected. There is a shared understanding and a shared responsibility to address the problem. The therapist's acceptance of her enabled her to accept herself, show her true self and not hide anymore. The relationship is stronger when one feels less fearful of disclosing, even when distress is felt within the client/trainee beforehand. However, the disclosure at this point is more about the content of disclosure rather than the act of disclosing. The therapist's interest and curiosity enabled her to disclose further. She and the disclosure topic were made to feel important; the therapist wanted to know, and help her. The therapist's interest was an invitation for her to open up, giving her permission to disclose, and conveyed there is nothing wrong or bad about talking about this.

been done to you' (20) (7) (7) (6) Trust (21)	I: Mmm, mmm. So what you know if you think about both of your experiences what aspects of therapy would you say that helped facilitate your disclosure? You know thinking about kind of maybe your therapist, the way they responded to you or when just generally, what aspects of therapy helped? Adel: Yeah I think, I mean with the first one I didn't feel these things but I think definitely to disclose things to therapists you have to feel like you have a good therapeutic relationship erm also maybe that there's some time that's gone on in the therapy that's not right at the beginning of therapy, or for me anyway, I mean you might go to therapy with a gasping issue that you just need to tell someone erm but I definitely think yeah you need to feel comfortable you need to feel like a therapist isn't judging you erm. I: And what could you know the therapist be doing that helps kind of you know facilitate that you know to help you feel comfortable and to feel more safe? Adel: To I think be a quite curious about you maybe and to ask you know to ask questions and ask people to say more about certain things and to not be too leading but to be kind of containing and structured enough so that the, so that the the client feels like they're being kind of held but their allowed to kind of go off as well like they're they're free and contained all all in one.. I: Yeah yeah.	I could have explored this further and asked how the therapist's questions help her disclose further. Unhelpful factors – to not take notice of the actual experience of disclosing and how difficult that is – this left her feeling rejected and thinking the topic of disclosure is unacceptable. She felt ignored and for the therapist to not be aware of her feelings perhaps made her feel further disconnected from the therapist – she felt detached from the process. Unhelpful to not be made to feel secure – for emotions to not be held and made sense of by the therapist whilst they're disclosing. During disclosure – a lot of emotions and negative thoughts – the client/trainee is therefore more aware and vigilant of therapist's response. A response which is vague in nature and a non-verbal disclosure which is unclear and can have two different meanings and can result in the person disclosing to initial feel uncertainty and the assumption that the therapist is responding negatively. Non-verbal disclosures can be interpreted as negative and rejecting of the person as well as their disclosure. After disclosure – unhelpful to respond to content of disclosure initially. Disclosure topics and feelings attached to it vary.

Appendix 14: Transcript, analysis and themes for interview 6

(13)	Adel: ...that they can go where they want but then if they go somewhere that it's you know dangerous for them or scary for them then the therapist is there for them.	If disclosure is considered highly difficult and significant – it is better for therapist to not portray themselves as the expert on that topic and offer their view. The client/trainee disclosing is very open to wanting and needing support so whatever is provided by the therapist at that point will be assimilated quickly, including nonverbal behaviour/disclosure from the therapist. If initial response is unhelpful, this will too be absorbed instantly and lead to devastation for the client/trainee.
(13)	I: Yeah, yeah. And what about kind of thinking about your position as a trainee as well, when earlier when you mentioned about feeling kind of uncertain about whether to talk about something because you're a trainee, you know what aspects of therapy do you think has been helpful so far to kind of help you feel comfortable because you're a trainee as well to disclose? Or what do you think they, you know they could have been doing? What would be helpful?	Another helpful factor - therapist's to be more open, in particular when it is visible or obvious they may be hiding something from clients. Clients can sense this and a lack of openness can lead to distrusting the therapist.
(13)	Adel: Erm *[pause]* I mean it is something that I think about, but I don't think that it's clear to my therapist that I am thinking that so maybe I don't know, I guess maybe if your client was finding it difficult to kind of disclose and maybe asking why that might be and you know if they did I think you know take it from the client really, if they did if they did come out and say that maybe you know sometimes they feel that they can't say things you know, then to maybe have a discussion about that.	Being generally responsive or active in the process can also aid trust and give a sense of whether the therapist is real and can be trusted. Presenting as a complete blank screen seems to inhibit disclosure. It seems the more curious a client is about their therapist, they may make more negative assumptions.
(1)	I: To just, so kind of discussing the difficulties with disclosing sounds like might be helpful?	She is aware as a therapist one cannot make disclosures and reveal all their thoughts. Though believes it is imperative that therapists should be genuine in their approach, open, honest, verbally and non-verbally – they should attend to the process. To be dissimilar in their manner and response, or ignore something obvious would lead one to be cautious and unsure about the therapist.
(20)	Adel: Yeah rather than say rather than the therapist say "oh you're a trainee I wonder if you find it difficult" because that might not be	She is critical of the therapist's approach – she does not feel the therapist was skilled as she was not doing what is expected in that therapeutic model. Therapist was empty and closed – "blank".

Appendix 14: Transcript, analysis and themes for interview 6

	right and...	
(2)	I: What would be kind of, why would that not be kind of the best approach to take	To be honest is to acknowledge what is going on and be truthful about that. Views the therapist as unprofessional. She imitates the therapist's hidden thoughts and laughs at the therapist's uncertainty about how to manage client's disclosure. The therapist is viewed as unprofessional, wrong and her approach is also perhaps perceived as unethical.
(2)	Adel: Erm *[pause]*. I think if it hasn't really come up then it's almost like an assumption maybe and maybe highlighting something that's not there, I mean there's nothing really wrong I guess with asking that coz the client can then just say "well no that isn't an issue". Erm so I guess you could do that maybe, you could do that as well yeah, to talk about it.	
(2)	I: And erm you know what have you, just kind of again thinking about what has has been helpful, I know you talk about kind of them being containing and structured at the same time and not kind of be quite reserved you know that's not helpful but what other aspects of therapy do you think has been helpful, in terms of how they responded or how they've been with you that's helped you to disclose? You know if you think about your position as a trainee as well and how what has made it comfortable for you to kind of come and talk about your difficulties?	Helpful aspects – a client needs to perceive the therapeutic relationship as positive, worthy and significant. Helpful aspects - Need to also feel content with the therapist as well as relaxed with the therapeutic space. Trusting that the space is safe as well as therapist – need to feel at ease. Also need to feel you can trust the therapist's response – not fear you will be put down or fear they will make you feel worse. Need to trust that the therapist will guide and take care of you in the moment of difficulty and disclosing. Particularly because there may be a "gasping issue" – an issue which has taken all your energy and is overwhelming you to the point you can't breathe. Need to trust the therapist will look after you when you feel this way.
	Adel: Erm, I think it's been helpful the way you know that they would link it back to, you know they would explore it with you but they would also kind of link it back to other kind of patterns and things that you talked about or ask you how how does this maybe relate to other experiences you've had in your life if at all erm and I think now being a trainee like I think that it is I feel more comfortable	Therapist response – they should be inquisitive, be interested in the client's experience of disclosure by asking more about it.

Appendix 14: Transcript, analysis and themes for interview 6

(13)	now because I feel like I have got to that stage of development where I am building more awareness, I mean obviously there are lots of issues, some of the issues are still there but I think it's maybe just experience that's made me feel more comfortable as a trainee, I'm not really sure how they could make me feel more comfortable as a trainee with disclosing apart from if they were to bring it up and say like I said before...	To stay in that moment with them and not guide them to a direction that suits the therapist. To allow the client space but at the same time to protect them from feeling too overwhelmed. To help them manage the emotions being experienced gradually and gently.
	I: Yeah, yeah.	
(8)	Adel: ..."Is this an issue?"	The client wants to feel nurtured, looked after and protected from further emotional distress. There is a desire for the therapist to watch over the client and ensure no harm comes to them. The therapist should be present in the moment at all times.
(2)	I: And it sounds like you know you know if we think about your personal development, it sounds like you becoming more aware of kind of your own needs and you're ability to contain certain things and not when you know how you described it "spill out", you know it sounds like that's been quite helpful as well.	Exploration of whether the helpful aspects are also applicable to position as a trainee or whether they differ.
	Adel: Mmm mmm.	
(2)	I: It allows you to kind of know what to bring, how much to bring as well.	As a trainee – she has been mindful of what she can and cannot disclose. Exploration of difficulties with disclosing would therefore be helpful for trainees.
	Adel: Mmm, yeah.	It may not be clear to therapists there is an issue so perhaps the trainee has some responsibility in making this transparent as more focus is put on appearing positive.
	I: And you know, I know we've kind of touched upon kind of what's been difficult about disclosing, erm not just kind of fear of being judged but also kind of the therapist's response has made it	Therapist should be attentive to trainees' discomfort and difficult to with disclosing – they should actively address it so a discussion can take place about it.

Appendix 14: Transcript, analysis and themes for interview 6

	difficult, can you think of anything else that's made it difficult for you to disclose?	As a trainee, they may be more likely to not show they're experiencing difficulties so they can be perceived positively and be deemed suitable as a psychologist.
(8)	Adel: *[Pause]*. It's difficult to disclose if if what you're talking about involves somebody else as well because, I think you don't always want the the therapist to th' you worry that your therapist will not only be making a judgement on you but making a judgement on the other people that you're talking about and I think that makes it quite difficult maybe sometimes.	She feels taking a direct approach in addressing disclosure is unhelpful
(11)	I: Mmm mmm.	I was referring to the therapist addressing the issue first when there is an apparent difficulty, rather than the therapist asking when there is no sign of difficulty. My question was too quick. I perhaps should have clarified and then asked a more open question
	Adel: And I think, I mean I know from experience of giving therapy that some clients do find it difficult to say you know "Oh this is an issue that I have and it's developed from the relationship I had with my mother" and they really you know avoid you know they really dislike saying anything negative about the mother or the father or whatever because "I love my mum, I love my dad", that kind of thing. So...	Pause – thinking about the implications of the issue of disclosure being raised by the therapist first.
Topic of disclosure (22)		Her response illustrates she thought my question refers to therapist's addressing the issue when there is no difficulty and also that I am implying there is nothing wrong with this approach as she later says this approach may be ok. Raising disclosure as an issue for trainees without there being a clear indication of difficulty may lead trainees to then be concerned about what they disclose. – They've been made aware it can be an issue sometimes and thus may be more vigilant.
(15)	I: So kind of not, so feeling quite guilty about saying anything about their relationship as well as not wanting the therapist to kind of view them negatively as well.	
	Adel: Yeah!	My question is very verbose and could have been simpler. It can be taken as that I am asking her to separate her experiences and think about what it was like as a client and then as a trainee. This can be difficult to think about and to recall moments when you may have alternated between a client role and a trainee role. She may not have done that.
(2)	I: You're in a way wanting to protect them at the same time.	

