Clinicians' Self-Disclosure Within the Therapeutic Alliance with a Trauma-Related Disorder

Jenna Jo LaMaster

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

The purpose of this qualitative case study was to explore how therapists build therapeutic alliances with their clients in trauma-based therapy using self-disclosure in the southern United States. The field of psychology benefitted significantly from a clearly defined and operationalized study that focused on the specific forms and usage of self-disclosure within the trauma-based therapeutic alliance, which advances the current research and uncovers the understanding of this potentially helpful intervention. The researcher used a case study approach and collected data using a semi-structured interview approach. These interviews were then examined using coding and the NVivo software. Theoretical coding was utilized to recognize and develop categories and patterns that emerged during the selective coding process. Relationships between the codes or themes were identified throughout the emerging theory or phenomenon. The results of the study include patients feeling less judged and more connected to the therapists that used self-disclosure as a connection tool.

Keywords: therapist self-disclosure, trust, vulnerability, trauma, non-immediate self-disclosure, therapeutic alliance

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Dedication

Without the unwavering support of my family and friends, I would not have found the strength to complete this research. I dedicate this work to them as a visual representation of their love and support. I especially want to dedicate this research to my nanny, Jo, who taught me the gift of kindness and the value of human connection.

Acknowledgments

I want to acknowledge the professors at Liberty University for their guidance and constant prayer for this degree. I cannot thank the faculty and students who walked alongside me throughout this journey. I could not have completed this dissertation without the generous contributions of my colleagues, who shared their time, energy, and knowledge to cheer me on during the rough moments. I also want to acknowledge the therapists out in the trenches with others, showing up and carrying the weight. We are all indebted to the healers of the world. Lastly, I want to acknowledge Brené Brown for opening the conversation about vulnerability and paving the way for deeper conversations about the power of emotions.

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List of Abbreviations

Acceptance and Commitment Therapy (ACT)

Cognitive Behavioral Therapy (CBT)

Dialectical Behavioral Therapy (DBT)

Eye Movement Desensitization and Reprocessing (EMDR)

Immediate self-disclosure (ISD)

Licensed Professional Counselor (LPC)

Licensed Clinical Social Worker (LCSW)

Mental health professional (MHP)

Non-immediate self-disclosure (NISD)

Post-traumatic stress disorder (PTSD)

Self-disclosure (SD)

Social Penetration Theory (SPT)

Therapist self-disclosure (TSD)

Trauma-based therapy (TBT)

Chapter One: Introduction

Overview

Therapists have been using various clinical interventions for decades. The choice of intervention is often personal and has intense impacts on treatments. Consequently, therapists use classical and inventive therapeutic approaches and clinical interventions to form a working alliance with patients while stimulating change in an ethical and practical space, which results in the therapists being responsible for the ever-evolving field of psychotherapy by influencing the development, implementation, and overall assessment of the clinical interventions used to develop the therapeutic alliance. While classical approaches have achieved long-standing endorsements, other approaches have been controversial. The researcher used this study to fill the gap between past research and open the discussion into the developing field of analysis to self-disclosure (SD) research by investigating the decisions and outcomes regarding SD in trauma-based treatment.

Each therapist takes a different stance on the appropriateness of the interventions and their choices of which clinical tools are helpful. Despite the growing acceptance within the psychotherapeutic community, SD has remained taboo. SD is ultimately defined as the therapist revealing personal information about themselves to their clients, intentionally or unintentionally. According to the American Psychological Association (APA, 2022), SD involves revealing personal or private information about oneself to a patient. In relationship research, SD has promoted feelings of closeness and intimacy.

Within psychotherapy, many consider the disclosure and communication by the patient of their individual and innermost feelings to be a prerequisite for therapeutic change and overall personal growth (APA, 2022). Furthermore, the treating therapist's use of revealing pertinent

revelations and information can be valuable to develop rapport and earn the patient's trust if used with discretion and clinical prevalence. SD can create a therapeutic alliance by stimulating therapeutic understanding and connecting the therapist and the client. SD is a form of intervention that carries serious risks. A developing body of research seeks to understand the therapeutic impacts and ethical implications of SD as a therapeutic tool.

