

Therapist Self-Disclosure with Clients from Diverse Backgrounds

by

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Abstract

The psychological literature on therapist self-disclosure in counselling and psychotherapy has shown to be a beneficial tool in working with clients' in-session. Current research on therapist self-disclosure suggests that not all therapy skills have been successfully adapted when working with clients of from diverse backgrounds. Using a grounded theory approach, nine therapists were interviewed about the ways in which they use self-disclosure with clients from differing social locations than themselves. Four major themes emerged from the data: 1) *Understanding Therapist Self-Disclosure*; 2) *Conceptualizing 'Diversity'*; 3) *Contexts in which Therapists Conceal Themselves from the Client*; and 4) *Contexts in which Therapists Reveal Themselves to the Client*. The results showed that participants were more inclined to disclose sooner and with greater comfort when working with someone from a similar ethno-cultural background whereas they were more cautious and less inclined to disclose to a client if they were from an unfamiliar cultural background.

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Chapter One

Introduction

The number of visible minorities¹ in North America is increasing at a rapid rate (e.g., Chung & Atkinson, 2000). These numerical increases of ethnic populations can be attributed to both immigration trends and differential birth rates between non-minorities and visible ethnic minorities (see Atkinson, Morten & Sue, 1993; Sue, 1991). Visible ethnic minorities in North American society face different obstacles in their daily existences in comparison to non-minorities. Many are immigrants or the children of immigrants who have often given up financial security, the comfort of a familiar way of life and sold all their possessions in order to finance the passage to North America with the hope of making new and successful lives for themselves and their families. Cultural and language differences are not the only aspects that increasing populations of visible minorities must adapt to, as they may not have previously experienced the preconceived notions that their ‘Otherness’ brings to a post 9/11 continent and mainstream culture that continues to be fed on diet that nurtures fear in the form of xenophobia.

Although there are many successful ethnic minorities who have opted to come to North America as skilled workers, entrepreneurs and international students, they find themselves feeling isolated within a society that is often riddled with racial micro aggressions and xenophobia. Ethnic minority clients were often victims of “hate” crimes including but not limited to: threats, physical assaults, derogatory racial slurs, negative attitudes towards inter-ethnic romantic relations, property damage, harassment, job discrimination, bullying, racist attitudes and stereotypes, increasing policing, and educational/ financial disadvantages across North

¹ According to Statistics Canada (2006) the term visible minority is reserved for “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (see <http://www12.statcan.gc.ca/census-recensement/2006/ref/dict/pop127-eng.cfm>). In the Canadian context, South Asians, East Asians and Blacks comprise the largest visible minority population groups.

America, underscoring the urgent need to better serve visible ethnic minority clients (see Sue, Arrendodo, & McDavis 1992). Uninformed mental health practitioners were ill-equipped with the knowledge and skills to effectively work with and treat ethnic minority clients. This lack of multicultural knowledge and lack of cultural competence goes beyond a lack of skill and knowledge but also brings to question a need for mental healthcare practitioners to examine internalized racism and cultural biases (see Sue, Rivera, Capodilupo, Lin & Torino, 2010).

However, not all minorities in North America are immigrants, there exists a high numerical presence of second generation or even third generation offspring. A significant number of ethnic minorities in Canada are also refugees. According to statistical data from the Immigration and Refugee board of Canada (2015), 19,900 refugee claims were finalized in 2014. Another 16,500 refugee claims are pending as of December 31st, 2014. Unlike immigrants that leave their homeland, many of the refugees have experienced war, famine, faced the loss of their families, seen the destruction of their homes, experienced internment, endured torture and other forms of persecution for religious beliefs, sexual orientation, and gender based violence and political activities. Many are in dire need of emotional support to heal from the trauma that they have experienced as well as to navigate their new lives in an unfamiliar culture. These staggering numbers highlight the urgent need for refining multicultural counselling practices, as it exists today, to even further to respond to the growing demand for mental health services by refurbishing their 'normative' ways of relating to their clients within the session.

Past research has shown that visible minority populations tended to underutilize psychological health services and drop out of treatment at higher rates in comparison to non-minority clients (e.g., Cheung & Snowden, 1990; Sue & Sue, 1999). In response to widespread misunderstandings, prejudice and discrimination towards ethno-racial minorities, both within the domain of mental health services and the broader socio-cultural context, Sue (1988) spearheaded

a call to action for psychologists to address the unique needs of minority clients. The unique needs of minority clients are particularly complex because they often involve more than just a difference of culture and world view. Many have endured unspeakable amounts of guilt for leaving their families behind. Others may face financial uncertainty or have to adapt to dependence on government support when they had previously been financial independent and self-sufficient. The emotional upheaval that a lack of community and family are often difficult for therapists from the dominant culture, no matter how well-intentioned, to comprehend as they have no point of reference from which to understand. For example, many minority clients have assumed financial responsibilities for family members who were left behind in their homeland. This is often difficult for a therapist from the dominant culture to understand as independence from family is often considered a rite of passage into adulthood. This brings to question the idea that therapists from the majority culture should examine within themselves the presence of implicit racial biases and the existence of aversive racism (see DeVos & Banaji 2005; Dovidio, 2001; Sue, et al., 2010).

Sue et al. (1998) suggests understanding non-dominant cultural groups is not enough for counsellors. Instead counsellors ought to actively challenge their own attitudes and belief systems and recognize how these mental processes were influenced and shaped from its' own cultural context. In a similar vein, Ridley (1995) asserts that counsellors examine their own biases to gain an understanding of how their own teachings, beliefs and attitudes towards members of the non-dominant group may be discriminatory or ethno-centric. Building upon previous conceptualizations, Arthur and Stewart (2001) recommend "that counsellors must be assisted to move from a position that assumes a singular, mono-cultural reality, to that of adopting a worldview that is respectful of multiple belief systems" (p.5). This is especially significant in Canada because a significant 20.6% of the population according to the 2011 census

was born overseas. Furthermore this percentage is the highest since 1931, when 22.2% of the population was foreign-born outside of the country (Employment and Social Development Canada, 2015).

Some scholars suggest that a more accurate understanding of how culture influences psychological practice is reflected by transposing the sequence of words from “the person within the culture” perspective to a “culture within the person” perspective (Pedersen & Ivey, 1993). This linguistic shift and subsequent change in ideology, is intended to underscore the importance of how cultural meanings and symbols become internalized and subsequently govern our knowledge base, beliefs, actions, feelings, thoughts, worldview and values among other psychological variables. Towards this end, increasing multi-cultural counselling competence is an utmost priority. In essence, multicultural counselling competence refers to providing psychological services to people with a different worldview effectively (Diller, 1999). Operating from within a multi-cultural counselling perspective, therapists incorporate their client’s heritage, values, and attempt to understand them through how they conceive of their own problems and preferred mode of intervention (McCormick & Amundson, 1997).

Fernando (2010) suggests that a practical consequence of deconstructing the single, presumably nationalist, dominant majority identity into many separate identities is to enable open-ended adaptation for people living in a diverse society. This is especially significant in North America, where patterns of immigration and interracial marriages are responsible for what are known as ‘hyphenated identities’ (Nunan & Choi, 2010). For example, it is possible for an individual to have parents of two separate nationalities and/or ethnicities. Also to be born in one country whilst having immigrated to another and identify with the cultures of one’s parents. The country of birth as well as place of residents also play a role while maintaining intimate cultural ties with that of the individual’s partner and being cognizant of having a child that has all of the

above as her/his heritage. Lee (2014) reinforces Fernando's idea of an individual with separate identities merging together within a larger social fabric, by asserting that within a society "Each individual holds simultaneously multiple but unique personal, familial, and cultural identities within their larger socio-political-cultural groups" (p.15). An awareness of the intersection of said multicultural identities should be considered an essential component of counselling practices in North America. Counsellors who gain an understanding of their client's worldview are more effectively able to build a therapeutic relationship and respond in a manner that the client would deem as helpful (Arthur & Stewart, 2001). Adopting a culturally-sensitive worldview can have implications for skills and techniques used with clients from diverse backgrounds. For example, Diller (1999) observed Chinese immigrants preferred counsellors who were more directive, authoritarian and paternalistic in their approach compared to clients from the majority culture. Ways in which skills and techniques are used with clients of the majority group may not be applicable to clients of a particular minority group.

Mainstream psychological practice focuses on the individual's verbal and emotional expression, along with self-disclosure and insight (Diller, 1999; Sue et al., 1998). While these are not the only models of helping, Diller (1999) suggests expanding the role of the counselor to include: advocate, adviser, teacher and/ or facilitator. Accordingly, it is the responsibility of the counsellor to become well-vested in a culturally-sensitive practice (Arthur & Stewart, 2001) rather than write off the client as being reluctant to participate. Therapist self-disclosure could be considered the key to a culturally-sensitive practice. This is because the therapist could if appropriate to the context, volunteer an instance where she/he felt misunderstood or undervalued due to a cultural difference. While interacting within mainstream society has the potential of being a transformative incident, it will allow the client to feel less isolated or even feel that the therapist empathizes with the client's plight.

Mainstream psychological practice propagates a healing practice that almost exclusively requires the clients to self-analyze and dissect their thoughts, verbalizations and emotional expressions, with the aid of therapist self-disclosure and offerings of insight to the client, among other tools (Diller, 1999; Sue et al., 1998). The problem lies in the reliance on micro-dissection of affective and cognitive experience. These micro-dissections of experience within the therapy room, albeit effective in North American and Europe, are perhaps not the only way in which human suffering can be alleviated. Moreover, these dominant models of helping rely on the client to be familiar with the verbal modes of self-analysis and the ability to dissect, organize and sequence their experience in order to be effective when in fact many people are unaccustomed to this dominant model of healing. Diller (1999) suggests expanding the role of the counselor to include: advocate, adviser, teacher and/ or facilitator. Accordingly, it is the responsibility of the counsellor to become well-vested in a culturally-sensitive practice (Arthur & Stewart, 2001). Darou (1987) provides the example of people who identify as First Nations who place greater emphasis on unconscious processes, non-verbal forms of communication, and a tendency to not express anger. Rather, according to Darou (1987), First Nations people are more likely to organize their experiences in terms of space rather than time. An understanding of cultural differences could greatly improve the model of health delivery to clients. Or in the very least, an appropriate acknowledgment by the therapist, self-disclosing that they lack the necessary background in the cultural knowledge but have a willingness to learn and understand. This would greatly enhance the client's experience by bridging an otherwise asymmetrical situation.

For these aforementioned reasons there is an exigency to better understand how self-disclosure operates within cross-cultural dyads and is used by therapists as a tool to potentially restore symmetry within the therapeutic encounter.

The Rationale & Research Question

One specific area of multicultural competence that has yet to receive adequate research attention is the implementation of knowledge through skills in psychological practice with clients who do not belong to the non-dominant group. Specifically, the technique of therapist self-disclosure has been understudied within this population. Little empirical work has been done to test whether visible minority clients view self-disclosure the same way as therapists working in multicultural counselling settings do. Previous studies fail to take into consideration the impact of self-disclosure on visible minorities. Moreover, even less research has been conducted on therapists' perceptions on their self-disclosures to clients.

There has been a proliferation of research building competencies pertaining to *knowledge* and *awareness* within the multi-cultural counselling competency framework (see Sue, Arredondo & McDavis, 1992; Arredondo et al., 1996). Ultimately, what is absent or underdeveloped from the scholarship is a lack of understanding as to how to specifically adapt and / or understand the common *skills* and techniques of psychotherapy to clients who comprise of a minority group. Notwithstanding generic guidelines offered by leaders in the area of self-disclosure. The present study will attempt to explore therapist perceptions in terms of their use of self-disclosure with clients from the dominant culture along with ethnic minority clients. It is my hope that the present study will reveal the type of content that is shared between therapist and clients that contain a *cultural component* to it. This is in order to inform the broader field of multicultural counselling and help develop individual therapists in achieving a greater level of multicultural competence in order to enhance the quality therapeutic experience of minority clients.

Chapter Two

Literature Review:

Therapist Self-Disclosure

This chapter will review previous research on theoretical conceptualizations of therapist self-disclosure. This section is intended to summarize the various understandings of the term therapist self-disclosure. It will also recapitulate the history of self-disclosure and locate its' origins within psychoanalysis and how it has evolved from then to its' contemporary use within psychotherapy of all denominations. Furthermore, this chapter will review the empirical research on its' use and effectiveness within present day psychotherapy. Lastly, this chapter will review the literature on the use of therapist self-disclosure when working with clients' of minority status.

Definitional complexity around therapist self-disclosure permeates the literature. Various scholars in the field use differing denotations and connotations with self-disclosure. Much of the definitional complexity is a product of theoretical orientation. The categorization of therapist self-disclosure is surrounded by a tremendous degree of debate. For this reason a universally agreed upon definition is difficult to locate. Sidney Jourard (1971) was one of the first to describe the concept of therapist self-disclosure as “the process of making the self-known to other persons” (p.248). Jourard's definition is expanded upon by Goldstein (1994) who states that:

“ The therapist's conscious verbal or behavioural sharing of thoughts, feelings, attitudes, interests, tastes, experiences or factual information about himself or herself or about significant relationships and activities in the therapists life. Self-disclosure takes many forms: wearing a wedding band; decorating an office according to personal tastes...talking about how one has solved problems, handled situations, or thought about life; going to events where a patient will be present and /or has invited one, such as weddings, professional conferences or artistic performances where it is impossible not to reveal aspects of one's personal self” (p. 419).

Goldstein refers to therapist self disclosure in terms of circumstances that are directly relevant to her/his personal life that could be made by making a direct reference to how they handled a situation with another individual, or a personal or professional detail about his/her life or a reaction toward something the client has stated. Furthermore, it is virtually impossible to not disclose anything at all. Intentionally withholding personal information is still a form of communicating one's ideas, values, and beliefs about sharing (or the lack thereof) at the very least. As evident from Goldstein's definition above, the concept of the therapist self-disclosure paradigm is primarily divided into two main types. One type is known as *Intrapersonal*, which is also sometimes referred to as self-disclosing. In this method, the therapist reveals an aspect of themselves, in regards to their own past. For example, the therapist could mention details about their previous educational training, a similar situation or experience they have had to the client or even a fairly superficial and impersonal detail such as where they travelled to while on vacation. The other type of self-disclosure is known as *Interpersonal* or *self-involving* and occurs when the therapist shares his/ her immediate personal reaction about the client to the client (see Bridges, 2001; Cherbosque, 1987; McCarthy & Betz, 1978; Wilkensen & Gabbard, 1993).

Similar demarcations have split therapist self-disclosure based on personal information versus demographic information. Whilst other attempts to categorize therapist self-disclosure have been based on the similarity or dissimilarity of the therapist experience to the client (Watkins, 1990), other scholars had opted to conceptualize therapist disclosure as outcome-based bifurcation with regards to whether or not the disclosure had evoked a positive or negative effect on the client (e.g., Andersen & Andersen, 1985; Robitschek & McCarthy, 1991). This suggests little consensus among scholars in how to conceptualize the concept of therapist self-disclosure. Wachtel (1993) echoed the sentiments captured by proponents of the intrapersonal and interpersonal split into the three broad categories: (a) reactions about the client made within-

session compared to (b) disclosures about the therapist's status, background, personal feelings, and (c) experiences that took place outside of therapy (also see Nilsson, Strassberg & Bannon, 1979).

More recent articulations of therapist self-disclosure broke down the concept into four subtypes: 1) disclosure of facts; 2) disclosure of feelings; 3) disclosure of personal insights, and 4) disclosure of personal strategies (Hill & O'Brien, 1999). Building upon Hill and O'Brien's sub-categorizations, Knox and Hill (2003) added three more disclosure subtypes to the list, forming a combined total of seven subtypes. These additional subtypes included: 5) disclosure of reassurance/ support, 6) disclosures of challenge; and 7) disclosures of immediacy. This style of sub-division was highly content oriented in nature. Knox and Hill (2003), define therapist self-disclosure as "an interaction in which the therapist reveals personal information about him/ her, and/or reveals reactions and responses to the client as they arise in the session" (p. 275) (also see Hill, Mahalik & Thompson, 1989; Watkins, 1990). This definition is useful as it provides a less narrowly conceived of definition and description of therapist self-disclosure, which presumably is agreeable to most scholars and practitioners due to its' highly specific nature.

Historical Overview of Therapist Self-disclosure

Traditionally, therapist self-disclosure was discouraged due to the risk that the client would perceive such an action as unprofessional projection of the therapist's personal life. The role of the therapist was understood to be analogous to a '*tabula rasa*', in which all and any material the patient brought with them into the session was simply reflected back to the client until an interpretation of the patient's pathology via transference could be deduced by the clinician/ analyst. Paralleling the ethos maintained within the realm of physical sciences, the therapist would remain neutral and objective towards the patient. Moreover, clear boundaries

between therapist and patient had been demarcated and personal engagement with the patient of any kind was contraindicated since it could disrupt the transference process and/ or corrupt the interpretation of the intrapsychic material germane to his/ her pathology presented by the patient. This is evidenced by Freud's early writings "[that] the doctor should be opaque to his patients, and like a mirror, should show them nothing but what is shown to him" (Freud, 1912, p.117). First and foremost, Freud believed therapist self-disclosure could potentially contaminate the transference reaction which was the cornerstone of psychoanalytic practice at the time. Classically trained psychoanalysts following in the footsteps of Freud had warned against the dangers of disclosures. Secondly, therapist self-disclosure would redirect the patients' attention from their private fantasy life in favour of processing and responding to the material revealed by their therapist (see Farber, 2006). Hesitations and reluctance to use self-disclosure was maintained due to fear of overburdening the patient with therapist problems thereby inadvertently reversing the roles of the actor and observer within the therapeutic encounter.

Furthermore, therapists were cautioned against self-disclosure due to the danger that the patient would focus more on the therapist's life as a deflection strategy. Later on, Langs' (1975) work supported the classical psychoanalytic position adhering to the maintenance of boundaries in order to not obstruct interpretation which could ultimately prove detrimental to the patient's healing process. In a similar vein, Epstein (1995) advised against the demystification of the therapist as it allowed the client an opportunity to examine his/ her own inner life. Contemporary theorists in support of clinical neutrality purported that therapists who choose to self-disclose run the risk of blurring their own motivations by satisfying the patient's craving and curiosity to know more about their therapist's personal life (Hanly, 1998). However, not all therapists who were privy to the Vienna circle agreed with Freud and his psychoanalytic followers. For instance, Sandor Ferenczi (1926) departed from his intellectual predecessor, by encouraging his patients to

write poetry, engage in discussions, and challenge their resistances to achieve affective insight. This active approach to therapy laid the foundation for mutual analysis between therapist and patient (e.g., Aron, 1996). Ferenczi, among others, dissented from Freud and his adherents' strict stance on adopting a posture of analytic anonymity.

As psychoanalytic thinking evolved away from the classical model, so did the stance on therapist self-disclosure. For example, object-relations theorists (e.g., Melanie Klein, D. W. Winnicott, Henry Guntrip & W.D. Fairbairn) held a middle position on clinical detachment and clinical neutrality. Members of the Object-Relational school of thinking re-conceptualized the classical Freudian focus on drives and instead re-directed their focal attentions on the 'object' (i.e., the person). Donald Winnicott (1965) noticed in his clinical work with persons afflicted with schizophrenia that they did not respond well to a distant and withholding therapist as their psychic organization had been severely ruptured and thus he shifted his position to engaging more directly with his psychotic patients. Henry Guntrip (1975) recalled hearing his own therapist Fairbairn say, "You can go on analyzing forever and get nowhere. It's the personal relation that's therapeutic" (p. 145). The supposition, as per Guntrip's memory of Fairbairn, is that therapist self-disclosure bears the capacity to fortify the therapeutic alliance since it is one of several ways to enhance the personal relationship to the client; thereby, resulting in greater levels of engagement in the therapy process and ultimately in turn improving client outcome. This shift away from insight-based therapy and re-focusing the emphasis on relational factors was mirrored by 'relationally based' psychoanalytic thinkers as well (e.g., Aron, 1996; Greenberg & Mitchell, 1983).

As the practice of psychoanalytic thinking began to evolve, intersubjective and relational theorists shifted the practice of psychotherapy from one-person to a two-person collaborative, interpersonal process (Aron, 1996; Greenberg & Mithchell, 1983). Renegades in the field like

Owen Renik completely disavowed the original principle of a therapist upholding a ‘blank screen’ position as evident in the following quote “we need to begin by not just discarding the principle of analytic anonymity, but by contradicting it” (Renik, 1995, p. 482). This radical departure from and antagonistic attitude towards therapist ‘withholding’ was in alignment with Kohut’s Self-Psychology, specifically the concepts of ‘twinship’/‘kinship’.

The downfall of the classical psychoanalytic position was not only contested among psychoanalytic/ psychodynamic practitioners but also disparaged by other practitioners of non-Freudian theoretical persuasions. For example, humanistic and feminist thinkers alike were strong proponents for the use of therapist self-disclosure within the psychotherapy session. Both Sidney Jourard (1964, 1968, 1971) and Carl Rogers (1951), both pioneers of the Humanistic tradition, emphasized the importance of therapist openness and honesty with the client. Klein Michels, Kolden & Chisolm-Stockard (2001) meta-analysis showed that therapist genuineness in client-centered psychotherapy was associated with positive outcome in 34% of the studies examined. None of the studies reviewed in this study found a negative relationship between therapist openness and outcome. Openness does not mean complete transparency of every fleeting thought and feeling. Many therapists prefer to err on the side of caution against too much disclosure. This is due to the potential harmful effect that over familiarity can have on the client, the client-therapist relationship and also the issue at hand. For example, disclosing private sexual practices and/ or the communication of sexual feelings towards the client is considered a counselling *faux pas* (e.g., Kirschenbaum & Jourdan, 2005; Norcross, 2002). A situation such as this indisputably violates the boundary between patient-therapist. An extension of therapist genuineness in the therapy room is their willingness to disclose significant life events (e.g., marriage, divorce, retirement) they encounter outside of therapy. Guy (1987) recommends sharing significant life events with the client is advantageous because it demonstrates that a

person can live a meaningful and fulfilling life while still dealing with the trials and tribulations of the interpersonal-relational world rather than view it as an impossible goal.

The cognitive-behavioural tradition and its' contemporary derivatives have also endorsed the use of therapist disclosure including but not limited to: rational-emotive therapy (e.g., Ellis, 1966), reality therapy (Glasser, 1965, 2000), choice therapy (Wubbolding, 2009) to name a few. Other therapies that adopt an even more liberal position towards therapist self-disclosure include the following: humanistic-existential, feminist modalities of psychotherapy, family, marital and group therapy (e.g., Ackerman, 1954; Bateson et al., Haley, 1959; Minuchin, 1965; Satir, 1967; Whitaker, 1958, & Yalom, 1965). Since the early 20th century when therapists upheld a 'cloak of anonymity' there has been a universal shift among theorists and practitioners that therapist self-disclosure can be beneficial to clients. Yalom (2002) states quite poignantly "there is every reason to reveal oneself to the patient and no good reason for concealment" (p.83), thereby highlighting the discord between early writings on therapist disclosure in contrast to contemporary perspectives. To come full circle, Freud himself did not strictly follow his own precepts of analytic anonymity. Freud was infamous for socializing with his patients, gossiping and sharing personal photos with them (Aron, 1996).

Why, when and how disclosure is used?

Currently, there is a vast amount of empirical literature supporting the utility of therapist self-disclosure as an effective tool to use with clients (e.g., Barrett & Berman, 2001; Watkins, 1990; also see Ziv-Beiman, 2013 for an overview). What remains less understood is the specific ways in which therapists proceed to go about disclosing? Therapist self-disclosure brings with it many complications such as what to say, how to say it and when to say it. Singer (1977) as cited

in Farber (2006), can attest to therapist fears surrounding the use of self-disclosure (e.g., ‘will my patient accept me if she or he knows me?’)(p. 151).

Farber (2006) outlines a series of questions that therapists can ask themselves prior to disclosing as outlined in the excerpt below.

“Will my disclosure set up expectations for more frequent and intimate disclosures?” ‘will my disclosure be perceived as a reward by my patient, such that subsequent nondisclosure (or less intimate disclosure) will be perceived as withholding or punitive? Will my disclosure be perceived as an implicit communication that there was a better way of doing, saying, or thinking about something? Is this particular disclosure appropriate for this particular patient? Does this disclosure aid in the patient’s therapy?” (p.153).

The above excerpt highlights the contemplation process as to how and whether therapist self-disclosures will impact the client in some meaningful way. Farber highlights the complexities involved in deciding when to disclose, if at all. Some disclosures may neither be helpful or harmful but are rather mundane statements. Comments such as: “Hmmm, I saw that movie too”; “Yes, I do have a bit of a cold.”; “I don’t watch much TV” are disclosures that have very little impact on the client (see Farber, 2006). Even here, the use of seemingly mundane statements can potentially facilitate building a working relationship with client or at the very least model some level of social skills- especially for clients who are severely impaired or who are closed-off (Denney, Aten & Gingrich, 2008). Should a therapist refuse to answer an innocuous question about television and movie preferences? Sometimes therapist disclosures are unavoidable within the treatment process in spite of efforts to conceal them. Clients can infer therapist preferences, tastes and personality styles through choice of dress (e.g., wearing an engagement or wedding ring, hairstyle, clothing style), physical appearance (e.g., age, pregnancy), and how the therapeutic space is decorated (e.g., family photos, books) (Constantine & Kwan, 2003). Disclosures among cross-cultural therapy dyads are even more inevitable according to Constantine and Kwan (2003). For example, skin colour is visually evident and can provide ballpark clues into the patient’s or therapists ‘racial’ or

even ‘cultural’ identity. Disclosures can also be inadvertent insofar via transference-countertransference whereby past experiences with other persons of the same culture are brought into the therapy session and projected onto the therapist, the client, or onto both of them.