Appendix 14: Transcript, analysis and themes for interview 6

	Adel: Yeah that kind of thing. Erm, I can't really see what else.	
	I: What about the therapist and how they kind of respond to your, you know, I know you kind of mentioned them not saying enough makes it difficult, is there anything else that they do that you think that you think might hinder, you know to disclose?	Exploration about other aspects of experiences that may be similar to current disclosure also facilitates other disclosures.
(15)	Adel: If they say too much as well *[laughs]*. If they give too too much of an opinion I think that's that could also make it unhelpful. Erm [pause] yeah I mean the therapist's response at that time is really, really really important I think. Erm...	As a trainee – feeling comfortable in therapy, being more attentive, responsive to own needs and personal issues has come with time. She has developed personally – for instance feeling more together, recognising emotions and also there is no longer difficulty with not being able to cope with overwhelming emotions, which then results in saying everything.
(15)	I: For future disclosures?	
	Adel: Yeah, and I think as well like if I mean I haven't really done this very mu' I haven't really done this very much but I guess if you were disclosing something about your relationship with the therapist or if you were disclosing something like that you might be worried about your relationship with the therapist, how the, how the therapist might feel about you.	It seems towards the end of training – there is more confident in the self and more belief that as a person she is ok and not open to criticism or inspection by the therapist – in regards to her profession. Perhaps as you're reaching the end, there is less fear and less opportunity for you to be threatened or be told you cannot continue. Knowing this/having this knowledge perhaps also aids feeling more at ease in therapy and thus disclosure.
(7)	I: Afterwards?	
	Adel: Afterwards, yeah. If you were to say something about them or you know that your therapeutic relationship or if you were to disclose, I mean I haven't done this but like say if you were to	

Appendix 14: Transcript, analysis and themes for interview 6

	disc' if you were to have some thoughts or feelings that were kind of socially unacceptable or you know maybe worrying that the therapist might, what the therapist might think of you afterwards.	
(5)	I: Mmm mm mm, Yeah, yeah.	She is in agreement with my reflection of how she has developed personally. – For her, she has moved from disclosing everything, to disclosing gradually and being more conscious/aware of what she is going to disclose.
	Adel: Sorry that's more to do with therapist judgement *[laughs]*.	For her, there's more thought, planning and preparation before the disclosure.
	I: And you know, now kind of thinking about your personal development how do you think you know your experience of disclosures, erm your ability to disclose or not disclose, how has that impacted on your personal development?	Being aware of disclosing as a trainee may have also contributed to this and not just having developed personally as she talks about having this in mind when she is in therapy.
(5)	Adel: Erm *[pause]*.	Prior to disclosure – there's also concern about loved ones being criticised if they are part of the disclosure topic. – This too inhibits disclosure.
	I: Whether it is in relation to yourself or you know to others.	There are perhaps times when one wants to disclose but does not seek an opinion or interpretation about significant others. It's an incredible difficult situation. They are consumed with guilt and shame for themselves and also about a significant other – in such disclosures there are perhaps more intense emotions and more worry experienced. Not only is there a risk of implicating self but also a risk of implicating another – the decision to disclose in this case must therefore require much deeper thinking preparation and planning.
(5)	Adel: I think, I think the second experience especially allowed me to realise what assumptions I was making about what I was saying and maybe what other people might think about what I was saying, and that those assumptions were maybe you know, that was an issue and it was kind of me making evidence against my pre-supposition that that would happen and I think that kind of does lead to reflection and some development, erm *[pause]* and also professional development as well I guess, coz you can kind of see what works, what doesn't work in therapy that can maybe	There is a fear of loved ones being blamed by the therapist for issues raised by clients. Also guilt and shame felt by clients owing to talking negatively about loved ones.

Appendix 14: Transcript, analysis and themes for interview 6

	help to improve your therapeutic practice too.	Any disclosure which may result in loved ones being seen as responsible for client's issues or they will be disapproved of will result in the disclosure not being made.
	I: Okay, and how has it kind of impacted on your professional development?	This type of disclosure is experienced as highly difficult and they cannot bear to hear horrible things being said, not only by the therapist but themselves too.
(8)	Adel: Erm, I guess I guess through, I know obviously things work differently for different people, but erm just kind of being sensitive to feelings that come up and erm ways of maybe you know being helpful being like I was saying before, being supportive and things like that and acknowledging difficulties and erm exploring rather than kind of being more interpretive, like I think maybe	She too was concerned about this in her initial therapy and has observed this with clients.
(18)	interpretation might not be that important, it might not be that useful at that stage but it's more about kind of treading carefully, treading lightly and you know not going in with a sledgehammer.	She was unable to make a full disclosure initially about her partner and treaded softly around the topic.
	I: Mmm, and kind of your own experiences of of disclosures kind of helped, kind of influenced that, is that right?	Disclosure about loved ones is a struggle/a dilemma. It's a choice between wanting to release the intense emotions and putting significant others at risk of being viewed negatively and being condemned.
'Do to others as you would have them do to you' (23)	Adel: Mmm, because I guess what you disclose, you know something that I've disclosed or something that clients have disclosed to me as well, even though it's really hard for the for the client to say that, it's something that maybe the therapist is already aware of,	It's hard to choose between protecting self and protecting another – the risks and benefits need to be weighed up.
(20)	or erm maybe has a sense of that that might be the case and rather to kind of go in with "oh yes and the form' formulation and how this links to things," rather than doing that, to kind of stay with	The therapist's perception on the topic of disclosure can be experienced as unhelpful.
(23)	the client's experience of that was difficult and let's just tread really carefully now and explore that before then you know once the client's built up some more resistance or is more kind of	The therapist's response after the disclosure is deemed very important as it influences what happens next – it impacts on the therapeutic process. Repetition of words "really" – illustrates how imperative the therapist's response is as this guides other disclosures.

Appendix 14: Transcript, analysis and themes for interview 6

	happy to be talking about that topic, more used to talking about that topic then kind of looking at it in more detail and more depth.	
(23)	I: Mmm mm yeah. And erm, and kind of thinking again about your personal development, you know is there any other ways that it's been kind of helpful or how has it impacted on it, or you know has it been kind of positive or negative, your disclosures? I know you talked about your relationship with your first therapist and their response wasn't very helpful, I mean what impact did that have?	Disclosures regarding the relationship with the therapist are also difficult to make. There is a fear about making this type of disclosure. There is a risk of being perceived negatively/disapproved of by the therapist and the relationship being affected in a negative way.
	Adel: Well, on my relationship?	
(21)	I: Mmm.	I perhaps should have explored whether she has made such disclosures and what that was like as she mentions she has not done it very much – therefore has at times made disclosures about the therapeutic relationship.
	Adel: Erm, well I think here over time I just kind of worked it out for myself really. I kind of realised that the thoughts that I was having were were maybe quite natural and that you know it was more to do with, that it, I know this is what I hoped it would be but I think you know it was and is still, so being in the relationship that you know erm, it's natural, you know it's quite natural and normal *[laughs]* to be to have certain thoughts and that doesn't mean it's catastrophising things I think erm, so yeah I think I just kind of through all sorts of activities through, doing therapy myself through being...	There is a fear of not just the disclosure being unaccepted but also perhaps being unaccepted as a trainee. "Socially unacceptable" – she may be referring to her disclosure or response to the therapist may be considered unacceptable on a professional basis and also deemed unacceptable by the course as well. To be unaccepted means to be rejected and to be refused to continue, not only as a client but the fear may be as a trainee too.
	I: Mmm mm mm.	There is a fear of being scrutinised by the therapist if a disclosure about the therapist were to be made.
	Adel: ...Not not that experience of being in therapy but actually doing	

Appendix 14: Transcript, analysis and themes for interview 6

(8)	therapy myself really helped and being with my peers and you know my friends at university and things and doing the same course and talking to them about not necessarily that particular issue but just talking to them about things and you know our development and stuff...	Pause – indicates she is trying to reflect on the impact disclosure has had on her personal development.
	I: Mmm mm mm.	
(2)	Adel: ...And it kind of opens you up and it facilitates a lot of development in you, I think a lot of different elements of the course do that and I think that led to my awareness at that time erm which helped me so it wasn't necessarily the the therapy in itself didn't help me then but other things did.	She was speaking very fast here. – She was trying to illustrate how she has been able to identify her thoughts are assumptions – and thus not necessarily true. The disclosure enabled her to reflect on her experiences, she was then able to see how her perceptions of things always matched her assumptions. – The initial disclosure helped her to see how this way of thinking is unhelpful. Disclosure has enabled her to learn about herself further.
(2)	I: Right.	Disclosing enables her to reflect and draw upon other experiences. This then facilitates her personal development as she makes changes.
(8)	Adel: Whereas now I feel like the therapy is a really good, me having therapy is helpful in that way and is facilitative in my personal development more than you know before	Disclosure also enables her to see how it can be used with clients and what helps aid and inhibit disclosure too. Disclosure impacts on professional development positively – through being more attentive to clients, making them feel listened to, encouraging them to open up and also by being there for them.
(8)	I: And kind of what changes do you notice now that you're able to kind of bring stuff to your therapist and be able to work through those things, you know what differences do you notice in how you've kind of developed personally compared to before.	Disclosure also enabled her to learn to stay with the experience of disclosing and to not jump ahead to discuss the topic of disclosure. Additionally to not offer an opinion or perception as a therapist. Commenting on the disclosure topic itself at the point of disclosure is harmful and can feel threatening.
	Adel: Well I think it's just a lot of awareness really erm and I think also maybe boundaries and stuff I can kind of negotiate a bit more a bit more easily now I know a bit more about the kind of role of the	

Appendix 14: Transcript, analysis and themes for interview 6

(8)	therapist, the expectations that maybe you can put on a therapist and that kind of thing that maybe my first therapist I was expecting to be the expert and to know everything and to tell me what my problems are and to solve my problems and things.	An interpretation can feel like an attack on the client as well as what they have said. She describes the therapist's interpretation as "going in with a sledgehammer" – with a weapon to destroy the disclosure to pieces. It is thus imperative to take a gentle approach, to uncover the process gradually as clients are susceptible to making negative assumptions about the therapist's response. She further highlights the importance of staying with the experience and difficulties with disclosing, what that felt like rather than the topic or trying to relate it to the formulation. "Tread carefully" – to go slowly and gently
(8)	I: Mmm mm, yeah, it sounds like erm kind of having your therapist kind of responding to your disclosures appropriately and in a way that was quite helpful, sounds like how this has helped you is to be able to, your ability to kind of make sense of it when you're not in therapy as well, erm you know when you're having kind of difficulties, you know it sounds like you've been trying to make sense of it and be able to contain and not come back and like you said you know, say everything and rather kind of knowing when to say what.	
(18)	Adel: Yeah, yeah.	Being too active can lead the client to feel unheard, rejected and also be put off to talk further about it.
	I: I mean is there anything else that you kind of feel is important about what we talked about or just about generally your experience of disclosure?	Taking such an active stance without acknowledging the disclosure experience can result in clients shutting down and feeling as though their disclosure is insignificant – something to take lightly, particularly as there is a rise of emotions prior to the disclosure, accompanied with fear of being dismissed and rejected.
	Adel: Erm, no I don't think so. I don't think so.	
	I: Okay well thank you for that.	Providing space and not rushing clients also enables clients to feel safe and build trust which then enables them to talk further about it.
	Adel: No problem.	