As psychotherapy evolves with acceptance of the role of interpersonal relationships, both in developing the therapeutic alliance and resolving psychopathology as a mutual, reciprocal experience, the foundation of communication and trust between therapist and patient has gained importance within the therapeutic process. Lin and Utz (2017) discussed that self-disclosing information might influence the recipients' perceptions of the discloser. The fundamental responsibility of the continuation of modernizing and evolving psychotherapy is to develop, assess, and implement the clinical tools to ensure the chosen practices are ethical and effective in expanding the therapeutic alliance. While some outdated therapeutic interventions view SD as taboo and controversial, SD is gaining acceptance among specific theoretical approaches.

SD is when clinicians reveal personal information about themselves to their clients, and a fast-growing body of research seeks to understand the therapeutic and ethical implications of this therapeutic technique. As psychotherapy modernizes, scholars have begun recognizing the role of interpersonal relationships and the power found in reciprocating experiences within the therapeutic alliance. The communication between the therapist and the patient may continue to gain popularity and has shown importance within the therapeutic process. The roles of SD concerning intimacy and narrativity on perceived closeness within the social exchanges are essential to understanding SD's effects on the therapeutic alliance (Lin & Utz, 2017). Currently, where social media and telehealth are the new averages, self-disclosing is gaining popularity

(Kang & Gratch, 2011). The ever-growing attention to the relationship between the therapist and patient has led to an interest and increased examination of SD and its impact on the therapeutic alliance within a trauma-informed treatment dynamic.

This chapter examines the Background of self-disclosure, including how self-disclosure was shaped and why the approach is essential to the researcher. The Problem and the Purpose Statements are introduced in this chapter, outlining how the design was developed, presenting the research questions, and connecting the researcher to the research.

Background

A general psychology background is essential to comprehend the development of SD and the discussions around the approach. The various schools of psychology hold differing views on SD. Classical psychoanalysis considers therapist self-disclosure (TSD) taboo, believing that establishing an interpersonal connection between the therapist and the patient leads to the materialization of unconscious conflicts and pushes the patient and therapist to project upon one another. The purpose of SD can differ for every patient, situation, and therapist. Although Freud often ignored his rules and stance on SD, his program evolved into the keystone of psychoanalytic techniques. Usually, the decision to SD is situational and requires training (Hearn & West-Olatunju, 2015). Even throughout Freud's lifetime, many of his colleagues and students defended the usage and practice of TSD.

Previous researchers argued for psychoanalyst TSD to open and share a mutual relationship with their patients to strengthen the reciprocal therapeutic relationship. Kronner and Northcut (2015) stated that there are more detailed disclosures when the therapist is self-revealing personal history or experiences. Past studies from Hill and Knox (2002) insinuated that the use of SD is one of the minor interventions by therapists. However, TSD can create

substantial therapeutic benefits for the patients, such as providing alternative perspectives and opportunities to unlearn culturally dominant narratives. Until this point, researchers examined the value of SD as a clinical tool and ceased investigating its therapeutic value.

Studies by Bloch (2019) and Danzer (2019) indicated that SD and attunement to the patient's needs may offer irreplaceable benefits when SD is used. Therefore, it has been theorized that using SD as an intervention can advance multiple therapeutic goals simultaneously by producing a therapeutic change in situations and relationships where other classical interventions have been unsuccessful. Current research by Danzer alluded to serious ethical concerns relating to the core values of therapy, including beneficence, nonmaleficence, fidelity, autonomy, and justice. Consequently, SD should be studied and employed cautiously.

Research by D'Aniello and Nguyen (2017) highlighted how different forms of SD, including immediate, nonimmediate, verbal, and nonverbal, may generate distinct impacts significantly affecting the therapeutic alliance and the potential for benefit or harm. Furthermore, the authors suggested that the combination of SD and other therapeutic approaches, coupled with the overall ambiguity of their impacts, produced the current ethical uncertainty surrounding SD as a clinical tool and highlighted the need for continued examination of SD applications, influences, and validations across many mental health disciplines. Current studies resulted in unclear and opposing results, often overlooking the importance of different types of SD and the failure to create a comprehensible body of data. There is a gap in identifying the larger patterns and trends within current therapeutic approaches, especially surrounding trauma-based treatments.

Psychology benefits significantly from a clearly defined and operationalized study focusing on the specific forms and usage of SD within the trauma-based therapeutic alliance to

advance the current research and uncover the understanding of this potentially helpful intervention. Trauma therapy and trauma-based approaches are new within psychology and include various techniques, such as introspection, vulnerability, and safe spaces. As a trauma-based licensed therapist, the researcher intended to explore specific cases of TSD and personal experiences with trauma-based approaches while using a clear operational definition of SD. Consequently, this study may open conversations toward the therapeutic alliance.