Given the complicated nature of therapist self-disclosure, recent efforts have been made to systematically guide therapists on when and how disclosure is appropriate. Knox and Hill (2003) recommend a list of 10 guidelines for therapists to follow in determining when and how to disclose. These recommendations are listed as follows: (1) Disclosures should be made infrequently because the very power of this tool may hinge on its scarce use. (2) Therapists should be cognizant of the content they are disclosing. Sexual practices and fantasies are off-limits for sharing. (3) Therapists should aim to strike a balance between over sharing personal information that may burden the client with the therapists’ problem and impersonal information that feels meaningless and ineffectual. (4) Therapists can customize their disclosures to suit individual client’s needs. For example, disclosing too much personal information to a borderline patient can be used by the patient to test the boundaries and manipulate the therapist. (5) Therapists must understand why they are disclosing. The conservative approach is to disclose to the patient only if it meets their needs, however, recent advances in *two-person psychology* recognizes the place for therapist’s needs as well (e.g., the therapist’s desire to want to be genuine with the client in the room). (6) Following a disclosure, therapists ought to immediately turn back the focus onto their client. Even if we accept the stance of *two-person psychology* insofar as therapists can be the primary beneficiaries of disclosures at times, the overall service should be for the client. (7) Therapists should remember that statements made about the interaction between therapist and client is a high risk- high gain tool. On the one hand, clients may be able to benefit from such verbalizations made by their therapist insofar as they can draw parallels about the relational pattern used with their therapist and their interpersonal

communication style to those in their personal life outside of therapy. On the other hand, clients may become defensive or feel offended by their therapist's willingness to communicate their reaction. (8) Self-disclosures made in the termination phase of therapy are particularly powerful as it allows the client an opportunity to internalize some of the characteristics the therapist possesses following termination of the treatment. (9) Therapists should track the client's response to self-disclosures especially observations made about the process. Therapists can double-check with the client about how they feel with regards to what was just said in the room. (10) Therapists ought to only disclose about issues and personal struggles that they have come to terms with in their own personal life. This is especially important if the client is struggling with a similar situation to the therapist. Take for example, a situation where a therapist has suffered the loss of a parent and also has a client who has suffered the same loss. The therapist in this hypothetical situation has not yet come to terms with this loss. In such a situation, the therapist should opt to not disclosing this information with the client, despite the shared common experience. The omission of this personal experience is to ensure that the therapist can maintain some emotive distance and a level of objectivity with regards to the client's situation.

Despite these recommendations, the arena of therapist self-disclosure continues to leave a considerable grey area in actual clinical practice. Many clinicians are compelled to produce spontaneous decisions as to when to disclose in order to maintain the flow of the therapeutic conversation. In short, to optimize interactions during sessions. Thus, clinicians may not have the luxury of time to assess and reflect on their motives behind a particular disclosure till well after the session. The underlying cause of the therapist's decision to disclose may be unconscious.

Basescu (1977) sums up the anxieties of the therapist in the following excerpt:

"It is not so easy for me to be a human being. I think it would be easier for me to be a mirror. The rules for being a mirror are more clear-cut than the rules for being a human... Am I being reassuring by saying I have experiences like yours? ...My point is that as the value of self-disclosure by the therapist has become

recognized, it has provided me with, among other things, additional opportunities to worry and wonder. It is much easier to avoid all self-disclosure than to have to decide what is or is not desirable to express. But is it more therapeutic?" (pp. 159-160).

The above excerpt by Basescu (1977) underscores the gravity of the decision-making process involved in self-disclosing. Mirroring appears to be easier than expressing empathy and understanding from the point of a shared experience. The additional opportunities to wonder could potentially occur at the risk of overlooking other aspects of the client's situation. Riddled with self-doubt, many therapists, according to Basescu, must waver back-and-forth as to whether sharing their own personal experience in a singular moment in time during the conversational exchange is perceived as helpful or not by the recipient (i.e., client/ patient). This requires the attending practitioner to cultivate the unique skill of possessing a self-oriented consciousness and other-oriented consciousness, operating in tandem, and then subsequently evaluating how the client will receive the therapist's personal experience via verbal transmission. If the decision to disclose is made, then special attention is paid to its' contents, tone, delivery, timing and lexical choice in order to maximize its' utility.

Taken together, clinicians of all theoretical orientations may vary the degree of disclosure used in their practice; however, most agree that it is an important helping tool. Clinicians may disclose for the most part to serve the client and use this tool with the best of intentions, yet what is not very well understood is the extent to which a well-meaning disclosure is actually perceived by the client as helpful. Another important factor to consider is the need to make split second decisions as to which aspects of the client's issues are more urgent than others. Lee and Horvath (2014) reference the need to prioritize aspects of the session in an often time sensitive manner by noting that in the process of clinical practice the therapist makes important choices and decisions with regards to responsiveness in various aspects of therapy: what interventions to use, which

client issues to prioritize and engage with, and how to deliver selected intervention skills on a moment-to-moment basis.

Benefits of therapist self-disclosure

Therapist self-disclosure if used sparingly and above all appropriately can function as a vital tool in optimizing a session with a client. Bishop and Lane (2001) enumerated a number of common reasons for the use of therapist self-disclosure. Firstly, therapist self-disclosure is useful for building rapport by specifically fortifying the bond between therapist and patient. Many clients would feel more comfortable confiding in a therapist who was able to communicate with them on a level that is less antiseptic and more humanistic. In such situations self-disclosure could potentially break the ice and pave the way for a smoother transition into the session. Secondly, many patients may feel alienated in their experience and are helped in knowing their therapist underwent a similar experience. Thirdly, many patients benefit from here-and-now observations about the process as it stimulates affect in the room almost immediately allowing for an opportunity to explore the present feelings that have been aroused (also see Knox et al., 1997). Simon (1990) showed that some therapists disclose in service of de-stabilizing the inherent power imbalance between therapist and client.

In a ground-breaking quasi-experimental design study, Barrett and Berman (2001) divided therapists into two groups. The experimental group of therapists were instructed by researchers to match their client's disclosures on both topic and intensity whereas in the control group there was no formal instruction on how to proceed with the self-disclosure. For example, if a patient discussed his/her hurt feelings following romantic dissolution, the therapist would proceed to share with the client a similar experience if they were assigned to the experimental group. Results revealed that patients assigned to the experimental group reported less distressing

symptoms compared to those in the control group. These results suggest not only is the self-disclosure in and of itself important, but a reciprocal exchange between therapist and patient can reduce distress. Qualitative research also lends support to the conclusion that therapist self-disclosure can be useful. For example, Nye (2003) relates how her experience with Alopecia Areata, an autoimmune disorder that causes hair loss, understand the body image struggles that her patients with eating disorders struggled from. Educated at a psycho-dynamically oriented graduate school, she initially struggled with the decision of whether or not to self-disclose her illness. Despite being advised against it by her own therapist, she made the decision to write a memo advising her patients about her situation. Being an eating disorders specialist, she reported “feeling fraudulent” about her negative feelings in regards to her own body image. She sent the same memo to her patients suffering from eating disorders as well as her general psychotherapy patients. She reported that while some of the patients responded positively, some chose not to acknowledge the memo at all. While she states that the lack of response could either be interpreted as the recipients being satisfied with her communication about her situation or being a source of discomfort. One of her patients who had long resisted more intensive treatment for her eating disorder had agreed to pursue it. Nye states that she wonders if the timing of the self-disclosure had motivated her to take a more intensive step toward healing. Nye’s final conclusion that her self-disclosure had allowed her to model an important aspect of the journey toward healing for her patients. She feels that by allowing herself to show her vulnerability in regards to her body image, she has allowed them to feel less alone in their struggles and thus enhanced the client-therapist bond.

Therapists fears about self-disclosures

Researchers have conducted various studies examining the benefits of therapist self-disclosure and for the most part these researchers have found positive results. Other studies on have focused on therapist fears about disclosing. For example, in a study with a sample 365 social workers, findings revealed many practitioners chose to not disclose for the following reasons: (a) fear of diverting the focus from the client onto the therapist; (b) curtailing the amount of time the patient has to speak, (c) fear of hindering the transference reaction, (d) stirring confusion about the therapist and patient roles in the session, and (e) concerns about appearing unprofessional. Geller (1994) noted many novice therapists fear confrontation since it increases the risk of being perceived as unlikeable by their client. Furthermore, therapists differ greatly from one another on ability to tolerate an atmosphere of the intimacy levels, tension, tone, and affect present in the room (Farber, 2006). Therapists and patients alike can become frustrated when therapists withhold their feelings from the patient. Patients lose out on the opportunity to receive helpful feedback when this is the case. Moreover, patients are less likely to express their negative reactions if therapists themselves are unable to model it for them (Hill et al., 1993) ultimately hindering the progress of therapy (Safran & Muran, 2000). McWilliams (1994) raises an interesting point in that once a self-disclosure has been made the therapist cannot reverse the effects (i.e., a therapist cannot change his/ her mind at a later time point to return to a state of ‘invisibility’ to the client).

Self-disclosure and therapeutic outcome

Hill and Knox (2002) revealed that more than 75% of the studies analyzing ratings of non-client observers’ perceived high disclosing therapists more positively than their low disclosing counterparts following a viewing of a psychotherapy videotape. Hill and Knox’s

(2002) provided partial support for Watkins' (1990) conclusion that therapist self-disclosure should be used in moderation- too much or too little is perceived unfavourably. Moreover, high-disclosers implicitly encourage clients to disclose more as well, lending support to the hypothesis of conversational reciprocity and social exchange theory (e.g., Chaikan & Derlega, 1974; Derlega et al., 1973; Walster, Berscheid & Walster, 1973; Worthy, Gary, & Khan, 1969). Of particular mention, Hill et al., (1988) showed therapists rated the use of self-disclosure as an intervention that is the least helpful whereas clients reported therapist self-disclosure was the most helpful among the arsenal of potential techniques at the disposal of therapists commonly used in counselling. In a follow-up study, Hill et al., (1989) divided therapist self-disclosure into four categories: involving (i.e., conveying thoughts and feelings about the client in therapy), disclosing (i.e., sharing an aspect of the therapist's personal life with the client), reassuring (i.e., validating the client's experience), and challenging (i.e., confronting the client). Both therapists and clients reported reassuring forms of self-disclosure were the most helpful.

Costin and Johnson (2002) showed that therapists treating patients with eating disorders who themselves struggled with these same issues before were better able to develop rapport, model the recovery process, and challenge patient ego-centric views more effectively. This study substantiates the notion of the 'wounded healer' as advantageous. A therapist having successfully overcome an issue such as an eating disorder, and thus being able to selectively disclose details to a patient could potentially empower the patient to believe that overcoming the disease is not an impossible goal. The idea of the 'wounded healer' first originated with Carl Jung who sought to become a therapist, in part, to come to terms and soothe his own insecurities with regards to his poor physical health in childhood (see Dunne, 2000 for an overview). The idea of a 'wounded healer' is further elaborated by Sussman (1992) who suggested the power to heal stems from the healer's ability to draw upon their own past in order to empathize with their

client giving credence to the phrase ‘it takes one to know one’. Schwartz and Flowers (2010) distinguish between therapists “who understand the client’s pain” versus therapists “who have felt the client’s pain” (p. 122). This excerpt is consistent with the aforementioned viewpoint that a common experience can prove beneficial to the client.

McGovern and Armstrong (1987) suggest therapists be mindful of over-identifying with the client’s issues. Therapists who have dealt with similar issues run the risk of failing to listen to their client because of erroneous thinking that they’ve been through what the client is thinking or feeling. Goldstein (1994) refers to a case where she was a patient and was seeing a therapist who shared the same birthday as she did. She was pleasantly surprised when the therapist somewhat hesitantly disclosed that they shared the same birthday. Years later after Goldstein had completed her training; she discovered that a patient of hers had the same birthday. She impulsively disclosed the fact to her client. The client reacted negatively to the disclosure and felt that Goldstein was trying to impose on her “special day”. The client then referred to her childhood trauma of having parents who would undermine her and make her feel unimportant. Goldstein regretted her self-disclosure and reevaluated her choice as being self-indulgent. This is one such example of a therapist running into the risk of over-sharing intimate details about her own life, which was not welcome by the client and created an unpleasant situation.

Another potential concern is the violation of the therapist’s right to privacy. However such a risk is often minimal as many psychotherapists are often reticent and cognizant of boundaries. The age and experience level along with orientation is another valid factor to analyzing the implications surrounding self-disclosure occurring more frequently amongst younger or more experienced therapists in North America. Holmqvist (2015) conducted a study on the use of self-disclosure among Swedish psychotherapists. The goal of the study was to analyze the frequency and types of self-reported self-disclosure interventions from different

orientations, different ages and experience levels using *The Counsellor Disclosure Scale*. A random sample of 300 therapists was stratified in three age based strata: under the age of 46, 46-56, and 57 and older. A random selection of a 100 was selected from each stratum .61% agreed to participate. Their respective years of experience according to stratum are as follows: 73 had worked for up to 5 years, 68 between 6-15 years, 22 between 16-25 and 16 for 26 years or longer. Holmqvist (2015) reports that significantly dissimilar results occurred between therapists of different orientation. Cognitive behavioral therapists disclosed more about different aspects of their lives than psychoanalytically and psychodynamically oriented therapists. The therapists from the older age group strata had psychoanalytic and psychodynamic training to a greater extent than the younger therapists. Also those with psychoanalytic and psychodynamic training preferred to disclose less about their training, orientation and diagnostics regarding the client in comparison to the cognitive behavioral therapists. The cognitive behavioral therapists, on the other hand, preferred to disclose more about personal matters, indicating that they were more willing to model and thus normalize the client's experiences. The younger therapists in general, disclosed more about their training and experiences. This could be because they felt more obligated to appear professionally competent. They were also more inclined to reference relationships. Holmqvist speculates if this is due to being trained in the recent past where less of an emphasis on the psychodynamic notions of neutrality was imposed. Another reason for the selective disclosure on private matters could be the younger therapist's awareness of social media sites such as Facebook and Twitter where it is possible for an individual to share certain aspects of themselves (see Holmqvist, 2015).

In sum, there are various factors influencing client's perceptions of therapist expertise, likeability and helpfulness. Most studies have focused on the frequency of therapist disclosure,

however, the content and the level of intimacy of the disclosure must also be taken into consideration prior to drawing any firm conclusions.

Research on self-disclosure with specific cultural groups

Wetzel and Wright-Buckley (1988) showed that African-American therapists who used therapist self-disclosure more frequently were more likely to garner increased levels of disclosure from their African-American client. Interestingly, African-American clients in this same study were more likely to trust and feel safe in the presence of their African-American therapist. However, when an African-American client receives services from either a high or low disclosing Caucasian therapist, the client's comfort level did not increase nor did it decrease. Rather, African-American clients preferred more personal disclosures from their Caucasian therapist, ostensibly to foster trust within the early stages of the therapeutic relationship.

Kim (2003) showed that East Asian participants preferred disclosures of strategy compared to other forms of disclosure (e.g., approval/ reassurance, facts/ credentials, feelings). Therapist disclosures of insight were perceived as moderately helpful by clients. Furthermore, the more intimate the disclosure (as perceived by both therapist and client) the greater the perceived level of helpfulness from the therapist and the client. Lee (1997) showed that Asian-Americans clients were more likely to perceive their therapists as authority figures than their Caucasian counterparts and they were also more likely to defer to their therapist's opinions. Constantine and Kwan (2003) recommend psychotherapists working with Asian-American clients pay particular attention to disclosures pertaining to their credentials. According to Constantine and Kwan (2003), Asian-American clients may value their therapists' credentials more than Caucasian clients do. Often these types of disclosures are conveyed indirectly through business cards, brochures, and office décor.

Research using a sample of Mexican-Americans revealed that clients perceived high disclosing therapists as having less expertise (Cherbosque, 1987). Mexican-American clients were willing to disclose more to therapists who were disclosing less. Sue and Sue (2003) suggest this perspective is in accordance with cultural values that enforce professional boundaries between therapist and client. Over the course of therapy, via familiarity effects, Mexican-Americans may begin to engage the therapist into a two-person psychology process, whereby trust develops and therapist self-disclosure is more appropriate.

Limitations of studying therapist self-disclosure in visible minority populations

The limitations of the above studies were the homogenization of particular ethnic groups (i.e., African-Americans, Mexican-Americans). Trimble (1991), warns psychologists against the dangers of lumping entire ethnic groups into a single category. A phenomenon termed ‘ethnic glossing’². In the United States, much research is conducted on African-Americans and Hispanics (given the demographics) and yet research on these ethnic minorities provides an ‘illusion of homogeneity’. For example, the use of the category Hispanic artificially constructs and misleadingly unifies an ethnic group based on a shared language to the neglect of other pertinent socio-cultural features that may influence their personality. First and second-generation Hispanic Americans have diverse backgrounds ranging from Puerto Rican to Mexican to Guatemalan. Even after being equipped with a clinical sensitivity to the Hispanic-American client’s country of origin, it is still not enough to contextualize the individual’s identity as there exists gender, class, regional, dialect, urban-rural differences that must be attended to between and within Hispanic-Americans (see Chamorro, 2003). Consequently, conceptualizing groups in

² Vontress (1988) does not see ethnic glossing as an insurmountable obstacle. From an existential framework, humans share commonalities with regards to pain and suffering in which therapists can relate to their clients on the basis of a common universal cultural (Vontress, 1988; also see Vontress, 1971).

this manner continues to reinforce stereotypes. This critique of ‘ethnic glossing’ is not limited to the scholars of the West but also to cultural psychologists studying their population of interest from within that country who favour one type of categorization (usually gender and ‘race’) to the neglect of all others socio-cultural features.

To take it further, even the term ‘ethnic glossing’ is a misnomer in terms of its’ focus on ‘ethnicity’. Glossing over any salient identity feature is commonplace in the behavioral sciences and not restricted to ethnicity. The most common form is arguably sex or gender whereby generalizations are made about both groups on the basis of differing anatomical and physiological characteristics. These differences are then exacerbated by explanations put forth that socio-cultural influences facilitate differential personality development between the ‘two’ genders. Sex differences are well-founded in the research based on averages; however, these group based averages only emphasize points of dissimilarity. More recently, scholars have advanced positions suggesting that there are far more similarities between the sexes and the genders than there are differences as well as more variation within the same sex and gender. If doubt is casted on the generalizations made on a very overt and well-studied social identity feature such as sex and gender, the same concerns need to be raised with all of the other less well-studied social identity variables such as: class, religion, age, sexual orientation, urban-rural, and other regional differences. At the same time, it is imperative to avoid clustering all people together thereby ignoring important cultural differences in terms of history, heritage, values and diverse ways of relating to others. The challenge is the negotiation between recognizing individual capacities for uniqueness within a framework of group differences.

Summary

This chapter reviewed the history of self-disclosure by tracing its’ history to psychoanalysis. Beginning with psychoanalysis the chapter draws attention to the development

over the years of how self-disclosure gained more widespread acceptance among mental health professionals by shifting the emphasis on the therapeutic relationship whilst de-emphasizing the importance of insight. Various thinkers have re-conceptualized self-disclosure from simply the deliberate sharing of a personal experience to a more encompassing one including: self-involving statements (i.e., therapist interpersonal reaction to the client) and non-verbal means of communication (i.e., office décor, wedding rings). Contemporary theorists have the notion of therapist self-disclosure even further by factoring in any direct and/ or subtle communication of the therapists' values, beliefs and intentions. Contemporary multi-cultural counselling theorists have adopted the stance that visual appearance and manner of speaking can provide social information to the client about the therapists' cultural background, which in and of itself, is a sub-type of self-disclosure. Furthermore, this chapter recapitulates the previous empirical research conducted on therapist self-disclosure in terms of timing, efficacy and use within cross-cultural dyads.

This chapter reviewed the history, origins and definitional complexity pertaining to therapist self-disclosure. Moreover, it highlighted the difficulties involved in defining the construct.. Originating with Freud and his theoretical stance prohibiting the 'use of self' (despite a lack of strict adherence to his own postulations himself), the chapter reviewed the main reasons why therapist self-disclosure was perceived as anathema to the therapeutic process. Mainly, the undue influence therapist insertion of him/ herself into the client's narrative could adversely effect ability to interpret the transference without bias and complete clarity. In addition, 'the use of self' had been cautioned against because of the blurring of the boundary between therapist and client. As therapy had advanced from its' inchoate stages, many scholars and clinicians alike from various theoretical orientations suggested that the 'use of self' could be a major factor in facilitating a stronger bond between therapist and client. Contemporary theorists have argued

that the therapeutic alliance is the most important ingredient in determining the outcome of therapy. Empirical research reviewed in this chapter has supported the assertion that the therapeutic alliance is central and that the use of therapist self-disclosure is indeed positively perceived to by clients, which is in service of strengthening the bond between therapist-client. Finally, this chapter reviewed the extant literature on therapist self-disclosure as it applies to inter-ethnic pairings and concludes that further research is necessary to better understand the contexts in which self-disclosure is used when working with clients from diverse backgrounds.

In the next chapter, a history of multicultural counselling is reviewed. The proliferation of scholarship in multi-cultural counselling, in conjunction with, the recognition of inadequate clinical skill in the counseling room has led leaders within the field to urge all academics and practitioners alike to develop multicultural competency in working with their clients' from diverse backgrounds. In particular, this next chapter will discuss how the specific clinical skill of self-disclosure has developed over the years as it pertains to multicultural counselling. More specifically, the research involving the use of therapist self-disclosure within the context of cross-cultural dyads will be summarized.

Chapter Three

Literature Review:

Multicultural Counselling

Historical Overview of Multi-Cultural Counselling

In order to understand the challenges and urgency of multicultural counselling, it is important to understand the impact of worldview and the asymmetry of power relations between colonizers those who were oppressed and subsequent neocolonial attitudes that have historically plagued the field of mental health. Pioneering work in the field of multicultural counselling that took these factors in account, can be credited to several individuals (such as Clemmont Vontress, 1967, 1974, 1979; Moodley, Epp & Yusuf, 2012; Moodley & Walcott, 2010). Vontress was one of the first to highlight the challenges in working with African-American clients because of their legacy of intergenerational trauma. In some of his early work, Vontress noted the difficulty of establishing rapport with Black clients because they travel with an intense emotional reaction towards White people based on their lived experiences (Vontress, 1971). The legacy of intergenerational trauma that Vontress refers to when referring to African-American clients is explained by Fernando (2010) who asserts that:

“The Western worldview, based on control, has within it an assertiveness that has paid off in material gain by the West; African and eastern acceptance has promoted a passivity that has allowed the West to dominate and exploit both the people and resources of the earth to the point of destruction... the rational, justifiable anger of African and Asian people and the understandable guilt of the West-both arising from recent history—are entwined respectively with traditional non-western acceptance and traditional western aggressiveness in the feelings that determine the concept of mental health in their cultures today” (p.43).

Fernando is referring to the neocolonialist attitude that governs how ethnic minorities are treated from the standpoint of how the systematic racism allows for the intergenerational trauma of the oppressed to continue. He is critical of the western perspective that continues to allow

minorities to be marginalized without considering the factors that lead to the backlash in the first place.

The danger, however, of conceptualizing people of colour as entirely unique is the potential that counselors may ignore factors that are universal to all humans. According to Vontress, “[the counselor] may fail to realize that black people are human beings first and black secondly, that they become tired, grow old, and finally die, like all other human beings” (Vontress, 1971, p. 9). The existential perspective purported by Clemmont Vontress, as applied to multi-cultural counselling, highlights the shared commonality of human experience. Thus, practitioner’s working in multi-cultural settings were at risk of potentially minimizing and/ or misunderstanding the client’s presenting concern, via over-focusing on one or more salient identity marker(s) such as: ‘race’, colour, ethnicity, nationality or culture, at the expense of more pertinent symptoms and experiences related to their distress narrative.

Throughout the 1970s, awareness was raised on the relationship between mental health and racism. Initiatives were made to interrogate mainstream practices with respect to the widespread use and presence of culturally insensitive models, institutional racism and the absence of mental health practitioners from ethnic minority backgrounds (Robinson & Morris, 2000). Inequities, misdiagnosis and cultural insensitivity in mental health provision began to raise questions amongst scholars and practitioners alike for radical reform within the sphere of clinical practice. Some mental health professionals arrived at the conclusion that “racism was itself a mental illness striking at the nation’s health” (as cited in Turner & Kramer, 1995, p. 4). In doing so, Turner and Kramer offer an acute critique of the way in which social inequities and social inequalities are understood and subsequently produced and reproduced within the microcosm of the therapeutic encounter; thus redefining racism from a socio-cultural problem to

an intrapsychic ailment plaguing the scholars and practitioners whom purvey the dominant and hegemonic models.