(8)		Initial disclosure did not impact on personal development positively. She feels time enabled her to develop personally, as well as well other aspects of her life and training. Laughs – in recognition that negative thoughts are normal. It seems her first therapist made her feel quite bad about herself as only time away from her first therapist enabled her to see that it is usual to have negative thoughts and this does not mean there is something wrong with her. Offering therapy has also been helpful – it perhaps helped her to develop self-confidence and self-belief in her ability to things. Being around peers and having support from them has also contributed to her personal development. A shared experience with peers perhaps enables them to disclose to them and seek support in how they manage certain issues, for instance difficulties in personal therapy.

		She spent more time with peers after her first therapy ended. She feels personal therapy on its own has not contributed to her personal development / awareness of self, but other elements of the course too. Experience with second therapist has contributed to personal development. Her disclosures to the second therapist was more positive, The therapist's response was more tentative and she stayed with her feelings of difficulty with disclosing – this enabled her to gradually feel safe to discuss the topic of disclosure in more detail which then led to making changes. Since her first therapist – she has more knowledge and is more aware of her role and the therapist's role. Owing to this knowledge, she is more confident and feels more in control as a client/trainee. The therapist is not viewed as the expert and she views herself as an equal contributor to the therapeutic relationship and process. There is no expectation from the therapist to fix her – she has moved towards feeling comfortable with who she is; more self-confidence and belief in her ability to be a good psychologist too. She does not fear having problems as this is considered

		"natural" and "normal", whereas before, she feared as a psychologist she should have less issues and perceptions of a particular nature. Disclosure has enabled her to be reflective even when not in therapy. She is able to think about her difficulties and process them to an extent which ensures she is able to express her disclosure more comfortably and gradually. However, planning her disclosure and the response beforehand may lead to disclosures being more delayed as she anticipates risks and benefits more now than before.

Appendix 15: Emerging themes and quotes for interview 6

❖ Quotes in italic represent quotes which also fall under other emerging themes

Emerging themes	Quotes	Line Number
1) Portrayal of the 'perfect trainee'/ The false self	I felt quite open to having personal therapy to be honest with you when I first started erm because I thought you know I was really interested in what it would be like.	9-12
	I thought it was important for when I saw clients myself to kind of know what it was like to be in the position of having therapy and also that it would be useful as well for me to kind of learn more about myself so that maybe didn't influence the therapy and that the therapy wasn't as much about me and to focus on them.	12-19
	To kind of see what it's like the different dynamics and how you might feel.	34-35
	It would be quite helpful to kind of be aware of the emotions that clients potentially could have so that erm you were just kind of mindful of that and how that might affect the therapy and be sensitive to the tone of the therapy at the beginning and maybe you not bringing up too much right at the beginning.	39-45
	Oh I can't be thinking this, I'm a counselling, trainee counselling psychologist.	609-611
	It is something that I think about, but I don't think that it's clear to my therapist that I am thinking that.	818-820
2) Parallel process	*I thought it was important for when I saw clients myself to kind of know what it was like to be in the position of having therapy and also that it would be useful as well for me to kind of learn more about myself so that maybe didn't influence the therapy and that the therapy wasn't as much about me and to focus on them.*	12-19
	It was mandatory for the course because I had to do it and it kind of helped me to to have that first step.	24-26
	To kind of see what it's like the different dynamics and how you might feel.	34-35
	I didn't go with a specific problem.	140

Parallel process	We were more kind of dealing with everyday kind of issues it was probably, I can imagine now as a therapist how that could be quite how that could be quite challenging with dealing with what's just coming up day to day.	143-147
	I think if you are a client and there is something big that is going on that you don't feel comfortable talking to your therapist about [...] if you then go and tell them then it's a big step you want some response!	382-387
	I kind of use therapy really as just kind of for me and it helps my professional development.	545-546
	It's difficult to disclose something so obviously you know but if you don't have the experience of doing having the experience of doing it and feeling that emotion I think that could make you more sensitive.	692-696
	If it's a big deal then they're obviously very kind of open to suggestion and client's are very open to suggestion and sensitive to reading into something and any kind of anything negative maybe. This is how I'm thinking a bit.	743-747
	As a therapist sometimes I think things that I don't say to the clients.	763-764
	If they did come out and say that maybe you know sometimes they feel that they can't say things you know, then to maybe have a discussion about that [...] Rather than the therapist say "oh you're a trainee I wonder if you find it difficult" because that might not be right.	824-832
	Some of the issues are still there but I think it's maybe just experience that's made me feel more comfortable as a trainee.	863-865
	I'm not really sure how they could make me feel more comfortable as a trainee with disclosing apart from if they were to bring it up and say like I said before [...] "Is this an issue?"	865-870
	I know from experience of giving therapy that some clients do find it difficult to say you know "Oh this is an issue that I have [...].	895-897
	Through all sorts of activities through, doing therapy myself through being [...] Not not that experience of being in therapy but actually doing therapy myself really helped.	1014-1018

3) A desire to unburden the self of distress/ catharsis	It almost felt like it gave me an excuse to have personal therapy even though I was quite kind of open to that".	19-21
	There were times in my life where it would have been really useful to have had personal therapy.	56-57
	I thought that it would be really helpful because my my dad had just died and I thought that'd be useful to kind of talk about some of the emotions that were kind of being brought up for me in that	59-63
	I was so kind of confused and that there was so many things going on at first with the course and kind of emotionally I felt quite kind of able to disclose more emotions rather than actually what what was kind of going on.	87-91
	I did need personal therapy at that time and maybe I needed to kind of make sense of that a bit more and so I think that maybe neediness or neediness to have personal therapy erm actually made me it quite easy for me to self-disclose.	93-98
	I disclosed different things you know I disclosed emotions.	100-101
	It was probably bought on by maybe stuff happening outside of the session, that's maybe you know why I was talking about it in the session.	281-283
	It was becoming kind of obvious maybe to me or obvious to her, that you know I had a like a certain like doubt or whatever about the relationship.	296-299
	It was feeling like, I need to say this but I don't really know how.	315-316
	It was something in the week that had kind of come up a lot for me.	589-590
	It was to do with kind of yeah what was going on like the thing that was maybe affecting me at that moment the most	600-602
4) Imperfect sense of self	Taking the first step and going for therapy was something that scared me a bit, and because I was almost you know it was mandatory for the course because I had to do it and it kind of helped me to to have that first step	22-26

Imperfect sense of self	I would feel certain emotions but I didn't really feel like I was able to reflect on them that well and and because of that maybe accept accept them? Or I think maybe I was quite resistant even though I was experiencing lots of feeling I wasn't really open to change maybe?	157-162
	Doing therapy really really helped erm me to kind of develop and erm to kind of you know be a bit kind of better in that relationship so that when I came back into it, it was erm, it was a bit easier for me to kind of use therapy and easier for me to disclose and maybe be a bit more structured and to kind of be more open to changes, open to feedback and things like that	170-176
	I think it was a difficult, I think it was quite difficult for her to work with me maybe because I didn't have a point of focus and things and because maybe I wasn't that ready to change and maybe a bit resistant to change.	185-189
	My last session was the only time that she did offer any reflections and I took them quite kind of negatively erm and, I remember my last session she made me cry.	216-219
	I felt upset that she had said that and I think that it was the fact you know I was upset about it, it wasn't like it was a release and that you know that would kind of help me.	239-242
	I remember, *[pause]* certain kind of like feelings that I was having about the relationship, I wasn't I didn't really feel like I wanted to kind of admit, or, to myself or really say out loud.	262-266
	I felt like I wanted reassurance. I think that maybe was part to do with me not being open to change at that time or open to reflection at that time and that maybe I wanted to say what was bothering me but I don't want to do anything about it.	347-351
	I think quite often it is because you do feel like you feel negative and you feel bad about having those feelings or you feel ashamed or you feel something negative, some strong negative emotions. There is some stigma around what you are saying.	389-394
	Feelings of like being ashamed about what I was, what I was thinking what I was feeling.	501-502
	Feeling kind of embarrassed feeling kind of like, I was like smiling kind of not giggling, but almost kind of like 'oh this is, this is embarrassing' type thing.	509-512

5) Fear of rejection/ disapproval	When I started my first session of therapy you know you feel quite vulnerable because you are talking about quite personal things to someone you've never met before.	36-39
	The fear for me of bringing it up was being ashamed, being erm afraid of being judged negatively for what I was about to say by the therapist.	526-529
	Sometimes I'm talking about the course but it's not the erm [...] The only thing and because of that, that worries me sometimes that maybe she, you know I might be judged for "Oh you know well she has these issues and maybe she shouldn't be a therapist if she is thinking in this way or if she is you know not developed in this way very much".	548-556
	I was very worried that she was thinking because she wasn't really saying anything that she was thinking "oh this girl, she can't be a therapist because she's got too many problems of her own".	560-564
	It made me more weary of disclosing it because erm it was something that related to I think that kind of related to kind of influences in culture and how I felt maybe I should be and what I should be doing. [...] As a counselling psychologist I should maybe you know not be so kind of buying into those types of discourses and I should be able to be more open.	570-578
	The thing about the therapist judgement and "Oh I can't be thinking this, I'm a counselling, trainee Counselling Psychologist.	609-611
	Worrying what the therapist's response would be.	613-614
	If you were disclosing something about your relationship with the therapist or if you were disclosing something like that you might be worried about your relationship with the therapist, how the, how the therapist might feel about you.	925-929
	If you were to disc' if you were to have some thoughts or feelings that were kind of socially unacceptable or you know maybe worrying that the therapist might, what the therapist might think of you afterwards	934-938
	That's more to do with therapist judgement.	940

