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FEMALE ADOLESCENT'S EXPERIENCE OF THEIR THERAPIST CRYING IN THERAPY

Kassidy Pendleton
University of Kentucky, kassidypen@aol.com

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Kassidy Pendleton, Student

Dr. Trent S. Parker, Major Professor

Dr. Hyungsoo Kim, Director of Graduate Studies

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THESIS

A thesis submitted in partial fulfillment of the
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By

Kassidy Pendleton

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Director: Trent S. Parker, Professor of Family Sciences

Lexington, Kentucky

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ABSTRACT OF THESIS

FEMALE ADOLESCENT'S EXPERIENCE OF THEIR THERAPIST CRYING IN THERAPY

Therapist self-disclosure is an important topic and the literature explains that how a therapist responds to their client can greatly impact the treatment process and therapeutic alliance. One of the ways that therapists respond to their clients is through crying. Although there have been studies that conclude that the majority of therapists do in fact cry in therapy, no studies have tried to understand how this response is perceived by clients. This qualitative study aims to understand the client's perspective and how therapists' crying affects the treatment process and therapeutic alliance. The informants in this study were adolescent females who attended a particular therapeutic treatment center. Data was collected through a series of semi-structured interviews. Data was analyzed through a grounded theory approach in which open, axial, and selective coding was used. The results from this study indicate that therapists crying in therapy can be perceived as both beneficial and detrimental in regards to the treatment process and therapeutic alliance.

KEYWORDS: Alliance, Crying, Self-disclosure, Therapist, Treatment

Kassidy Pendleton

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By

Kassidy Pendleton

Trent S. Parker, Ph.D.

Director of Thesis

Hyungsoo Kim, Ph.D.

Director of Graduate Studies

April 10, 2015

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Chapter One: Introduction

How a therapist responds to a client during a therapy session is important for the treatment process and the therapeutic alliance (Blume-Marcovici, Stolberg, & Khademi, 2013; Kahn & Fromm, 2001; Summers & Barber, 2010). One way that therapists respond to clients is through self-disclosure. According to the literature, one way therapists self-disclose is through experiencing and expressing emotions similar to those that are expressed by the client (Ziv-Beiman, 2013). Blume-Marcovici et al. (2013) took this idea a step further by explaining that a therapist's emotional expression to their clients during session is important for the treatment process and the therapeutic alliance.

One way that therapists can express their emotions is through crying. Some of the emotions that can promote crying are frustration, sadness, or even happiness (Vingerhoets, 2013). Individuals seek therapy to help them work through traumatic experiences, process grief, or adjust to life's circumstances. Based on the work that is conducted in therapy it is not uncommon for clients to cry during session, and according to recent research it is not uncommon for therapists to also cry during session (Blume-Marcovic et al., 2013).

Because it is not uncommon for therapists to report crying during therapy, it is surprising to discover that little research has focused on therapists crying. This leaves clinicians and researchers wondering how often therapists self-disclose through crying in therapy and if their crying is helpful or harmful to their clients ("The Tears of a Therapist," 2013). More research needs to be done in order to better understand the frequency of therapists crying during therapy and how a therapist crying affects clients.

Given that limited research has focused on therapist's self-disclosure through crying, therapists and clients alike can benefit from increased knowledge in this area. Understanding therapists self-disclosing their emotions through the action of crying may help future therapists better understand the effects their crying may have on clients. Research that is focused on the client's perspective of their therapist crying is particularly beneficial to this field. For example, if therapists report crying in a session at some point in their practicing career, it is important to understand how the client felt during these specific situations. Client feedback is important for therapists because it can contain information that can be used to help benefit the treatment process and strengthen the therapeutic alliance.

Literature Review

Self-Disclosure of the Therapist

Knowing how a therapist responds to clients is important for the treatment process and the therapeutic alliance and, leads to a better understanding of the effects of specific types of responses. Ziv-Beiman (2013) explains the importance of using integrative interventions as a way to respond to clients. She goes on to explain that one of the most powerful integrative interventions is self-disclosure of the therapist. Like any other intervention, self-disclosure can come with serious risk, but self-disclosing communications can also be broadly effective (Ziv-Beiman, 2013). Self-disclosure of the therapist deepens the therapeutic alliance and initiates change in regards to emotions, thoughts, behavior, motivation, and relationships (Ziv-Beiman, 2013).

Clinicians and researchers explain the importance of defining self-disclosure of the therapist (Knox & Hill, 2003; Watkins, 1990; Ziv-Beiman, 2013). The term has had a

vague use throughout the literature. Watkins (1990) published a review of over 200 studies that focused on therapist self-disclosure. In his findings he identified four different types of therapist self-disclosure: (a) disclosure of positive or negative experiences; (b) sharing a positive or negative opinion about the client; (c) demographic data; and (d) communication of emotional reactions similar to those of the client (Watkins, 1990). These four types of therapist self-disclosure can be place into two categories: Immediate disclosure and nonimmediate disclosure (Ziv-Beiman, 2013).

Immediate versus nonimmediate disclosure. Immediate disclosure (also referred to as interpersonal or self-involving disclosure) is defined as expressing feelings and attitudes toward the client or therapeutic process or an in-session event (Ziv-Beiman, 2013; Audet, 2011). An example of this is when a therapist who expresses feeling anxious when their client raises their voice (e.g. 'As you tend to raise your voice, I am feeling increasingly anxious'). Immediate disclosure is related to the client in the here and now (McCarthy & Betz, 1978).

Nonimmediate or intrapersonal disclosure includes the therapist's biographical information, personal insights, and coping strategies (Ziv-Beiman, 2013). Therapists display nonimmediate disclosure by sharing personal beliefs, values, or experiences that tend to shift the focus away from the client (Audet, 2011). For example, a therapist can share his or her personal experience of being diagnosed with an illness with a client who is going through a similar situation. Nonimmediate disclosure is often used to facilitate rapport, render the therapeutic alliance to be more egalitarian, demonstrate the human fallibility of the therapist, and model new perspectives and behaviors (Audet, 2011).

Self-disclosure of the therapist seems to be gaining increasing attention and legitimacy in terms of its beneficial effect (Ziv-Beiman, 2013). This trend suggests that therapist self-disclosure can have positive effects on the therapeutic alliance and treatment outcomes (Lambert, 1991; Norcross & Goldfried, 1992). More research is needed that explains how therapist self-disclosure can encourage clients to further open themselves up during therapy (Farber, 2006; Watkins, 1990).