The decade of the 1980s, multicultural scholars further promulgated the idea that neglecting ethno-racial factors would lead to the provision of mental health services that were insensitive (Vontress & Epp, 1997). Gross generalizations were made on the basis of White, middle-class participants and misapplied to ethnic and racial minorities leading to inappropriate conclusions derived from assessments, misdiagnosis, and misinformed psychotherapy practices (Turner & Kramer, 1995). Robinson and Morris (2000) eloquently summed up the ethnic-racial crisis as: “Counseling was basically a service provided by White Americans who were trained by White educators and supervisors in the use of interventions derived from White theories which were based exclusively upon White cultural values” (p. 241). Implicit within this message, scrutiny of the ethno-racial backgrounds of the students and educators alike was warranted in hopes to inspire change and diversify the cohort of new trainees and challenge mainstream perspectives taught within the field of psychology. Given this ethno-centric reality, pressures were placed on teaching and training institutions in psychology to re-articulate their dominant theoretical frameworks of operation. This meant altering, modifying and creating new curriculum and pedagogy that incorporated and opened up a space for multi-cultural training to students enrolled in a psychology graduate program. Furthermore, this also necessitated an adjustment in how practitioners, whom may have been previously educated in dominant and hegemonic models of practice to adapt their skills and techniques taught to them in working with clients of diverse backgrounds.

In the year 1990, Pedersen declared multicultural practice as psychology’s “fourth force” that warranted and demanded the attention of all practitioners (Pedersen, 1990). By 1992, leaders in the field such as Derald Wing Sue and his colleagues (1992) made a call to the profession for

widespread inclusion of multi-cultural counselling education for all those providing psychological services (see Sue, Arredondo, & Mc Davis, 1992). Around this time period the American Psychological Association had substantiated efforts of lead scholars in garnering attention to the importance of multicultural counselling. In their efforts, the American Psychological Association managed to mandate service providers to re-educate and re-train as part of a revised Ethical Code. The rise of multi-cultural counselling grew in response to the dominant traditional approach which deemed counselling with White clients as also being appropriate for ethnic and ‘racialized’ minorities (see Abreu, Chung & Atkinson, 2000, for a brief review).

Leaders in the field of multi-cultural counselling argued previous psychological conceptions of ethnic and ‘racialized’ minorities were misguided and erroneous (e.g., Ponterotto, 1988; Sue & Sue, 1990). For example, proponents of early models claimed that ethnic and ‘racialized’ minorities were less developed and were lower on the evolutionary hierarchy. Popular assumptions of ethnic and ‘racialized’ minorities as primitive were widespread (i.e., the pathological/ inferiority model). Another pervasive model at the time was the Genetically-Deficient Model that suggested visible ethnic minorities lacked any of the desirable genes. Finally, many social scientists succumbed to believing in a “cultural deprivation” model which postulated that ethnic and ‘racialized’ minorities were part of an impoverished culture and to no fault of their own that somehow stunted their psychological development (Abreu, Chung & Atkinson, 2000). In sum, the ethnocentric views which had once dominated and pervaded psychological circles had portrayed ethnic and ‘racialized’ minorities as an inferior sub-species of human leading to a great deal of backlash by scholars operating from an anti-oppressive and/or multicultural framework.

More recently, multi-cultural practice has broadened its horizons to encompass gender, sexual orientation(s), religion, social class, and (dis)ability status among others. Sue et al., (1992) argue that although the broader and more inclusive definition of multi-cultural counselling is legitimate and important, it poses the disadvantage of diffusing issues of 'racism' with other important issues such as 'homophobia' 'sexism' and 'classism', thereby ignoring the unique concerns and needs of ethnic and 'racialized' minorities. Helms and Richardson (1997) support the aforementioned position advocating for separation between the fields of multicultural counselling and diversity issues suggesting the conflation of the two arenas create ambiguities and confusion within research. Furthermore, clustering together various salient identity markers can attenuate the positive impact of identity-specific scholarship, clinical training and advocacy in the field when subsumed under a singular umbrella of 'multi-cultural and diversity studies'.

Multi-cultural counselling outcome research

Historically, ethnic minorities were deemed unsuitable or ill-equipped for psychotherapy interventions (see Abreu, Chung, & Atkinson, 2000). More recently, research using samples comprised of ethno-racial clients have converged to refute prior assumptions that ethnic minorities cannot benefit from mental health services. Studies have shown ethnic minority clients are more likely to utilize psychological services if they are matched with a therapist who shares a similar cultural background (e.g., Cabral & Smith, 2011; Karlson, 2005; Maramba & Hall, 2002).

Furthermore, language similarities between therapist and client were predictive of increased use of mental health care services. Chamorro (2003) who has a Dominican mother and a Spanish father analyzes how multicultural self-disclosure is inevitable due to her Castillian accent when speaking in Spanish to clients. Chamorro (2003) believes that the degree of

mutuality is not deliberately selected because accents real geographical origins and also because both the therapist and client are participating in an exchange during the session that is not in the mainstream language. Of special significance is the language ideology in the United States where she practices. Spanish is not considered a prestige language and therefore conducting a treatment in the language can potentially be viewed as a collective identification with disempowerment. Rather than finding that the connection her Spanish speaking patients attempted to forge with her useful, Chamorro notes that predominantly Latin American patients would often refer to her Spanish heritage, in terms of the origination of the language. That is referring to Spain as the mother-country. She found this transference to authority uncomfortable. She is honest about her own discomfort at being treated so differentially and regards the countertransference interaction as including her own. Another observation she had made about her own behaviour regarding adjusting her accent while speaking Spanish (also see Litjmaer, Moodley & Sunderani, 2013).

Empirical studies have shown that ethnic minority clients are more likely to drop-out of treatment when they are paired with ethnically dissimilar therapist (e.g., Sue, Fujino, Hu, Takeuchi & Zane, 1991). Matching therapists to clients based on language similarity also predicted better outcomes, as measured by scores on the Global Assessment Functioning scale. Surprisingly, there are no conclusive results with respect to better outcome with ethnic matching (see D'andrea & Heckman, 2008 for a review on outcome studies). Taken together, there is an overwhelming amount of research studies which have demonstrated that client's perceive culturally-sensitive therapists as far more effective and helpful than non-culturally sensitive therapists (e.g., Gim, Atkinson, & Kim, 1991; Pomales, Clairborn, & LaFramboise, 1986; Sadowsky, 1991).

Multicultural Competencies

The emergence of multicultural competence, subsumed under the overarching multicultural counselling movement, reflects the need for psychologists to learn and hone in on specific areas that are relevant to clinical practice. Just over a quarter century ago, the American Psychological Association required psychology departments across the country to implement multi-cultural training to their students so they could better serve the diversity of clients they would be helping (Korman, 1974). Sue and colleagues (1992) had provided the framework for developing multicultural competencies for the American Psychological Association. In hopes to improve multicultural competence, specialized programs and courses were created and offered to develop these skills to work with clients from a broad range of ‘races’ ‘ethnicities’ and ‘colours’ (Buckley & Foldy, 2010).

Three common approaches to understanding multi-cultural competence with ‘ethnic minority’ clients are the: universalistic, particularist, and transcendist positions. The universalistic position focuses on the similarities between therapist and client as two human beings that can both encounter struggle. Adherents of the universalist position believe emphasizing differences can interfere with therapy and perpetuate stereotypes (Pinderhughes, 1989; Wohl, 1989). The particularist position highlights the unique social histories and experiences between various ethnic groups (e.g., Sue & Sue, 1999). Finally, the transcendist position attempts to synthesize both approaches by understanding that all human share commonalities as well as culturally-determined differences. (e.g., Tyler et al., 1991). Given ethnic minority clients are more likely to terminate therapy after one-session at far greater rates than non-minority clients, multi-cultural competence among practitioners is becoming increasingly important (Sue et al., 1991). Furthermore, ethnic minority clients seek mental health services at

far lower rates than non-minority clients (Sue, 1998; Vessey & Howard, 1993) indicating that mental health services can strive to become more accessible to ethnic minorities.

Counselling competencies specific to working in multicultural settings can include: (a) the use of alternative modes of thought and information processing style to communicate more effectively with a client, (b) acknowledging ‘racial’/ ethnic differences in the beginning phases of therapy, (c) utilizing a multiplicity of verbal and non-verbal responses to clients, (d) integrating or referring clients to traditional cultural healers, and (e) meeting the needs of client through flexibility and accommodation (see Maxie, Arnold & Stephenson, 2006 for an overview). The area of identifying multi-cultural competencies is fraught with disagreement, for example, Sue (1998) critiques the aforementioned broad areas of multi-cultural competencies outlined as lacking in specificity and failing to be informative to therapists on ‘how to’ implement these into actual clinical practice. In response to these general multicultural competency guidelines, many scholars have honed in on more specific areas. Within the framework of the general guidelines, specific areas therapists are requested to be mindful of within counselling and psychotherapy are: (1) identifying the effects of racism on mental health; (2) acknowledging the ways oppression affect identity; (3) developing an awareness of how history, politics and institutions intersect to disadvantage certain groups of people more than others; (4) understanding how race, socioeconomic status, and the acculturation process can exert detrimental effects on mental health (e.g., Caylef, 1986; Cross, 1978; Helms, 1990; Hull, 1987; Sadowsky, Lai, & Plake, 1991; Sue & Sue, 1990).

An alternative approach is the four-factor model as proposed by Sadowsky, Taffe, Gutkin and Wise (1994). Sadowsky et al., suggest multicultural competence consists of the following four key components: *skills*, *awareness*, *knowledge* and the *relationship* between therapist and client. Within this framework, the present study focuses on therapist self-disclosure as one of the

components (namely *skills*) subsumed under the global concept of multicultural competence. The use of therapist self-disclosure can be used as a tool to increase therapeutic efficacy (e.g., Hill et al., 1988).

In cross-racial and cross-cultural dyads, therapist self-disclosure is one way to communicate cultural sensitivity to the client and build the relationship (Constantine & Kwan, 2003). Unfortunately, due to the paucity of research examining ‘culturally-relevant’ content within the session between therapist and visible minority patients, little is understood about this dialogic process. (i.e., White therapist self-disclosing to an ethnic minority client). Not all content a client presents is culturally-relevant, however, when material has a cultural basis, how does the therapist respond to the client? More specifically, what personal information does the therapist self-disclose from their own experiences as a cultural being? When, within the session do they do so? And why?

Considering the importance of therapist self-disclosures in the therapy room, the present study aims to explore the nature and type of content communicated by therapists in the form of self-disclosure which are specific to working with ethnic minority clients. Lee (2013) references a case of inadvertent therapist self-disclosure with a client from a different culture. The therapist was in her fifties, identified as white and had over twenty years of post-doctoral experience in the field. The patient was an immigrant from Argentina in his forties with two young children, who was seeking therapy due to depression arising from conflicts with his ex-wife. He expressed feelings of loneliness and feelings of isolation from not being able to see his children. He also stated that he was frustrated by not being able to participate in a more active capacity in his children’s lives by helping them with their homework. He mentioned that he did want to get involved with playing soccer once more though he was quick to distinguish himself from a soccer fanatic. The therapist appears over eager to establish an awareness of herself as being multicultural proficient by over emphasizing the importance of soccer in his life. She brings it up several times

which makes it appear as if she is attempting to impose her cultural ideal of a Latin American male as opposed to accepting his comment as being a small part of the overall issue of his depression. She also disregarded the fact that the client's role as a father played a role in his overall cultural identity, by referencing him needing something that was a part of his life independent of his family. What is particularly significant is her apparent ignorance about the central role of family ties in the patient's culture and social location, while at the same time imposing her ideal of him as a soccer fan despite being told that he was fond but not a fanatic. In doing so, she created a situation that calls for understanding of multicultural competence as being more than the act of acquiring knowledge and skills but also dealing with the powerful emotions and unconscious biases surrounding race and racism (See Sue et al., 2010; Sanchez-Hucles & Jones, 2005).

Therapist self-disclosure in the context of multi-cultural counselling

It is difficult to understand the complexities that bring to question why previous work investigating therapist self-disclosure research has ignored the 'elephant in the room' (i.e., ethno-cultural-racial differences between therapist and client) considering the paucity of research available in this regard. One possibility is that Eurocentric views of understanding the client still prevail today. In this vein, visible minority clients are constructed as the 'Other' within research and are seen as the exceptions to mainstream clinical practice. Alternatively, it is plausible researchers in the area of therapist self-disclosure adopt a 'universalist' framework thus conceptualizing cultural differences as irrelevant or peripheral to understanding what happens in the session between therapist and client. Does client receptiveness to therapist self-disclosure differ based on their ethnic similarity to their therapist? From the perspective of visible minority clients', interactions with Caucasians may have led to prejudice and discrimination eliciting negative reactions (Terrell & Terrell, 1984), thereby influencing the emotional reception of a

disclosure made by their Western-trained therapist. Lee (2013) references a case of inadvertent therapist self-disclosure with a client from a different culture. The therapist was in her fifties, identified as white and had over twenty years of post-doctoral experience in the field. The patient was an immigrant from Argentina in his forties with two young children, who was seeking therapy due to depression arising from conflicts with his ex-wife. He expressed feelings of loneliness and feelings of isolation from not being able to see his children. He also stated that he was frustrated by not being able to participate in a more active capacity in his children's lives by helping them with their homework. He mentioned that he did want to get involved with playing soccer once more though he was quick to distinguish himself from a soccer fanatic.

The therapist appears over eager to establish an awareness of herself as being multicultural proficient by over emphasizing the importance of soccer in his life. She brings it up several times which makes it appear as if she is attempting to impose her cultural ideal of a Latin American male as opposed to accepting his comment as being a small part of the overall issue of his depression. She also disregarded the fact that the client's role as a father played a role in his overall cultural identity, by referencing him needing something that was a part of his life independent of his family. What is particularly significant is her apparent ignorance about the central role of family ties in the patient's culture and social location, while at the same time imposing her ideal of him as a soccer fan despite being told that he was fond but not a fanatic. In doing so, she created a situation that calls for understanding of multicultural competence as being more than the act of acquiring knowledge and skills but also dealing with the powerful emotions and unconscious biases surrounding race and racism (see Sue et al 2010; Sanchez-Hucles & Jones, 2005). Drawing upon the work of Perez Foster (1998), these unconscious biases and emotionally laden reactions to the client by the therapist can be considered 'cultural countertransference'. 'Cultural countertransference' has the capacity to hinder the therapeutic

process by manifesting itself when the therapist makes false assumptions about the client (at perhaps an unconscious level) disclosing his/ her reaction to or drawing from his/ her experience to relate to the client, however, the reception of the disclosure by the client is deemed non-beneficial or culturally-insensitive (see Lee, 2014; Stampley & Slaughter, 2004). These dyadic mis-attunements via inappropriate therapist self-disclosure, within session, are the by-product of egocentric and Eurocentric ways of relating to the client that “fall flat” (i.e., not perceived by the client as helpful or effective). However, not all ‘cultural countertransference’ is inherently negative (see Burkard, Knox, Groen, Perez & Hess, 2006; Shecter, 1992). Much like ‘transference-and-countertransference’ phenomena involving intra-ethnic pairings, ‘cultural countertransference’ also has the potential to strengthen the therapeutic bond in the context of inter-ethnic pairings- and in turn improve the overall strength of the therapeutic alliance by connecting two people via shared experience informed by a shared ‘cultural knowledge base’. Given the increased risk for mis-attunements, misunderstandings, impasses, and ruptures to occur within cross-cultural dyads, more research is warranted with regards to how therapist self-disclosure is used with clients from diverse backgrounds.

Summary

In this chapter, the literature on multi-cultural counselling is reviewed and summarized. Although research on cross-cultural dyads was conducted throughout the 1960s and 1970s, a turning point was when Derald Wing Sue and his colleagues (1992) made the “call to the profession” urging psychologists and mental health professionals alike to further understand the changing cultural demographic landscape of the United States (and by extension Canada). This call to the profession propelled multi-cultural counselling to forefront on the priority list within the field of psychology. Subsequently, Arredondo et al., (1996) had operationalized some of the key areas for therapists to direct their attention towards. One of the focal areas leading scholars

in the field encouraged further development in was therapist *skills* (See Arredondo et al., 1996).

This chapter discussed the skill of using therapist self-disclosure within the context of multi-cultural competency. This chapter asserts, based on the work of Lee (2013), that because ‘culture’ is embedded within the person, an understanding of therapist self-disclosure devoid of cultural context is futile; thus necessitating the need to conceptualize therapist use of self-disclosure as having some cultural basis (which vary on degree between conscious awareness and unconscious influence). Little research has been conducted on the use of therapist self-disclosure within cross-cultural dyads. As a result, clinicians are with specific guidelines on how to incorporate self-disclosure in working with clients from a differing background than themselves. Previous initiatives championed by multi-cultural leaders within psychology such as, Derald Wing Sue and Patricia Arredondo, presumably well-intentioned, insist upon mental health professionals that they re-train, adapt to, and refine their clinical skills in working with clients of diverse backgrounds, however, they have offered little guidance in the specifics of “what to” and “how to go about” disclosing to someone of a different background in the counselling room. Moreover, leading contemporary scholars in the area of therapist self-disclosure such as, Clara Hill and Sarah Knox have offered many practical suggestions in using self-disclosure (e.g., Hill & Knox, 2004; Knox & Hill, 2003) but have more often relied on quantitative data and without a specific focus on working with clients from diverse backgrounds notwithstanding (Burkard, Knox, Groen, Perez & Hess, 2006). The present research hopes to build upon the small amount but recent scholarship examining therapist self-disclosure in working with clients from diverse backgrounds. Also, this research is an effort to bridge the gap between the literature on therapist self-disclosure and multi-cultural competency pertaining to skill development.

Chapter Four

Methodology

Introduction

The central topic of inquiry is “how do therapists use self-disclosure in their practice when working with clients from diverse backgrounds?” The present study will investigate the types of personal experiences therapists communicate to their clients and whether the content of their self-disclosure varies as a function of their own ‘social location’ in relation to their client’s ‘social location’. A corollary topic in the present investigation is under what circumstances do therapists opt to withhold personal information from their clients? To answer these research questions, as to whether therapist self-disclosure changes depending on client’ variables (i.e., ethnicity, ‘race’ and other marker of diversity), interviews will be conducted with experienced therapists currently working in the field. Therapists (i.e., participants) will be asked about their experiences in using self-disclosure in addition to, contexts in which they do not use disclosure. A qualitative methodology will be adopted to better understand when and how and with whom are therapist self-disclosures utilized. Moreover, the examples that participants generate from their clinical work will be analyzed for content and organized thematically.

Qualitative Approach

For the purpose of the present study, given the nature of the main research questions, a qualitative approach was used. Of interest were participants’ particular and subtle ways of communicating personal experiences and the content of those personal experiences in the context of working with clients from diverse backgrounds. Considering psychotherapy is largely a verbal process, the details and specifics about what in fact therapists do communicate to their clients in the privacy of their consulting room was most suited to a qualitative approach. Advantages of a

qualitative approach is the capacity to collect rich and detailed data rooted in personal experience that would potentially be missed with positivist and/or frequentist approaches such as quantitative analysis (see Charmaz, 2011). Moreover, as discussed in the literature review previously, much of ‘what is said’ and ‘not said’ by therapists to their clients can fall below the level of their conscious awareness (see Lee, 2014; Lee & Horvath, 2013). Taking into consideration, the paucity of research on the topic of self-disclosure in working with minority and diverse clients the present study adopted a Grounded Theory in hopes to develop a greater understanding of an understudied topic.

Rationale for using Grounded Theory

The grounded theory approach offers several strengths. Counter to interpreting the data to fit an existing theory, a grounded approach generates its own theory based on the researcher’s inductions made from the data. Rennie, Phillips and Quartaro (1988) outline the strengths of a *theory-generation* approach in contrast to the more popular *theory-verification* approach in detail. *Bottom-up* approaches opposed to *top-down* approaches, allow for experiences to be generated as the data emerges. Theory development follows data collection rather than precedes it (also see Charmaz, 2011). Glaser (1978) proposes emerging theories should satisfy the following four criteria: 1) the theory should appear to be a plausible explanation, 2) sizeable pieces of data should not be excluded from the analyses, 3) procedures should be well-defined and adhered to in a consistent manner, and 4) the theory emerging out of the data should be relevant and fuel further research questions.

Another aspect of the grounded theory approach is it allows the researcher to clearly state their own biases. This allows the reader to form their own conclusions based on the lens by which the researcher is operating. The researcher’s open disclosure and transparency of their

own social position and standpoint they are categorizing and interpreting the data from is noble insofar as he/ she takes a proactive stance in acknowledging his/ her own subjectivity involved in the research process known as 'reflexivity'. Through the use of 'reflexivity' the researcher indirectly communicates to the reader that there is no singular or universal way of categorizing and interpreting the data. This places the technique of grounded theory at an interesting vantage point insofar as replication of the results in future studies are largely dependent on the perspective of the researcher to make the determinations of which points of similarity and/ or difference will be used from the information supplied by their respondents.

Rennie, Phillips and Quartaro (1988) suggests that the main strength of the grounded theory approach lies in its' persuasiveness. Organizing the data into meaningful categories establishes the basis for guiding the reader to form their own conclusions. In some ways, once the data is organized into some meaningful way, based on a dimension of similarity, the emergent theory would follow from the data adhering to the principle of parsimony. In addition, the grounded theory approach benefits from the depth of information provided by interviewees, akin to the case study method but also the researcher reaps the rewards of utilizing more than one individual case for so he/ she can tap into a common theme that characterizes their participants experience. Replication of experiences is central to the purpose generating a new theory to explain the phenomena of interest.

Another hallmark of the grounded theory approach is that data collection is not completely standardized. The questions that comprise each interview are unique from each other. Although an interview guide may aid the interviewer in focusing on a specific areas, these questions need not be rigidly adhered to. Moreover, questions asked to the interviewees can change based on the information supplied from previous respondents. This dynamic process affords the interviewer flexibility to hone in more closely on the area of inquiry. As a result of

this built in flexibility, the phenomenon under investigation is more likely to showcase itself clearly from the data (see Rennie et al., 1988).

There are several limitations to the grounded theory approach. One aspect of the grounded theory approach is that verbal reports are transcribed but are not quantified. As a result, the verbal reports generated from the interview constitute the entire data set. The drawback of exclusively relying on verbal accounts is that interviewees may be unaware of certain psychological processes the interviewer is asking them to comment on. Thus many interviewees may be unable to articulate certain psychological processes that are germane to the area of focus for the researcher (Rennie et al., 1988). Although it is customary in a grounded theory approach to create theories which would be easily recognizable to the respondents, Henwood and Pidgeon (1992) suggest a ‘negotiated joint reality’ between the researcher and the researched should be strived for. This is especially important in cases where the phenomena of inquiry is not obvious to the interviewees.

Another limitation to the grounded theory approach is the extent to which the results are generalizable. Given the laborious nature of transcribing each interview, researchers using a grounded theory approach typically use a small sample size. In turn this threatens the researcher’s ability to draw universal conclusions from their findings (Rennie et al., 1988). Lincoln and Guba (1985) propose the use of the term *transferability* instead of *generalizability* to denote that findings from a grounded theory approach can still apply to other segments of the population insofar as the context in which these findings were derived from remain the same.

Research Process

Research Participants and Recruitment

Nine participants were conveniently sampled for the purpose of the present study from a wide range of mental health service agencies and institutions. The inclusion criteria for

participation in the present study is that the participant has an understanding of when and how to use therapist self-disclosure. Unfortunately there are no clear guidelines, “gold standards” or even agreement among mental health professionals at what point in a therapists career they are no longer considered a neophyte. This is exceedingly difficult because some mental health professionals have had more years in school than others (e.g., clinical psychologists compared to psychiatric nurses). Accordingly, the inclusion criterion to participate in this study are as follows: 1) have a minimum of 5 years of post-training experience; 2) are working full-time in the mental health field; 3) are maintaining their own individual therapy caseload with clients from both the dominant and minority culture; and 4) have familiarity with the use of therapist self-disclosure. Demographic and professional biographical information of the participants can be viewed in Appendix F. Prior to the commencement of the data collection phase, a document outlining the nature and purpose of the study detailing any potential risks to the participants during the research process was submitted for approval to the University of Toronto Research Ethics Board (REB). There were no safety concerns as deemed by the REB and thus approval for the present study had been granted.

Research Interviews

Participants were instructed to read the information sheet and sign the consent forms if they wish to proceed. One copy of the consent form will be for their records and one for ours. Participants will proceed to complete the demographic questionnaire which takes approximately 5 minutes to complete including selecting a pseudonym. Participants will be asked if they have a story to tell or if they prefer that I guide them through the process based on an interview guide (See Appendix A). Interview questions were constructed based on general themes pertaining to the topic of therapist self-disclosure. Probing questions followed participant responses to obtain

clarity if needed. Following the interview, participants will have the opportunity to discuss any questions, concerns and/ or reflections they may have. At this time, participants were verbally debriefed about the nature and purpose of the present study.

In the present study, emails (Appendix B) were constructed and sent to mental health networks in the Greater Toronto area to garner interest in potential participants to partake in the present study. Interested participants contacted me through telephone or by email and a meeting time and place that was mutually agreeable to both parties was arranged to conduct the interview. At the time of meeting the participants, they were each provided with an written information letter detailing the purpose and structure of the study (Appendix C), two copies of the consent form (Appendix D), a copy of the demographic questionnaire (Appendix E) and a list of the topics to be covered in the interview (Appendix A). Participants were asked if they preferred to be interviewed at their workplace/ agency, on the University of Toronto campus or at a neutral meeting place (e.g., a meeting room in a Toronto public library). All of the participants preferred to meet at their place of work or in their home.

In the present study, the inability of respondents to be fully cognizant of why they self-disclose in the way that they do poses several challenges. First gaining a potential understanding of cause and effect was rendered virtually impossible. Second, juxtaposing how self-disclosure was used with clients of the dominant culture with clients of the minority culture proves difficult because respondents in the interview may be unclear if they do indeed engage in different types of self-disclosures based on the ethnicity of their client. Self-disclosures can often occur without much forethought or afterthought into the matter. To rival these potential challenges, two strategies were employed. Firstly, building comfort with the participant by not delving into the potentially unconscious processes immediately. Second, organizing and sequencing the interview guide in a way, using prompts as well, that allowed for respondents to recall specific examples of

when and how they used self-disclosure with their client opposed to only focusing on their global impressions on the subject matter.