6) Therapeutic process	It's kind of changed you know the more that I've kind of developed on the course and different therapists and so, coz I've had two different therapists.	74-76
	The decision for it to come out was more because, it was a bit like you know in the sessions, it was a bit like free associations *[laughs]*, your just kind of talking and and it just kind of you know came out.	266-270
	The general process of the therapy that made that come out.	272-273
	It definitely strengthens the relationship, the therapeutic relationship when you feel like you can tell your therapist something that's uncomfortable and it's accepted and you know you work with it you talk about it.	716-720
	I think definitely to disclose things to therapists you have to feel like you have a good therapeutic relationship erm also maybe that there's some time that's gone on in the therapy, or for me anyway.	786-790
	You need to feel comfortable.	793
7) The imperfect therapist	I thought we were doing cognitive analytical therapy that's kind of what she advertised but then it turned out to not really be that.	79-81
	After my 8th session or something I said "Oh do you have a formulation?" and she said "Oh we haven't been doing CAT because it hasn't really felt like it suited you", and... I did feel a bit, kind of unsure about the therapist at that time because she wasn't really being that transparent with me.	112-117
	She wasn't a very kind of active therapist.	118-119
	I wasn't sure kind of what was going on in her mind, it almost felt like maybe I was disclosing some things and then she wouldn't really respond that much.	123-126
	I was thinking oh maybe something's going on in her mind maybe she's going to kind of bring up some interpretations, she's going to reflect on what I've said and maybe offer some insight but she she never really did.	128-132
	I didn't maybe feel like I was getting that much from her at the time.	133-135

The imperfect therapist	I wonder if that was maybe quite overwhelming for her.	151-152
	I don't think maybe she was that good at containing me.	191-192
	I would feel like I was going for therapy and I was just talking *[laughs]* and just saying stuff and there was nothing really, there was no real kind of response.	194-197
	I didn't feel contained so I'd kind of come out of therapy feeling worse than when I'd gone in in the first place [Yeah] And that didn't change as we kind of developed, I had twenty sessions with her!	197-203
	I know that that can happen at the beginning where it could be quite overwhelming but then usually things do kind of get better but [...] That didn't really happen for me.	204-209
	My last session was the only time that she did offer any reflections.	*216-217*
	If you were going to say something could you not have bought it up in in other sessions and then we would of had time to erm we'd have time to kind of work on the rupture or you know process of what had just been said.	223-227
	You've opened something up here and we're finishing today so it kind of ended on a rupture which I think was a shame.	244-247
	She didn't really offer any interpretation, she didn't really offer any any kind of summary or anything. [...] It wasn't really that containing.	332-335
	It was like a significant thing that I was saying, but nothing really came afterwards.	344-346
	I didn't get reassurance I didn't really get anything as I didn't get much containment.	373-374
	To work with with the issue rather than just you know not doing anything and thinking, "Well I can't reassure, I can't reassure.	402-404
	In my mind I wanted a certain response, I wanted a resp' I wanted a response! I didn't really want no response and that was what I was getting. [...] I was wondering you know is this, is she just wanting me to work this out myself with no guidance, you know what what is her role here, what does she think her role is here.	461-468
	It was between us and nothing was being done with it and I felt like I'd done my part and I needed something from her.	484-486

The imperfect therapist	Even though she just nodded I felt like there was quite a lot of judgement.	653-654
	It's unhelpful for the therapist not to acknowledge the difficulty of what you're of what you're saying.	731-733
	It's unhelpful not to, contain you [...] to maybe just like make a like a nod or something that can is so open to interpretation when you're very hyper' hypersensitive to..."I don't feel good about this" and then they don't say anything.	733-739
	It's yeah important obviously not to make a judgement on what somebody has disclosed.	740-742
	She thinks psychodynamic she wasn't picking up on any kind of transference counter-transference she wasn't saying "Oh it feels like you want me to say something and I wonder what it feels like that I'm not saying anything", it was just very kind of blank.	769-774
	Maybe she was thinking 'Oh, what do I do? *[Laughs]* what do I, what do I do now?' *[Laughs].* Maybe she wasn't very experienced.	776-778
	If they say too much as well *[laughs]*. If they give too too much of an opinion I think that's that could also make it unhelpful [...] The therapist's response at that time is really, really really important.	917-921
8) Self-awareness/ development	I feel like now I'm a lot more contained.	99-100
	I built the awareness of where those emotions are coming from and things and so I almost don't feel like I'm just spilling out and needing to kind of disclose everything, it's more, I'm just a bit more together.	101-105
	I think that reassurance would have been unhelpful at that time.	375-376
	I noticed that I do have kind of problems maybe with doing that, you know that's getting better now but at the time you know we *have problems of kind of being transparent.*	470-474
	At the moment in my life I'm very kind of content with my life. [...] because the things on the surface are good.	591-599
	Because of my own development I I didn't feel like I wanted to do that anymore, I felt like I wanted to kind of understand and work on it myself.	657-660

Self-awareness/ development	I think now being a trainee like I think that it is I feel more comfortable now because I feel like I have got to that stage of development where I am building more awareness, [...] I think it's maybe just experience that's made me feel more comfortable as a trainee.	859-865
	Allowed me to realise what assumptions I was making about what I was saying and maybe what other people might think about what I was saying, and that those assumptions were maybe you know, that was an issue and it was kind of me making evidence against my pre-supposition that that would happen and I think that kind of does lead to reflection and some development.	951-958
	I just kind of worked it out for myself really. I kind of realised that the thoughts that I was having were were maybe quite natural.	1004-1007
	It's quite natural and normal *[laughs]* to be to have certain thoughts and that doesn't mean it's catastrophising things.	1011-1013
	Being with my peers and you know my friends at university and things and doing the same course and talking to them [...] about things and you know our development and stuff [...] And it kind of opens you up and it facilitates a lot of development in you.	1019-1026
	I think a lot of different elements of the course do that and I think that led to my awareness at that time erm which helped me so it wasn't necessarily the the therapy in itself didn't help me then but other things did.	1026-1030
	Me having therapy is helpful in that way and is facilitative in my personal development more than you know before.	1033-1035
	It's just a lot of awareness really erm and I think also maybe boundaries and stuff I can kind of negotiate a bit more a bit more easily now.	1041-1043
9) Surge of emotions	When I did first go in I was kind of spilling spilling out.	138
	I had a like a certain like doubt or whatever about the relationship at that time and I think that just kind of made it come out me just talking and talking and talking and it becoming more and more obvious and more and more like I maybe that I just wanted to tell the therapist that I I I was aware.	297-303
	I felt like there was some pressure almost that I needed to say something.	319-320

10) Non-verbal disclosure	She kind of said something and then I I kind of broke down in tears.	234-236
11) Guarded disclosure	I was talking about this this problem in kind of general and then just through talking about it and talking about it you could kind of see that there were patterns in what I was saying although what I was saying was kind of hinting at some feelings I was having thoughts I was having and it was kind of almost becoming kind of the elephant, 'the elephant in the room'.	285-292
12) Anticipated benefits of disclosing	I was kind of hoping that if I said something it would maybe make it better or then we could kind of work on that.	326-328
	I maybe wanted reassurance.	372
	At that time to have maybe you know reassured the feeling of worry but not reassured the situation that I was talking about.	376-378
	To work with with the issue.	402
	I wanted reassurance that the way that I was feeling was maybe you know natural.	436-437
	My mind like kind of fantasies about of what they what they would be like and what they would think about what I was going to say.	533-535
	It was helpful because I think I had some like preconceptions about what she might how she might respond and how other people might respond.	703-705
13) The ideal therapist	Nodding like she understood what I was saying and that it was like a significant thing that I was saying.	343-345
	To kind of be a bit a little bit more active, I think I wanted her to be a bit more active.	378-380
	I think that it is important maybe for the therapist to be quite active in that and to contain to say you know "Seems like maybe your worried or ashamed about this, this is right, its normal for you to maybe feel like this, it's natural for you to feel this way and you know, thank you for disclosing this".	394-400
	She responded you know in a way that was helpful I thought to me.	614-615
	She was saying "Silly, really, why why do you feel silly?" and you know kind of like helping me along.	620-621

The ideal therapist	She said you know thankfully "I can see that that was difficult for you', she said 'I'm really pleased that you felt like you were able to tell me and thank you for telling me', [...] she was kind of more active and erm you know expressed her understanding, that it was significant for me to say it.	638-644
	It felt supportive.	652
	There was less of a judgement and it was more collaborative and erm and more that not feeling like the therapist was the expert.	661-663
	The way she was supportive with it made me feel less afraid of the judgement.	670-672
	She just explored it with me, she just asked me more questions and that and allowed me to explore how I felt about about the thing I was avoiding bringing up.	720-723
	To I think be a quite curious about you maybe and to ask you know to ask questions and ask people to say more about certain things and to not be too leading but to be kind of containing and structured enough so that the, so that the the client feels like they're being kind of held but their allowed to kind of go off as well like they're they're free and contained all all in one.	798-804
	They can go where they want but then if they go somewhere that it's you know dangerous for them or scary for them then the therapist is there for them.	806-808
	It's been helpful the way you know that they would link it back to, you know they would explore it with you but they would also kind of link it back to other kind of patterns and things that you talked about or ask you how how does this maybe relate to other experiences you've had in your life.	853-858
14) Negative consequences	I felt panic.	416
	I regretted saying anything to her to be honest and I was kind of wondering what she was thinking about and I felt a bit frustrated I think with her.	457-460
	I didn't really feel like I was in control almost that it was my thought, my feeling but I didn't own it 'coz it was out there now, it had almost kind of like I'd passed like *it was between us and nothing was being done with it.*	481-485
15) Anticipated risks of disclosing	Being worried that certain feelings that I was having about my relationship meant that I should end the relationship, that the relationship wasn't right.	424-427