Clients Perception of Therapist Self-Disclosure

Throughout the literature, the client's perspective of therapist self-disclosure has rarely been examined (Audet, 2011). Nilsson, Stressberg, and Bannon (1970) conducted a study based on observer perceptions of mock therapy sessions with non-clients. In this study, they found no evidence that supports self-disclosing therapists as being viewed as less competent or less mentally healthy.

In studies where clients were used as the participants, the results conclude that therapist self-disclosure can be perceived as both negatively and positively affecting treatment. In a qualitative study conducted by Wells (1994), the results explain that half of the eight participants that were interviewed reported that therapist self-disclosure led to reduced credibility and confidence in their therapist's abilities. However, despite the negative perceptions, participants believe that therapist self-disclosure may be a useful intervention if used more appropriately (Wells, 1994). It is important for therapists to consider clients' readiness and be sure to maintain a professional role while self-disclosing. This explains, at least in part, findings by Knox, Hess, Petersen, Hill (1997), that therapist self-disclosure facilitated clients perceiving their therapist as more real,

human, and imperfect. These perceptions lead to the therapeutic alliance being viewed as more egalitarian (Knox et al., 1997).

To shed further light on therapist self-disclosure, Audet (2011) conducted a study that focused on client perceptions of the impact that therapist self-disclosure may have on therapeutic boundaries and professional qualities. The data collected from this study indicated that participants perceived therapist self-disclosure as both negative and positive. Out of the nine participants, only two of them reported their therapist's self-disclosure as negative. These two participants explained that their therapist's disclosure made them feel disappointed in their therapist's life choices, and they felt less confident that their therapist would be able to help them. Participants that perceived their experience as negative indicated that the self-disclosure of the therapist was too frequent, lengthy in detail, repetitive, poorly aligned with their needs, or did not seem to match their issue or personal values (Audet, 2011).

Out of the nine participants, five perceived their therapist's self-disclosure as positive (Audet, 2011). The participants that perceived their experience as positive indicated that self-disclosure was infrequent, low-to-moderately intimate, similar to their experience, or positively supported their needs and the therapeutic alliance. They also explained that their therapist's self-disclosure made their therapist seem more credible. Self-disclosure helped them to view their therapist as having 'real life experience' rather than simply textbook experience (Audet, 2011).

While this study provided information on what self-disclosure of the therapist can do to therapeutic boundaries and therapist's professional qualities, it did not recognize how therapist self-disclosure influences the treatment process or the therapeutic alliance. This

study also examined therapist self-disclosure as a broad definition, rather than focusing on a specific type of self-disclosure. The need for specificity in exploring therapist self-disclosure through crying will provide a more accurate assessment of how it affects clients.

Prevalence of Therapist's Crying

Before understanding the literature associated with therapists crying during therapy, Blume-Marcovici et al. (2013) stress the importance of understanding the definition of crying. Most of the literature agrees with Vingerhoets and Cornelius (2001) when they define crying as "tears in one's eyes due to emotional reasons" (p. 7). Emotional responses that may bring tears to a therapist's eyes may include, but are not limited to, empathy, apathy, frustration, anxiety, sadness, happiness, connection, or guilt (Nelson, 2012; Vingerhoets, 2013).

Blume-Marcovici et al. (2013) administered a survey to 684 psychologists, postdoctoral psychology fellows and psychology graduate students, 72% of the participants reported that they have cried in therapy. Out of those therapists that reported crying, 30% of them reported that they had cried in therapy during the past four weeks. Only 28% of the therapists reported that they had never cried during therapy. This study also indicated that the therapists who reported a greater frequency of crying in daily life were also more likely to report a greater tendency to cry in the therapy room (Blume-Marcovici et al., 2013).

The results of this study were not intended to encourage or discourage crying for therapists, but simply to better understand the frequency and tendency of therapists crying. This statistic may intrigue couple and family therapists and researchers and

suggest that more empirical studies are needed to better understand the effects of therapists crying. By understanding that nearly three out of four therapists report crying in therapy, it seems vital to understand if this response is perceived as helpful or harmful in regards to the treatment process and therapeutic alliance. From this, therapists can become better educated on how their self-disclosure of emotions through crying affects their clients.

Are Therapist's Tears Helpful or Harmful?

When trying to understand the significance of therapists crying in a clinical setting, researchers are often faced with the question, "Are therapist's tears helpful or harmful?" Much of the research regarding this matter suggests that therapists crying in therapy is therapeutically appropriate and may even be beneficial for the treatment of the client. However, there are opinions that therapists crying in therapy "may break professionalism or harm the client" (Blume-Marcovici et al. 2013, p. 224).

The research that concludes that a therapist crying in therapy is therapeutically appropriate comes from case studies of therapists describing their interpretation of the experience. The majority of the literature that is associated with therapists crying in therapy agrees that therapist's crying can display empathy and strengthen the therapeutic alliance (Blume-Marcovici et al., 2013). Therapists that self-disclose emotions are perceived by their clients as warmer and more personable (Vandernoot, 2007). One therapist described her experience as enhancing the therapeutic bond by saying "When (the patient) told me about the sudden death, I teared up, experiencing these losses with him" (Alden, 2001, p. 239). Another case study regarding therapist's crying explains that a therapist crying in therapy can help clients feel reassured and can be a helpful way to

join with clients (Mayotte-Blum et al. 2012). Nelson (2012) describes therapist's tears as being helpful by saying:

> When there is a good solid connection with the patient, when the therapist's strength and availability as a caregiver are assured, crying by the therapist may be felt as a deeply empathic response that draws therapist and patient closer together (p. 211).

From the therapist's perspective, crying seems to have a positive outcome for clients. Lazarus and Zur (2002) explain that boundaries which allow emotional expression can still be ethical and should be indicated as long as they have therapeutic intent. In other words, strict boundaries that create a professional distance between the therapist and client that emphasize the power differential between them degrade the status of the client to a mere object (Dineen, 2002; Tomm, 2002).

Despite this support, other literature suggests that therapists' crying could be potentially harmful to clients. This research indicates that a therapist crying in therapy could create role-reversal (Blume-Marcovici et al., 2013). This role-reversal in the therapeutic relationship can leave clients feeling awkward or uncomfortable (Nelson, 2012). Therapist disclosure can be viewed as boundary crossing or boundary violation (Audet, 2011). Some of these boundary concerns include forming a type of friendship, taking the focus away from the client, and making the client feel the need to care for the therapist (Gutheil & Gobbard, 1990; Wachtel, 1993; Zur, 2004). Therapists who have self-disclosed by sharing their emotions have also been reported by their clients as being less professional (Vanderoot, 2007).