Researcher- Social Location

The grounded theory approach recognizes the potential for researcher bias and influence in the data collection process thereby encouraging the researcher to explicate their social location (see Charmaz, 2011). I was born in Canada in the city of Toronto and have spent all of my life within the city limits proper as well as the surrounding suburban regions. My socially constructed gender identification is male. I am the son of Ugandan refugees who once fled their country during the 1970s because of threats of persecution led by the government in power during that historical period in time. I identify as a Canadian-Ugandan-Indian. More proximally my ancestry can be traced back up to four generations of Ugandan residency and nationality and more distally to the Indian subcontinent. Parts of my identity position me in space of privilege. I am a Master's student at the University of Toronto and a child of a middle-class family throughout the majority of my existence. English is my first language, I am able-bodied and married to a woman as a person whom identifies as a man (thereby upholding status quo). As such, I am sensitive to my capacity to potentially reproduce knowledge emanating out of the positivist tradition; thereby reifying 'racist', 'classist', 'ableist', 'sexist', 'ageist' and 'heteronormative' theories within the present research endeavor. To combat these potential limitations to my understanding of people from a different social location than myself, I make efforts to be conscious of the ways I am privileged and its' ability to research the lens to which I observe, select, and analyze the experiences the participants whom volunteered for this study have shared with me.

Data Analysis

Coding

All participant audio recorded interviews will be transcribed verbatim to maintain accuracy. Transcribed data will be analyzed using the grounded theory method (Glaser & Strauss, 1967). A grounded theory approach is appropriate for the proposed project considering the absence of previous studies investigating therapist self-disclosures in a systematic manner. The subject matter is largely exploratory thus a grounded theory approach will allow for themes to emerge from the data itself. Participants' narratives that are similar in content will be identified and categorized together. Interrelationships between identified themes will be assessed. As a final step in this process, a theory will be constructed to "make sense of the data". The use of interviews affords the therapists participating in the present study to share their knowledge and experiences in an open-ended way to determine the context behind the use of self-disclosures as a therapeutic intervention.

The audiotaped interviews were transcribed word for word and were subsequently transferred via USB onto a laptop and then transcribed word for word using the Window's Media Player program. The setting on Windows Media player was placed on a slowed down speech so that the speed at which the participants offered their experiences could be transcribed with relative ease was utilized. Following the transcription process, interviewers were then coded as per the procedures outlined by Fassinger (2005), in which the data were handled in a series of stages. The initial stage of the coding process is referred to as *open coding* characterized by breaking down each verbal account into concepts. Concepts are units of meaning based on a point of similarity. Subsequently each concept is labeled using the terms drawn from the participants themselves in order to preserve as much fidelity as possible to the data. As Fassinger points out, there is no agreement in the field as to the length of each meaningful unit (see

Charmaz, 2000; Morrow & Smith, 2000; Rennie, 1995). In a sequential fashion the first coded unit of meaning was taken and then compared to the second coded unit of meaning.

Determinations were made on the basis of similarity or difference. Subsequently, the third coded unit of meaning, the fourth coded unit of meaning, the fifth coded unit of meaning and so on and so forth were all compared to previous coded units of meaning until patterns emerged whereby a label was applied to the cluster of related coded units of meaning to then form a *category*. As new interviews were conducted and transcribed by the researcher, new data either fit into the pre-existing categories generated by participant responses or new categories can be formed allowing the data to be organized and then reorganized until no new categories could be generated without redundancy.

The second stage of coding involved the *constant comparison method*, in which subcategories are formed for each category. Comparisons are made along four dimensions: (1) understanding how each category and subcategory related to each other, (2) new data was compared to already-generated categories, (3) categories become increasingly more descriptive and comprehensive in what they could encompass, and (4) disconfirming data were analyzed and used in a way to re-conceptualize the existing categories formed. The second stage of coding comes to an end when it reaches a level of saturation, meaning that new data ceases to provide allow any new categories to emerge or provide depth to existing categories (e.g., noticing redundancy in participants' experiences is an indication of considering the termination of the second stage). Once the data has been placed into categories, interrelationships between each category and subcategory were examined.

In the final stage of the coding process, *selective coding*, narratives were derived from the data that could connect all the categories together providing in a cohesive manner to develop an explanatory model for the data. Interrelationships between micro-level and macro-level features

of the interviewees' reports were highlighted and explicated. Interrelationships were also examined in their sociopolitical context to add a level of depth to understanding. Lastly, the written presentation of the analysis utilized snippets of actual participants' verbal accounts to provide the reader with an idea of what each category entails. Thus, the grounded theory approach makes frequent use of quotations made by participants. Transcribed quotations were provided for the purpose of reflecting the actual voices of the participants and their lived experiences.

Memo Writing

Memo writing is another integral part of the grounded theory approach. In memo writing the researcher explicitly record in detail his/ her decisions along the way. Notes outline the process of collecting and analyzing the data. Succinctly put:

“Memo writing captures the evolving ideas, assumptions, hunches, uncertainties, insights, feelings, and choices the researcher makes as a study is implemented and as a theory is developed, providing a means for making transparent the interpretive, constructive processes of the researcher” (Fassinger, 2005, p. 163).

The excerpt above illuminates the step-by-step process memo writing entails. Cognitions and emotions about the study the researcher may have during any point in the process becomes documented. These memos will assist the researcher in being aware of his own biases so as to prevent preconceptions about the data as it unfolds to minimize the influence of the analysis once the data is collected. Furthermore, memo writing can facilitate and guide the researcher to refine and polish the interview questions between participants interviews to help hone in on the phenomena of interest (i.e., how therapist self-disclosure is used with clients from diverse backgrounds).

Auditing

Auditing refers to process involving monitoring the researcher's coding, categorizing and theorizing. It entails making sure that the theories and concepts derived from the data indeed reflect the participant's experiences based on the information they supplied in the interview. More broadly, it can refer to all activities performed with the purpose of interrogating and scrutinizing the researcher's collection and handling of the data. Part of the auditing process is consulting with peers to serve as a checkpoint to ensure interpretations made from the data are reasonable.

Summary

Nine practicing therapists were recruited from various psychotherapy ListServ websites in and around the Greater Toronto Area. Prospective participants were contacted via email to gauge their interest in taking part in this study on therapist self-disclosure with clients' from diverse backgrounds. Prospective participants were provided with a "Letter of Intent" and a "Consent Form" prior to the commencement of the study itself. Once consent is given, participants were asked questions about the ways in which they use self-disclosure with different clients and to recall examples of how they implemented this within their work. These interviews were audiotaped. Audiotaped interviews were transcribed verbatim. Using a grounded theory approach, the data were analyzed for themes and subthemes and then subsequently categorized.

Chapter Five

Results

This chapter explores the participants' experiences of using therapist self-disclosure with clients from a diversity of backgrounds within their scope of practice. Four key themes emerged from the data: *Understanding Therapist Self-Disclosure*, *Conceptualizing 'Diversity'*, and *Contexts in which Therapists Reveal Self to the Client* and *Context in which Therapists Conceal Themselves from their Client*. (see Figure 1.). The main findings of this study revealed that participants would share information about themselves on occasion and some of these disclosures had no cultural basis whereas other disclosures were pertinent to having a shared culture to the client. The data also showed that participants were hesitant to disclose on particular topics about themselves to particular clients- especially if the client was from a different culture.

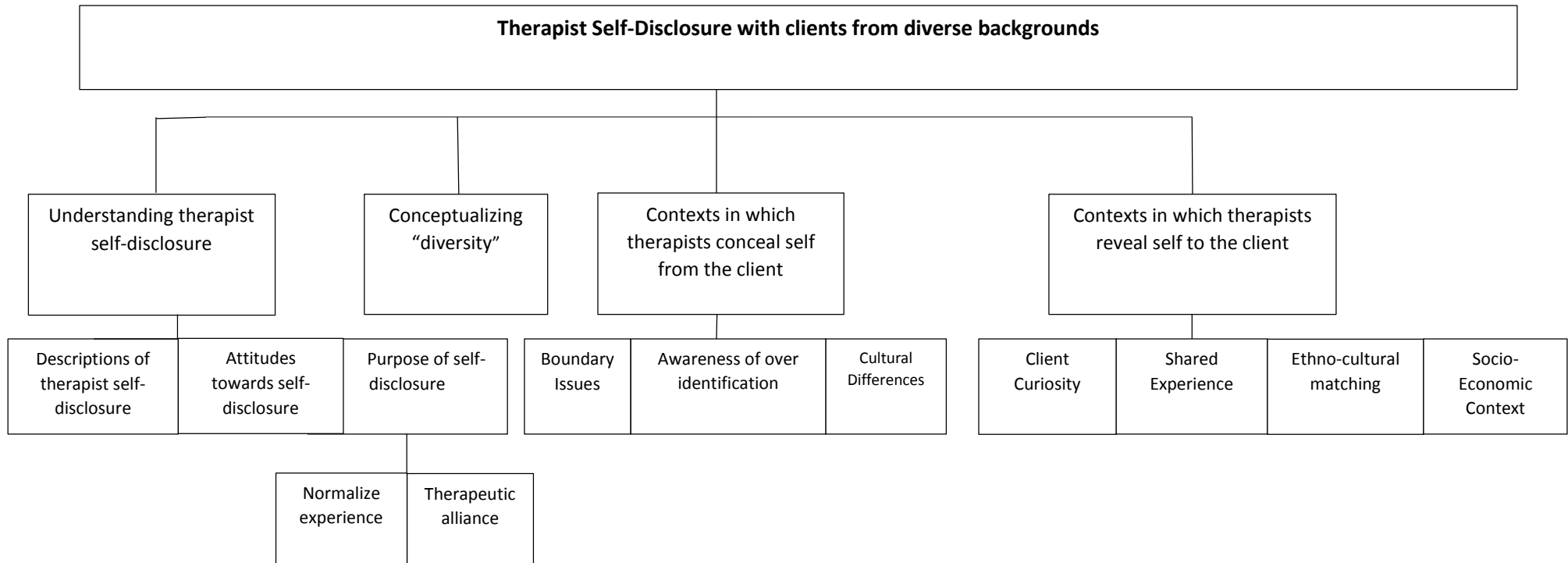


Figure 1. Overview of the key themes & subthemes: Therapist Self-Disclosure with Clients from Diverse Backgrounds.

Understanding of Therapist Self-Disclosure

Participants reflected upon and shared their general understandings and viewpoints pertaining to therapist self-disclosure. Their responses suggested three subthemes: *Description of Therapist Self-Disclosure*; *Attitudes towards Therapist Self-Disclosure*; and *Purpose of Therapist Self-Disclosure*. The key theme of Understanding of Therapist Self-Disclosure begins with participants understanding of what it means to use self-disclosure in therapy.

Descriptions of Therapist Self-Disclosure

Many participants indicated that self-disclosure was a process which they offered some information about themselves to achieve therapeutic effort. For example, Nicole said,

Self-disclosure is when I decide to include a piece of information about myself that I think will be of therapeutic benefit to the client.

And Lyle shared that

Okay so to me that means sometimes if you're trying to help a client you may give an example from your own life.

Nicole and Lyle offered their by describing what therapist self-disclosure is to them.. Most of the participants shared a similar idea that disclosure involved sharing an aspect or experience from their own life with the client. Some participants perceived self-disclosure was 'teleological' and had a specific purpose.

As Kev says,

so therapeutic self-disclosure would be disclosing information that would contribute... to [the clients'] growth, healing, path, journey, [and] awareness...Revealing information for solely that purpose.

Participant Kev echoed Lyle's idea that it would need to be helpful and beneficial to the client in some way. Many of the participants shared the same views as Kev and Lyle, for example Susan said,

When I talk about myself, you wanna have a reason for doing so that is therapeutic... [and] so it's not meeting my needs... There's gotta be a reason why.

Susan explains that therapist self-disclosure cannot be used in service of meeting the needs of herself. Some of the participants stated that when they disclose, that they do so in a purposeful and intentional manner. Many of the participants shared the view that self-disclosure was used to benefit the client.

Attitudes towards self disclosure

Participants shared their thoughts about their overall attitude towards the use of therapist self-disclosure. All of the participants used therapist self-disclosure at one time or another, however, the participants tended to be aware of the benefits and drawbacks when using this therapeutic technique. The participants in this study indicated that they were careful and cautious when using self-disclosure. For instance, Harvey says,

I think, you gotta be very careful. It all becomes a cost-benefit analysis. Is it gonna do any disservice to me or the client to share that with them. If it's going to be negative then I seriously consider it. And it's not a thing that I use all the time. "I survived the trauma, I've gone through it, so pull up your bootstraps kid". It's more so a springboard to open up to think more critically.

Harvey states that he evaluates the pros and cons of disclosing prior to doing so. In particular, more thought is put into a disclosure if it has been a traumatic experience for Harvey. Another example, offered by Mis reiterates the importance of deliberation prior to disclosing. As Mis says,

I do disclosures but again it is in the context of how long I'm seeing the client. What's the issue? Where are we in the working phase? It's very guarded. It's like two sides of a coin, disclosure can be a positive thing, and it can also have huge implications. So that care, and that attention, and that attention and intention has to all be lined up.

Harvey and Mis shared the belief that self-disclosure should be used with caution and purpose. The participants were discerning and strategic in their use of self-disclosure. Moreover the participants had emphasized the importance of timing, for example, for Mis, the length of the

therapy is an important determining factor in deciding to what extent she will disclose to her clients. Many participants reported that they were more likely to use therapist self-disclosure if they have been working with a particular client for an extended period of time.

Many of the participants had ambivalent feelings towards disclosing to their clients. For instance, both participants Kev and Susan were uncertain as to how much they ought to disclose. As Kev observed:

I have to be extremely selective as to when to throw in [my] two cents... I think about it 10 times before I choose to self-disclose [and] sometimes I feel like I have a bit of verbal diarrhea.

Susan also expressed similarly:

I wonder in my own mind [if] they're interested and [if] I'm wasting their time... They're here to talk about themselves. Do they really care about my family or my kids or my exercise routine?

Much like Harvey and Mis, Kev will be methodical in her disclosures and yet in other instances she wonders if she is revealing too much to the client. Similar self-doubt is emphasized by Susan. For Kev and Susan, they both question how much they should reveal to the client. Conversely, on the other end of the spectrum, some of the participants were more inclined to use self-disclosure and were comfortable doing so.

As Ursula commented:

I am comfortable with it, I don't feel like I want to hide anything deliberately I just don't go out of my way to show anything... I guess honestly I am surprised at how private some people are and guarded.

Ursula shares that she is quite comfortable disclosing but will not make it a point to offer personal information. All of the participants felt the use of self-disclosure has the potential to be helpful in therapy. For example, Nicole says,

I do believe self-disclosure is a very helpful tool when used. Nothing specific to culture or race. It's honouring the "I-Thou" as opposed to any kind of hierarchy where the "I" is

so present and the “Thou” isn’t so present. Bringing my own humanity, when appropriate, in the session can help the client accept themselves.

Many of the participants felt the use of therapist self-disclosure is helpful and does so by bringing their own humanity into the session, as outlined in the above excerpt. Self-disclosure in this regard, for Nicole, facilitates the client towards a state of self-acceptance. The participants still maintain an awareness that there are limits as to what can be disclosed and exercise restraint in what, when and how they disclose.

Some participants share ways in which disclosures are inevitable through non-verbal modes of communication. As Kev says,

The photo I have on my website, I’m outside near the Pacific Ocean on an island in hiking boots versus someone who is in an office. [It] might scare the crap out of somebody who was scared of walking, or doesn’t like nature, or feels like I’m going to judge them if they’re overweight because here I am looking athletic. [Or] it may attract other people sharing that bit of personal information.

Kev recognizes the various possible interpretations her website may evoke in her clients. According to Kev, clients may react positively to her photograph whereas other might react negatively. The participants reported that non-verbal means of disclosure can have an impact on the therapeutic process. Many participants were also cognizant of ways in which inadvertent disclosures can manifest itself (e.g. a photograph on their professional website). Some participants in this study had mixed attitudes towards inadvertent disclosures involving non-verbal modes of communication regarding: office space, professional website, clothing style, and the location of their office.

Participants from this study reported that they did go out of their way to reveal themselves to their clients unless the opportunity presents itself to do so. All of the participants recognized the potential beneficial value in therapist self-disclosure, however, the participants in

this sample varied on degree as to how often disclosure was used in their practice and how comfortable they were when using it based on whom (i.e., the client) they were disclosing to.

Purpose of Self-Disclosure

The next theme that arose from the data was the *purpose of self-disclosure*. The participants reported that self-disclosure, when used, was purposeful and goal-directed. There were two sub-themes that had emerged from the data when participants were asked to comment on the purpose of therapist self-disclosure. The two themes that emerged were to *normalize the distressing experience of the client* and to foster the *therapeutic alliance*.

Normalize the distressing experience of the client

The sub-theme of *normalizing the distressing experience of the client* was subsumed under the category the *purpose of self-disclosure* emerged from the data. As indicated by Nicole, many of the participants within this sample reported using self-disclosure in hopes to make the client feel like they are “normal” and/ or “not alone.” As Nicole stated:

It’s a way of saying: “Yeah, I’ve been there too!” I offer it [opposed to] learn from my example. It’s that I have similar experiences that I want to share and if there is something in it for you then great. If not, don’t worry. I am giving a message that I am not perfect. I am human like everybody else. It really helps humanize the therapist which in turn helps the client realize that we all have our struggles and they are normal and that they are seeking out support.

For Nicole disclosure was used to humanize themselves and convey they too are flawed and experience hardships as well. Some participants used therapist self-disclosure to share something personal with the client so that they would not feel isolated in their negative experience. For example, Nicole recognized that:

There is a history of sexual abuse in my family of origin and as well I personally have had an experience with that. So it depends if the person is wrapped with shame and guilt. Something that has happened and it is a dirty secret in their family and I might deem

sharing about my personal history a valid therapeutic intervention in saying to the client “you are not alone, no shame in it.”

Clearly, Nicole recalls a time in which she shared with her client her own experiences with sexual abuse. The participant revealed this to the client with the intention of de-shaming and making them feel less isolated. There were also variations in how participants used therapist self-disclosure to normalize the experience of their clients. Some of these methods were less verbally direct. Susan and Ursula highlight ways in which participants would normalize their clients experience without making a direct reference to themselves.

Susan indicated that:

Sometimes I want to disclose something. Instead of disclosing about myself I will say “many people who have children in their 20s find that to be a challenge too”. I am speaking out of personal experience but they think that I might be talking about another client so I am accomplishing the same thing without saying it is me. I am normalizing their experience.

And according to Ursula:

I make a general statement, “ya, you know it seems that this is a phenomena in culture today” just to help them know that they aren’t alone.

Susan conveys to the client that she is speaking about other clients when in fact she is drawing from her direct experience with parenting struggles. Rather than saying something along the lines of “from my experience as a parent with my children...”, she speaks about it in a more general way. This manner of disclosing is more impersonal and allows Susan to share an experience that she thinks will be helpful to the client without directly verbalizing it. Furthermore, from the client’s perspective, it may or may not be perceived as a therapist self-disclosure.

Susan and Ursula highlight that just because a therapist draws from their personal experience it does not or may not necessarily be received as self-disclosure from the client’s standpoint. For Ursula, may have experienced something similar to the client she does not use verbal method of communication to show that understanding. Much like Susan, Ursula will make

a general statement that might be rooted in her personal experience to shift the client's internal frame of feeling alone to a position of. Both Susan and Ursula draw from their personal experience but do not directly communicate to the client that they themselves were indeed the people's experience they were drawing from. This way of disclosing is much different than people like Nicole whom directly shares her own personal experience with the client. Several therapists in this study would try to conceal that the experience they spoke of was their own. Instead, these participants would disclose by sub-communicating to the client the following message: "many other people in this world have gone through what you've gone through too so I hope you know that you are not alone".

Therapeutic Alliance

Several of the participants thought sharing personal information was important in building the relationship with the client and emphasized the building rapport and creating the bond, which are integral parts of the therapeutic alliance.

Lyle believed that:

If you're trying to help build a therapeutic relationship you might self-disclose you've experienced something similar to theirs.

And Susan brought to light:

It's almost like not too disclose from time to time is like putting up too much of a wall. I think it's in managing the relationship that informs me to do so.

Both Lyle and Susan emphasize the relationship which informs them to disclose or not. Lyle states that if has a common experience to that of his client he considers disclosing. For Susan, she wonders about whether she discloses too little. Susan teeters on being there for the client's needs but also wonders to herself if she might be putting up too much of a "wall". Some

of the participants maintained that using therapist self-disclosure is a perceived positively by the client as indicated in the excerpts below:

As Nicole illustrated:

Clients respond really well when I include something personal.

Harvey reported that:

Sometimes there is therapeutic gain for the client, for the rapport of the relationship.

Ursula observed similarly to Nicole:

If I do self-disclose if it means it's going to help them feel more comfortable.

Another way in which participants disclosed information which supported the therapeutic alliance was by sharing their own marital status, the profession of their spouse and disclosing as to whether they have children or not, in order to obtain greater credibility. As Harvey says,

I will share that my wife is a teacher... Sometimes it will get me more credibility when working with couples who are separating and in helping them deal with the [children's] academic issues that are involved in the process.

Harvey uses therapist self-disclosure to gain credibility which is part of the therapeutic alliance in which the client can put more faith into Harvey in reaching his/her goals. Lyle a social worker by training, stands up to a serviceman during an on-call home visit to his client:

So I had a serviceman coming up to the house [of my client] and [he] came in and would talk to me and I would go "Excuse me! Maria³ is right here. Talk to her!". They wouldn't take her seriously. But I would say "Look at her!". I said to Maria afterwards "I didn't like the way [the serviceman] talked to you. He didn't talk to you. He talked to me. I think that was very rude". She laughed. It made her feel like I'm one with her.

Lyle is at times is required to assist his patient's in their own home. Lyle communicated his reaction to the present situation which in turn allowed him to strengthen the therapeutic bond

³ Maria is the pseudonym given for Lyle's client

between him and his client. In this case the participant disclosed his immediate reaction to the situation and his feelings to the client rather than a personal experience from his own life. According to Lyle it appeared to be positively received by the client thereby enhancing the bond between them.

Conceptualizing ‘diversity’

The key theme of Conceptualizing ‘Diversity’ begins with the participants’ own understanding of what a ‘minority’ person is since the terms can elicit different interpretations and associations for different participants interviewed in this study. Many of the participants associated the meaning of ‘minority’ by contrasting it to who they perceived to constitute the majority- ‘Anglo-Saxon’, ‘Protestant’ and ‘White’. The data reveal that persons who did not fit into the three aforementioned overlapping (albeit not identical) categories were perceived by participants as having belonged to the ‘minority’ group, as Susan claimed that:

I guess anyone who is not Anglo-Saxon protestant.

Ursula shared her opinion as:

I mean maybe it’s anybody who’s not obviously white.

And Sonia believed:

Maybe because I live in Yonge and Eglington area, I might say that African-Canadians are minority for me

Harvey then went on to express:

It’s more how long they have been Canadian. Are they 3rd generation Canadian or a more recent immigrant?

Many of the participants commented on whom they perceived as belonging to the minority group. The data revealed that persons who were African-Canadian or were ‘non-‘white’’ or ‘non ‘Anglo-Saxon’’ were considered to be part of the minority group. Conversely, some of the participants had a differing views of what makes someone constitute the minority group. For example Sonia shared:

I came here from Ukraine, but in Ukraine everybody are either Ukrainian or Russian Or Jewish... generally it's clear the minority is the group of people who are not from the main part of the population... it could be people from Kazakhstan, Georgia, Russian and some of them are visible. You can see that this guy is from Georgia, he has an accent, and he has very specific traits.

In this case, Sonia highlighted the importance of geographical relativity. In other words, for Sonia the idea of minority is dependent on the demographics of the country a person resides in or was brought up in. Similarly, Mis recalls an example based on numerical majority of a particular area. As she says,

I have a client and she's from Newfoundland... She was working at a Tim Horton's and she came in and really complained to me. She said "Mis they don't hire white people there. Everybody that I work with are, ya know- not white. And here I am from Newfoundland and live in Scarborough!" ... and she said "you know you gotta be East-Indian to live and fully operate in Scarborough." This idea of the inversion in terms of a white person experiencing [oppression/ discrimination/ prejudice] is interesting to me.

Both Mis and Sonia conceptualize 'minority' as persons who are not part of the more populous ethno-cultural group. One participant associated the 'minority' group with acculturation more than anything else. As Harvey says,

I can think of one client who was American who lived here for about six years. She went around singing the star spangled banner all the time. She was not a Canadian and never was going to be a Canadian. That's who she was.

Harvey perceives 'minority' has more to do with how recently the person may have immigrated to Canada. In contrast, Ursula reflected upon the terms 'visible minority'. For her 'visible minority' meant someone who is noticeable and stands out. For example, Ursula reports:

I grew up in the country [rural part of Ontario] and the visible minorities were of colour right, but then moving here [as in Toronto] it was more of an economic thing... I'd say a visible minority here might be more of an impoverished person- a street person right... I did volunteer work at CAMH on Queen Street for a few years and ya those people that would hang around, you know they'd get their day passes, or take people out for the day. That was a visible minority. Hanging around the hospital there.