Anticipated risks of disclosing	I was worried that when I disclosed that sometimes you know I was having doubts or whatever or that I wasn't happy with a certain thing that she would say to me "Oh yes" you know and kind of not say explicitly but that I might feel like it was implied "Yes you should end this relationship" and that scared me.	427-433
	At the time I wanted to think it was me, so because it being me and it being my problem was easier because then maybe I could fix it whereas if it was the relationship or you know something, that was kind of doomed *[laughs]*, I don't know I was worried that that's what she might say and then what would I do with that?	439-445
	It wasn't as intense as when as before I said I think when I was actually saying it it was a bit easier.	631-633
	You worry that your therapist will not only be making a judgement on you but making a judgement on the other people that you're talking about and I think that makes it quite difficult maybe sometimes.	890-893
16) False self	These are things that I should have brought up with her at the time but and I think I noticed that I do kind of [...] *have problems of kind of being transparent*.	469-474
17) Therapist on trial	It was related to that specific thing I hadn't thought about disclosing but it's part of a like wider issue erm that I had thought of disclosing.	519-522
	I said something like, oh well you know there is this thing but erm I dunno I feel really silly about it.	618-619
18) Positive consequences	I felt a bit of a relief.	635
19) Professional awareness/ development	Being aware of how maybe other clients might be feeling, you know my own clients might be feeling in therapy.	688-690
	Make you more sensitive to it and reflect on what you could do differently and that kind of thing if you were the therapist.	698-700
	Also professional development [...] you can kind of see what works, what doesn't work in therapy that can maybe help to improve your therapeutic practice too.	958-962
	Rather than kind of being more interpretive, like I think maybe interpretation might not be that important, it might not be that useful at that stage.	971-973
	I know a bit more about the kind of role of the therapist, the expectations that maybe you can put on a therapist.	1043-1045

20) True self	Through speaking to her about it, it made it less of a stigma for me if you see what I mean, and I think making it less of a kind of 'no no no I'm not going think about that, I'm going to avoid that' actually made it more acceptable.	706-710
21) 'Do unto other what has been done to you'	To have some kind of congruence really, I think yeah that's it really, that she wasn't being very congruent with me.	767-769
	If your client was finding it difficult to kind of disclose and maybe asking why that might be and you know if they did I think you know take it from the client really.	820-823
22) Trust	You need to feel comfortable you you need to feel like a therapist isn't judging you.	793-794
	Once the client's built up some more resistance or is more kind of happy to be talking about that topic, more used to talking about that topic then kind of looking at it in more detail and more depth.	990-993
23) Topic of disclosure	It's difficult to disclose if if what you're talking about involves somebody else as well.	887-888
24) 'Do to others as you would have them do to you'	Being sensitive to feelings that come up and erm ways of maybe you know being helpful being like I was saying before, being supportive.	967-969
	Acknowledging difficulties and erm exploring rather than kind of being more interpretive, like I think maybe interpretation might not be that important, it might not be that useful at that stage but it's more about kind of treading carefully, treading lightly and you know not going in with a sledgehammer.	970-975
	To kind of stay with the client's experience of that was difficult and let's just tread really carefully now and explore that.	987-989

Appendix 16: List of themes for all interviews

Interview 1	Interview 2	Interview 3
1) A desire to unburden the self of distress/ catharsis	**1)** Professional awareness/ development	**1)** A desire to unburden the self of distress
2) The Imperfect therapist	**2)** A desire to unburden the self of distress/catharsis	**2)** Parallel Process/ The divided self
3) Therapist disclosure	**3)** Fear of rejection/ disapproval	**3)** Therapeutic process
4) The ideal therapist	**4)** Therapeutic process	**4)** The ideal therapist
5) Therapeutic process	**5)** Guarded disclosure	**5)** Trust
6) Trust	**6)** Trust	**6)** Guarded disclosure
7) Imperfect sense of self	**7)** The ideal therapist	**7)** Mistrust
8) Mistrust	**8)** Parallel process/ The divided self	**8)** Unguarded disclosure
9) Parallel process/ The divided self	**9)** Self awareness/ development	**9)** Negative consequences
10) Portrayal of the 'perfect trainee'/ The false self	**10)** Self-doubt	**10)** Anticipated risks of disclosing
11) Fear of rejection/ disapproval	**11)** Anticipated risks of disclosing	**11)** Fear of rejection/ disapproval
12) Guarded disclosure	**12)** Imperfect sense of self	**12)** Imperfect sense of self
13) Professional awareness/ development	**13)** Positive consequences	**13)** Surge of emotions
14) Self-awareness/ development	**14)** True self	**14)** True self
15) Anticipated risks of disclosing	**15)** The imperfect therapist	**15)** Positive consequences
16) The true self	**16)** Mistrust	**16)** Anticipated benefits of disclosing
17) Surge of emotions	**17)** Anticipated benefits of disclosing	**17)** Topic of disclosure
18) Anticipated benefits of disclosing	**18)** Surge of emotions	**18)** The imperfect therapist
19) Topic of disclosure	**19)** 'Do to others as you would have them do to you'	**19)** The integrated self
20) Negative consequences	**20)** Negative consequences	**20)** Therapist disclosure
21) Unguarded disclosure	**21)** Therapist disclosure	**21)** Portrayal of the 'perfect trainee'/The false self
22) Positive consequences	**22)** Portrayal of the 'perfect trainee'/The false self	**22)** Self awareness/ development
23) The integrated self	**23)** Unguarded disclosure	**23)** Professional awareness/ development
24) 'Do unto others what has been done to you'	**24)** Topic of disclosure	**24)** 'Do unto others what has been done to you'
25) Emotional fatigue	**25)** Therapist on trial	
26) Therapist on trial	**26)** 'Do unto others what has been done to you'	

Interview 4	Interview 5	Interview 6
1) Therapeutic process **2)** Parallel Process/The divided self **3)** Self-awareness/ development **4)** Portrayal of the 'perfect trainee'/The false self **5)** Imperfect sense of self **6)** Fear of rejection/disapproval **7)** A desire to unburden the self of distress **8)** Guarded disclosure **9)** Positive consequences **10)** Mistrust **11)** Topic of disclosure **12)** The imperfect therapist **13)** Anticipated benefits of disclosing **14)** The ideal therapist **15)** Trust **16)** The true self **17)** Therapist on trial **18)** Surge of emotions **19)** Negative consequences **20)** Anticipated risks of disclosing **21)** Professional awareness/ development **22)** 'Do to others as you would have them do to you'	**1)** A desire to unburden the self of distress **2)** Imperfect sense of self **3)** Parallel process/ The divided self **4)** Portrayal of the 'perfect trainee'/The false self **5)** Therapist disclosure **6)** 'Do unto others what has been done to you' **7)** Fear of rejection/ disapproval **8)** Guarded disclosure **9)** Therapist on trial **10)** Self awareness/ development **11)** Professional awareness/ development **12)** Anticipated benefits of disclosing **13)** Surge of emotions **14)** Unguarded disclosure **15)** Therapeutic process **16)** Trust **17)** The imperfect therapist **18)** Negative consequences **19)** Mistrust **20)** Anticipated risks of disclosing **21)** The ideal therapist **22)** Positive consequences **23)** True self **24)** Topic of disclosure **25)** The integrated self	**1)** Portrayal of the 'perfect trainee'/The false self **2)** Parallel process/The divided self **3)** A desire to unburden the self of distress/ catharsis **4)** Imperfect sense of self **5)** Fear of rejection/ disapproval **6)** Therapeutic process **7)** The imperfect therapist **8)** Self awareness/ development **9)** Surge of emotions **10)** Non-verbal disclosure **11)** Guarded disclosure **12)** Anticipated benefits of disclosing **13)** The ideal therapist **14)** Negative consequences **15)** Anticipated risks of disclosing **16)** Therapist on trial **17)** Positive consequences **18)** Professional awareness/ development **19)** True self **20)** 'Do unto others what been done to you'. **21)** Trust **22)** Topic of disclosure **23)** 'Do to others as you would have them do to you'

Appendix 17: Initial clustering of themes for interview 6

Self • A desire to unburden the self of distress/ catharsis • Portrayal of the 'perfect trainee'/False self • Parallel process/The divided self • Imperfect sense of self • True self • Self-awareness/ development	**Therapeutic process** • The imperfect therapist • The ideal therapist • Therapeutic process • Trust • Therapist on trial • Fear of rejection/ disapproval
Disclosure • Non-verbal disclosure • Guarded disclosure • Topic of disclosure	**Before disclosure** • Surge of emotions • Anticipated risks of disclosing • Anticipated benefits of disclosing
Outcome of disclosure • Negative consequences • Positive consequences	**Development** • Professional awareness/ development • 'Do unto others what been done to you'. • 'Do to others as you would have them do to you'

Appendix 18: Illustrative quotes for all themes

Master Theme One: Disclosing the self

Subordinate theme: A desire to unburden the self from distress		
Quote	**Interview**	**Line Number**
I felt there was a lot I needed support with and wanted to kind of talk through.	Emily	21-23
I really wanted to be angry in the sessions.	Emily	39-40
There were things I wanted to talk about, around relationships and sex and my own past history.	Emily	338-340
I need to go back and talk with my therapist about this. [...] Rather than sort of keep it inside and not sort of share it with her…and somehow in absence have resentment [...] towards her in therapy...	Eric	401-409
I actually went through a process of thinking I do want to talk about this to someone, but I don't know whether I want to talk to to a man about it".	Lara	87-90
Initially it was a lot of erm, sort of emotional containment and expression and just feeling quite relieved from whatever angst that was being expressed.	Alva	69-72
My return in second year, the first thing I said "I I I want to talk about us, and I know I shied away from it and it's been really difficult for me to be open about it but, I'm definitely more ready now and you know I will welcome it if you did push me, erm about it.	Alva	220-225
Whoever I'd been in therapy with I probably would have disclosed it to.	Alva	906-907
I was actually quite pleased I think. Erm, I'd been thinking about having therapy for a while.	Ishi	7-8
There were times when part of me really wanted to *[pause]* get round to disclosing that side of myself.	Ishi	236-238
I'd been really looking forward to the session and I'd thought about the sort of things that I would want to discuss with him [...]. I was really really keen on being able to share things and open up	Ishi	647-650
I thought that it would be really helpful because my my dad had just died and I thought that'd be useful to kind of talk about some of the emotions that were kind of being brought up for me in that.	Adel	59-63