Situation to Self

I used this study to fill a significant gap developed from current research. My goals were to explore the emerging field of SD while investigating the types of SD and the therapists' decisions to self-disclose within the therapeutic relationship, precisely how SD can be used within the context of trauma, and survey its value. As a trauma therapist, I find more uses for SD in creating a deeper therapeutic connection. Since 2020 and the rise of the coronavirus disease (COVID-19), therapy has changed. Current research studies, including Bloch (2019) and Danzer (2019), indicated that SD can add value to the therapeutic alliance and requires further examination as a clinical tool. These studies suggest that SD may offer unique therapeutic benefits if SD is used in attunement to the patient's needs.

Ziv-Beiman (2016) theorized that SD can advance multiple therapeutic goals concurrently, producing a significant therapeutic change in situations where other therapeutic interventions have been ineffective. Overall, SD is a complex intervention that warrants further investigation into its ethical and potential therapeutic benefits (Benko, 2018). I am also interested in the differences between immediate versus non-immediate SD and their impacts on trauma-based therapeutic alliances. There were limitations to the body of research that added to the vagueness encompassing SD and elicited further research into this intervention's implications

and operation. After reading the current studies, I found there is a need for further exploration of the definitions of SD and to continue the dialogue around the trauma-based treatments, the distinctly operationalized classifications of SD, and the dynamics of situations within the therapeutic alliance that has the potential to produce valid and generalizable data.

Current literature contains limited research addressing therapists' SD choices regarding their traumatic experiences and living with the aftermath, especially since COVID-19 and the global change from in-person sessions to telehealth. A gap in the current research about SD has been noted, emphasizing the implications of non-immediate SD for clinical practice. In self-disclosing their therapy, coping skills, and lived experiences, therapists who identify as having had a traumatic experience are singularly composed to integrate their clients' experiences as therapist and client, suggesting some factors influence their decisions and the impacts of the non-immediate SD intervention itself may be unique to the traumatic experiences therapy.

Problem Statement

Therapists may miss an opportunity to connect with their clients by not ethically using SD. SD is gaining popularity as psychotherapy has changed (Danzer, 2019). As psychotherapy is changing, the views on using SD must be examined. Therapists alienate themselves from their patients when they could be establishing healthy relationships. Therapists are missing the opportunity to reach patients when they alienate their patients by not utilizing the connection-building technique of SD. The global problem lies in the development of the therapeutic alliance with the use of personal connections through self-disclosure. Many reject the notion of TSD being taboo and embrace it as a practical approach to developing trust and openness. There is a need to investigate the influence of SD on the part of therapists in the effective trauma-based treatment of their clients. Because SD within the trauma-based approach has not been

established, this study utilized research to show how non-immediate SD affects the therapeutic alliance. Freudian and older therapeutic approaches that place a taboo on SD are antiquated, and a more reasonable, balanced perspective is developing (Bloomgarden & Mennuti, 2015). According to Benko (2018), therapists who self-disclose appear to have a more substantial impact on the therapeutic relationship, although the data on how this happens is inconsistent.

There has been a recent increase in research into SD and the differentiation between immediate and non-immediate SD. Prompt SD is often defined as therapists' reactions and possible countertransference in the therapeutic dialogue. In contrast, non-immediate SD is when the therapists disclose personal information during the therapeutic conversation. However, there is a need for more research on the therapeutic alliance, specifically regarding telehealth and new-age approaches. Danzer (2019) highlighted how patients might become more aware of the effects of their behaviors when therapists self-disclose their reactions to the patients. Goldstein and Palombo argued that the intentional use of TSD could strengthen the empathic attunement and introspection necessary for engagement and treatment in some patients, which would be considered immediate SD (Carpenter & Greene, 2015).

While immediate SD has increased in recent years, become more widely accepted, and is often integrated into clinical practice, non-immediate SD remains controversial. Sando (2014) found that many clinicians disclose to their clients who have experiences with specific disorders. This study provided insights into how non-immediate SD affects the therapeutic relationship by exploring the reasons for SD and the therapists' choices about disclosing information from their personal experience within the trauma-focused therapeutic alliance. The researcher sought to develop an operationalized definition of SD and how it relates to non-immediate SD regarding aspects of the therapists' personal experiences with trauma. Therefore, the researcher

investigated the ever-emerging field of SD inquiry and explored the factors affecting non-immediate SD.