Bowen family systems therapy explains the importance of self-differentiation. Self-differentiation is the ability to think and reflect, and to not automatically respond to emotional pressure (Kerr & Bowen, 1988). Nichols (2013) explains that undifferentiated people can easily be moved to emotionality. If a therapist is undifferentiated, then he or she becomes too reactive towards their clients and cry during session when it may be harmful to their client. For example, clients with anxious-ambivalent or avoidant attachment styles may find crying to be quite threatening for them (Nelson, 2012).

In a case study of a therapist treating a 13 year old boy who was quadriplegic, he explained that his experience of crying had a negative impact on the therapy process. The therapist reported feeling guilty for allowing his tears to fall and explained the importance of therapists being able to hold themselves together (Vingerhoets & Cornelius, 2001). Therapist's tears may be overwhelming, unsettling or distancing for some clients (Nelson, 2012).

The Need for Further Research

Although self-disclosure of the therapist through crying plays a role in the therapeutic process, it seems to be overlooked in professional training and literature (Nelson, 2012). In a setting where the therapist's response can affect the therapeutic alliance and treatment process, it seems vital to have a better understanding of the effects of therapist's self-disclosure through crying. It has also been acknowledged that it may be impossible for a therapist to never use self-disclosure in the therapy setting (Peterson, 2002; Zur, 2007). This idea suggests that it may not be important to understand if self-disclosure of the therapist is happening, but under what circumstances it seems beneficial to treatment (Audet, 2011).

Purpose of Present Study

The purpose of this qualitative study is to understand the effects therapists crying has on clients. A therapist crying was defined as: “tears in one’s eyes due to an emotional response” (Vingerhoets & Cornelius, 2001, p. 7). The primary research question was: How has your therapist crying affected the treatment process and therapeutic relationship? The interview questions that were asked were focused around the primary research question (see Appendix A).

Chapter Two: Methodology

Qualitative Research

Qualitative research is used to further explore an issue. Qualitative research generally works through an inductive lens, meaning that it analyzes data from the bottom-up (Creswell, 2013).Throughout the data collection and analysis process, the researcher uses themes to better understand the research question. Because data is typically gathered through face-to-face interactions, data collection is done in the natural setting of the informant (Denzin & Lincoln, 2011). During the interview or the observation, researchers are focused on understanding the informant's meaning of the phenomenon and understanding the process that they have experienced (Corbin & Strauss, 1990). Because the researcher is the key instrument in data collection, it is important for the researcher to be aware of their own biases, worldview, and assumptions that may contribute to data analysis (Denzin & Lincoln, 2011).

Researcher as Key Instrument

Bracketing is used to help researchers recognize their own biases and attempt to not let them interfere with how the data is analyzed (Creswell, 2013). As the key instrument in this qualitative study, I will disclose my own beliefs, interests, and experiences that may influence my bias.

My interest in self-disclosure of the therapist through crying began during my undergraduate career while I was working as a mentor at a residential treatment facility for adolescent females. As a mentor I had the opportunity to attend the group therapy sessions at this facility. I can remember one group session in particular. The young women were learning how to process the traumatic things that had happened to them

during the early years of their life. One young woman was sharing her experience of working through some of her trauma and the relief that she had been able to feel. As she talked about no longer feeling shameful for the things that had happened to her, she began to recognize her self-worth. She began to cry as she talked about the peace that she was finally able to feel. I then noticed that as she was talking, the therapist who was conducting the group session also had tears in his eyes. I watched the therapist interact with this young woman by expressing how proud he was of her for being able to connect with those positive emotions. He never tried to wipe his tears or apologize for expressing his emotions. Instead he let the tears well up in his eyes and it appeared that his emotional expression was used as a powerful intervention to connect with this client.

I think this experience will always stick out in my mind. It was then that I realized that at times it may be appropriate for therapists to express their own emotions through crying. I believe that self-disclosure of the therapist through tears, when used appropriately, can help to unite the therapist and client and strengthen the therapeutic alliance as well as the treatment process. My personal experience has led me to predict that from this study it will be understood that clients feel closer and better understood by their therapist after witnessing them cry and explain that this experience has benefited their treatment process. As a result, I believe that therapists should become more aware of the impact that their own emotional expression through crying can have on their clients.

Research Design

For the purpose of this study, an exploratory qualitative study was used. This exploratory qualitative study has “movement” and was used to understand the process of an experience (Creswell, 2013). Once the process was analyzed, a theory was developed

that was grounded in data from the informants that explains the process (Corbin & Strauss, 2007). The exploratory qualitative study design was used to understand client's experience when they witnessed their therapist cry during therapy due to emotional expression and how it affected the treatment process and therapeutic alliance. This study was conducted through an interview process in which clients were asked to report their interpretation of their therapists crying. Informants were asked questions to better understand if they found their therapist's tears to be helpful or harmful in regards to their treatment process and the therapeutic alliance.

Participants

Informants were gathered from a residential treatment center (RTC) that is located in northern Utah. One hundred and two clients who attend this RTC were asked to participate in an interview process. Out of this sample, eight clients from this RTC were interviewed for the purpose of this study. This particular RTC is an inpatient treatment center that works with clients who are suffering from emotional issues, such as trauma, eating disorders, or substance abuse. All eight participants were white females, and had been seen by a therapist in individual, group, and family therapy sessions (See Appendix B). At some point during their treatment, these young women had witnessed their therapist cry. Their ages ranged from 13 to 17 years old. All of the informants were living in northern Utah and attending high school (grades 8-12) at the time of their interview. Pseudonyms were used to protect the informant's confidentiality and to also protect the disclosure of their therapist.

Sampling Approach

The present study used criterion and convenience sampling approaches. Criterion sampling required informants to have witnessed their therapist crying during a therapy session at some point during their treatment process. The informants in this study reported that their therapist did not cry in therapy until further along in their treatment when they felt that a relationship had been established. Convenience sampling was used because informants were recruited from a particular RTC. The RTC that the informants were gathered from is the center that I worked at during my undergraduate career. I contacted the director of the center and was given permission to use the clients at this RTC for my study. The director agreed to present this study to the clients and asked who would be willing to participate. I then contact the willing informants via telephone to answer questions about the study and schedule times for the interviews.