I did need personal therapy at that time and maybe I needed to kind of make sense of that a bit more and so I think that maybe neediness or neediness to have personal therapy erm actually made me it quite easy for me to self-disclose.	Adel	93-98
Things had come up for me in that week that were affecting me in that kind of area that's why I bought it up.	Adel	524-526

Subordinate theme: Imperfect sense of self		
Quote	**Interview**	**Line number**
I don't think I was in the in the right place erm and I think for me was almost it's one of the reasons I come into...one of the reason reasons I was training to be a counselling psychologist to have my own personal therapy.	Emily	126-130
I was afraid that you know if I show that I was on the brink of [laughs] of depression then they'd throw me off the course or something.	Emily	19-142
For a long time in my relationship with my husband I was kind of almost as if, like I was having my terrible two tantrums that he was having to contain, that I wasn't having when I was a child.	Emily	773-777
I wasn't afraid that she would breach confident [...] err, confidentiality or not sort of go behind my back and do it, but that she would feel the need to breach confidentiality.	Eric	93-98
I think I was seeking approval and to an extent and smile is often interpreted as [...] approval of whatever it was that I was sharing that it was you know that I wasn't being judged or that I wasn't being erm...sort of viewed in a negative way.	Eric	800-806
And there was a lot of concern about, you know, was I practicing, you know in an appropriate way? Was it ethical practice or was I [...*laughs],* you know, just making it up or doing things in the wrong… err, wrong way and you know, potentially was… was I harming the people I was seeing.	Eric	74-81
The way I viewed myself and things like that which was, which was quite difficult.	Lara	238-240
Sometimes I'll have a tendency to dwell on things.	Lara	292
Sometimes I'll be like no he is right I, this is this is my stuff I have been silly erm, [*pause*] then, I'm not handling this in the best way.	Lara	403-406

I didn't think it was important enough, it wasn't really something I wanted to look at [...] and then the symptoms just got worse and worse and I knew it would continue because I was in this placement until this year and *[pause]* and it was just the elephant in the room in my head and it was, I was just avoiding it now.	Alva	232-240
Avoiding her because I felt like I'd failed her and I wasn't doing well enough and I should be improving.	Alva	379-381
I feel quite heavy about that, worried that I wouldn't get better.	Alva	421-422
I'd been thinking about having therapy for a while. [...] Erm, but [...] kept putting off the decision, in some way.	Ishi	8-12
I think there was there was a lot of shame around some of my disclosures.	Ishi	459-460
I still feel erm a bit exposed and I I, I still do it with a little bit of trepidation.	Ishi	948-949
I would feel certain emotions but I didn't really feel like I was able to reflect on them that well and and because of that maybe accept accept them? Or I think maybe I was quite resistant even though I was experiencing lots of feeling I wasn't really open to change maybe?	Adel	157-162
I remember, *[pause]* certain kind of like feelings that I was having about the relationship, I wasn't I didn't really feel like I wanted to kind of admit, or, to myself or really say out loud.	Adel	262-266
I think quite often it is because you do feel like you feel negative and you feel bad about having those feelings or you feel ashamed or you feel something negative, some strong negative emotions. There is some stigma around what you are saying.	Adel	389-394

Subordinate theme: Fear of rejection and disapproval		
Quotes	**Interview**	**Line number**
You got to be able to kind of work with stuff and not be and not break down.	Emily	152-154
And not wanting to say how difficult things really were because I was fearful they might you know throw me off the course or something [...] It's like one thing I would never, I remember saying I would never go to a GP to say if I was struggling because I would be afraid of that being on my records.	Emily	158-165

I think it was about how I would be perceived or how I would be judged.	Emily	563-564
Being concerned that if I indicated that I wasn't practicing in a ethical way err, then that…you know, that that might have consequences, that she [...] you know, somehow would contact my err, university.	Eric	87-92
Having felt very supported throughout the session really, still sort of worrying that what would happen? You know, would she be as supportive in the next session.	Eric	285-288
It was the way that I thought he would view me as a result.	Lara	120-121
I had my symptoms erm starting again and I would avoid talking about that in therapy.	Alva	230-232
Actually at the end of the day my college, and have the power to qualify me or not.	Alva	268-269
When I did give her feedback on all the difficult things I couldn't say before, it was really really difficult, like I couldn't really look at her straight and I was talking really quickly.	Alva	445-448
When the day arrived, I would not do it. I would I would, sort of, do something else. We'd, we'd end up discussing something different.	Ishi	213-215
I was quite anxious about how it would be received.	Ishi	243-244
Although it it did feel the right thing to do, erm, a slight sense of expectancy, what was going to happen as a result of that, how would he react?	Ishi	380-382
The fear for me of bringing it up was being ashamed, being erm afraid of being judged negatively for what I was about to say by the therapist.	Adel	526-529
I was very worried that she was thinking because she wasn't really saying anything that she was thinking "oh this girl, she can't be a therapist because she's got too many problems of her own".	Adel	560-564
If you were to disc' if you were to have some thoughts or feelings that were kind of socially unacceptable or you know maybe worrying that the therapist might, what the therapist might think of you afterwards.	Adel	934-938

Subordinate theme: Parallel Process: The divided and false self		
Quote	**Interview**	**Line number**
I think it's really hard because I do think there are so many kind of overlap between kind of personal and professional development.	Emily	835-837
We have to be emotionally robust.	Emily	146
I've happened to have personal therapy after erm after a placement so I come from kind of like my head's in two different places.	Emily	1010-1013
Realising that, in a way, no matter what I shared […] you know, the therapist would sort of treat me in the same way. Erm, and it wouldn't sort of have consequences in regards to my training.	Eric	43-48
I came to the decision that if I was gonna do therapy, personal therapy and if I was gonna practice as a psychologist, err, I needed to engage [...] in this pro… process properly and there wasn't any point of me paying err, every week to go to therapy [...] if I wasn't really gonna engage in it.	Eric	176-184
I'm a trainee and everything else has been so structured in my life [...] There's so many other boxes, which I've always needed to tick".	Eric	651-656
Sometimes I can get frustrated back and then sometimes I can be more accepting and it feels okay.	Lara	407-408
It's just made me understand the client's experience more than perhaps I would have before.	Lara	678-680
My therapist has to sign this sheet of paper saying 'fitness to practice'. No! 'Fitness to practice concerns have arisen from personal therapy'.	Alva	271-273
It was just a really weird experience to be in that sort of parallel processes, giving therapy for one disorder [...] And then bringing that same disorder for your own therapy [...] Not wanting to do the same treatment approach.	Alva	308-315
I would feel like I was being a drain on her and then that would influence what I would bring in and how I would relate to her in the session.	Alva	374-376
It took a while for us to build a relationship because I, sort of, kept wondering what was happening and and trying to, erm, draw some some lessons or or develop some training insights, erm, sometimes from sessions.	Ishi	40-44
If I'd gone into therapy for therapy [...] On my own accord [...] I think it would have been a bit easier to begin with.	Ishi	44-49

I'm sure if I had been in the shoes of a client period, I would maybe have remarked on it. I may have felt a bit awkward er but, probably, not to the extent of then questioning his, erm, his his, erm, abilities as as a therapist.	Ishi	94-98
I kind of use therapy really as just kind of for me and it helps my professional development.	Adel	545-546
Oh I can't be thinking this, I'm a counselling, trainee counselling psychologist.	Adel	609-611
It is something that I think about, but I don't think that it's clear to my therapist that I am thinking that.	Adel	818-820

Master Theme Two: The therapeutic process and disclosure

Subordinate theme: The therapeutic process and trust		
Quotes	**Interview**	**Line number**
I think it helps me knowing that he is doing psychoanalytic training and so therefore there's something about that that maybe I perceive that he is able to kind of, I don't know what it is because I know that perhaps his training has an ability to kind of look at the complexity of human beings and so there is something about that then makes me feel safer.	Emily	77-83
I think it helps me knowing that he is doing psychoanalytic training and so therefore there's something about that that maybe I perceive that he is able to kind of, I don't know what it is because I know that perhaps his training has an ability to kind of look at the complexity of human beings and so there is something about that then makes me feel safer.	Emily	314-317
With him I get a sense of I can say things and I can say what's going on.	Emily	525-526
I've had the same therapist for the three years during the training [...] which has helped to bring a strong therapeutic relationship.	Eric	30-34
As therapy went on and I started feeling more comfortable err, sharing things.	Eric	41-42
I think…having the space where I could go and talk about whatever was on my mind. I purposefully chose a therapist erm…with a therapeutic approach, which is not structured.	Eric	623-626
It felt like our relationship was a bit stronger and that I trusted him a lot more.	Lara	182-184

I wasn't worried about so much what he thought but that I'd, I'd been with him long enough to to, for him to know, for him to have more of a rounded picture of me that wouldn't be terribly painted by anything else I shared.	Lara	253-257
He has a higher up chair erm it does seem silly, like I've gotta gotta quite a comfy chair and he's got quite a high one but the first thing I noticed when I we' when I went in was that I was kind of almost lower and at a disadvantage.	Lara	561-565
There is so much value that comes out of of that free associating and, and lack of thinking through what you are going to say which I was not doing very much before.	Alva	539-542
After a few discussions like that we had it got much easier and I felt much braver to bring it up.	Alva	513-514
I think a lot of it had to do with the moment [...] How I felt on that particular day [...] With him in the room and how much I felt, at that particular moment, that I could trust him with with my things and that I, I could let myself go I suppose.	Ishi	223-229
I think the length of the therapy and the fact that we managed to build a good rapport.	Ishi	528-530
We often had interruptions because he went away or because he had training and erm, that that probably didn't help very much, certainly in the early year; the first year of the therapy because I I, I felt we had a little bit of tenuous relationship at times and I wouldn't feel like disclosing very much after that.	Ishi	636-642
The decision for it to come out was more because, it was a bit like you know in the sessions, it was a bit like free associations *[laughs]*, your just kind of talking and and it just kind of you know came out.	Adel	266-270
I think definitely to disclose things to therapists you have to feel like you have a good therapeutic relationship erm also maybe that there's some time that's gone on in the therapy, or for me anyway.	Adel	786-790
You need to feel comfortable you you need to feel like a therapist isn't judging you.	Adel	793-794

Subordinate theme: The ideal therapist		
Quotes	**Interview**	**Line number**
I could talk to a therapist who is willing to take risks maybe and willing to to talk about any types of material.	Emily	232-234