Purpose Statement

The purpose of this qualitative case study was to explore how therapists build therapeutic relationships with their clients through SD in the southern United States. This study aimed to close the gap in the current knowledge and research about TSD and to understand and develop the various factors that influence a therapist to self-disclose during the trauma-based therapeutic alliance. Henretty and Levitt (2010) and Ziv-Beiman (2016) noted that client-centered therapists have continually argued that modeling openness, strength, and vulnerability with the patient can cultivate trust, credibility, and empathic understanding.

Significance of the Study

The results of this study may be significant in examining how SD is related to human connection. The base of human contact can be explored through the social penetration theory. The social penetration theory was initially developed to outline how SD helps move a bond from superficial to more intimate by revealing information about oneself (Pankhania, 2020). There must be an exchange of information for relationship development and a positive therapeutic alliance. The exchange can be a therapy tool or the therapist's choice of interventions. There is a norm of reciprocity that is fundamentally situated within this interaction, suggesting that when a person discloses something, the responder is often obligated to also disclose something at the same or close in proximity of intimacy to maintain the norm or equity of the bond (Bitar et al., 2014).

The researcher aimed to understand the factors behind information sharing and exchanging emotions through SD. The choices are being made by licensed therapists who have

either undergone their traumatic self-therapy or are specifically trained in a trauma-based approach. Specifically, this study was designed to understand non-immediate SD and what guides therapists to disclose or not disclose aspects of their personal trauma experiences. At this stage in the research, SD was generally defined as the therapist sharing personal information with their patients during or outside of the therapeutic relationship. The theory guiding this study was the social penetration theory. The social penetration theory, which claims that by gradually revealing emotions and experiences, patients gain a greater understanding of their issues and develop deeper trust, was proposed in 1973 by Altman and Taylor (Carpenter & Greene, 2015).

This study's findings may direct professionals to look at the role of the trauma therapist. The goal was to examine how therapists use themselves and their experiences as therapeutic tools to relate to their patients and hopefully promote a therapeutic change. Furthermore, the researcher challenges therapists to question their knowledge surrounding SD, which may prompt questions about how the psychology community distinguishes between patient and therapist, what expertise and approaches need sanction, and how to develop and understand the use of SD regarding the therapeutic alliance. By providing the discussion points and a safe space to explore the voices of therapists who have also lived and healed traumatic experiences, this study pursued open dialogue within the educational community to examine how mental wellness is approached and breaking down the taboos to open communication and inspire other ways of knowing and healing that exist within psychology.

Research Questions

This study validated the need for non-immediate SD regarding an intrapersonal communication approach. There were two specific research questions addressed in this study.

RQ1: How do therapists develop therapeutic relationships with their clients through self-disclosure as a trauma-based approach?

RQ2: What types of non-immediate self-disclosure do therapists use during therapeutic sessions?

Definitions

1. *Self-Disclosure (SD)* – SD is a branch of communication that involves intentionally and unintentionally sharing personal information about oneself. It can also be thought of as the process of communication that gives other people access to one's personal views and beliefs. This revelation about oneself is also known as the genuine self (Greene et al., 2006). SD is often used in developing relationships and deeper bonds. SD has been defined as a communication tool.
2. *Therapeutic Alliance* – The therapeutic alliance measures the therapist's and the client's mutual engagement within the therapy work, representing one of the most critical components for success regardless of the treatment modality used (Stubbe, 2018). The bond formed through therapeutic alliance builds the foundation for healing, especially within trauma-focused therapy approaches. The therapeutic alliance is essential in creating a working relationship between patient and therapist. This alliance is also referred to as a treatment relationship.
3. *Trauma-Based Therapy* - Trauma-based therapy is rooted in understanding how the traumatic experience impacts a person's mental, behavioral, emotional, and spiritual well-being. The purpose of trauma-based therapy is to assist the client in building skills and strategies for processing the emotions and memories of a traumatic experience. The most widely accepted trauma-based approach is eye movement desensitization and

reprocessing (EMDR). EMDR was developed by Francine Shapiro (2013) and addressed the physical and emotional responses to trauma.