Ursula perceives people who are below the poverty line and live on the street are visible minorities. From her experiences working at the Centre for Addiction and Mental Health, the people who stood out for her the most were those who had been patients at the hospital.

The participants in this study had different interpretations and perceptions as to what type of person is a ‘minority’. In this study there was no agreed upon description of a person occupying ‘minority status’. The same participants revealed that they had differing interpretations of what ‘minority’ meant to them. For example, Ursula commented earlier that she believes a ‘minority’ might be someone who is not ‘white’ and also believes that a ‘visible minority’ is someone of low socioeconomic status and/ or with a mental (dis)ability. For some participants ethno-cultural factors were pertinent. Other participants conceived of ‘minority’ from a numerical standpoint- as the statistically least populous group of people residing within a particular neighbourhood. Some of the participants’ connotations for the term minority had more to do with ‘acculturation’ and length of time spent in Canada. The diversity of responses elicited by the question ‘whom do you consider a minority’ indicates a lack of consensus among the participants in this study.

Context in which Therapists Reveal Self

Participants shared a wide a variety of examples of when they used therapist self-disclosure with their clients. All of the participants in the study were able to recall at least some instances when they did share something personal from their own life with the client. Many of the participants would share a personal reaction they had to the client or to the immediate situation their client was in. Disclosures varied from each other on content with some disclosures related to culture whilst other disclosures did not have a cultural basis. All of the participants in this study disclosed using words but on some instances disclosures were made via non-verbal channels. The key theme of *Contexts in which therapists reveal self* was broken down into four

subthemes: (1) *Client Curiosity*; (2) *Shared Experience*; (3) *Ethno-cultural matching*; and (4) *Socioeconomic Context*.

Client's Curiosity

Under the major theme of *Contexts in which Therapist Reveal Self*, the sub-theme of *client's curiosity* emerged from the data. The participants reported that many of their clients were naturally curious about them. Several participants stated that their clients' would ask them straightforward questions in which they responded to. Questions that participants were asked by their clients ranged from inquiries into their family life to their religious practices and spiritual beliefs.

For some participants they would answer the question the client had asked of them but not offer additional information or elaborate further. As evidenced below, participants were willing to answer questions that participants had. For example Susan:

People ask "do you exercise?"..., and I say yes and I tell them what I do. I answer just what they ask.

And Ursula expressed:

People, on occasion, do ask if I have kids, or "how old are your kids?" If the client asks me a specific question I will answer them, as opposed to say "well why are you asking me that question?"

Many of the participants were asked questions about their children and family. Some of the participants did not see an issue with answering client inquiries. As Harvey says,

See there are pictures of my kids up top [Harvey pointing to the shelf in his office]. Some people may notice that and ask a question. And I will let them know about the kids and what they do.

For Ursula and Harvey, both have experienced clients' inquire about their children, to which they would provide a direct answer. Not all of the therapists within this sample supplied a direct answer to the client's inquiries of their personal life. As illustrated in the by Mis,

People ask if you're "married or single?", "what's your religion?", "what's your political beliefs?" and things like that. Those kinds of really personal things. People are always curious, "what do you do?", "what's your life like?". If it is not relevant I would bring it to their attention. [I might respond to the client with] "you're asking me a really good question but I'm not sure how this fits into the goals we have set."

Mis explains that she is goal-oriented in her approach and redirects questions from clients she is asked. At first she explores with the client the meaning of their inquiry and if determined to be irrelevant to the client's presenting concerns she then refocuses the conversation back on the path towards objectives. Other participants reported that they were more transparent and less hesitant in disclosing. For instance, Ursula says:

I was working with schizophrenic people at CAMH. If people asked me stuff I didn't hesitate to share my personal struggles. It was more of a back and forth sharing. I would be completely transparent.

Unlike some of the participants whom self-perceived themselves as "guarded" or "cautious", Ursula described herself as transparent with her personal struggles with patients afflicted with a psychotic disorder. She would answer questions the clients had asked her without hesitation.

Some of the participants reported being asked direct questions about their faith and/ or belief system. For both Harvey and Lyle, they would share their faith if asked by their client.

According to Harvey,

The client's partner called and said that they only want to talk to someone who is Christian and I said, "I am not Christian [and] if that's going to be a problem I can find somebody else for [you]".

Lyle indicated that:

He said "are you Muslim?" to me, so therefore I cannot *not* self-disclose now. I had to be honest with him. So I said "I'm not a Muslim", [He then asked] "Are you a Christian?" I said "Yes, I identify with that faith. I don't follow it but I grew up with that."

The data revealed that the participants' clients' would often be curious about their personal belief systems and wanted a therapist whom may have shared the same belief system as themselves. Participants were upfront and honest with their clients when asked a direct question.

Shared Experience

Emerging from data participants reported that when they had points of commonality with their clients the more likely they were to self-disclose. All of the participants were willing to disclose to their clients when having underwent a similar experience to their clients'. Below are examples emanating out of the data showing that participants used disclosure when they could relate to a client's experience. For example, Nicole explained

The situations in which I would use self-disclosure is that when I feel that I had a similar experience to what the client, to a place where the client is, or I was stuck where the client was.

Nicole uses self-disclosure when she has experienced something similar to her client or when she perceives the therapy has reached an impasse. Others recalled specific examples of when they would reveal themselves to their client such as when having gone through a similar struggle. As Susan shared:

So I would say, "when my kids were little, you know I had similar pressures and similar struggles and really you are doing the best you can. And we are going to work this through". Because then it helps with them seeing me as human and it opens up the doors to ask more questions.

Harvey believed that:

I would disclose that I was an ex-smoker. An explain that the strategy [hypnosis and the smoking cessation program] worked for me and the goal of that was to empathize with the person and share with them some of the struggles they are going to face and you can make it and be successful.

Ranging from raising children to quitting smoking, the participants reported they were able to connect with their clients' experience because they too have gone through it. The data revealed that having a shared experience was a frequent context in which therapists would

disclose themselves to their client. Some of the participants were willing to disclose their personal psychological difficulties they had once experienced with depression and abuse. As shown in the next two excerpts, Brady and Kev offer their personal stories of hardship with their clients. As Brady reported:

[Some] of the clients [who] have been meeting with me for more than a year know that I went through a tough time at age 41. Relationships with women broke up or lost jobs. [I] cried for 7 months pretty much every day in a row. But something really great came out of that and I kinda explain what I think I went through and how I came out of it and what good things happen as a result of it.

Kev also shared:

Amidst this stream of distress that she was living in for a couple of months, I had shared the fact that I had also struggled with my parents and that I grew up in a somewhat abusive household and shared with her how that I had to also address it and then it was very distressful .. [I] made the point that I had managed to come to terms with it and have a completely fulfilling life in the understanding that my childhood wasn't as rosy as I thought it was....it was extremely profound for her [and] brought her to tears.

For Brady & Kev these shared experiences was offered if they deemed the client would benefit. Participants in this study who provided their client's with personal examples of difficulty saw it as a profound moment in the therapy process. When the participants made an intimate disclosure they emphasized that the fact that they themselves had accepted and/ or overcome the difficulty. Not all disclosures were of an intimate nature. Harvey reveals to his client that he is a squash player and engages in dialogue about squash:

I was working with a black client and he was 24. We had some common interest things like in this case he was a squash player. And I would discuss the game with him. So the fact that he was black and even younger was irrelevant. That was not an issue one way or the other

For Harvey ethnicity and 'race' is unimportant in determining whether to disclose or not. Harvey recalls a client whom he shares his opinions, a type of disclosure, on a mutually enjoyed sport they have in common. Participants did not see disclosing their recreational activities as an

issue if the client shared the same hobby or interest as them. For some participants disclosures involved sharing their experience of being marginalized themselves. For instance, Mis recalls a time in her life when she felt “Othered”, and draws upon her experiences to connect to clients who feel marginalized or ill-treated themselves. She says:

I have a lot of Caribbean men who come to see me for example who are bus drivers for a large company here in Toronto. Their interpretations of having gone through slavery, systemic oppression, feelings like they are being mistreated in a militaristic kind of environment. I can align sociologically because I’ve lived in a society that had ‘classism’ and ‘racism’. My personal journey of being ‘Othered’ and seeing how they are presenting the problem and lived experience. I think those are unique ways of doing self-disclosure.

Mis reports that she aligns with her clients who have experienced discrimination since she herself in her country of origin had experienced similar struggles. The culture in which the Mis had grown up in had been stratified by ‘class’ and ‘colour’. When clients present with issues pertaining to slavery, systemic oppression and mistreatment, the participants in this study were able to relate to their client’s experience by remembering times in which they had felt that way as well. In the next excerpt, Lyle recalls a time in which he was treating an older female of Chinese heritage. Initially, Lyle was unsure about how he might be perceived but through finding common ground with his client of a different culture, age, and gender he reports that he was able to connect with the client:

I was working with an older female from China. When I first met her I thought ‘what on earth can I do with this client?’ because I thought she was from a very different social location than me. ... people who are not the same culture, might start to perceive me as being oppressive and just dismiss me... She’s an [Asian] female, I am a white male. How is she gonna perceive me? She mentioned she was having struggles with her children. I said “well you know I’ve also experienced that”. I think by saying that it helped to keep the relationship going... Then [I found] out that one of her daughters has a white male partner and another one has a white male spouse. She started to mention how she would defer to them. I guess she somehow had a level of respect for men from my same location

The data revealed that in the context of a shared experience between the participants’ and their clients, disclosures were commonplace. Disclosures ranged in content from discussing a

recreational activity to experiences with racism to experiences of triumph over psychological difficulty. Not all shared experiences between the participants and their clients had a cultural basis, however, many participants such as Lyle and Mis did share examples of how they could relate to their clients of a different culture by drawing upon their own experiences.

Ethno-cultural matching

The participants in the study reported using their own personal experiences by drawing from their own culture in working with. The data revealed that sharing a common identity with the client had a number of positive effects on the interaction between the participant and their clients. A shared cultural background and/ or common ethnic heritage would elicit particular types of self-disclosures that were culturally-based and offered the clients a level of comfort. Furthermore, participants stated that if a client was of a similar background to themselves they would be inclined to make use of therapist self-disclosure earlier on in treatment. As Lyle shares:

I think if it was a similar background I would have probably used [self-disclosure] sooner, but then not necessarily because it kinda depends on how the relationship goes.

Lyle reports that he utilizes self-disclosure earlier in therapy with clients he feels more comfortable with, which in part is based on the client's cultural background in relation to his own. The participant in this study reported that they feel more comfortable disclosing to someone of the same ethnic background. As Ursula says,

One thing I've noticed is that people of a certain ethnic origin, somehow the quality of their psychic energy is such that they might be more a kin to how I am, I might feel more at home with them or more natural. Not necessarily I'm gonna disclose more but maybe in my demeanor.

For Ursula, the frequency of her disclosures to the clients in the culturally-different or culturally-matched context may or may not differ, however, the features of her demeanour may exert an influence on the interaction between herself and the client. Ursula suggests that her

demeanour is a way of revealing herself to the client. Other participants such as Nicole reports that having a similar ethnic background increases the level of comfort for the client:

I think a similar ethnic background may provide comfort [to clients] who are afraid of going to therapy. “Fear of judgement”, “fear of appearing weak”, everyone wants to be understood. If there are points of similarity then it assures people that they are safe and will be understood.

Similarly, Susan explains:

Mostly what they say is “you’re Jewish right?” Even though they can see by my name that I am Jewish and look Jewish... Certainly I would have more of a context like getting together for the High holidays, or Passover.. I will throw in a Yiddish word once in a while. Or they will say “you know what that means right?”. And I will be like ‘yeah , yeah’. I think they come to me because they want that level of comfort. I have a high percentage of Jewish clients and I think they choose to come to me because of that.

As evidenced in both of the above excerpts participants perceived their clients to feel more comfortable with them if they were culturally/ ethnically/ or religiously matched to themselves. Participants reported that their clients would feel safer and better understood if they were from a similar cultural background. For Susan, an awareness of the cultural context provided her with the ability to understand the client more. Susan would confirm that she is of Jewish descent to her clients and discuss Jewish-specific events such as: the High Holidays or Passover. Some of the participants reported that disclosures were made to their clients without verbal communication. As Susan mentions above, many of her clients can guess by her visual appearance and last name that she is of Jewish faith or descent. The participants in this study reported that they themselves would feel more comfortable disclosing to someone of a similar cultural background and that the client would feel more comfortable too, if the therapeutic dyad was ethnically matched.

Some participants were inclined to share personal stories about themselves when dealing with clients from a similar cultural background. For example, Nicole offers two instances with

different clients from an Eastern European background in which drew from her own cultural heritage to share help the client. As Nicole says:

I guess some eastern-European mothers can be a little cold and seemingly un-nurturing. My grandmother was like that. She was a very warm grandmother but a very cold mother. If a client is talking about a difficult relationship with their Eastern-European parents- especially because a lot of clients will self-doubt [since] they are fed the message “you are just creating this”, “you are too emotional” or “you take things too seriously”. I might draw on my own experience that way and be able to support the client that their parent can be with them one way and their grandchildren in a different way.

In this example Nicole in response to her clients’ distress narrative about family shares with the client her own experiences of having had a grandmother whom was warm towards her but cold towards her mother. This personal experience was shared with her client to help the client change her perception about family. As Nicole explains further:

Inspired [by] my own Ukrainian background I may include some of my own family experiences if I have a client who is Ukrainian or Polish. For example, if someone is talking about their own partner who won’t stop drinking... Alcohol abuse is common in Eastern Europe. It was accepted that men drink too much. My grandfather was an alcoholic [and] my grandmother put up with it. She couldn’t say “no, this can’t go on in my house”. I use it to help the client, understand why the other parent may not have intervened and protected the child from the alcoholic parent.

Nicole reports that she is inclined to share her personal experiences of alcohol abuse within her own family with her clients from a similar cultural background. She draws upon shared cultural knowledge that she has had with her client and communicates her experience to provide insight as to why women in her culture are unable to intervene and protect children from an alcoholic parent.

The data revealed that some of the participants who were familiar with a particular culture even though they themselves were not from that culture would be inclined to speak about their experiences that had a cultural-basis. As Kev says,

With clients from South Asia, whom, are very familiar with the energetic body, acupuncture, working with Chakras, for example, I work with eastern healing modalities [and] I was very comfortable disclosing my personal experiences in working with

energetic healing...[but] much more cautious in disclosing that with clients born in Canada or U.K or Western Europe... It's not determined by the cultural background. If the [client] is South Asian [and] born there than I am very comfortable.

Kev identifies as a 'White' therapist born in Canada of European heritage yet feels more comfortable sharing personal information about herself with South Asians. Kev feels more inclined to discuss energetic healing with clients from India and is less comfortable disclosing that information to clients whom are Canadian and /or Western European. In a similar vein, Mis can also relate to some of the issues faced by South Asians. As Mis explains,

I am seeing a client right now, the person comes from India, [the client says to me]: "You know what it's like. We get beat up", "We don't have a voice", "and we're secondary". You might validate this. Nodding to say yes [that] I can relate from [a] cultural context. You don't want to say "I don't know what it's like" because I come from a culture where women get beat up easily and they don't have voices and so on, when I look back at my own upbringing.

Mis was raised in the Caribbean and has ancestors whom originated from India. Mis explains that she can relate to the experiences of her female East Indian client (even though she is not directly from that culture) and discloses to her clients that she knows what it is like to come from a place where women are "secondary" to use her words. For both Mis and Kev, cultural knowledge is drawn upon in their work when disclosing to someone who is from a different culture, insofar as they have familiarity with the client's culture.

The data revealed that participants were likely to share particular disclosures that had a cultural basis with clients whom were of a similar ethnic background to themselves. One of the central sub-themes of this study which had emerged from the data was ethno-cultural matching between the participants and their clients. Based on the results of this study, participants were able to utilize their shared cultural knowledge with their clients in a perceived helpful way.

Socio-economic context

Socio-economic context is considered a salient marker of identity. Emanating out of the data, some of the participants would share their experience of recalling a time when they had financial struggles or housing problems and communicate that information to the client. They were able to utilize their personal experiences with monetary difficulty to connect to their clients.

For instance, Kev recalls:

[my client] was struggling with finding an apartment- with roommates and terrible landlords. And I made a quick quip about how I've gone through that, "when I was younger it was a disaster living in da da da",... and she responded in "oh you too!",...it was sort of 'Oh! I've been there. Yes it was a bloody mess! It was awful living under those conditions, I here ya'. But she really responded to it!

Kev shares an experience when she was younger and did not have a lot of money about the difficulties of living in a sub-standard place of residence to which seemingly her client had to connected. Similarly, Lyle draws upon a his recent experience of having no electricity during the Toronto ice storm of December 2013 to identify with his client. As he says:

I recently [have] been working with an older female client living in a house without a main source of heat for two years or running water...I said, "you know I can understand how frustrating it must be for you, being in a house with no heat"... I said "I realize you do have heat in one room, but not having [heat] in the rest of the house. May I suggest to you that I have the same problem. My hydro was off, we had an ice storm, hydro was off for 3 days and my family was really at risk there, and so trying to get them to a warmer place". So I said "you know maybe I can identify a little bit with what you may have been experiencing".

Both Kev and Lyle draw from their personal experience with difficult living conditions as a way to relate to their client. The clients in these examples appeared to respond favourably upon hearing that their therapists had some personal experiences with what it is like to struggle in sub-standard living conditions too.

Therapist self-disclosure is not confined to verbal modes of communication. How the therapist dresses, how the therapist ornaments their office space, and what photographs the

therapist chooses to display have the capacity to reveal social class to the client. Some of the participants in this study were class-conscious and made efforts to conceal their status differential. For example, both Ursula and Lyle were purposeful in what they wore participants deliberated on their choice of clothes. As Ursula says,

I won't wear any kind of elaborate jewelry, I don't have any anyway...I'm careful not to look ostentatious in any way.

And Lyle adds:

I don't dress in fancy dress pants, I don't wear dress shoes, I don't wear a tie, I don't wear a fancy jacket. Regular everyday jacket, everyday pants, running shoes because I don't wanna present myself as somebody who is in authoritative position.

Lyle and Ursula made it a point to not over dress. For Ursula she did not want to look ostentatious and Lyle did not want to come across as an authoritative person. For Ursula and Lyle by not ornamenting themselves or dressing in 'fancy' clothes they are revealing an aspect of themselves to the client offering the clients a window into who they are based on what they do choose to dress as. The participants also commented on the location of their office space. For instance, Ursula explained that her office can inadvertently communicate the economic class she is associated with. For Ursula her home is her office in which she performs therapy out of. As Ursula says,

Personally, I wish I could move from this neighbourhood because some people associate this neighbourhood with a certain class too.

Socio-economic context is another way in which disclosures to clients are made. In this study the participants drew upon personal experiences of financial hardship, deplorable living conditions they may have struggled with in the past and/ or utilize indirect methods of disclosing or concealing socio-economic status via clothing, jewelry and office location.

Context in which therapists conceal themselves from the client

One of the central themes that emerged from the data was when and how therapists were able to conceal themselves from their client. This major theme was subdivided into the following three subthemes: (1) Boundary issues; (2) Awareness of potential overidentification; and (3) Cultural Differences.

Boundary Issues

Under the major theme of *concealing self to the client* the subtheme of boundary issues emerged from the data. The sub-category of *Boundary Issues* reflected the participants concerns around transgressions within the therapeutic context. Participants reported that they were reluctant to disclose if it had the potential to cross a boundary between themselves and their client. Some participants would refuse to answer a question because it infringed upon the boundaries. For some participants the emphasis on protecting the boundary and being appropriate was of high importance. As Mis says,

well if they ask direct questions in certain areas...I would say “it’s a good question but I am not comfortable in answering it right now”. The thing that I think is important when you look at the therapeutic relationship is the protection of the boundary issue

For Mis, when asked a question about an area of her life that she is uncomfortable answering, she responds by validating the client’s question first and then replies by informing her client that she will not supply an answer to the client’s question; in service of preserving the boundary. In a similar vein, Susan explains,

It’s kind of when kids ask you about sex, you tell them you don’t elaborate because it wouldn’t be appropriate.

Both Mis and Susan are cautious to not over disclose on particular topics. Mis's strategy is to tell the client that she is uncomfortable with answering the question whereas Susan reports that she would not supply an elaborate answer.

In the next excerpt, participant Brady speaks of the tension between the dangers of using therapist self-disclosure and drawbacks to not doing so. As Brady says,

The problem is I think like with all rules they prevent abuse but they also prevent excellence, and so I think the really creative therapist broke all kinds of rules, in terms of how therapy is supposed to be done including self-disclosure. So I just think it's a shame there's been such an emphasis on no disclosure. Yes I'm glad there's been a shift of the last 20 years and yet there's still the problem of the abuse around disclosing, where now you're unloading you're bad feeding onto your clients.

From Brady's perspective, the over-sharing can induce guilt in the client whereas under-sharing can prevent excellence in therapy. Participants were cognizant of the negative effects of sharing personal information and how disclosing had the potential to lead to a sequela of undesired responses (i.e., client guilt, discomfort and inappropriateness). Thus, some of the participants in this study were not inclined to disclose if it crossed a boundary (or had the potential to do so).

Awareness of Over-Identification

This category reflects the contexts in which the participants are aware of how they might elicit a negative reaction in the client or a client may elicit a negative reaction in them. The participants in this study reported that some of their clients' reminded them of aspects of themselves, or people they knew, and/ or experiences that they have also encountered. Moreover, participants suspected that disclosing via verbally or non-verbally certain aspects of themselves, or experiences they have had, carried the potential to elicit a negative reaction in the client. As a result, participants made the decision to withhold or conceal particular information about themselves from the client. Participants expressed awareness of the potential that disclosing

their own experiences could stir up negative feelings or trigger unwanted memories in the client or be perceived by the client as culturally-insensitive. Conversely, participants also expressed awareness in ways that clients could evoke a negative emotional reaction in themselves thus participants maintained the position of withholding any disclosures involving their negative feelings about the client to the client.

Sonia expressed:

We all are alike [as] people. As in this case with [human] drama, what happens to your clients could happen to you as well. And then you are emotionally involved. You have a choice either to share or to become more careful and put your problems aside... If it's painful for me, then if I disclose "oh I have the same problems", the client will feel guilt and may want to help me and then you switch the roles [and then] I have to give [the client their] money back.

And Kev reported:

We're going to resonate with a lot of stuff so we can't be disclosing everything we've all gone through: anxiety, stress, dysfunctional family life or traumas in relationships.

As Sonia explains, humans share many commonalities. The trials and tribulations a client may be struggling with are the same trials and tribulations the therapist might have struggled with as well. Sonia reports that she is unlikely to disclose simply because of a shared experience to her client. Sonia reports that disclosures from her perspective can potentially induce guilt in the client which deters her from disclosing. Kev, much like Sonia, shares a similar view about resonating with a lot of the material the client presents with. As Kev describes humans have much in common in regards to anxiety, stress, dysfunctional family life and interpersonal-romantic traumas. According to the participants, a shared experience is not sufficient enough to disclose personal information.

In the next excerpt, Lyle offers a specific example of when he was working with one of his clients and how he was reminded of his early childhood negative experiences, which had

infuriated him. Lyle does not disclose his personal feelings towards the client because of its' potential to adversely affect the therapeutic process. In the example below, Lyle states that he is inclined to withhold disclosures from clients' who trigger him in some way:

When I see things in them [the client] that are racist it triggers me because when I was a young boy I would fight racism when I saw it. For example, one time when I saw a white boy like me spitting on a black kid I went after him and beat the crap out of him. I guess I was always fighting for people who were not being treated properly. I guess when I come across a client who is very, if you don't mind me using this term, a "redneck attitude", it really infuriates me. I have to be careful to watch how things trigger me with a client like that.

Some participants in this study reported that they were hesitant to disclose clients' because of uncertainty around how the client will perceive the disclosure. The participants expressed that they would rather err on the side of caution (i.e., not disclose personal information about themselves) than to be perceived negatively and/ or unfavourably. As Harvey says,

I would be more careful or more cautious and less willing. I wouldn't be sure of the impact it would have on the person. I am projecting this [but] they might say "well you don't know the rules from back home, you've never lived there".

Harvey is very cautious when disclosing to clients from a different cultural context because he thinks about how the client will receive his personal experience. Harvey suggests that he cannot know for sure how the client will respond or react to his disclosure and when in doubt he opts to conceal his thoughts and/ or experiences from the client. Harvey states that he projects his fear- namely of being accused of cultural-insensitivity. Thus, for Harvey, he explains that he is more cautious when disclosing to someone from an unfamiliar cultural background to himself. Other participants also reported cautiousness but when disclosing information about themselves or their family that might evoke a negative reaction in their client. For example, Lyle is a white, male therapist and exercises a lot of caution when disclosing and not disclose about 'race' related content to his clients. An example Lyle reported, is that he would never disclose to his clients is

that he has some family members who he believes are racist. Lyle states that he would not disclose this information to his clients because it would damage the relationship they have. As Lyle says,

I do have family members who are I would say quite racist. I would not disclose that because you can't choose your relatives you can only choose your friends. I would not choose them as relatives. I'm stuck with them. I would not disclose that because to me that would be just damaging.

Both Harvey and Lyle offered examples of culturally-relevant pieces of information that they would not disclose to their clients for fear of eliciting a negative reaction in them. Participants in this study believed that withholding particular pieces of information about themselves was a precautionary measure to preserving the therapeutic relationship- especially with regards to content related to 'race' and culture.