I thought "God this person is not going to..." rather than him responding defensively [...] Or saying "Oh don't be so..." you know, actually he was able to hold that and that made me think he can hold a lot of stuff.	Emily	402-408
He's not shocked!	Emily	467
My personal therapist has been very good at identifying things, which sometimes I haven't identified in me.	Eric	136-138
And no pressure. And I think, yeah, so that has been a real sort of contributing factor to me […] feeling comfortable talking.	Eric	665-668
To have a place where someone has been…or seems to be, I guess you'd never completely know this, but someone…a place where it seems that someone is being completely genuine and still empathetic and [...] still non-judging.	Eric	718-724
With empathy I think and he's, and I know when I've disclosed a few things, he's sometimes, he's just sort of sat with me and let me feel really sad.	Lara	343-345
I remember telling him about, erm, the death of a very loved erm, pet and being very upset and he res' he responded by erm saying something like "We recently lost a cat that we'd had for seventeen years" and just by responding in that way didn't make me feel as quite as ridiculous as perhaps I would have with with someone who hadn't said that. I think that that's something that really stands out.	Lara	354-362
I felt more understood and as though he was interested I suppose which also really helped disclosure.	Lara	522-524
I'd ask her how she felt and she would answer honestly.	Alva	510-511
I never felt that she handled my disclosure in a really inappropriate way or in a way that was quite derogatory or erm punitive.	Alva	604-606
My view of my therapist was that she was always kind and always compassionate and she was actually quite competent and faith that she would be able to handle my disclosure	Alva	650-653
He was fully attentive to what I had to say and and non-judgemental, but not too close [...] And not taking it to a personal level that I felt I could open up and disclose.	Ishi	325-329
When the disclosure was was, was shared and then worked on well it obviously led to further disclosure [...] Wanting to to open up more.	Ishi	432-436

His ability to, to to be silent when I felt silence was best and to just wait until I had completely [*pause*] explained myself without without, so I could really capture the essence of what I wanted to share. Erm, and then sometimes it really helped that he could he could, sort of push me gently and then then enable me to go a little bit further and to reflect a little bit more.	Ishi	487-494
She said you know thankfully "I can see that that was difficult for you', she said 'I'm really pleased that you felt like you were able to tell me and thank you for telling me', [...] she was kind of more active and erm you know expressed her understanding, that it was significant for me to say it.	Adel	638-644
She just explored it with me, she just asked me more questions and that and allowed me to explore how I felt about about the thing I was avoiding bringing up.	Adel	720-723
It's been helpful the way you know that they would link it back to, you know they would explore it with you but they would also kind of link it back to other kind of patterns and things that you talked about or ask you how how does this maybe relate to other experiences you've had in your life.	Adel	853-858

Subordinate theme: The imperfect therapist		
Quotes	**Interview**	**Line number**
She'd often make comments after I'd get up half hallway argh halfway through sessions? End of the sessions, "Ah I really like your bag" or and that to me kind of broke kind of the relationship between or the boundaries.	Emily	92-96
One of the reasons I came out of personal therapy with my female therapist is it felt she really couldn't contain some of my material, or that what I would disclose would be too much for her to bear [...] I just got a feeling that she wasn't able to contain some of the things I wanted to talk about.	Emily	25-34
Feeling disappointed and feeling kind of let down. Erm, I think feeling misunderstood really, feeling really misunderstood.	Emily	702-704
She shared something of how she views the world and… and that didn't match up with mine. [...] that was one thing, which… which influenced the therapeutic process then for a few weeks. I remember sort of then going back err, the following week and… *[pause]*… not being as happy about being there and not really being sure, well do I wanna share other things with this person?	Eric	384-392

I remember being… *[laughs]* yeah, annoyed with my therapist at the time, thinking that err who… who is she to take away my positive view of *[laughs...]* of…of life.	Eric	369-374
Sternness *[laughs...] the best way I can maybe...describe it is a* lack of smiling sometimes [...] I think she was trying... to... to not give too much away in a facial way and and to try maybe in a way to try to be a blank screen.	Eric	753-760
he just asks me fewer questions about certain things yeah so, so if we talk about something he will seem I suppose less interested and a bit harsh but perhaps explore it less because we've been over it again.	Lara	383-387
I don't think I could have worked with a therapist who is very direct, very fast paced.	Lara	539-541
When he has disclosed things to me erm I, that that's kind of, he disclosed he has daughters or something like that and that that kind of felt like it changed things so I suppose that that's impacted in a way that if I ever disclose anything with a client I probably wouldn't because I I didn't find it particularly helpful.	Lara	701-706
There was in my opinion, my self-sense of the power imbalance, it was just a bit too big for me to be able to just say that to her.	Alva	95-97
I would share something about my life and we discuss it. Sometimes it feels quite unsatisfactory in terms of *[pause]* sort of I was looking to realise something from that discussion but I didn't get it.	Alva	582-586
If I did see her crossing her arms or erm looking quite sullen, that would influence the mood in the room or how I felt in the room, or if she looked particularly tired then I would be careful not to overburden her.	Alva	685-689
Sometimes being very open about the fact that he cared for me and that genuinely freaked me out completely [...] Erm, trying to reassure me that he he cared and and that wasn't the right approach for me. I think that that really frightened me.	Ishi	314-320
I can't help feel that somehow it might have hampered me, in in some of my discussions because I know there were things I felt that I'm not going to talk about that very much, because he doesn't seem very interested.	Ishi	821-825
I need that space around me to be able to formulate my thoughts, to to bring up things and if I feel he's invading that space, even though it's obviously not physical [...] but if I feel he is invading that with his concern and his, erm curiosity and his intensity, it's too far. I just, I can't I can't think and I no longer want to disclose very much	Ishi	857-866

She didn't really offer any interpretation, she didn't really offer any any kind of summary or anything. [...] It wasn't really that containing.	Adel	332-335
It's unhelpful for the therapist not to acknowledge the difficulty of what you're of what you're saying.	Adel	731-733
It's yeah important obviously not to make a judgement on what somebody has disclosed.	Adel	740-742

Master Theme Three: Process of disclosure

Subordinate theme: Surge of emotions		
Quotes	**Interview**	**Line number**
It… it's something I needed to talk with someone about. Err, and it was something, which was sort of…*[sighs]*…not distressing me, but it was something, which was on my mind quite a lot at the time. Err, and…and I guess maybe to some extent, causing a little bit of distress.	Eric	253-258
It kind of crept up on me I think there was a moment where it was like, sod it I'm just gonna tell him.	Lara	156-158
My distress levels were really high [...] And it was just getting out of control.	Alva	254-256
Sometimes I was so anxious I didn't really have the brain space to think about what I was gonna say and it just happened in session.	Alva	475-477
My anxiety levels were just so high, I don't really remember actually thinking coherently about it.	Alva	479-481
I thought it in advance, ""Well, that that is something that I'm, I'm gonna tell him on Monday", because I used to see him on Mondays. Erm, and and "I want to discuss that with him" or "I want to bring it up now" because I think it's time	Ishi	206-211
When I did first go in I was kind of spilling spilling out.	Adel	138
I had a like a certain like doubt or whatever about the relationship at that time and I think that just kind of made it come out me just talking and talking and talking and it becoming more and more obvious and more and more like I maybe that I just wanted to tell the therapist that I I I was aware.	Adel	297-303
I felt like there was some pressure almost that I needed to say something.	Adel	319-320

Subordinate Theme: Anticipation: Guarded and Unguarded disclosure		
Quotes	**Interview**	**Line Number**
There's also something about being aware that he's not going to explode or it's not going to be the end of the world or it's not going to be catastrophic or it's not going to kind of lead to huge confrontation,	Emily	505-509
You got to be able to kind of work with stuff and not be and not break down so I guess there was a part of me that was quite mindful of not wanting to give away too much	Emily	154-156
I felt she'd been judgemental about one thing well I can't really go there with anything else.	Emily	342-344
I may err, at least times quite guarded [...] I was concerned that if I said the wrong things in therapy, err, for instance, if I spoke about…I remember especially when I started personal therapy, that's around the time when I'd started seeing clients for the first time as well [...] And there was a lot of concern about, you know, was I practicing, you know in an appropriate way?	Eric	60-75
I thought, well if… if I'm not practicing in an appropriate way, I need to figure it out now rather than […] sort of continue with this process for years and years and years and potentially harm clients [...] Err, so I need to… and I need to get someone else's opinion on this.	Eric	216-224
I've always been interested in sort of progressing in a way or [...] or improving or…or I'm not sure if improving is the right word, but exploring, learning more about myself.	Eric	448-452
I don't remember a conscious decision, "Today I'm going to talk to him about this". It just kind of happened.	Lara	100-102
I sensed that he got frustrated with me, sort of going "And then she did this" and er so for a while I kind of toned it down and I suppose it did affect what I talked to him about then.	Lara	423-426
It felt like the problem had been not, not resolved but that we'd work together on it and it had been helpful to disclose it	Lara	177-178
I knew in a way I had to work through this in personal therapy so it wouldn't influence me in my own erm practice.	Alva	144-146
In a way my therapist, has the power in my training [...] And, and yeah that was definitely a huge concern [...] And I I said it to her and at the time as well that I'm really worried about your, view of me and the fact that you‟ll declare me not fit to practice.	Alva	275-284
I was just really worried about hurting her feelings [...] I was		

very calculated with what I was going to bring and what I wasn't going to bring [...] But actually that stilted a lot of things and in therapy and the outcome	Alva	525-546
I went into it not wanting to force it, not feeling a pressing desire to disclose things about myself, knowing I would have to do it.	Ishi	156-159
I had no particular plans to to bring anything to his attention and yet I found myself going into something very personal [...] So I think a lot of it had to do with the moment [...] How I felt on that particular day [...] With him in the room and how much [...] I could trust him.	Ishi	219-228
If I were to share something very personal with him, erm, he wouldn't *[pause]* take it in, in the right way.	Ishi	287-289
I was kind of hoping that if I said something it would maybe make it better or then we could kind of work on that.	Adel	326-328
It was helpful because I think I had some like preconceptions about what she might how she might respond and how other people might respond.	Adel	703-705
You worry that your therapist will not only be making a judgement on you but making a judgement on the other people that you're talking about and I think that makes it quite difficult maybe sometimes.	Adel	890-893