Informed Consent

Because these informants were minors at the time of the interview, assent was required from them, as well as consent from their parents or legal guardians, to participate in this study. The informed assent and consent forms were approved by the Institutional Review Board (IRB) before informants were recruited. The IRB reviewed the informed consent to ensure ethical treatment of the informants. The informed consent included the purpose of the study, the benefits and possible risks of participating in the study**,** confidentiality information, and the informant's rights.

Procedure

Clients of this RTC were informed of the study in early August of 2014 and the interviews were scheduled in November of 2014. Data was collected through a semi-

structured interview, and depending on the answers given by the interviewee, interviews lasted anywhere from 37-64 minutes in length. Because the interviewees were located in a different state than I, interviews were completed via telephone. All informants were expected to complete the interview and agreed to answer the interview questions as clearly and honestly as possible. Memoing was used as the data was collected as a way to write down ideas that seemed to surface from the interviews (Creswell, 2013).

Informants were asked various questions about their specific therapy session when they witnessed their therapist self-disclose by crying. Questions were focused on the informant's interpretation of their therapist's crying, rather than the content of their therapy. Questions were designed this way to respect the client's confidentiality and to also keep the focus on the purpose of the study. Data was collected using a constant comparison approach and informants were also given the opportunity to participate in up to three interview sessions. This process of going back and forth and gathering new interviews was intended to help fill in the gaps and assist in discovering a theory (Creswell, 2013).

Data Interpretation

Because an exploratory qualitative study designed was used, data interpretation consisted of three phases: open, axial, and selective coding (Creswell, 2013). When transcribing the data, I relied on the transcripts and field notes from the interviews. These texts helped to assist me in categorizing the information during the open coding phase. I continued interviewing participants until saturation was reached and new information was no longer being provided.

After the interviews were completed, I then moved on to the axial coding phase. In axial coding I identified a single category from the open coding category list. The phenomenon of interest was based on the category that seemed to be extensively discussed by the informants or seemed central to the purpose of this study (Creswell, 2013). Once a central phenomenon of interest was established, other open categories were analyzed to see how they influenced and related to the central phenomenon (Eaves, 2001).

Once I completed the axial coding phase, selective coding was used to explain the central phenomenon's categories and how they were connected (Creswell, 2013). A proposition was then generated from a theoretical model that was developed to process the collected data (Creswell, 2013). Finally, a theory was developed to explain the effects clients experience from witnessing their therapist cry (Corbin & Strauss, 1990).

Validation and Evaluation

Four validation strategies were used to strengthen this qualitative study. The first strategy was peer review, which provided an external review of the research process (Creswell, 2013; Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Erlandson, Harris, Skipper, & Allen,1993). My thesis committee reviewed my study plans and made suggestions to strengthen my study and develop a reliable theory backed by data (Corbin & Strauss, 1990). As Lincoln and Guba (1985) explain, my committee members played "devil's advocate", meaning that they asked hard questions to help challenge and strengthen my study.

The second validation strategy that was used was negative case analysis. Not all of the data that was collected fit a pattern or theme, and I recognized the importance of

reporting the negative analysis with the intention of providing a realistic theory of the studied phenomenon (Creswell, 2013). For example, I was aware that informants may not perceive their therapist's crying as either harmful or helpful, and this information would be important to include.

Clarifying research bias was used throughout the study to alert the reader of my position and assumptions that impact this study (Merriam, 1988). I was transparent in my writing by including my personal bias and beliefs about therapist self-disclosure through crying. I am aware of my biases and attempted to use bracketing during the collection and analysis of the data. I was also transparent during the interview process, and answered honestly questions that the informants asked about my personal beliefs.

Member checking was also used as a way to involve the informants in the data analysis, interpretations, and conclusions (Stake, 1995). I asked the informants to read rough drafts of the findings and asked for their feedback (Stake, 1995). By using member checking, participants had an opportunity to voice their opinion of the accuracy of the findings and suggested changes that needed to make in order for their perception to be accurately portrayed.

Chapter Three: Results

In accordance with the literature there were two major themes that the informants used to describe their therapist crying in therapy. Informants either described their therapist's crying as being beneficial or they described it as being detrimental in regard to their treatment process and therapeutic alliance. For each of these major themes, there were three sub-themes that emerged from the data.

Therapists Crying Being Perceived as Beneficial

Within the major theme of therapists crying being perceived as beneficial, three sub-themes emerged. The subthemes were: (1) Therapists crying created a deeper connection, (2) Crying marked a turning point in their treatment, and (3) It fostered a sense of courage.

Connection. The informants who felt their therapist's crying was beneficial reported that they felt better connected to their therapist. For Autumn, she described her experience as being "one of those times when I felt very connected to him." Autumn went on to say:

> I think some people might misinterpret when therapists cry because I've seen people be like "why are you crying? I'm the one that is supposed to be crying." But I think for me it was a more positive experience. I felt completely connected with him. I felt like I was able to relate to him, and talk about some really hard things with him, and that he was actually listening and trying to understand and hear how I've experienced these things and what my view point is on them and what feelings and emotions there were around these experiences and what I needed to do to get through them… I don't think it was like he cried and then my

> life just freakin' magically got better. I think I was just way more connected with him so I was able to be much more open and honest with him because I just felt more comfortable with him.

Furthermore, Delaney also talked about her experience of her therapists crying influencing them to have a deeper connection. For Delaney, before seeing her therapist cry she explained that she "didn't feel as connected to [the therapist]," but after seeing him cry she reported "I realized that he really cared about me and my family. I felt really connected to him. I felt like he truly cared about me and was truly proud of the progress I had made."

Hannah echoed what the other informants reported about the connection between her and her therapist becoming stronger:

> My therapist experienced a loss in his family so I asked him what happened and he teared up a bit and I teared up too cause it was sad. Um, so I kind of like connected with him too. I dunno, I just feel like it makes our bond stronger… He doesn't talk about his experiences, which would be quite inappropriate, but he still connects with me. I don't need to know those details of his life to be able to connect with him. He's not trying to know. He's trying to connect.

Jackie explained that her therapist crying strengthened the connection she had with her therapist Jackie feel better understood. Jackie explained this by saying:

> It made me feel like emotionally safe as in… like usually I'm crying and I'm upset and I'm the one showing emotion, and her showing that emotion made me feel like connected to her and it made the room more safe, because she understood.