4. *Trust* - Trust in the context of SD pertains to how accurate the disclosure is and how closely it represents the user's true self. Trust also refers to the depth of the relationship between the therapist, the discloser, and the patient, the receiver. Trust is a central component within the therapeutic alliance and is the abstract mental attitude towards someone deemed dependable (Thagard, 2018). Trust is built when vulnerability and accountability intersect within the therapeutic alliance. Trust is the foundation of SD within relationships.
5. *Vulnerability* - Vulnerability is uncertainty, emotional exposure, and risk (Brown, 2019). Vulnerability is not a weakness regarding human connection; it is the most truthful measurement of courage. Vulnerability is often used to describe how one defines their story and trauma. Vulnerability is opening and accepting oneself and is used when telling one's trauma story or background.

Summary

The purpose of this study was to explore how therapists build therapeutic relationships with their clients through SD in trauma-based therapy. The problem was that therapists alienated themselves from their patients when they could utilize the connection-building technique of SD. Noticeable psychotherapy theorists and researchers have begun looking into what SD encompasses. Researchers have voiced their concerns over the lack of a concrete definition of SD (Lin & Utz, 2017).

Definitions of SD often vary from simplistic dictionary definitions to descriptions involving types of disclosure (Benko, 2018). Interest in self-disclosure is growing as more

therapists explore the therapeutic relationship. A growing body of evidence on therapist SD suggested that it establishes a closeness within the therapeutic alliance and leads to better self-understanding and a more profound sense of self (Ziv-Bieman, 2016). Mental health professionals and therapists are defined in this study as licensed, master's or doctoral-level practitioners in the mental health field, including but not limited to psychology and social work. This study was essential to explore how mental health professionals and nonprofessionals perceive therapeutic SD.

According to studies by Locke and Colligan (1986), SD positively affects physical health and provides a source of release for the disclosing party. Several studies highlighted by Sando (2014) examined the levels of SD and content. Other studies outlined by Ziv-Bieman (2016) indicated that therapists are likely to self-disclose apologies for professional mistakes, statements showing respect for the patient, and stress-coping strategies. The participants can use SD to connect and build a therapeutic relationship.

In this context, SD shows the client that the therapist values them. It is essential to uncover the levels associated with SD to understand why some therapists use SD. Although Sidney Jourard was not accredited until 1958 with coining the term SD, the debate about its use has been ongoing for decades, and mental health professionals are generally cautioned in their training to use SD scarcely (Benko, 2018). Granello and Gibbs (2016) demonstrated that mental health professionals (MHPs) and mental health trainees hold favorable views of those with mental illness and must consider different approaches to building a therapeutic relationship. Using this positive approach in trauma work may enhance the therapeutic alliance and empower the understanding between therapist and client.

Chapter Two: Literature Review

Overview

TSD has been a long-standing debated topic in counseling and psychotherapy (La Porte et al., 2010). The issue of TSD has increased theoretical debates and empirical research within various mental health arenas (Audet & Everall, 2003; Bitar et al., 2014; D'Aniello & Nguyen, 2017; Kelly & Rodriguez, 2007). Since the beginning of 2020, with the introduction of COVID-19, platforms delivering therapy and relevant ethical principles have evolved. With more clinicians conducting therapy from the confines of their residences, implementing SD seems inevitable. Controversy about TSD and what it is has complicated clinical discussions (Farber, 2006). The general outlook on the use of TSD depends on the extent to which it is seen as helpful or hurtful; disclosure within Bottrill et al.'s (2010) research has been deemed as therapist behavior, Audet's (2011) deemed it as boundary-crossing, and Bottrill et al. indicated it was a helpful intervention as an expression of trustworthiness and authenticity.

In this chapter, the researcher reviewed the history and prior research on SD, focusing on the theoretical and empirical literature to gain insight into the diverse views of SD. The researcher developed a working definition of SD practices and provided a brief overview of the argument regarding SD's usefulness. The researcher situated the dynamics of trauma-focused therapy and personal experiences with trauma-based therapy within the matrix of the broader ethical, clinical, and theoretical interests.

While a therapist might be unable to remain genuinely disconnected and anonymous due to recent societal changes, there may still be a line between one who reveals too much and one who tells too little (La Porte et al., 2010). Furthermore, disclosing too much information may raise questions about ethical implications and boundary violations. The first step in the

discussion of TSD was to explore the reality that therapists and mental health professionals generally disclose at some point. Given the advances in theory, research, and society, a larger purpose of this study went beyond whether disclosure happens. By considering a more critical discussion of what can and should be disclosed to patients, therapists use vulnerability to create closeness, opening the therapeutic alliance and increasing healing.