Non-verbal means of withholding information was expressed by participants in this study. Participants recognized that there were indirect ways to reveal their marital status, sexual orientation, and/ or family dynamics to the client without saying it. Some of the participants commented that they would conceal aspects of their personal life by how they decorated or '*not-decorated*' their office space via photographs. For instance, Ursula states that she is careful to not display photographs in her office of her family for fear of it being perceived negatively by her clients'. As Ursula says,

I would never have photographs of my kids in my office ... you don't know if clients wish they could have children and maybe see photographs of yours or clients that have an aversion to kids and then they see yours... Same with [romantic] relationships I happen to be in. I don't give any indication of any of that. [Some patients] struggle with being alone and not being able to find a partner. Again, that whole thing is fraught, because some people really resent others that are in relationships.

Ursula reports that she gives no indication about her romantic relationships and children she might have. Akin to the other participants, Ursula exercises caution for concern about

stimulating a negative affective experience in the client should they come to discover information about Ursula's personal life.

The subcategory of *Awareness of Overidentification* subsumed under the major theme *Contexts in which therapists Conceal Self* captured the experiences of the participants who felt that the risk of disclosing personal information could elicit a negative reaction or response in the client, thus participants were inclined to not disclose as a result. Some of these non-disclosures pertained to cultural experiences and others types of personal information that was withheld by participants pertained to their marital status and sexual orientation, and some of the concealed content pertained to the 'traumatic' experiences they had in common to their clients.

Cultural-Differences

Emerging from the data, the theme of *Cultural-Differences* was revealed. This subcategory addresses ways in which and reasons why participants conceal personal information, experiences, beliefs and opinions from their clients. The subcategory of *Cultural-Differences* reflected a major context in which the participants felt less inclined to disclose. Several participants reported they did not know how to utilize self-disclosure with a client from a cultural background they were unfamiliar with. As Sonia explained,

If I feel that this person is from another culture. If the client is more of a stranger for me than I need more time to become familiar with him or with her. I think it's more about the cultural differences than about ethnic or [being a] minority or whatever.

For Sonia, unfamiliarity with a client's culture was a salient factor in deciding to disclose or not. Some participants were cognizant of cultural differences and withheld disclosures in working with clients from another culture. Similarly, Brady emphasizes that,

Providing therapy to someone who is very different than yourself, does require a bit of a different skill set in terms of being careful that you don't violate that person because you don't know their rules and expectations and norms and customs.

The participants were careful when disclosing to someone different than themselves. Moreover, unfamiliarity with the cultural norms and customs led to potential violations, which participants would try to avoid. Many of the participants echoed the sentiments of Brady with regards to not-knowing the “norm” and “expectations” in working with clients from a different cultural background. For instance, Harvey says,

Some issues I am not quite sure what the ‘norm’ or ‘expectation’ is for them so I am more careful to raise or challenge their precepts because it might be more established in their cultural background. I have to respect their background whether I agree with it or not. So if I was going to self-disclose I do it more carefully or I think more seriously about doing it. And I would be less willing to do it. I think “is there going to be a therapeutic benefit to whole thing?” or it may add to some alienation to them coming from a different system and not appreciating who they are and not respecting their background and their attitude.

Harvey speaks of the importance of not disclosing if it can lead to conveying to the client a lack of respect of their cultural background. Like Brady, Harvey also reiterates the significance of understanding the expectations and norms prior to disclosing. Harvey pointed out that premature disclosing to clients of a different cultural background can result in alienation for them. Lyle also is aware of his social position and reflects upon the power imbalance between himself and the clients he works with:

I think when its’ someone not from my social location I feel hesitant to use [self-disclosure] until I really know how they see the world and how their dynamics with their family are like... I am already representing a power position. I’m always very sensitive to the power imbalance. I feel that if was to [self-disclose] sooner with someone of a different social location, ‘are they gunna see that as another form of oppression?’... To me it’s arrogant to say I’ve experienced what you have.

Participants believed that disclosing too soon to a client would foster a negative perception of themselves and be perceived as for oppression, as Lyle explained above. Participants recognized the possibility of coming across in an ‘arrogant’ manner due to differences in social location.

The data revealed that many of the participants were hesitant to disclose anything about themselves to the client- especially when speaking about their families. Some participants

commented on the reluctance to disclose their interpersonal experiences about family members to clients' of differing cultures. As Nicole says,

It is important that I not tell someone of Chinese culture to tell their parents to “take a hike”. If they haven’t even thought of it themselves as being able to say” “no I am sorry I cannot do this at this moment”. Respecting the parent is one of the fundamental pieces of the family. Showing no disrespect and saying “no” is often viewed as disrespect. No room for a child’s anger. There is not a space made for expressing anything that is under the anger umbrella (I include annoyance, frustration and various dilutions of it).

Nicole outlines the dynamics found within Chinese culture where there is a level of deference children must show towards their parents.. In a similar vein, Nicole offers another detailed example of how if she had client from Iran she would not encourage the woman to stand up to her parents:

Let’s say I have a young woman, who has moved from Iran with her parents and is struggling with bridging the gap between the culture she is coming from and the oppression she might feel in being a teenager, or young woman here around the issue of sexuality for instance. I wouldn’t share or be inclined to how I stood up to my parents to and found my own sexuality which won’t be helpful in her dynamic. So it is finding out what is possible, in the realm of possibility and still being able to function within the context of the confines of the family dynamic.

According to the participants, sharing their own methods of assertiveness was perceived as not helpful in the context of culturally-different clients bringing into the session distress narratives about their family. In both of the excerpts above, Nicole maintains that she would not encourage her client of either Iranian and/ or Chinese heritage to stand up to their parents. Furthermore, Nicole contends that she would not draw from her personal experiences in these scenarios to assist the client since she it might not be deemed as helpful. Similarly, Kev offered an example of how she chose not to disclose the negative experiences she had with her parents because the client she was working with was of Indian heritage. Kev withheld how she handled the situation of family discord from her client since it would not be a possibility for a client. Kev explains that she had stopped speaking to her own parents but would not communicate her

method of conflict resolution to her client. Kev describes her thoughts on concealing personal experiences from certain clients as evidenced by the following excerpt:

So it was a client from India, a very different relationship to her parents than I would have had with my parents...some of the experiences which she had with her parents here, we might have screamed abuse. But there [in India] it's a strong father, it's an authoritative family... but it would probably be more compromising for me to share that I no longer talk with my mother... in fact it probably would have distressed her to think "is that what's she going to advise me? This is not possible for where I come from for me to eliminate my parents in my life. They're so integral and they're so vital"

Nicole and Kev both recall examples of their clinical work with clients of Iranian, Chinese and Indian ethnicity in which cultural differences were apparent leading them to not disclose. Participants were cautious when discussing parent-child relations or sexuality with clients of a different cultural background. Many of the participants in this study were aware of how their disclosures could offend or be disrespectful towards their clients, which led them to the decision to conceal or withhold from sharing. These excerpts also highlight the ways in which the client's background influences the therapist decision to not disclose.

Summary

Four key areas emerged from the data: (1) Understanding therapist self disclosure; (2) Conceptualizing "diversity"; (3) Contexts in which therapists conceal self from the client; (4) Contexts in which therapists reveal self to the client. The first key area revealed three major subthemes: (a) Descriptions of therapist self-disclosure; (b) Attitudes towards therapist self-disclosure; (c) Purpose of self-disclosure. In the first major sub-theme participants expressed similar ideas as to what they believed therapist self-disclosure was and entailed. Commonalities in the participants' responses were related to sharing some aspect or personal experience about themselves for the purpose of helping the client. In the second major sub-theme participants had a mixture of attitudes towards the use of therapist self-disclosure. Some of the participants were used therapist self-disclosure sparingly whereas other participants were more inclined to use self-

disclosure less judiciously.

Within the subtheme of purpose of self-disclosure, two sub-subthemes emerged: Normalizing the distressing experience of the client and the Therapeutic alliance. Many of the participants expressed their reasons for using therapist self-disclosure in order to make the client feel less alone and to improve the relationship between themselves and the client. The second key area was Conceptualizing “diversity”. Participants expressed various ways in which they conceptualized clients whom they worked with from diverse backgrounds. Some participants shared that clients from a diverse background entailed someone from a different culture than their own or had a shorter immigration in Canada. Other participants reported that diversity in clientele meant working with people who were of a particular ‘race’ (i.e., non-“White”) and/ or were of a particular ethnic background. Some of the participants shared that their diverse clients were people who were of lower socio-economic status. In the third key area, which was the contexts in which therapists conceal self from the client, three subthemes emerged out of the data: (a) Boundary issues; (b) Awareness of over identification; and (c) Cultural Differences. The participants shared that they would be less inclined to share personal information and/ or experiences from their life if there was potential to transgress a boundary or they did not feel comfortable answering a question the client asks of them. Many of the participants also felt that if they identified or could relate to either the client or someone their client was speaking about within their life they might not disclose, especially if it could damage the therapeutic alliance. Some of the participants were disinclined to transmit personal information about themselves for the potential that their client would have a negative reaction towards them because of it.

Cultural-differences between the participant and their client was another common context in which participants exercised restraint and caution when disclosing. Many of the participants were unsure how their self-disclosure would be received by a client who was from a different

culture than their own. Some of the participants did not see it as beneficial to disclose to clients whom may have a differing frame of reference and thus self-disclosures used with culturally non-matched clients were seen as more susceptible to be ineffective and potentially damaging. The fourth key area was contexts in which therapists reveal self to the client. Under this major theme emerged four subthemes: (a) Client curiosity; (b) Shared experience; (c) Ethno-cultural matching and (d) Socio-Economic context. Many of the participants reported that their clients would ask them direct questions in which they would provide a straight-forward answer to. Common questions asked of the participants by their clients were their ethnic background, marital status and if they had children. Participants expressed that if they had a similar experience to the client and they perceived that sharing their own experience to the client could be beneficial to their client in some way than they would likely disclose. Many of the participants reported that when their clients were of a similar cultural background to their own they were more willing to share.

Furthermore, participants reported that the types of shared experiences in the culturally-matched context would often produce similar types of experiences that the participant would be inclined to reveal to their client. Participants perceived themselves as well as their clients to feel more comfortable in the therapeutic relationship when the dyad shared a similar ethno-racial background. The socio-economic context was another context in which therapists would reveal an experience they had with their client. Many of the participants shared that they had worked with clients who did not have a lot of money. In addition, many of the participants expressed instances when they too struggled financially or with housing-related issues in which they were inclined to share their experience with their client whom also experienced similar difficulties to themselves.

Chapter Six

Discussion

The present study investigated whether or not therapists' self-disclosures differed on the basis of content when working with clients from a similar or dissimilar social location than themselves. Specifically, the present study sought to understand the content of the disclosures made by therapists directed towards their clients, to document their experiences and chronicle their motivations for disclosing and not disclosing. A central question of the present study was to explore the question of "Does therapist self-disclosure differ from each other as a function of client factors? (i.e., ethno-'racial' background, gender, sexual orientation, class, (dis)ability, age, and religion- also referred to as the 'Big 7' identity markers for short. See Moodley, 2007)". The results of the present study revealed a number of major themes in which the participants' could recall when disclosing to a client from a diverse background(s). The major sub-themes obtained from the results as to when therapist self-disclosure was used as follows: (1) client's curiosity of the therapist's personal life; (2) therapist having a shared experience to the client; and (3) when therapists were working with clients' from a similar social location.

The present chapter intends to: (1) better understand the key themes involved in the participants responses that had been extracted from the *Results* section prior, (2) draw connections between these themes and sub-themes, (3) outline the central themes and its' point of convergence and divergence from previous scholarship within the field; and finally, (4) derive a theory from the themes/ sub-themes; for the purpose of simplifying the complex interpersonal dynamic that occurs between therapist and client in a room, as it pertains to the use of self-disclosure with a client from a dissimilar social location. The question that seeks further analytic

study is if it is beneficial to therapist-client interaction if an immediate acknowledgment is made by the therapist in regards to their similarity or difference in sociocultural background.

In this chapter, the term ‘Big 7’ identity markers was used as a way to not confine the study to ‘ethno-racial’ identity features. However, the term ‘social location’ was used by many of the participants so in keeping with using the same vernacular as the participants the term ‘Big 7’ interchangeably with the term ‘social location’. Of the ‘Big 7’ only four of these salient identity markers entered into the conversational space with the participants; namely- (a) gender, (b) social-economic class, (c) religion and (d) ‘race’/ ethnicity. In contrast, three out of the ‘Big 7’ identity markers remained unmentioned by participants when speaking about their experiences of using self-disclosure with their clients. The three categories that were not mentioned at any point within the dialogue during the semi-structured interview were: (1) sexual orientation, (2) age, and (3) (dis)ability. We must ask why these factors were not part of the main discussion when discussing their clinical work with clients from a diverse background. It is plausible that the identity markers such as: age, sexual orientation and (dis)ability did not enter the consciousness of the participants being interviewed when asked about their work with their clients.

Alternatively, were these variables of age, sexual orientation and (dis)ability perceived as more taboo than discussions on ‘race’, gender and class? Or, perhaps, the ‘race’ and gender of the participants’ clients were more readily visible and thus cannot be disguised or obfuscated whereas sexual orientation and (dis)ability are often ‘invisible’ and therefore can be cloaked with relative ease (see Litjmaer, Moodley & Sunderani, 2013).

Nonetheless, in spite of the aforementioned speculations, it remains unclear as to why some of the ‘Big 7’ identity markers were addressed by participants and not others. Perhaps, some further insight can be gained by drawing upon the work of Moodley (2007). In his work, he argues that a paradigm shift in multi-cultural counselling research is an ongoing process of

occurrence. Therefore, equating multi-cultural counselling to the objective study of persons of a particular 'race', 'colour', ethnic background and/ or cultural group is inherently problematic. The dominant approach of conceptualizing 'identity', 'culture' and 'diversity' presupposes a fixed category versus an understanding that both the concepts of culture and diversity are far more dynamic and fluid in structure and form, than previously theorized. The fluid nature of both culture and diversity is further affirmed by Lee (2014) who argues that each individual holds simultaneously multiple but uniquely personal, familial, and cultural identities within their larger socio-political-cultural group structures. Therefore the construct of the self cannot be de-contextualized from the socio-political-cultural environment.

The construct of self within the context of a socio-political-cultural environment provides ample opportunity for therapists to understand the client as culturally hyphenated individual (see Giampapa, 2001). According to Giampapa (2001), hyphenated identities refer to the self-perceived change in a person's cultural identity, which can be the result of acquiring elements of a new culture they are exposed to and/ or is incorporated into their psyche often as a result of immigration (e.g., Chinese-Canadian, Puerto Rican-Hispanic-American, Indo-Caribbean-Canadian, Jewish-Polish-Torontonian). In these cases, the person preserves some aspects of their cultural, religious, language and/ or national heritage in conjunction with the culture they are presently living in. It is important to understand the client as an individual with a culture whose motivations and experiences cannot be dismissed or ignored. For example, the acceptance of hyphenated identities in multicultural counselling would enhance the therapeutic process if a client's identity is accepted as a cultural being whose unique situation, experiences and motivations have occurred throughout her/his lifetime while they occupied a range of geographical and cultural spaces. For example, a 20-year old female immigrant from Mauritius, who moved to Toronto at the age of eleven, could disclose how she has negotiated a range of

identities throughout her life. She could for example identify ethnically as an Indo-Mauritian at the age of ten when she lived in Mauritius. She could, if she sees relevant to her identity, consider herself Mauritian-Canadian at the age of twenty.

Therefore, it is indisputably important to understand that the concept of culture is significant to self-disclosure in terms of both creating a safe space in which the therapist either acknowledges the difference in culture or if relevant, reveals his/her own culture. For this purpose, Moodley (2007) suggests that an inclusive understanding of all of the ‘Big 7’ identity markers with all of its’ overlapping and converging points of intersection are important in the advancement of multi-cultural counselling research considering we live in a multi-ethnic, multi-faith, multi-gendered, multi-racial, multi-abled, multi-sexual etc., society. The multi-cultural counselling movement, albeit well-intentioned, has promulgated the idea of developing knowledge, skills and awareness in working with clients from dissimilar ethno-racial backgrounds (e.g., Arredondo et al., 1996; Sue, Arredondo & McDavis, 1992), however, some have criticized this intention as being unattainable. According to Dean (2001), cultural identity is constantly changing and thus cannot be something that a therapist develops competency in. Rather, Dean (2001), proposes therapists acknowledge their lack of cultural knowing and operate from that framework of not-knowing and not-being able to know. The participants in this study expressed hesitation around disclosing to their clients of a different culture. How is that to be interpreted? Were the participants operating from a stance of “not-knowing” and therefore not-disclosing?

In addition to the overlapping and converging points of intersection, the decision of whether or not to disclose to the client is relevant in the context of this study because the results also showed that when the participants in the sample were asked about contexts in which they did not disclose to their clients, two major themes emerged from the data: (1) awareness of over

identification; and (2) when the client was from a different social location. Consistent with previous research on the topic of therapist self-disclosure in a multi-cultural context, the results of the present study showed that the content of therapist self-disclosure is influenced by many of the ‘Big 7’ salient identity markers.

Participants were asked to reflect on key terms (i.e., ‘majority’ ‘minority’ and ‘therapist self-disclosure’), prior to understanding when disclosure is used, to whom is it being disclosed to, how is it being disclosed and what is being disclosed within the context of therapist-client multi-cultural dyads. According to cognitive and personality theorists, developing an understanding of the semantic meaning of ambiguous words such as, ‘minority’, can be derived from conceptualizing the word based on its’ binary opposite (Kelly, 1955). In this study, participants were asked to reflect upon their subjective understanding of both ‘minority’ and ‘majority’ in relation to one another. Drawing from Personal Construct Theory (Kelly, 1963), interpretations, meanings and conceptualizations are obtained from by understanding what the meaning of a word is by recognizing what it does ‘not’ entail nor include. For example, the words in the phrase “minority client” can be understood as one end of a pole based on the characteristics, features and representations of what the subjective understandings of the word(s) “majority client” are perceived to mean within the cognitive space of the participant. Commencing the interview by obtaining participants’ personal meanings associated to the key terminology (i.e., ‘minority’ and ‘self-disclosure’) is part-and-parcel and consistent with the Grounded Theory approach.

When asked to describe, participants had offered a wide array of differing interpretations and understandings to the words ‘majority’ and ‘minority’. The results section revealed that several of the participants echoed each other’s sentiments in terms of associating the word ‘majority’ with ‘Anglo-Saxon’, ‘Protestant’ and/ or ‘White’. These responses were in accordance

with the interpretation of ‘visible minority’ as outlined by the Statistics Canada (2009) website which defines ‘visible minority’ as: “persons who are non-Caucasian in race or ‘non-white’ in colour and who do not report being Aboriginal”. The above set of interpretations and understandings of the words ‘majority’ and ‘minority’ suggest a cultural/ ethnic/ ‘racial’ connotation associated with its’ meaning. It was unclear as to why some of the participants regarded ‘majority’ in the way that they did. Conversely, some participants did not share the same connotation of ‘majority’ to mean ‘Anglo-Saxon’, ‘Protestant’ and/ or ‘White’. For example, did the participants associate the concept of ‘majority’ with ‘Anglo-Saxon’, ‘Protestant’ or ‘White’ because of the historical timeline in which some persons of British descent immigrated to Canada? Or did these participants from the study sample associate the word ‘majority’ with clients of British descent because people from British background since this group of people are numerically the largest portion of the Canadian population? (see Statistics Canada Census, 2011). Alternatively, did the participants in this study associate the concept of a ‘majority’ client with characteristics of the social-economic position ‘White’, ‘Anglo-Saxon’, ‘Protestant’ have within society.

To complicate matters further, there was no consensus among participants about the meanings of ‘majority’ and/ or ‘minority’; not every participant understood ‘majority’ to be associated with features and characteristics of persons of British and/ or of European origin. For example, as evidenced in the above *Results* section, one of the participants emphasized ‘geographic relativity’ in terms of developing an understanding as to what the concepts of ‘majority’ and ‘minority’ entails. Some of the participants adopted a view that challenged mainstream understandings of ‘majority’ and ‘minority’. One of the participants responded with the idea of minority being understood in relation to and within the context of her own nationality- growing up and living in the Ukraine. For this participant, the ‘majority group’

referred to someone of ‘Ukrainian’ ‘Russian’ or ‘Jewish’ descent whereas the ‘minority group’ referred to someone of ‘Georgian’ and/ or ‘Kazakhstan’ origin. According to Statistics Canada Census (2011), East Asians and South Asians comprise of the largest non-European population, with an even larger proportion of these two ethno-cultural populations residing within the Greater Toronto Area. Within the Toronto context, the largest portion of ethnic groups are concentrated within the suburban areas of the city’s border; Scarborough, Markham, Brampton have less than 40% of its’ local population reporting a European-Canadian, ‘White’ cultural-racial background (see Statistics Canada Census, 2011), in contrast to, the downtown city core of Toronto and/ or uptown suburban North York, in which European-Canadian and/ or persons whom self-identify as having a ‘White’ racial background are greater than 50% of the local population, demographically (see Statistics Canada Census, 2011).

Understanding ‘majority’ and ‘minority’ from this framework underscores the importance of ‘geographical relativity’ when conceptualizing these terms. Based on the demographics of a particular region, certain ethno-cultural groups might be perceived to be the ‘dominant’ group because they are the numerical majority which has the capacity to translate into ‘social capital’; ‘cultural capital’ and ‘economic capital’ (see Bourdieu, 1972). However, as some of the participants alluded to, a member of the ‘majority’ group may inhabit a space by numerical demographic census standards in which they would constitute the ‘minority’ (e.g., White patient residing in Scarborough) thereby inverting and challenging dominant models of ‘majority’ and ‘minority’ status. Moreover, it opens up a space for a multiplicity of notions around what is a majority and minority rather than positioning the two constructs as ‘singular’ and antithetical to one another. The above example is one way in which the flaws of dichotomous thinking around issues of ‘minority’ and ‘multi-culturalism’ rupture and erode pre-conceived, fixed and static interpretations of words like ‘minority’ (see Moodley, 2007 for a further discussion). For one

participant, a visible minority had more to do with economic class and financial means as she associated ‘visible minority’ (e.g., someone standing outside of the Center for Addiction and Mental Health hospital), which indeed can be quite visible; as evidenced by particular distinguishing features such as: demeanour, style of dress, .gait, speech and mannerisms of people who happen to ‘hang around’ the vicinity and perimeter of the regional mental health facility. The social perception of the underclass as a visible minority is intriguing because it takes the concept of ‘minority’ and brings in the aspects of ‘class’ whilst intersecting it with ‘(dis)ability’. By this index of visible minority, the term does not exclusively imply nor is it confined by, a specific set of skin pigmentations or ethnic heritage or physiognomic facial feature or a particular hair texture. For these aforementioned reasons, the question of ‘what does a person from a ‘majority group mean?’ or ‘what a does a person from a minority group mean?’ warrants revision since participants were generating answers that were markedly different from one another or unclear as to what is being asked. Being asked these questions, in and of itself, would also evoke alteration in participant’s responses and stimulate re-consideration within the participants’ heuristic knowledge base as participants’ tried to articulate their initial impression of the semantic meaning only to revise it a later point in time during the interview. Perhaps, an alternative way of conceptualizing ‘majority-minority’ is from the standpoint of diversity by replacing the words ‘majority’ and ‘minority’ with the broader concept of ‘diversity’.

In contrast, many of the participants reported ‘colour-blindness’ insofar as they saw themselves and the client, as two ‘beings’ in a room working together on a shared vision, which has been an approach postulated by previous researchers (e.g., see Fukuyama, 2011; Vontress, 1979, 1988; Vontress & Jackson, 2004). Considering that many participants felt that distinctions between people based on ethno-cultural heritage, skin pigmentation, physiognomic features are arbitrary they reported that they do not alter their way of interacting with the clients from diverse

backgrounds. These sentiments are echoed by some theorists whom posit that “everyone experiences some form of cultural marginality or unbridgeable difference from others. The forms of these experiences vary. But there is common core sameness that can illuminate our understanding of patients when we identify with it” (Shecter, 1992, p. 341). Do therapists’ perceive and believe that cultural differences are irrelevant in their ability and effectiveness to help? Many of the participants in this study shared the view that cultural differences is “not a big deal” nor does it impede. This highlights a discrepancy between perception and action since many of these same participants were less likely to use disclosure with someone of a differing cultural background when topics that were of “cultural-relevance” were implicated (e.g., parent-child relations, sexuality, religion).

By adopting the human universality approach, it begs the question as to why continue to explore the ‘Big 7’ identity markers any further if is not deemed as meaningful enough to alter a clinicians way of ‘being’ and ‘relating to’ the client? The main reason is that there were perhaps nuances and subtleties in what therapists would be willing to reveal and conceal based on the client’s social location would inform their choices of what they might share or what they might hide. Lee (2014) argues that cultural influences on the therapist are “unconscious” in nature and ‘deeply embedded’. Furthermore, Dean (2001) asserts that “it is difficult to separate ourselves from our own ‘cultural baggage’” (p. 626). The therapist cannot distance themselves from the socio-cultural reality which influences their own perception. Theoretical understandings of the role culture has in therapy have highlighted conflicting views. On the one hand, humans experience very similar struggles that manifest within the interpersonal context of close relationships (i.e., parent-child conflict, negotiating family relations, and romantic disputes). On the other hand, the way in which the client presents their narrative of suffering to their therapist can often have a ‘cultural basis’ insofar as two clients with a similar ‘universal’ presenting

problem (e.g., marital dissolution) may have differing ideas, values and beliefs around what constitutes romantic harmony. Thus, the onus is on the therapist to gauge the client's readiness to receive a self-disclosure which is contingent on the degree of similarity and dissimilarity between the therapist and client in their beliefs and attitudes around romantic harmony. Higher degrees of similarity (or perceived similarity via transference) within the therapeutic dyad bears the potential for increased alliance strength.