Subordinate theme: Therapist on trial		
Quotes	**Interview**	**Line number**
there were times that I would say things and I'd maybe with other people expect certain reaction, er a smile, a frown whatever and I wouldn't get it either way good or bad.	Eric	761-764
So I went in and I just and said a lot of stuff about "I'm feeling, I'm feeling really embarrassed and I've been avoiding talking about this" and I laid down her, my expectations and her expectations of what I might say.	Alva	242-246
Sort of expecting him to do the work, in a way, and then, sort of, testing him a little in how far he would he would go and how how comfortable he would make me feel about it.	Ishi	161-164
Just send a little feeler and then if I had the same response again, then I would just decide that this is something for my journal or you know, not not something for therapy.	Ishi	610-613
There was times when I wanted him to ask questions. I I		

wanted to be *[pause]* left to decide what these times would be. And and sometimes he managed that very well and I opened up and then we made lots of progress.	Ishi	884-888
It was related to that specific thing I hadn't thought about disclosing but it's part of a like wider issue erm that I had thought of disclosing.	Adel	519-522
I said something like, oh well you know there is this thing but erm I dunno I feel really silly about it.	Adel	618-619

Subordinate theme: Consequences: Positive and Negative		
Quotes	**Interview**	**Line Number**
It's allowed me to kind of work through any anger.	Emily	777-778
I felt most relaxed I've been for for a long time.	Emily	797-798
I come out of therapy feeling shattered and drained and really tired.	Emily	1007-1009
I found it really rewarding to go there and to be able to reflect on issues, both clinical issues, but also personal issues.	Eric	123-125
Being able to talk about it was a real relief.	Eric	258-259
When I left the session I was maybe a bit anxious.	Eric	282-283
I felt physically drained and sort of mentally drained.	Lara	299-300
It's been useful and I, and it's, like I said it was kind of a sense of relief.	Lara	230-231
It actually was incredibly painful and exhausting as well.	Lara	308-309
Just feeling quite relieved from whatever angst that was being expressed.	Alva	70-72
I was just feeling really uncomfortable and my whole body was tense.	Alva	486-487
There's something quite niggling that I wanted to look at and I did disclose it, or I I talked about it and we talked about it but it still feels quite unresolved.	Alva	591-593
It felt really nice actually.	Ishi	365
I felt quite, quite proud and and relieved.	Ishi	388-389

Two-three sessions later we didn't, we hadn't really worked with it [...] or the way he tried to bring it up was not how I"d meant it and then I started feeling disappointed.	Ishi	417-421
I felt panic.	Adel	416
I regretted saying anything to her to be honest and I was kind of wondering what she was thinking about and I felt a bit frustrated I think with her.	Adel	457-460
You worry that your therapist will not only be making a judgement on you but making a judgement on the other people that you're talking about and I think that makes it quite difficult maybe sometimes.	Adel	890-893

Master Theme Four: Impact of disclosure: Personal and professional development

Subordinate theme: Developing self-awareness		
Quotes	**Interview**	**Line Number**
I think in the past I would have maybe suppressed that feeling, had that emotion and really not know what to do with it whereas I was I was able to actually kind of confront it.	Emily	493-496
I've always had these you know polar opposites that you can, can't be, you know you can't be successful and ambitious and also caring and kind, It's like you've either gotta be one or the other kind of thing and I think I've kind of learnt to kind of meet in the middle a bit.	Emily	733-738
One thing it has helped me most with is recognise what is my own anxiety and what belongs to something else or what's almost put into me by other people.	Emily	787-790
That's been very interesting and rewarding as well to…to sort of get a…a greater understanding of who I am...and [...] and what I value in a way.	Eric	141-145
It sort of highlighted in me that maybe sometimes er...I seek approval but it isn't necessary always necessary to be seeking it [...] or sometimes I seek it too often and that that can be counterproductive if I'm not careful.	Eric	821-826
Maybe more reflective in a way erm... and more... well I wonder whether it's made me more comfortable... sitting with uncertainty sometimes.	Eric	857-860
The disclosure has been helpful in kind of fitting my life together and why I think in a way I do because of certain experiences so it's helped to make sense of my experiences.	Lara	438-442
It's changed the way erm I carry out relationships and, and just		

think about my life I suppose and who I am.	Lara	447-449
I feel like there's more of an element of choice so if I choose to stay in a relationship with this person, I can either be really open and say how I feel and perhaps damage the relationship or I can just be the way it is or I can leave it, so it feels like, I'm more accepting and more, and have more respons' take more responsibility.	Lara	640-646
There was so much material to be gained from that disclosure in terms of why I said this to her, why I felt this way.	Alva	529-531
Just knowing how I position myself and how sort of, my transference and counter-transference are reaction from others, it's definitely erm, given me an understanding of how I to relate to other people.	Alva	763-767
I feel a lot more stronger" I feel a bit more resolved in me and I'm really really happy that that part of me erm, has had a bit of a chip broken off and it's slowly crumbling.	Alva	817-820
The experience of talking about something very personal, something that I hadn't shared with anybody and realising that I could share that and it wasn't gonna, you know, I didn't need to feel embarrassed about it or, you know, it was it was not something, it was not some sort of horrible secret. Erm, it was just something human.	Ishi	449-455
To accept, and even embrace erm aspects of myself which I I had split off quite a lot.	Ishi	920-921
It has helped me acknowledge the emotional charge of some of my disclosures.	Ishi	982-984
I built the awareness of where those emotions are coming from and things and so I almost don't feel like I'm just spilling out and needing to kind of disclose everything, it's more, I'm just a bit more together.	Adel	101-105
Allowed me to realise what assumptions I was making about what I was saying and maybe what other people might think about what I was saying, and that those assumptions were maybe you know, that was an issue and it was kind of me making evidence against my pre-supposition that that would happen and I think that kind of does lead to reflection and some development.	Adel	951-958
It's just a lot of awareness really erm and I think also maybe boundaries and stuff I can kind of negotiate a bit more a bit more easily now.	Adel	1041-1043

Subordinate Theme: Developing professional awareness		
Quote	**Interview**	**Line Number**
Having an understanding of what I want in my profession as a counselling psychologist so the importance to me of being in a place where we have time to think and reflect.	Emily	808-811
Working with some psychodynamic' psychodynamically it's kind of eradicating any myths that are kind of out there about you know working with someone who is a complete blank slate and has no emotions, it's been a lot more relational.	Emily	863-867
It's taught me about the importance of the room so you know in the service where you can sometimes maybe book rooms I really found that that's impacted on on my work.	Emily	885-888
I think personal therapy has been very influential in…in developing my professional identity in a way and err…and helping me…with my confidence and feeling more confident in what I'm doing as a professional.	Eric	570-574
It's also sort of emphasised the importance of some of the core foundations of my practice in terms of unconditional positive regard and empathy and and genuineness and so on to to make sure that I provide those in the therapeutic setting so that clients feel comfortable hopefully in disclosing things to me.	Eric	879-885
That was a very valuable learning from me where... it emphasised the importance of trying... to not be sort of biased in the therapeutic setting and not let my own views influence the therapeutic setting too much.	Eric	935-939
It kind of encouraged me to take a bit more responsibility with that and perhaps be a bit more, not professional, but sort of grown up I suppose in the way I conduct myself in placements.	Lara	654-657
It has definitely it's helped me understand why I behave in certain ways with certain clients.	Lara	663-664
If I ever disclose anything with a client I probably wouldn't because I I didn't find it particularly helpful.	Lara	704-706
It definitely helped with my time at that placement and It definitely helped to be a bit more boundaried with my patients.	Alva	789-791
And it's okay to upset the patients if that's what they need to hear [...] But always doing it in a kind and compassionate way *[laughs]*".	Alva	804-807
I think always always be kind and open to whatever they bring.	Alva	840-841

I think it taught me [...] certainly a lot about the, you know, what happens in a room from the from the client's perspective.	Ishi	180-182
It's helped me become I think more, more sensitive to the non-verbal and how my clients could feel unsafe with me if I wasn't careful, erm in in how I I responded or encouraged erm their own disclosures.977-981	Ishi	977-981
It's really [*pause*] impressed on me the the importance of not only being as attuned and as attentive as I can but when I make mistakes, which obviously I do a lot, to not just try and and sweep it under the carpet and and just own it and and look at it, you know again, sensitively.	Ishi	1007-1012
Also professional development [...] you can kind of see what works, what doesn't work in therapy that can maybe help to improve your therapeutic practice too.	Adel	958-962
I know a bit more about the kind of role of the therapist, the expectations that maybe you can put on a therapist.	Adel	1043-1045
If your client was finding it difficult to kind of disclose and maybe asking why that might be and you know if they did I think you know take it from the client really.	Adel	820-823

Subordinate theme: The Authentic Self		
Quotes	**Interview**	**Line Number**
Being able to express maybe more anger or envy or jealousy or erm or kind of disgust or contempt or whatever it may be.	Emily	639-642
Talking about real, *[pause]* difficult feelings, umm stuff that I just wouldn't even be able to talk about with some of my closest friends.	Emily	658-661
Through disclosing things in therapy I've been able to be a bit more open with some of my family.	Emily	739-741
I've been able to share everything completely without sort of having to filter it in any way.	Eric	128-130
Basically, adopting the way I've been with my therapist, with other people around me. Sort of feeling more comfortable sharing things, which are more…more personal in nature maybe with more people, gradually.	Eric	554-558
Without feeling the need to…to fit certain boxes or tick certain boxes and yeah, that's…that's felt really good.	Eric	649-651
That would kind of be everything, erm so, or the most things about me that he knew.	Lara	160-161

It’s made me more, it’s allowed me to be more emotional.	Lara	454-455
I’m actually glad that I have disclosed it and regardless of whether my symptoms disappear completely or not, that actually I managed to say it to her and work on it.	Alva	429-432
I feel so much freer to bring anything and just say whatever comes to my mind that might sound ridiculous or negative, embarrassing or punitive.	Alva	546-549
at least now I know I can say things erm even if they’re negative.	Alva	826-828
Disclosing intimate things about myself and being able to share some of my inner world.	Ishi	914-915
n sharing more of myself with friends and family. And again, I think that’s very much a, something that I think is generalised from the therapy.	Ishi	928-930
in the past I would either ignore them or or try and mask them or or just think well that’s, you know that’s, I can’t do anything about that now or that that’s not something I should really spend any waste any time on. And and that that that’s changed.	Ishi	969-973
Through speaking to her about it, it made it less of a stigma for me if you see what I mean, and I think making it less of a kind of 'no no no I’m not going think about that, I’m going to avoid that' actually made it more acceptable.	Adel	706-710