Theoretical Framework

Before the 1950s, most psychology was performed from a psychoanalytical viewpoint. Sigmund Freud developed this viewpoint and discouraged using TSD entirely (Bitar et al., 2014). The principal reason was that TSD allowed a therapist to depart from neutrality and the development of transference (Henretty & Levitt, 2010). Freud's followers began to view TSD this way, even though he often revealed many personal aspects of his life to his patients. From this psychodynamic point of view, the pull to self-disclose often points to the therapist dealing with early life experiences that are being triggered. Consequently, clinical thinking and reflection benefit the patient (Danzer, 2019). Therapists with a sense of urgency to use SD with a psychodynamic background should consult their peers or supervisor.

Psychodynamics prioritizes professional restraint. The benefits of using discretion when therapists feel compelled to self-disclose allow the MHP to use introspection by not disclosing or re-enacting their interpersonal challenges. The technique immediately developed after psychoanalysis. Ego psychology echoes that the therapist must be neutral (Hartmann, 1964). In classical psychoanalysis training, therapists are taught to avoid SD so the patients' conflicts and issues may not be transferred onto the therapist or within the therapeutic relationship (Ziv-Bieman, 2016). The problems of countertransference were introduced shortly after Freud. The relations theory states that the therapist must acknowledge their countertransference capability to

facilitate the connection of the unconscious patterns the patient transports into the therapeutic present (Mitchell, 1997).

However, contemporary object relations theorists encourage TSD of the countertransference that can occur to allow the patient to uncover each person's experience, deepening the therapeutic connection. MHPs practicing more recent varieties of psychoanalysis, including object relations theory and self-psychology, have a favorable view of the importance of SD within the therapeutic alliance (Ziv-Bieman, 2013). Self-psychology views the therapist as someone who puts their empathic subjectivity at the patient's subjectivity by using SD as a framework to engage in joint construction and mutual influence between the therapist and patient (Kohut, 1971). Bloch (2019) extended this concept by exploring the potential benefits of TSD as a psychotherapeutic intervention. Furthermore, Edwards and Murdock (1994) and Pope and Vasquez (2010) discussed how most therapists and clinicians have used some form of SD during their clinical careers.

Humanistic and existential schools of thought believe SD is a more critical therapeutic intervention (Carew, 2009; Ziv-Bieman, 2013). Although the Father of Humanistic Psychology, Carl Rogers (1951), never explicitly used the term SD in his book *On Becoming a Person*, he stressed the benefits of therapist transparency (Benko, 2018). Rogers outlined the use of congruence, which occurs when the therapist genuinely interacts with the client. Humanistic psychology highlights the importance of TSD in promoting an authentic therapeutic bond as a crucial instrument in accelerating the patient's growth and creating an effective therapeutic relationship (Bugental, 1987; Rogers, 1951). This bond between therapist and client builds a foundation of trust.

Using the humanistic approach, disclosing personal information, such as feelings and experiences, can be a way for the therapist to appear more authentic, thus promoting a stronger sense of self and congruency (Benko, 2018). Furthermore, when the MHP discloses personal information regarding feelings, treatment, or experiences, they practice a more humanistic approach. MHPs who use this theoretical background see SD as a therapeutic tool (Henretty & Levitt, 2010). Using this form of SD has built strong therapeutic relationships, increased authenticity, and established a functional level of empathy that models sharing emotional information with the patient. The humanistic approach allows the therapist to approach the patient with a whole frame of mind.

Different theoretical backgrounds have varied perceptions regarding SD. Training and schools of thought offer other guidelines for using SD in therapy (Benko, 2018). Existential therapists believe therapists should maintain congruence or transparency with their patients (Benko, 2018; Carew, 2009). Most contemporary therapeutic schools emphasize the understanding that TSD is inevitable (Benko, 2018). Yalom and Leszcz (2005) wrote about using SD in group therapy, identifying that SD not only helped the therapist to be more flexible and handle group dynamics but also increased the openness among the group. American psychiatrist Irvin Yalom developed the existential approach and viewed TSD as a core therapeutic technique to help patients cope with existential questions regarding the therapist as a guide or coach (Hill & O'Brien, 1999; Jourard, 1971; Yalom, 2002).