Rather than simply viewing them as their therapist, the informants also explained that their therapist became much more than that, which made them feel more connected. To explain this Isabella reported:

> I saw her as a person. It just showed me that therapists don't all come from the same background. You know like they're not all the same, like everyone goes through trauma at some point in their life. You know, it just makes me more think like therapists are like anyone. I can go to them and they might not be totally open at first, you know like it took some time for her to trust me that much. We had to work to that point. It really showed me like, give it some time and you will know how much your therapist can empathize with you. I know that's not how all therapists are. They're not all robotic. Just give it some time and maybe they will be robotic, or maybe they will be your friend, but just give it some time.

Jackie agreed with this idea and explained her experience of having her therapist take on a more personal role and therefore feeling more connected by saying "It kind of added a whole new thing of this is more than someone helping me through something, this was like an actual relationship where I have a real strong connection."

Turning point. The second sub-theme that supported the benefits of therapists' crying was that crying facilitated a turning point in their treatment. The informants described this turning point by explaining that once they saw their therapist cry, the therapeutic work became deeper and they were able to make progress at a faster pace. When talking about the moments they witnessed their therapist cry, the informants agreed that the moment stuck out in their mind as a positive experience. After that moment, they began to move forward in their treatment. Autumn explained how her treatment process

progressed further by saying, “I’m just really grateful to have him in my life because I don’t think I would have gotten this far without him. And I think my mom would say the same thing…I feel like it helped me move on in my treatment quicker.”

Jackie explained her therapists crying standing as a turning point by saying:

> It brought a whole new meaning to therapy. It felt deeper…and more emotionally safe. It affected my treatment in a positive way. Like I want things to get better and if she’s willing to show me that she cares and go deep with me then she deserves just as much from me. So it affected it because I wanted to work harder.

Delaney explained her experience of witnessing her therapist cry and how it stood as a turning point in her treatment process by saying:

> The first time I saw him cry was back in April. I had stopped working and I told him I didn’t like him and I didn’t want to do this so I told him why it wasn’t working. That was the first time I saw him cry and that was a huge turning point in my treatment…It helped because we were able to go into deeper stuff.

When sharing their experience of witnessing their therapist cry, Hannah and Paula mentioned how that moment stood as a turning point for them in regard to their treatment process:

> Paula: I also think at that point I really started moving forward in my treatment.
>
> Hannah: I feel like at that point our sessions got a lot deeper. I stopped trying to not cry. I like let it go.

Whether it be through their treatment process becoming deeper, or the informants feeling like they started making more progress, each respondent made mention of how their therapist crying stood as a positive turning point in their treatment.

Courage. The third sub-theme that emerged from the data was the idea of courage. The informants explained that experiencing their therapist cry in therapy caused them to see their therapist as being brave and having courage to be emotionally vulnerable. The informants also explained that seeing their therapist cry also gave them courage to be able to express their emotions. For Isabella she explained "during that therapy session I felt my emotions, and I showed it. It felt easier because she was showing emotions with me. It showed that she's not afraid to show emotion around me and that showed how brave she actually is."

Autumn explained:

> Seeing her be open, it was kind of like a bid to me… like "this is my bid to show you I'm willing to be open", it made me feel like if she was willing to do this then I was willing to do this with her… It gave me like courage and willingness to talk and feelings of importance…

Autumn went on to say:

> I think that emotions are a very valuable accessory to human nature and they can be very valuable. I know some people view emotions as weakness, and I view them as a strength. I think it takes a lot of courage to show emotion and to be able to vulnerable with people. So I think for a grown man to be able to cry to a sixteen year old girl and to be humble enough to say "I can't understand, but I feel for you." I find that to be very valuable and I think that takes a lot of courage… I think some people would be like "That's really weird", but I think emotions are really valuable. It showed that I mean something to him.

Another informant, Jackie, described how she experienced courage in her treatment by saying:

> It affected my relationship with her [the therapist] because… instead of going in and being like everything is great… I was able to be like "everything is not great". Like I was able to talk to her more about my feelings and what was actually going on. It made me brave. I felt more open to talk to her.

Paula explained that by seeing her therapist cry she was able to say "Oh, I can do this! I can be vulnerable!" When Paula was describing how the treatment processes seemed to get easier for her she said "I was able to show more emotions in therapy because I was like 'Wow, this person cares and they see me as a person'."

Hannah also spent time talking about her experience of becoming more courageous in therapy by saying "I feel like I became less hesitant to therapy as well because I was like 'I'm not alone'. I guess it kind of got easier. It helped me realize like, it's ok to cry and I'm ok and I'm allowed to cry."

Therapists Crying Being Perceived as Detrimental

Within the major theme of therapists crying being perceived as detrimental to the treatment process and therapeutic alliance, three subthemes emerged. The three subthemes that suggest therapists' crying in therapy is detrimental were: (1) Therapists crying created role-reversal, (2) Crying influenced the informants to become withdrawn from therapy, and (3) It created discomfort in therapy.

Role-reversal. According to the data, informants talked about how therapists crying can create role-reversal within the therapeutic alliance. The informants that described their therapist's crying as detrimental explained that they felt like they took on

the role of the therapist and had to take care of their therapist. Anne explained this by saying:

> I care-take a lot and so I felt like I needed to be like "oh, it's ok!" Like at home when somebody cries, I feel like I need to be there for them. And so it made me feel like I had to reverse roles. I felt like I needed to be there for her in that situation.

In another interview, Felicia described this idea of role reversal by saying:

> For me, therapy is one of those things where therapists are supposed to be like that strong adult figure. And so when…It's kind of like when I see my parents cry… like in my mind I'm like "you are suppose to be that figure for me. You're supposed to be strong." And crying for me is typically like a sign of weakness and so when it's like an adult like that, that I like look up to [that's crying] it's hard for me.

Felicia went on to describe this idea of role-reversal in the therapeutic alliance by saying:

> It was one of those things where like "it's my stuff to cry over, not yours". I'm in therapy and so I can cry over it and you can comfort me, but you're taking this to a whole different level when you take it upon yourself to cry over it… So before I saw her cry I saw her as like a very strong and dependable woman and almost like a role model in my life. I almost like idolized her and then right, right when I saw her cry I was like "Oh, oh no. It's happening". I… I… for a while was almost mad at myself because I was like "I can't believe that I didn't see it coming". I can't believe that I thought that things would have been different. I think I was getting much more emotional than I should be about just seeing a therapist cry but like…

> it dropped this element of like… there might not actually be any stable adults in the world, because the person who I had depended on the most to give me that, couldn't.