Contemporary psychotherapy process research substantiates that the therapeutic alliance is the most important ingredient in the counselling process (e.g., Barrett & Berman, 2001; Gelso & Hayes, 1998; Orlinsky, Ronnestad, & Willutski 2004; Stiles et al., 2004), it is reasonable to therefore suggest that intimacy is both valued and desired by the parties within the therapeutic dyad. Careful evaluation is required to accomplish an appropriate degree of intimacy whilst disclosing worldviews and culturally rooted ideas. Towards this end, therapists will, on occasion, reveal elements of themselves in service of establishing and maintaining a strong relationship with their clients- ultimately in hope to impact the outcome of the treatment positively.

Further support elucidating the importance of therapist self-disclosure emanates from research done on aspects of what is remembered and what is forgotten following the termination of treatment. For example, the empirical work of Wzontek, Geller and Farber (1995) provided evidence to support that therapist self-disclosure is oftentimes one of the few things that clients remember most saliently when the course of therapy has reached the end. In this study, 60 former recipients of psychotherapy were recruited and had been administered a battery of scales comprising of questions in a Likert-scale format. These administered tests included: the Therapist Representation Inventory, the Therapist Involvement Scale and the Therapist Embodiment Scale. Findings revealed that former patients whom had formed strong internal representations and internalized personal qualities of their therapists perceived their treatment as more successful.

Given that therapist self-disclosure is one avenue to evoke an ‘introjection of self’ into the client, it has the potential to have ongoing impact on the client.

The decision-making process as to what a therapist ‘can’ or ‘should’ reveal and what they ‘can’ or ‘should’ keep hidden is a murky area. This is because any personal information that is communicated to the client, intentionally or inadvertently, can influence the ‘internalized representation’ the client maintains of their therapist post-treatment. Geller (2003) requests therapists ask of themselves “is it appropriate for me to ask my patients to risk sharing their most intimate feelings if I am unwilling to take the same risk?” (p. 552). Internal conflict and uncertainties around therapist self-disclosure are an unavoidable conundrum for therapists to grapple with due to the influence of the traditional view that self-disclosure can interfere with the transference process. An asymmetry of experiences would potentially disrupt or even prevent the therapist-client bond. Although discomfort to a certain degree is unavoidable, self-disclosure in an appropriate is necessary if the discourse requires it. Participants in this study also reported that the instances in which they revealed personal experiences to the client was quite impactful on the clients they had worked with, thereby supporting previous research done by Wzontek, Geller and Farber (2005).

In the present study, the participants had different levels of comfort about what they were willing to reveal versus conceal, which was related to their therapeutic orientation. Participants operating from a predominantly Feminist, Gestalt, Rogerian and Relational perspective were more likely to disclose to their clients whereas participants who primarily identified as cognitive-behavioral and/ or psychodynamic were more cautious and judicious with their use of disclosures. These findings were consistent with previous research that has shown therapists operating from a Humanistic-Experiential or Feminist-Relational perspective are more likely to report greater levels of disclosure than counsellors/ therapists trained in and practicing from a psychoanalytic

framework (e.g., Edwards & Murdock, 1994; Hill & Knox, 2001). Although participants who identified as Cognitive-Behavioural in orientation or Psychodynamic appeared to disclose less often, the motivation for withholding differed. Cognitive-behavioral therapists tended to be focused and goal-oriented whereas practitioners from the psychodynamic persuasion tended not to want to interfere with the transference process and were hyper aware of boundary crossings. The results of this study are consistent with previous research that has shown psychodynamic therapists are less inclined to disclose personal experiences in comparison to therapists practicing from the other theoretical orientations (e.g., Carew, 2009). There appeared to be a significant impact of therapeutic orientation on both the of therapists' willingness to use and the frequency to which they used self-disclosure. In addition to therapeutic orientation there appeared to be an effect of ethnic matching on willingness and frequency of self-disclosure use with clients.

There are several lines of converging evidence suggesting ethnic matching is an important variable within therapist-client dyads. Drawing evidence from classic social psychological theories of interpersonal attraction, people are more likely to rate others who are similar to themselves as favourable (Byrne, 1961; Newcomb, 1956; Schacter, 1951; Sprecher et al., 2013), form positive evaluations of others whom they have more frequent exposure with (e.g., Zajonc, 1968) and are more likely to develop positive feelings towards others whom they are in close physical proximity to (Back, Schmukle, & Egloff, 2008; Segal, 1974). Human beings tend to seek out, respond to, and notice things that are familiar and similar to themselves and tend to be uncomfortable with things/people that are dissimilar to themselves (see Baron & Bryne, 2000). Ethnic matching may help reduce the number of differences between client and therapist, and thus promote increased therapist self-disclosure, reduce the likelihood that the therapist will minimize some of the important aspects of the client's lived experience since these are no longer differences but rather similarities. Another potential benefit of ethnic matching concerns the

multicultural sensitivity of the services provided. Historically, the provisions of mental health services have been geared towards wealthy North Americans of European heritage (Nagayama & Hall, 2001). Sue and Sue (2008) argue that the failure to tailor the mental health services to people of 'color' may have led to perceptions of racism, mistrust in mental health service providers, and unfavorable views of mental health institutions. Consequently, mental health provision is perceived to have been designed by Whites for Whites. This had spawned, among many things, a large quantity of studies conducted on ethnic matching. These studies investigating ethnic minorities' perceptions of and preference for ethnically similar therapists have received some support that ethnic minorities tend to favour ethnic minority therapists in comparison to European American therapists. Benefits included lower dropout rates and less appointment cancellation and/ or "no shows" than those who were not matched with therapists of a similar ethnicity (e.g., Coleman et al., 1995; Maramba & Hall, 2002).

Not all studies on ethnic matching have yielded the same results (see Shin et al., 2005). Theoretically, it is not only the ethnicity of the client that could affect the therapeutic interaction but also the ethnicity of the therapist. In a review of the research concerning psychotherapy with ethnic minorities, Sue (1988) addressed the dilemma inherent in the concept of ethnic matching. He proclaimed that ethnicity of the therapist or of the client are distal variables hence why mixed findings are reported in outcome studies on ethnic matching. What is known is that although groups exhibit cultural differences, considerable individual differences may exist within groups "ethnic matches can result in cultural mismatches if therapists and clients from the same ethnic group show markedly different values" (Sue, 1988, p. 306). Simply matching a client and therapist by ethnicity may not be an accurate match of values, attitudes, and life experiences. Without matching these factors, there appears to be little benefit to ethnic matching in general. Zane and colleagues (2005) suggest that factors such as cognitive compatibility impact treatment

outcome more so than racial or ethnic similarity. Therefore, more important than matching clients with therapists along ethno-racial dimensions, is to match dyads based on attitudes, values, and experiences in order to optimize therapeutic benefit. By logical extension, matching the therapist with the client on any of the 'Big 7' identity markers could produce more meaningful and helpful therapist self-disclosures since it increases the likelihood that a common or shared experience exists between them. Although there is some evidence that Asian American clients may actually have a preference for European American therapists, ostensibly due to internalized racism (Alvarez & Helms, 2001) clients have expressed a preference for a therapist of the same ethnicity. This effect has also been demonstrated among for Asian Americans (Atkinson, Maruyama & Matsui, 1978) as well as for Hispanic Americans (Lopez et al., 1991; Sanchez & King, 1986) and Native Americans (Haviland, Horswill, O'Connell, & Dynneson, 1983; LaFramboise & Dixon, 1981).

What about matching European-Canadian clients with European-Canadian therapists? Moodley (1999) highlights the importance of 'colouring in the white' and discusses the importance of being inclusive of all persons since we are all cultural beings. Research is scant on examining the impact of ethnic matching among 'White' and/ or European-Canadian therapists with European-Canadian clients, thereby necessitating the need for the field of critical 'White' studies to be incorporated within the multi-cultural counselling framework. Interestingly, the present study highlighted some of the positive aspects to cultural matching rather than simply basing it on 'race'. Many of the participants who shared a similar ethnic or religious background to their clients were more apt to disclose. The increased levels of disclosure may be related to comfort with the client and anticipating a positive reception by the client when the disclosure is delivered. To summarize, based on the participants' recall of disclosures they have used with their clients who were similar to them on the 'Big 7', the preliminary data of this study provides

evidence of a positive effect therapist disclosure can exert on the client when matched on any of the 'Big 7' dimensions. The ways in which therapists used self-disclosure was when (1) they were asked a direct question; (2) undergone a similar distressing experience to the client; and (3) shared the same cultural background as the client. Some of the participants would share personal narratives with clients who were from a different social location than themselves and would share their own struggles of inadequate living conditions. Many participants believed that culture/ race/ ethnicity was not a factor that influenced the extent to which they disclosed. These participants believed that people are just people regardless of their social location. However, upon inquiry there were subtleties in the content of what therapists disclose to their clients. Furthermore, the participants in this study would not be more reluctant to disclose to clients who were of a different cultural background than their own. Although the participants reported that the client's cultural background would not affect the amount they disclosed they did mention that it would impact the timing of their disclosure and that they would be more cautious about the content of their disclosure when counselling someone of a different ethnicity.

Meaningful assertions by the therapist in regards to the cross-cultural conflict is shown to affect client-therapist relations as evident from Lee and Horvath's (2014) study. In this study conducted on cross-cultural dyads, therapist's responses to the patient's culture-based concerns were examined. The three clients participating in the study were first-generation immigrants who were ethnic minorities. The criteria for including a client in the study were self-identification as a racial/ethnic minority, being older than 19, and being able to speak and read English. The first client was a Mexican immigrant in her 40s whose first language was Spanish. She sought therapy to address her ongoing conflict with her 17 year old daughter. The daughter was skipping school, running away from home, periodically using marijuana, and suspected of promiscuous behavior by her mother. This client expressed several factors that contributed to the tension with

her daughter due to her recent immigration and made a link between these factors and the daughter's acting out behaviours as being a symptom of her parents' struggles. According to the partial transcript provided in the study, the parents were initially focusing on the cultural differences between themselves and their daughters that made her behavior inappropriate in their eyes. The therapist appears to have very little to contribute beyond minimal responses such as "umm" and "'yeah". The therapist only contributed when directing the topic of the session into focusing on the daughter's behavior. This made it evident that the therapist was impotent in her ability to help the family with their cross-cultural dilemma (see Lee & Horvath, 2014). In the context of therapist self-disclosure, the participants in this study also reported being more cautious and hesitant when working with clients from a different background. These results are consistent with previous work that has suggested that therapists are likely to employ a client-centered or supportive therapy stance when working with culturally-different clients (see Comas-Diaz & Jacobsen, 1991).

Given differences in cultural values, it should not be surprising that ethnic matching may not impact all ethnic groups in the same manner. The vast heterogeneity that exists among people of the same cultural group may be largely responsible for the inconsistent and/ or not significant findings pertaining to client treatment outcomes. In reviewing the literature, Flaskerud (1990) found that most studies can be divided into one of three categories: (a) studies dealing with preference for therapist, (b) therapy process, and (c) therapy outcome. Wetzel and Wright-Buckley (1988) have found that African-American rated high-disclosing African-American therapists more favourably than their low disclosing African-American counterparts and/ or low-/ high disclosing European American therapist. Moreover, since most research has been conducted in the United States there might be national differences between which ethnic groups get selected for study. For example, Blacks living in the United States brought over from West Africa, during

the slave trade several centuries ago, may differ from ‘Black people’ residing within Canada, many of whom have a more recent immigration history with the majority of Canadian ‘Blacks’ tracing their ethnic and cultural background to the Caribbean. Or, alternatively, the large presence of South Asians as the largest group of “visible minorities” in the Canadian context may warrant a more refined study of this ethno-cultural group opposed to being lumped together with other vastly different cultural groups who happen to originate from the same continent (i.e., the category of “Asian”). The category of “South Asian” and the corresponding South Asian diaspora (e.g., Indo-African, Indo-Caribbean) have also been virtually absent or excluded altogether from the multi-cultural counselling literature despite the fact that migration patterns to North America pin point urgency for research with this particular ethnicity.

Research conducted on European American therapists working with clients from diverse backgrounds has shown that many therapists use therapist self-disclosure to promote a strong bond with their client within the therapeutic relationship, validate the role of racism/ oppression in their client’s experiences and use therapist self-disclosure to acknowledge their own biases and prejudices (see Burkard, Knox, Groen, Perez & Hess, 2006). The data revealed support for two out of three themes uncovered by previous research (namely promoting a strong bond with the client and validating racism and oppression in the clients’ life). There appeared to be no evidence in this sample to support that therapist self-disclosure was used in a way to recognize their own prejudices and biases. However, in addition to recognizing the role of racial discrimination and oppression (i.e., ‘racism’) in the client’s life, the participants in this sample had also reported using self-disclosure to acknowledge the role of sexism and ‘classism’.

Socioeconomic background appeared to be a significant component in connecting to and empathizing with the client. Some of the participants reported receiving positive reactions from their clients when disclosing about their own personal experiences with regards to money

scarcity or having experienced an undesirable living condition. The data from this study suggests that disclosing socio-economic background and its' corollary micro-experiences (e.g., waiting for, missing and transferring buses in the frigid Canadian climate) can foster a positive therapeutic alliance since it is an indirect way of showing empathy by implicitly communicating "Yes, I know what you mean. Not having enough money is hard. Let me tell you what it was like for me..." It is plausible that, on the one hand, clients will react positively to discovering that their therapist has had similar experiences (i.e., 'feeling like my therapist can relate to me') and yet, on the other hand, the upward social mobility displayed by the therapist having advanced from their working and/ or lower class beginnings could have the unintended effect of breeding feelings of inferiority or envy. Perhaps, more insidiously the client could interpret the therapist self-disclosure as a subtle criticism in the form of, for example: "I was once poor but now I am not, in part, because of my education and profession. So if I can move up so can you". This upward social mobility may not be possible for many of the clients given the resources they possess in conjunction with the circumstances they are in. Karlsson (2005) found that many researchers have underscored the importance of socioeconomic status in understanding differences in attitudes and treatment results between ethnic groups. Some of these research studies have positive outcomes found within ethnically matched dyads may have actually indeed been an artefact of similar socioeconomic backgrounds (e.g., Alvidrez et al., 1996).

In a similar vein, studies on gender matching (e.g., female clients with female therapists; male clients with male therapists) and its' impact on therapist self-disclosure have also yielded inconclusive results (see Henretty & Levitt, 2010 for a review). As with all of the previous studies on ethnic matching and investigations on therapist self-disclosures with ethnically or gender similar dyads, the dependent variable has been based on assessing the number of disclosures (i.e., frequency) made as well as on the overall client outcome. In the present study,

some of the participants shared aspects of their personal life that might have been classified as ‘gender-based’ or ‘gender-oriented’ (akin to “culturally relevant” talk and non- “culturally-relevant” talk as discussed by Lee & Horvath, 2014). Examples of therapist self-disclosures, as used by the participants in this study, that contained ‘gender’ as a central component included: discussing parenting strategies as a mother, negative experiences with men in the romantic context and the impact of sexual abuse they (i.e., the therapists/ participants) themselves had experienced. All of the participants acknowledged that they only shared these aspects of their life following a disclosure initiated by the client on the topic first. Therefore, it is evident, that therapist-self disclosure not only serves the purpose of reinforcing the therapist-client bond but also has the additional advantage of encouraging client’s to reveal details about themselves- this is especially true given the likelihood of clients opening up to therapists of similar ethnic backgrounds. To recapitulate, there are a multitude of reasons as to why therapists’ might disclose to a client. Most notably, when a therapist has undergone a similar experience to that of their client there is an inclination to use self-disclosure more freely. The cultural background of the client can influence the extent to which the therapist shares their personal experience specifically in contexts when the therapist and client are matched on ethnicity. What about contexts in which therapists do not freely disclose or feel hesitant about doing so?

Previous research has showed that therapists report a wide array of reasons for concealing themselves and opting to not disclose such as: (1) meeting their own needs; (2) shifting the focus from the client onto therapist; (3) interfere with the client’s steady stream of thought process, self-reflection and emotional content; (4) burden the client; (5) overstimulate the client; (6) blur the boundaries and/ or (7) corrupt the transference (see Edwards & Murdock, 1994; Geller & Farber, 1997; Simon, 1990). The findings of this study were consistent with much of the previous literature outlining reasons for why therapists do not disclose. Specifically, within this

sample, participants reported that they were hesitant and thus would *not* disclose if they felt it might gratify a need of their own, or felt like the disclosure may not be received positively by the client, and or could potentially blur the ‘professional’ boundary. In addition, many of the participants feared that they would say something that would damage the rapport with the client, in particular, if the client was from a different ‘social location’. In this regard, the present study is one of only a handful of studies in examining the impact of the clients’ ‘social location’ on the therapists’ willingness to not disclose. Many of the participants explained that they were cognizant of how cultural differences could negatively influence the reception of their disclosure.

For these participants, both the benefits and risks involved in using self-disclosure were explicated. On the one hand, it is a technique that can facilitate growth in clients and make themselves appear more human yet participants were riddled with hesitation and self-doubt of not wanting to transgress the therapeutic boundary within the session. Boundaries help to protect clients from therapist abuse and yet boundaries may also have the adverse effect of stifling creativity (e.g., preventing therapists from disclosing more personal information about themselves). Creativity is the pillar for excellent clinical work but because of anxieties around boundary crossings participants expressed hesitation and at times would err on the side of caution via withholding a personal disclosure- consequently leading to, perhaps, mediocrity in their efficacy with clients. As a general maxim, ostensibly operating at level below consciousness, it can be understood as “if my client is less like me than the less likely I will disclose to them. If they are more like me than I will disclose more to them”.

Several participants in the study did not disclose their personal experiences to the client even if they experienced a similar situation but were from a different ‘social location’. For example, one of the participants’ recalled working with a client of Muslim faith in which her parents had disapproved of her romantic partner choice because the client’s partner was not of

the same faith. Participants recalled a plethora of examples in which parent-child conflict was a cornerstone of the client's distress (e.g., Indian woman unable to get along with her parents; Iranian woman wanting her parent's approval while wishing to explore her non-heteronormative sexuality further). In these types of situations, participants were apt to withhold their opinion of encouraging clients to 'stand up for themselves' given the unfamiliarity with of the culture and religious belief system. These sentiments were echoed by many of the participants in not sharing their reaction pertaining to self-assertion with culturally dissimilar clients. This approach is consistent with previous work outlining recommendations on appropriate use of self-assertiveness training with ethnic minority clients (see Wood & Malinckrodt, 1990).

Perhaps, many of the same participants who stated they were 'colour blind' with their disclosures might have been 'colour aware' when determining whom *not to* disclose to and when to *not* disclose to them. More accurately, the phrase 'culturally aware' might be a better choice (for example, a person from a traditional European upbringing may also elicit the same reaction in the participants in which they would not disclose their personal experiences). The recurring motivation in all of the above examples appears to be a desire to not want to offend the client to come across as judgmental of their client. The topics of sexual exploration, choosing a romantic partner and asserting oneself to parents seem to be key areas in which the participants in this study were hesitant to utilize self-disclosure as a technique with their client from a dissimilar cultural background. This discussion also casts light on the need for increased training with regards to developing multi-cultural skills in an actual session. Most graduate training programs offer a single course on multi-culturally counselling with most of its' focus on fostering awareness rather than cultivating specific skills to use in session.

Towards this end, a theoretical model was crafted outlining the key findings from this study. Namely, the content of therapist self-disclosure differs depending on the cultural

backgrounds of the therapist and the client. Whether matched or un-matched, self-disclosure when used by the therapist is not impervious to external influences outside of the consulting room. Any personal information a therapist chooses to share with their client during the session is shaped by the same outer forces. Therapy can be regarded as a microcosm that parallels and reproduces the same cultural dynamics imbued in conversation as it exists between two people who socially interact outside of therapy.

Mid-Level Theory

To make sense of the data a mid-level theory was developed by integrating macro-level contextual (i.e., culture, socio-political factors) with micro-level counselling processes (i.e., transference phenomena, self-disclosure). A mid-level theory proves fruitful in the present research because it encapsulates a variety of internal, external and interactional features involved in self-disclosure within the counselling context.

Figure 2 illustrates the interconnections between what therapists communicate to their clients when culturally-matched compared to when the dyad is culturally-different. Each arrow signifies the directionality of communication between the two interlocutors (i.e., therapist and client). For example, an arrow base flowing from the therapist with arrow tip pointing towards the client symbolizes a particular sequence of transmission of information via therapist-to-client. Conversely, an arrow base flowing from the client with the arrow tip pointing towards the therapist symbolizes a particular sequence of transmitted information via client-to-therapist. The larger rectangular shape encompassing all of the contents is representative of the society at large. The darker shaded ovals signify *mainstream psychotherapy competency* and the *multi-cultural counselling framework*. Both mainstream psychotherapy competency and the multi-cultural counselling framework are not devoid of the larger socio-cultural context, hence being

encapsulated in the rectangular box. The lighter shaded oval, in-between the two darker shaded ovals, represents the overlap in which the multi-cultural counselling framework and mainstream psychotherapy competency dissolve into one another. These differing paradigms within the field of psychology collide in the center of the page suggesting that irrespective of whether therapist and client are culturally-matched or culturally-different they are both susceptible to the influences of both bodies of psychological knowledge. The darker shaded arrow represents less self-disclosure from therapist to client in the culturally different context in comparison to the culturally matched context. The next page offers a proposed illustrative model to assist in making sense of the central processes and factors involved in therapist self-disclosure (see Figure 2).

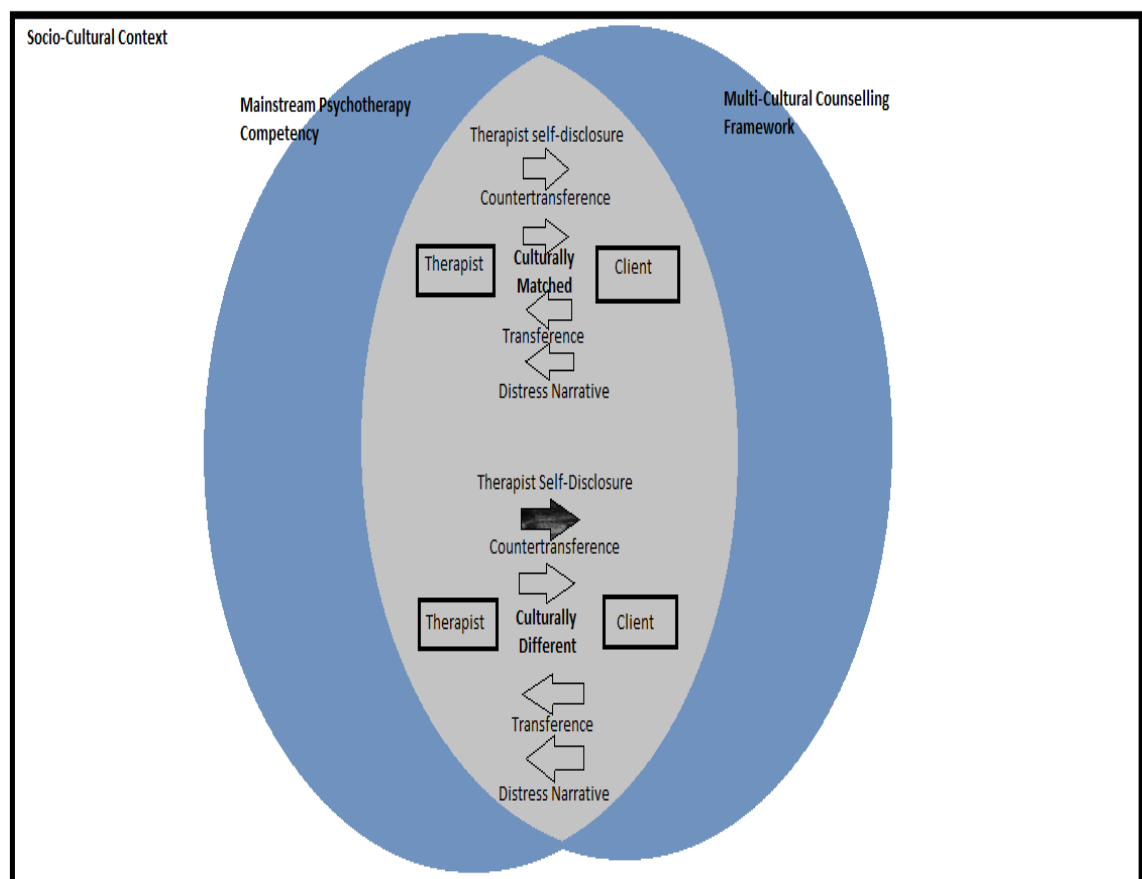


Figure 2: Therapist Self-Disclosure Model of Culturally-Matched and Culturally Different Dyads.