Withdrawn from therapy. The second subtheme that explained how therapists' crying was detrimental to the treatment process and therapeutic alliance is that the informants became withdrawn from therapy. Anne stated, "I don't know, it made me not want to go back. I kept going to that place where like I'm not worthy. Like if a therapist can't even deal with me than who can?" Anne went on by saying:

> I feel like it's appropriate for people to cry, I get that, but for my treatment I felt like they weren't appropriate. For me it made me feel like I had to shut down so they weren't helpful in any way to my process or my therapy or what I needed… I felt like I had to be like "OK, I can't talk about this anymore." I wasn't being completely open with her, because the time when I tried to open up a little bit it just ended up making me put more and more walls up…So it's like you, you know, the boundary has been pushed so you're like "OK, I don't want to get close anymore so I'm going to put these walls up so that it doesn't happen again"… I just felt like I had to watch what I said and what I talked about.

Felicia also explained how she became withdrawn from therapy:

> I felt *unsure*. I didn't' even want to go to therapy and not because not only did I not know what I was going to be talking about, I also didn't know how the therapist would react to it. So it made me feel really uncertain because that opened up a whole new possibility of emotions. So like, I didn't know if my

> therapist would now get mad at me for something that I said or something that I did, or like shame me for it.

Felicia went on to describe this idea of becoming withdrawn from therapy by saying:

> After that I pretty much became…pretty much withdrawn. I didn't want to go to therapy with her. I felt like the only way to make our sessions less uncomfortable was to show less emotion… I finally just went to my dad and I said "I don't want to go to therapy with her anymore."

Discomfort. The third sub-theme that suggests that therapist crying in therapy is detrimental is because it causes discomfort. Anne described how the treatment process became uncomfortable when she saw her therapist cry by saying "I definitely felt way uncomfortable. Like a lot of the time I feel worthless and like I'm not enough for people, and that's how I felt in that moment." Anne went on to describe the experience of becoming uncomfortable with the treatment process of her therapy by saying:

> I was already feeling very uncomfortable at home and then I felt uncomfortable in that place, where you know you're supposed to be able to feel very comfortable…And my therapist now doesn't make me feel that way. Like, my therapist now doesn't cry and I think that makes me feel emotionally comfortable in therapy, and it makes me feel like I don't need to hold anything back…. I know that there are therapists that cry a lot but for me it made me feel uncomfortable…It just like… it made me feel like "oh, maybe this isn't the person I should be talking to. Maybe this isn't a person I should be sharing all this stuff with."

Anne went on to explain how her therapist crying caused her to feel discomfort:

> I think that part of me definitely felt the she was emotionally weak. Part of me felt like I wasn't worthy and part of me felt like she wasn't worthy…like how can you be a therapist when you cry over things? I know that some therapists cry a lot, but for me it made me feel uncomfortable.

Felicia also described her treatment process becoming uncomfortable once she experienced her therapist cry by saying "It brought like a new element of uncomfortableness into my life. I think the only word that I can use to best describe what I felt is uncomfortable." Continuing on with this idea of therapy becoming uncomfortable, Felicia also said:

> I definitely did not feel comfortable with her feeling that much emotion like *for* me, you know? I would have rather have had it stay strictly professional, rather than have her cry and tell her how much she cares about me because that….it… it felt weird…She really tried to connect with me on a level that I just wasn't ready for.

Chapter Four: Discussion

Therapists crying in therapy is a topic that has rarely been studied in the literature but is a form of therapist self-disclosure that influences the treatment process and therapeutic alliance. When a therapist cries in therapy, it has the potential to be beneficial or detrimental to clients. This finding is similar to other findings discussed in the literature. As Ziv-Beiman (2013) noted, self-disclosure of the therapist can come with serious risk, but can also be broadly effective when working with clients. In the current study, six of the eight informants described their therapist crying as being beneficial in regards to their treatment process and therapeutic alliance. On the other hand, two of the eight informants described their therapist crying as being detrimental in regards to their treatment process and therapeutic alliance.

These findings support much of the literature that looks at self-disclosure of the therapist. Blume-Marcovici et al. (2013) explain therapist self-disclosure through crying can strengthen the connection between the therapist and client through the use of empathy. The majority of the informants in the current study agreed with this idea and explained that their connection with their therapist became stronger because they were able to trust their therapist and felt better understood. They reported that they found their therapists crying to be a form of empathy that they found to be beneficial in regards to their treatment process and therapeutic alliance. This type of self-disclosure, which can be interpreted as empathy, has the potential to have a positive effect on the treatment process (Lambert, 1991; Norcross & Goldfield, 1992). It encourages clients to further open up in therapy and positively affect the therapeutic alliance (Farber, 2006; Watkins, 1990). Based on the results from the current study, the use of empathy through the

therapist crying can influence the client to feel more connected to their therapist which can become important when moving forward in treatment.

The literature suggests that self-disclosure of the therapist can be a positive experience for clients, but fails to explain how this positive experience can help clients to move forward in their treatment process. The results from this study take the ideas from the literature a step further by suggesting that a deeper connection with the therapist can give client's courage to accomplish their therapeutic goals. The informants in this category explained that for them, being able to show emotion through crying was perceived as a strength, and something that took courage to be able to do. After witnessing their therapist cry they felt more comfortable to display their own emotions which made these informants feel brave and courageous.

Another similar subtheme in this study that has also been represented in the literature is the idea that therapist self-disclosure can lead to the therapist being perceived as more personable (Vandernoot, 2007). When the informants were describing how the connection between them and their therapist grew stronger, they introduced this idea of their therapist becoming more relatable. The informants reported that they saw their therapist as a person, and realized that they were not a superior figure, but that they were also human. Some informants described their therapist as being perceived as more of a friend to them, while other informants reported that they then saw their therapist as a role model, or a parent figure. The results from Audet (2011), explain that recognizing that therapists have real life experience, rather than just textbook experience can make the therapist seem more credible. It also makes therapists warmer and more personable (Vandernoot, 2007).