This above model conceptualizes the idea that transference and countertransference are *inevitable* and *inescapable* (see Constantine & Kwan, 2003) occurrences within the therapeutic dyad. Clients, early-on, have preconceptions about their therapists whilst therapists also have preconceptions about their clients. Furthermore, these preconceptions are rooted in prior exposure to or experience with other people they have interacted with at an earlier point in time in their life whom may bear resemblance to the client and/ or therapist. Impressions, preconceptions, assumptions, attributions and inferences about each other operate in a bi-directional manner. The more the client comes to ‘know’ the therapist, the clients’ initial assumptions and attributions are apt to be adjusted, altered and/ or deleted from his/ her mental framework. Similarly, the more the therapist comes to ‘know’ about the client, his/ her own mental framework can shift to incorporate the new information that the client reveals to him/ her. This model suggests an ongoing, perpetual process of revision between the therapist and the client in how they perceive each other and what they come to discover about one another. This model is consistent with the works of Perez-Foster (1998), whom proposed an intersubjective model in working with clients from a different cultural background and the ‘cultural transferences’ and ‘cultural countertransferences’ involved between the dyad.

At the macro-level, both client and therapist are exposed to the socio-cultural reality and context outside of therapy which influences their ideas and beliefs about each other prior to their first interpersonal encounter with each other. The interaction between the two actors (i.e., therapist and client) is a (re) production of the outside world within the confined micro-cosmic environment of the counselling session (also see Lee & Bhuyan, 2013).

During the initial point(s) of contact between therapist-client, impressions and perceptions are quick to form. These impression and perceptions are in a state of ‘flux’ as each person in the dyad reveals some aspects of themselves consciously or inadvertently as the

interaction unfolds on a moment-to-moment basis. These early pieces of information that are revealed can be non-verbal in nature: ranging from style of clothing, gait, office décor, jewelry signaling marital status and general deportment. Other types of non-verbal information revealed may have a ‘cultural’ basis such as: having an awareness of the therapist name and then subsequently associating the name to a specific ethno-cultural group or locating the name to a particular religious origination (see Litjmaer, Moodley, & Sunderani, 2013). These culturally-relevant units of social information are made, in conjunction with, interpreting and processing salient visual cues such as: the therapists’ colour of skin, hair texture and other physiognomic features that provide ‘approximate indications’ or ‘ball-park clues’ about the therapists’ cultural background.

Moreover, the preconceptions of the therapist take further shape when the element of verbal communication is added; inferring personality characteristics and cultural features of the therapist based on his/ her vocal tone, accent, and/ or lexical choice during the initial points of contact (see Litjamer, Moodley, & Sunderani, 2013). These initial points of contact between therapist and client may include but are not limited to: conversation over the telephone while booking an appointment, greeting each other in the waiting room, small talk that occurs between therapist and client, the preliminary conversation that takes place while negotiating the structure of the therapy process, negotiating the number of sessions, negotiating the amount of time per session, and disclosing professional education/ designations/ credentials. Likewise, ‘culturally-relevant’ information is gathered about the client vis-a-vis his/ her vocal tone, accent and/or lexical choice during these initial points of contact as well. This model highlights a form of engagement between two people (i.e., client and therapist) that is dialectical in form. Thoughts about the client’s cultural background and ways of responding to the client as a result of his/ her culture is what Perez Foster (1998) deems as ‘cultural countertransference’. Conversely, the

client is apt to respond to the therapist in ways that are culturally derived – ‘cultural transference’.

The process conventionally begins when the client verbally communicates a ‘narrative of distress’ to the therapist once prompted to do so by their therapist. Both the content of the client’s distress narrative and the delivery of how it is presented to the therapist are culturally-influenced. How the therapist perceives, interprets and makes sense of the ‘narrative of distress’ presented to him/ her is also interpreted from his/ her own cultural lens. Culture and self are inextricably linked for both the therapist and client and thus cannot be disunited. The therapist is equipped with professional knowledge about the human psyche taught to him/ her (i.e., mainstream psychotherapy competency) and uses this knowledge to assist him/ her attend to and respond empathically to the distress calls made by the client- in hopes to alleviate some of the symptoms of their suffering (i.e., low mood, anxiety, anger, confusion, bodily pain etc.). One ‘tool’, among many contained within the therapists’ ‘toolbox’ to aid in the alleviation of suffering, is *therapist self-disclosure*. Ways of attending to and responding to distress using self-disclosure are rooted in and emotionally-driven by personal beliefs, values, and Euro-centric based academic practices (see Perez Foster, 1998). Unlike *inescapable* and *inadvertent* types of therapist self-disclosure (which at some level are unavoidable), therapists may make a choice to draw upon their own personal experiences if it bears resemblance to their clients’ distress narrative. Therapists’ whom opt to disclose, via verbal transmission, their own experience to the client are carried out and performed in a strategic and deliberate fashion. When the therapist is of a similar cultural background to the client, the therapist becomes more inclined to share his/ her own personal experiences. When the therapist is of a different cultural background than that of the client, the therapist is less inclined to share his/ her own personal experiences.

Summary

This chapter began by recapitulating the data revealed within the results section and attempted to offer an explanation to make sense of the participants' reported experiences. Firstly, participants had similar ideas as to what constitutes self-disclosure and the purpose of using disclosure in the therapeutic context. In contrast, participants did not share similar ideas about what constitutes a minority client. This chapter also explains that it is difficult for therapists to parse out what aspects of their self-disclosure are "culturally-relevant" and which disclosures are exclusively based on a shared experience that are less culturally-relevant. This inability to neatly separate culturally-relevant disclosure from those that have less to do with culture give credence to the Culture-within-Self theoretical approach. Often therapists are unaware of the cultural influence has influenced their ways of thinking, feeling and relating to others. For therapists, at least within this study, many were able to identify narratives and experiences of the client that had a cultural-basis if the subject matter involved the following: parent-child relations, sexuality, dating/ marriage and experiences of discrimination. Lastly, this chapter elucidates an explanation for why therapists are more inclined to self-disclose to clients who are similar to them and less inclined to disclose to clients who are dissimilar from them.

Chapter Seven

Conclusion

The main purpose of the present study was to gain an understanding of how therapists use self-disclosure in their work with clients from diverse backgrounds. The present study's aim was gain a better understanding of these micro-communications that occur during therapy by casting a spotlight on the common ways in which therapists use self-disclosure. Little is understood about this phenomena thus a ground theory approach was employed. Nine participants shared various experiences of how they used disclosure in working with their clients. Key themes and subthemes were generated by interpreting, organizing and clustering participants' responses to form commonalities between units of data.

In the process of trying to better understand the content of therapist self-disclosure in the context of cross-cultural dyads, detailed information about what constituted 'diversity' and what self-disclosure entailed had also emerged out of the data. Participants had a wide variety of responses pertaining to whom they perceive to be a 'minoritized' client. In contrast, the participants were largely in agreement in regards to the constituents of self-disclosure. Moreover, reasons for using self-disclosure were explicated by the participants in addition to, reason for not using self-disclosure. Emerging from the data clients would often share personal experiences with their clients if they had undergone a similar experience. Cultural matching appeared to create more opportunities for shared experience thereby increasing therapist comfort with use of self-disclosure. Conversely, participants shared in rich detail their hesitations around disclosing to clients from a different culture. Not having a frame of reference and fears about offending/ coming across as insensitive/ damaging the therapeutic alliance permeated the narratives offered

by the participants as to why they were disinclined to disclose in the presence of cultural difference.

Limitations

One of several limitations in the present study was the small sample size ($n=9$) used. Given that only nine participants were interviewed for this study, the generalizability of these results as to “when” and “how” disclosure is used cannot be extended to the broader community of counselors and psychotherapists within the field of mental health. It is entirely plausible that any results and conclusions may be idiosyncratic to the participants involved. In spite of the aforementioned limitation, the present study is an attempt to offer preliminary findings that may stimulate further thinking around therapist self-disclosure, in hopes to foster future research within the area of therapist self-disclosure in the context of diversity.

Furthermore, the sample of participants were recruited based on convenience. In other words, participants were contacted via email through various counselling, psychotherapy and psychological Listservs. It is plausible that the counsellor whom responded to my online advertisement requesting participants differed than those who did not respond or declined the offer to participate. In addition, counsellors whom have an email account that is listed online may differ than those who might not be reachable via internet. Also, the participants in this study all resided within the Greater Toronto area and worked in the Greater Toronto Area which might lead to having had increased levels of exposure to clients’ of diverse backgrounds; thus differentiating the therapists in this study from other non-urban, non-metropolis dwelling social workers, psychotherapists and psychologists.

Another limitation of the present study is that no explanation is offered around causality. Does race, religion, gender, class, age, ability, and sexual orientation cause the therapist to share

personal experiences with clients of a similar social location? This question cannot be answered definitively or conclusively because of the methodology used. The very nature of grounded theory, a subtype of qualitative research, is limited in its' capacity to supply a causal mechanism for understanding a phenomena. Other methodological limitations include the inability to utilize all of the narratives by participants. The participants in this study when asked to recall experiences do not necessarily retell those experiences in a sequential, linear order when orally transmitting their experience to me. Thus, the very process of listening to, recording, transcribing and documenting the participants' narrative reflects both a non-linear and non-sequential form and structure. This process inherently bears with it an experimenter bias in terms of decision-making of what content is important to interpret, what content is important to include in the written component and what content is not important for the study's purposes and thus should be omitted. Nisbett and Wilson (1977), suggest that people's abilities to recall an internal or a past experience is variable and limited insofar as mental processes are prone to error, re-construction and influenced by the experimenter's line of question. Moreover, in the field of social psychology, evaluating others based on their actions is a type of social-cognitive error whereas judging ourselves on our intentions, known as the correspondence bias (see Jones, 1979), may be in operation within the therapist-client dyad. For example, therapists might overestimate the effectiveness of certain disclosures used based on their understanding of their own intentions versus accurately assessing the impact on the client. Furthermore, Loftus (1980) has shown through several compelling experiments that autobiographical memory is fallible, thus in the present study participants may have re-constructed their experiences of self-disclosing, or not have remembered all of the details surrounding the experience, or could not articulate their thoughts into words to capture the moment of self-disclosure they were recalling from a previous

instant with a client or may not have had a complete understanding and/ or explanation for why they chose to disclose the personal information of themselves that they did.

Yet, another limitation to the present research is that participants' may wish to maintain a positive social impression to me the interviewing student researcher thus only reporting instances of self-disclosure that produced a positive outcome while not disclosing to myself instances which had elicited a negative reaction in the client.

Future Directions

One promising avenue for future research is to assess the 'intentionality' of a disclosure communicated to a client by a therapist. Previous studies have focused, almost exclusively (1) did a therapist's disclosure occur, and (2) what was the content of the disclosure? Little attention has been paid, by researchers, as to what the therapist's intentions were prior to/ during/ and after the revealing of personal information of themselves to their client. In the present study, many of the therapist's discussed unintentional forms of self-disclosure. These forms of disclosure can range from: decoration in the office space, apparel of the therapist, and 'Big 7' identity markers of the therapist without mention of it. Within the present study the results showed that the participants communicated, albeit inadvertently, aspects of their personal lives to the client that may or may not have been therapeutic. Rather than studying the intentions of therapists wishing to self-disclose in a dichotomous manner (i.e., as in whether a disclosure occurred or the disclosure did not occur). It is plausible that therapist intentionality to disclose lies upon a spectrum of awareness as well as along a spectrum of volition (i.e., to what extent did I, the therapist, *intend* to communicate what I did to my client? Conversely, to what extent did I communicate personal information about myself to the client *unintentionally*?). Arguably, every

verbalization, utterance, and gesture reveals a small aspect of a person (Bahktin, 1986, 1990; also see Baxter, 2004).

In a similar vein, within the context of psychotherapy, since it involves two people, some of the same rules of social communication may apply in the counselling context as it does within the context of ‘normal’ social interaction taking place outside of therapy. Goffman’s (1959) seminal work highlights the importance of self-presentation, impression management, small talk and unspoken rules of politeness and decorum within everyday interpersonal exchanges. The participants in the present study did share experiences of revealing themselves to their clients at the time of greeting the client in the waiting room to the small talk they had after the session prior to the client’s departure. The participants’ did not comment *per se* on effect of the client’s diverse background on the content of what was being conversed about. Again, none of the participants reported theoretical training or identified as psychoanalytic proper which might have been a contributing factor to much of their willingness and openness to share aspects of themselves with the client (and hence less rigid adherence to the stance of clinical neutrality). Interestingly, many of the participants did not regard these small interpersonal exchanges (i.e., “small talk”) as therapist self-disclosure *per se*. This might have been because disclosure might have previously narrowly defined as technique and/ or skill to be used with deliberation during the treatment phase of the social interaction with the client. The participants may have interpreted the purpose of this study as focusing on the deliberate components of therapist self-disclosure as a tool to help the client rather than perceive that any and all communication can entail disclosure. To corroborate this viewpoint, Bridges (2001) states “self-disclosure is not only an inevitable, but also an essential, aspect of the therapeutic process” (p. 22). Drawing upon case studies from clinical practice, Litjmaer, Moodley and Sunderani (2013) argue the counselling

process is fraught with unintentional instances of revealing self to the client. Conceptualizing therapist self-disclosure may blur the line of any concrete definition ascribed to the phenomena.

Since counselling and psychotherapy is inherently an intersubjective activity, an extension of the present study could seek to involve the clients' of these participants (i.e., therapists) into the research. The inclusion of clients in this type of study could corroborate the viewpoints of the therapist and ultimately determine which particular therapist self-disclosures resonated with the clients and which did not. For example, the content of a disclosure by a participant in the present study may have been remembered as successful in the participants' mind but may have been either unremarkable or unsuccessful in the mind of the client. A research design involving semi-structured interviews with both therapist and client would add to our knowledge base by confirming the particulars of therapist self-disclosure which were seen as helpful. Specifically, if the clients and their corresponding therapists could be interviewed simultaneously without violating any boundaries and/ or ethical protocols than a cross-verification as to which disclosures were most meaningful to the client could more readily be understood- especially if it was close to the time in which the actual counselling session took place to enhance recall. The described mid-level theory proves fruitful insofar as what therapists might see an effective use of self-disclosure with a client may not be perceived in the same favourable way by the client. For example, a therapist may recall an instance in which they disclosed a common experience to the client that s/he underwent with the mind frame that it was a successful relational-building moment, intervention, teachable moment when in fact the client may have not felt that the personal information the therapist was sharing with him/ her was necessary/ helpful/ effective. To complicate matter, for those who prize defense mechanisms clients may indeed feign agreement or outwardly confirm that the therapists' sharing their

personal experience was meaningful when in fact it was not (i.e., misinterpreted nervous laughter, agreeable non-verbal cues, reaction formation). The proposed mid-level model would allow the client to cross-verify the therapists use of disclosure and confirm its' effectiveness. A variation of the research described above would entail actual sessions tape-recorded or videotaped and then played back for both the therapist and client reflect upon the disclosures, retrospectively and provide a rationale, intention or motivation for the therapist self-disclosure at that particular moment in time with cross-feedback from the client to verify whether it was effective or not.

Implications for mental health practitioners

- Practitioners can be mindful of what they reveal about themselves can positively impact the client but may also elicit and/ or trigger a negative internal experience within the client
- Practitioners be cognizant of the non-verbal channels through which personal information is communicated (e.g., wearing a wedding ring, family photographs, office décor)
- In a similar vein, practitioners may develop a greater awareness of how their accent, skin colour, can communicate cultural information about themselves to the client
- Practitioners may recognize that clients' will enter the counselling room with pre-existing ideas about the therapist because of the limited amount of personal information they have to go by (much of which has a cultural-basis such as the therapists name) thereby stirring up potential projections and transference reactions
- Practitioners may also be aware of the ways in which clients transference reactions could stimulate their own countertransference reaction

- Practitioners should also be aware that hesitations to disclose, albeit erring on the side of caution, may by the same token, stifle excellence and creativity within their work with their client
- Practitioners may also wish to understand that much of what is communicated operates at a level below awareness, or only have partial awareness of, in terms of the material they choose to share with their clients and how what ‘culturally’-based stimuli their clients may be reacting or responding to

Final reflections

Therapist self-disclosure is among one of several commonly used methods, interventions, and approaches to connect with clients receiving counselling services. The incorporation of self-disclosure in working with clients from diverse background has not been studied in-depth until now. The present study sought to add to and build upon the accumulating body of knowledge pertaining to therapist self-disclosure. The present study highlighted both effective and creative ways in which therapists can use self-disclosure in working with someone whom is dissimilar to themselves. Although self-disclosure is more often used with clients who share a commonality with the therapist the present study hopes to have challenged preconceived ideas around how to adapt a specific technique into the multicultural and diversity framework. Participants within this study illuminated the idea that moments when self-disclosure is used with clients can have a powerful and positive impact on clients. Furthermore, the present study aimed to recognize and better understand when not to disclose to clients from a different social location. Several key caveats were implicated in the participants’ responses of when not to disclose; such as when the therapist has a differing belief system or worldview pertaining to marriage, family conflict and

sexuality. Interestingly, the present study drew awareness to the variety of ways in which personal information and cultural information can be communicated to the client without the therapist's intention to do so.

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Appendix A

Interview Guide

Let's have a conversation about the following:

Part I

- a) Please briefly describe your counselling work and the type of clients you work with.
 - Settings; diversity of clients
 - Can you please describe the therapeutic approach/ orientation/ perspective you take with you clients and how has it that informed your use of self-disclosure?
- b) In your words, can you describe what therapist self-disclosure is?
- c) When do you use self-disclosure and what does that look like?
 - Can you recall an example from your work with a client where you used self-disclosure and what was that like?
- d) When do you not use self-disclosure and what is that like?
 - Can you recall an example from your work with a client where you did not use self-disclose and what was that like?

Part II

- e) Let's suppose you were counselling an ethnic minority client, would you use self-disclosure in the same way you would with a non-ethnic minority client?
 - What types of things might you disclose about yourself to the client?
 - Can you recall an example from your work with an ethnic minority client where you used self-disclosure and what was that like?
 - How about with White clients?
 - Do you share personal stories with them?
- f) What types of things might you not disclose about yourself to an ethnic minority client?
 - Can you recall an example from your work with an ethnic minority client where you did not self-disclose and what was that like?
 - How about with White clients?
- g) Any final reflections on your use of self-disclosure in your therapeutic work?
- h) Is there anything else you would like to say about self-disclosure or your work with clients that perhaps we may not had a chance to discuss?

Appendix B

Letter of Intention

I am a Master's student in Psychology at OISE/UT. I would like to invite you to participate in a research study. The purpose of this study is to gather information from therapists about the effects of therapist self-disclosures as a therapeutic technique in working with both clients who are visible minorities as well as clients from the majority cultural group. The results of this study are expected to be of importance to therapists, and may be of indirect benefit to clients, since it will contribute to the knowledge base of multicultural counselling.

If you are interested in participating in this study, I ask you to contact me at the phone number or email below. If you agree to participate, together we can arrange a time and place that is convenient for you to be interviewed. The interview will take approximately one to two hours, and includes a consent form, which you will keep a copy of, and a short written demographic questionnaire that will take approximately five minutes to complete. Your responses to the interview questions will be audiotaped in order to preserve the accuracy of the data. It will involve specific questions about instances in which you disclosed information about yourself that had a "multicultural component" to it. Complete definition attached. My hope is this interview will be both meaningful and helpful to your therapeutic practice although there is a possibility that some mixed or negative feelings may arise. You will have an opportunity to discuss these feelings with me at the time of the interview or at any point afterwards if you so wish.

Your participation in this study is completely voluntary. Your clients will not be told that you have chosen to participate in this study. Even if you call me for more information, you are under no obligation to be interviewed. If you do choose to participate, you may refuse to answer any question, and you may still withdraw from the study at any time.

Your name or any other information which could identify you or your clients will not be used in the reporting of this study. All audio tapes will be erased once the interviews are transcribed, and only I and my supervisor will have access to the transcribed data. All information you provide will be kept confidential unless it concerns a situation in which either someone is in immediate danger, or a child is at risk of abuse or neglect. In those two instances, I am required to report the information to the proper authorities.

If you have any questions about the study you may contact me or my supervisor at the contacts provided below. Thank you for considering participating in this study.

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Appendix C
Letter to Potential Participants

Hi,

My name is Shafik Sunderani. Currently, I am a master's student at the University of Toronto in the Clinical-Counselling Psychology Program working under the supervision of Professor Roy Moodley. My purpose for emailing you is to see if you would like to take part in a study on the topic of therapist self-disclosure. Therapist self-disclosure refers to "the revelation of personal information by a therapist to a client" We will be exploring the content of therapist self-disclosures when working with non-visible and visible minority clients. Specifically, this study will be asking you to reflect upon your experiences with clients from various ethno-racial backgrounds with regards to self-disclosure.

In order to participate in this study you must currently be working in the mental health field providing counselling or psychotherapy services on a full-time basis for a minimum of 5 years, be working with both non-visible and visible minority clients and you are familiar with using the technique of therapist self-disclosure.

If you choose to participate in this study, you will be interviewed by myself about your experiences as a therapist. The interview takes approximately 1-2 hours. If you are unable to do so, no worries. I know it can be difficult in our field to find the time to juggle everything.

Your participation is entirely voluntary. Would you be interested in taking part in this study?

Thank you so much for taking the time to read this.

Take good care,

Shafik

Appendix D
Consent Form

Study: The use of therapist self-disclosure with clients from diverse backgrounds.

I have read all the information provided. Any questions I had were answered to my satisfaction. I would like to participate in the study. I understand that giving my consent means that I agree to an audio taped interview and a possible follow up phone call; that my name and any information that may identify me will be kept confidential; that I may decline to answer any question; and that I may withdraw from the study at any time. I also understand that the results of this study may be published.

Name (please print legibly) _____

Signature_____

How would you like me to contact you, if needed? You may fill in any of the choices.

Phone: _____

Home:_____

Work:_____

Email:_____

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Appendix E

Demographics Questionnaire

Please either circle an answer, or fill in the blanks.

About you:

1. Which gender do you identify yourself as (if any)?

2. What is ethnicity/ race/ culture/ nationality do you most strongly identify with? (If more than one, include all that apply.)

a. _____

b. _____

c. _____

d. _____

3. How old are you now?

_____ years old.

- 5a. What country were you born in? _____

- 5b. What age did you move to Canada? _____

6. What is your professional designation? (circle all that apply)

a. Psychological Associate

b. Psychologist

c. Registered Nurse

d. Social Worker

e. Counsellor

f. Psychiatrist

g. Physician

h. Other _____ (please specify)

7. How many years have you been providing mental health services with a focus on individual counselling/ psychotherapy? _____
8. What was the name of the educational institution you received your mental health service training? _____
9. Choose a pseudonym for yourself _____

*the pseudonym you choose will be used in the write-up of the results. In order to safeguard your identity both the pseudonym you choose and your responses in the interview will be used for academic purposes only.

Thank you for taking the time to answer these questions.

Appendix F

Biographies of the Participants

Lyle is a male in his early 50's and is a social worker by professional designation. He self-identifies as Canadian and also traces his ancestry to both England and Germany. In terms of therapeutic orientation, Lyle reports that he operates primarily from a client-centered framework.

Brady, originally from California, is a male therapist in his late 60's. He received a doctoral degree in the history of psychology and then further re-trained in clinical and spiritual counselling from a Christian perspective. In terms of therapeutic modality, he primarily operates from both a Relational and Adlerian framework.

Mis, born and raised in Guyana, is female social worker in her early 50's. Mis reports that her ancestry can be originally traced back to India and her family has lived in Guyana for multiple generations. With regards to therapeutic orientation, Mis states that she is primarily Cognitive-Behavioral in her work with clients.

Susan, is a female in her late 40's, whom identifies as Jewish-Canadian. She is a registered social worker in terms of designation and uses primarily Cognitive-Behavioral therapy in her clinical work.

Harvey, is a male in his late 60's. Harvey self-identifies as Jewish-Canadian. He is a registered psychologist in Ontario and operates from a primarily Cognitive-Behavioral therapeutic orientation. Harvey also incorporates hypnosis in his clinical work with his clients.

Ursula, is a female in her early 50's. Ursula describes herself as "White" racially and of Canadian nationality. She traces her family roots to Czech Republic. Ursula is a psychotherapist with intensive psychodynamic training in which she operates from in her work with clients.

Nicole is a female psychotherapist in her early 50's. Nicole identifies as Canadian of Ukrainian descent. She was trained in the Gestalt institute and uses Gestalt therapy in her work with her clients.

Kev is a female psychotherapist. She is in her early 40's. Kev identifies as "White" and her family including herself were born and raised in Canada for multiple generations. Kev recognizes her ethnic ancestry is traceable to Eastern-Europe. Kev works with her clients from Feminist-Relational perspective.

Sonia is female psychotherapist in her early 60's. She was born and raised in Ukraine. She has extensive training in Gestalt therapy which is also the primary therapeutic orientation she uses in her work with her clients.

Table 1**Demographics of Participants**

Participants Pseudonym Name	Age Range	Gender	Ethnicity/ "Race"/ Culture/ Nationality (Self-Identified)	Designation	Therapeutic Orientation
Lyle	50-55	Male	Canadian + British + German	Social Worker	Client Centered
Brady	65-70	Male	Anglo-Saxon + American	Psychologist	Relational + Adlerian
Mis	50-55	Female	Guyanese + East Indian	Social Worker	Cognitive-Behavioural
Susan	45-50	Female	Jewish-Canadian	Social Worker	Cognitive-Behavioural
Harvey	65-70	Male	Jewish-Canadian	Psychologist	Cognitive-Behavioural
Ursula	50-55	Female	Czech-Canadian + "White"	Psychotherapist	Psychodynamic
Nicole	50-55	Female	Ukranian-Canadian	Psychotherapist	Gestalt
Kev	40-45	Female	Canadian + "White" + Eastern European Heritage	Psychotherapist	Feminist + Relational
Sonia	60-65	Female	Ukranian	Psychotherapist	Gestalt