On the other hand, the literature explains that therapist self-disclosure can be detrimental and lead to boundary crossing (Audet, 2011), and forming a type of friendship with the therapist can take the focus away from the client (Gutheil & Gabbard, 1990; Wachtel, 1993; Zur, 2004). The results from this study indicate that when the therapist is taking on a different role, the self disclosure becomes detrimental to the client. When this happens clients feel like they have taken on the role of therapist and feel the need to sooth their therapist.

Some of the informants agreed with this idea and explained that they felt like they had to disregard their emotions and make sure their therapist was emotionally ok. This study found that once clients had witnessed their therapist cry, they began holding back in therapy out of fear of making their therapist cry again. The informants reported becoming withdrawn from therapy because they felt that their therapist was not capable of "handling" them (as Anne and Felicia put it). Both of the informants who perceived their therapist's crying as detrimental reported apologizing to their therapist and feeling guilty because they felt like they had caused their therapist to experience a negative emotion.

Nelson (2012) reported that therapist self-disclosure can cause clients to feel uncomfortable. The informants in this study agreed with this and talked about how their therapist crying influenced them to feel let down and viewed their therapist as emotionally weak which caused discomfort within their treatment process and therapeutic alliance. The informants reported that the discomfort came from not knowing what emotional disclosure to expect from their therapist. The informants described that they began being cautious with what they said to their therapist, with fear of causing them to

cry again. The informants stated that once they saw their therapist cry they became so uncomfortable that they no longer wanted to attend therapy.

Clinical Implications

The purpose of this study was to understand the phenomenon of clients witnessing their therapist cry in therapy, and the results do have some clinical implications. For example, based on the results it may be interpreted that the amount of tears shed by the therapist influenced whether client's perceived the tears as either beneficial or detrimental. However, the results indicate this was not the case. The informants in this study all reported that the amount of tears expressed by their therapist seemed appropriate, but the way the informants interpreted the tears were either positive or negative. In my interview with Anne, an informant who perceived her therapists crying as detrimental explained "she was just kind of tearing, not really crying…just teary." In another interview with Isabella, who perceived her therapists crying as beneficial reported "There were just tears in her eyes, it's not like she was full on sobbing."

These results suggest that therapists may not be aware of the effect their tears have on their clients. These results suggest that therapists may find value in checking in with their clients after they have cried. As a therapist, asking client's how they perceived this experience may help to lessen the negative impact of the tears. The literature explains that therapists crying in therapy can lead to role-reversal and cause clients to feel uncomfortable (Nelson, 2012). By processing this experience with clients can help the clients to remain comfortable in therapy and keep the therapist in the role of the therapist. Audet (2011) explained that for participants who found their therapist's self-disclosure to be a negative experience reported that the disclosure was too frequent, too lengthy, and

did not align with their therapeutic needs. Future research should focus on the appropriate frequency of self-disclosure of the therapist and what kinds of details are appropriate.

The results from this study may also be comforting to clinicians. Because the same amount of tears were shed by the therapists who were perceived as detrimental compared to the amount of tears that were shed by the therapists who were perceived as beneficial, therapists can recognize that they will not always be able to control how their client perceives them. For therapists, rather than feeling like they should never self-disclose their emotions through crying because there is a chance that it could be harmful to their clients; they can use their crying as an intervention and process this experience with their client.

Future Directions

As the sample of the current study consisted of Caucasian females between the ages of 13-17 years-old, future studies should seek to expand the effects of therapists crying into other populations. Adolescence is often an emotional time of life (McGoldrick, Carter, Garcia-Preto, 2011), and therefore perceptions of crying may take on different meaning to other age groups and ethnicities. It should be noted that the two youngest informants found their therapists crying to be detrimental to their treatment process and therapeutic alliance. Future studies can benefit from understanding what meaning crying has throughout different stages of the life cycle.

Future studies should also start to explore what conditions exist that makes crying beneficial versus detrimental. As Wells (1994) explained, informants who found their therapists self-disclosure to be harmful went on to explain that if the disclosure of the therapist was done in a more appropriate manner, they would have found it to be

beneficial to their treatment. Understanding under what conditions clients find it appropriate for therapists to cry can better help clinicians to understand the effects of their self-disclosure and when it may or may not be appropriate. Paying particular attention to the sex of the therapist as well as the client may provide more beneficial results on how therapists crying can affect clients.

Conclusion

In conclusion, the results from this study indicate that therapists crying in therapy can be perceived as both beneficial and detrimental in regards to the treatment process and therapeutic alliance. When perceived as being beneficial, therapist self disclosure through crying can strengthen the connection between the therapist and client by making the therapist seem more relatable and adding an element of trust in the alliance. Therapists crying can also stand as a positive turning point in the client's treatment, and encourage the client to be more emotionally vulnerable in a positive way. When perceived as detrimental, therapist self-disclosure through crying can create role-reversal, causing the client to feel the need to take care of the therapist. It can also influence the client to withdraw from therapy and create discomfort with in the treatment process and therapeutic alliance.

Appendix A: Interview Questions

1. Think of a time when your therapist cried in session. Can you tell me what was going on and what happened?

2. What did it mean for you when your therapist cried in session?

3. How did it make you feel when your therapist was crying in session?

4. How did your therapist crying change your perception of therapy?

5. How did your therapist crying change your perception of the therapist?

6. How did your therapist's crying affect the treatment process?

7. How did your therapist's crying affect the relationship you have with your therapist?

8. In regards to your treatment, did you find your therapist's crying helpful or harmful?

9. How did you respond when your therapist cried?

10. How appropriate were your therapist's tears?

Appendix B: Demographic Information

Interview	Name	Sex	Age	Race	Educational Status
1	Anne	Female	15	Caucasian	High School Student
2	Falicia	Female	13	Caucasian	High School Student
3	Isabella	Female	16	Caucasian	High School Student
4	Autumn	Female	16	Caucasian	High School Student
5	Jackie	Female	15	Caucasian	High School Student
6	Delaney	Female	17	Caucasian	High School Student
7	Paula	Female	16	Caucasian	High School Student
8	Hannah	Female	16	Caucasian	High School Student

References

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Councelling Psycology Quarteryly, 24,*85-100

Alden, P.A. (2001). Gently wiping her tears away. In S. Kahn & E. Fromm (Eds.), *Changes in the therapist* (pp.117-131). Mahwah, NJ: Erlbaum Publishers.

Blume-Marcovici, A.C., Stolberg, R.A., & Knademi, M. (2013) Do therapists cry? The role of experience and other factors in therapists' tears. *Psychotherapy: Theory, Research, & Practice, 5,* 224-234.

Creswell, J.W. (2013). Qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks, CA: Sage Publications Inc.

Corbin, J., & Strauss, A. (2007). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*(1), 3-22.

Denzin, N.K., & Lincoln, Y.S. (2011). Introduction: The discipline and practice of qualitative research. *The Sage handbook of qualitative research* (4th ed., pp. 1-19). Thousand Oaks, CA: Sage.

Dineen, T. (2002). The psychotherapist and the quest for power: How boundaries have become an obsession. In A.A. Lazarus & O. Zur (Eds.), *Dual relationships and psychotherapy* (pp. 115-139). New York: Springer.

Eaves, Y. D. (2001). A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing, 35,* 654-663.

Ely, M., Anzul, M., Friedman, T., Garner, D., & Steinmetz, A. C. (1991). *Doing qualitative research: Circles within circles.* New York: Falmer Press.

Erlandson, D.A., Harris, E.L., Skipper, B.L., & Allen, S.D. (1993). *Doing naturalistic inquiry: A guide to methods.* Newbury Park, CA: Sage.

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

Gutheil, T.G, & Gobbard, G.O. (1990). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. In D.N. Bersoff (Ed.), *Ethical conflicts in psychology* (2nd ed., pp. 235-239). Washington, DC: American Psychological Association.

Kahn, S., & Fromm, E. (Eds.). (2001). *Changes in the therapist*. Mahwah, NJ: Erlbaum.

Kerr, M. E., & Bowen, M. (1988) *Family evaluation.* New York, NY: Norton.

Knox, S., Hess, S.A., Petersen, D.A., & Hill, C.E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44,* 274-283.

Knox, S., & Hill, C.E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology, 59,* 529-539. doi: 10.1002/jclp.10157

Lambert, M.J. (1991). Introduction to psychotherapy research. In L.E. Beutler & M. Cargo (Eds.), *Psychotherapy research: An international review of programmatic studies* (pp. 1-11). Washington, DC: American Psychological Association. doi: 10.1037/10092-041

Lazarus, A.A., & Zur, O. (Eds). (2002). *Dual relationships and psychotherapy.* New York: Springer.

Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Mayotte-Blum, J., Slavin-Mulford, J., Slavin-Mulford, J., Lehmann, M., Pesale, F., Becker-Matero, N., & Hilsenroth, M. (2012). Therapeutic immediacy across long-term psychodynamic psychotherapy: An evidence-based case study. *Journal of Counseling Psychology, 59,* 27-40.

McCarthy, R.P., & Betz, N.E. (1978). Differential effects of self-disclosing versus self-involving counsellor statements. *Journal of Counseling Psychology, 25,*251-256.

Mcgoldrick, M., Carter, B., & Garcia-Preto, N. (2011). Transformation of the family system during adolescence. In N. Garcia-Preto (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (4th ed., pp. 232-246). Boston, MA: Pearson Education Inc.

Merriam, S. (1988). *Case study research in education: A qualitative approach.*San Francisco: Jossey-Bass.

Nelson, J.K. (2005) Crying in the clinical hour. In J.K. Nelson, *Seeing through tears: Crying and attachment* (pp. 151-194). New York, NY: Routledge.

Nelson, J.K. (2012). Crying in psychotherapy: Its meaning, assessment, and management based on attachment theory. *Emotional Regulation: Conceptual and Clinical Issues*, 202-2014.

Nichols, M. P. (2013). Bowen family systems therapy. In M. P. Nichols & R. C. Schwartz, *Family therapy: Concepts and methods* (10th ed., pp. 76-96). Boston, MA: Allyn and Bacon

Nilsson, D.E., Strassberg, D.S., & Bannon, J. (1970). Perceptions of counselor self-disclosure: An analogue study. *Journal of Counseling Psychology, 26,* 399-404.

Norcross, J.C., & Goldfried, M.R. (Eds.). (1992). *Handbook of psychotherapy integration.* New York, NY: Basic Books.

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

Stake, R. (1995). *The art of case study research.* Thousand Oaks, CA: Sage

Summers, R.F., & Barber, J.P. (2010). *Psychodynamic therapy: A guide to evidence-based practice*. New York: Guildford Press.

The tears of a therapist (2013). *British Ps*ychological Society, *26,* 328.

Tomm, K. (2002). The ethics of dual relationships. In A.A. Lazarus & O. Zur (Eds.), *Dual relationships and psychotherapy* (pp. 32-43). New York: Springer.

Vingerhoets A. (2013). The human nature of crying. In A. Vingerhoets, *Why Only Humans Weep* (pp. 11-35). Oxford, UK: Oxford University Press.

Vingerhoets, A.J., & Cornelius, R.R. (2001). *Adult crying: A biospychosocial approach.* Hove, UK: Brunner-Routledge.

Vanderoot, A.J. (2007). *The relationship between the attachment-style of therapists and their utilization of self-disclosure within the therapeutic relationship* (Doctoral dissertation). Retrieved from ProQuest dissertations and theses database. (UMI No. 3268878)

Wachtel, P.L. (1993). *Therapeutic communications: Principles and effective practice.* New York: Guilford Press.

Watkins, C.E. (1990). The effects of counselor self-disclosure: A research review. The Counseling Psychologist, 18, 477-500.

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

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration, 23,* 59-74.

Zur, O. (2004). To cross or not to cross: Do boundaries in therapy protect or harm? *Psychotherapy Bulletin, 39,* 27-32.

Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations.* Washington, DC: American Psychological Association.

Vita

Kassidy Pendleton

EDUCATIONAL INSITUTIONS

B.S., Behavioral Science-Family Studies, 2012
Utah Valley University
Orem, UT

A.S., Behavioral Science, 2010
Utah Valley University
Orem, UT

PROFESSIONAL POSITIONS HELD

Teaching Assistant, University of Kentucky, 2014-2015
Intern Therapist, The Family Center, 2014-2015
Mentor, New Haven, 2012-2014
Court Mediator, Provo Justice, 2012
Intern, The Gathering Place Addiction Treatment Clinic, 2010

SCHOLASTIC AND PROFESSIONAL HONORS

Dean's List, Utah Valley University, 2010-2012
High Honor Roll, Utah Valley University, 2010-2012