Yalom and Leszcz (2005) argued in support of the humanistic approach because SD is more effective when it engages the client, adds to the positive emotions and ambitions, and is received warmly by patients compared to negative interactions. Although Yalom and Leszcz and Rogers (1951) encouraged SD use, they warned MHPs to consider several factors when deciding

on SD usage. Rogers acknowledged the group's or individual's needs and knew when to take on a less important role, putting the therapist or MHP in control to use SD as a helpful tool (Benko, 2018).

The cognitive-behavioral approach regards SD positively by acknowledging that strengthening the therapeutic bond by normalizing the patient's experience via challenging the negative interpretations of emotions and enhancing the motivation for change (Dryden, 1990; Goldfried et al., 2003). The cognitive-behavioral approach often utilizes TSD as an intervention in some service model-specific treatment goals (Satterly, 2006). To better understand the cognitive-behavioral therapy (CBT) of SD, Miller and McNaught (2018) interviewed six cognitive-behavioral therapists reviewing their histories of using SD intentionally with findings consistent with other client-centered models that cognitive behaviorists were open to using TSD when it had a clear clinical purpose.

Mental health professionals with an eclectic or mixed approach differ in their views of SD as these approaches vary widely (Edwards & Murdock, 1994). Family-centered practices can contribute to their stances on using SD, with some holding non-disclosure as ideal while others are more open to using SD (Gibson, 2012). These shifts in accepting and using SD prompt a discussion on the approach's implications within the therapeutic alliance. Other therapeutic approaches, such as multicultural, person-centered, and feminist, hold SD as necessary in promoting equality between MHP and their patient (Henretty et al., 2014; Henretty & Levitt, 2010; Ziv-Bieman, 2016). Modern therapeutic approaches, such as social penetration theory, CBT, and client-centered therapy, can be vague or brief in their discussions regarding using SD as a therapeutic tool.

For example, CBT identifies SD as a therapeutic tool, such as a therapist using Socratic questioning to help patients reframe their thoughts (Beck, 2012). In this context, SD allows the therapist or MHP to demonstrate how to adapt to more flexible ways of thinking. However, in the CBT manual, SD is addressed in one paragraph. The manual discusses SD in general; therapists using CBT orientations may use SD to achieve many goals. However, they are not limited to appropriate modeling behavior but are cautioned in training to consider their reasons for using SD (Benko, 2018; Ziv-Bieman, 2016).

According to Hayes et al. (2012), the acceptance and commitment therapy (ACT) training discussed using SD to develop a stronger working relationship with the patient by assisting the patient in feeling more connected, aiding the therapists to be perceived as more credible. The ACT training gets even more specific about using SD by stating that the therapist should not "spend more time self-disclosing than the client does" (Hayes et al., 2012, p. 152). In this context, the ACT therapist views SD as a natural human process that assists the patient in understanding their healing. By utilizing SD, the ACT therapist assists the client in seeing their therapist as part of the healing process, which helps ease the patient's concerns that they may be having abnormal experiences in some way because the use of SD assists them in seeing someone who has similarly struggled. In this approach, SD is a standard therapeutic tool that helps the therapist model openness and vulnerability. In the training and usage of ACT, SD is a commonly used technique to assist the MHP in modeling openness, positive self-regard, and trust.

Dialectical behavior therapy (DBT), developed by Linehan (1993), outlined an extended discussion on using SD within the therapeutic alliance. DBT therapists approach SD to communicate and promote many things in sessions effectively. Examples include validating the patient's experience and emotions, normalizing the patient's experience, exposure exercises such

as introspection, and modeling problem-solving skills. The DBT training manual noted that SD is a helpful tool in strengthening intimacy and warmth between the MHP and the patient. In addressing personal disclosure of the MHP, DBT specifies that "so long as a disclosure is in the patient's best interest, there are no rules (other than common sense and the guidelines above) limiting the information given to the patient" (Linehan, 1993, p. 382). DBT defines SD as sharing that is not definitional to therapy, but it is not unacceptable.

What was once ruled clinically taboo is slowly and steadily transitioning into an unavoidable therapeutic technique that cultivates the therapeutic alliance and widens the range of therapeutic goals. SD is reflected in the research on therapy styles and varies among schools of thought. Humanistic-based providers report using considerably more SD than those with a traditional psychoanalytic approach (Benko, 2018). Furthermore, therapists with a more eclectic or eccentric approach, namely those with cognitive or behavioral orientations, reported using limited amounts of SD in therapy.

Although psychoanalysts may not use SD frequently, this information may not be accurate because psychoanalysts may disclose significantly less than other schools of thought (Henretty & Levitt, 2010). The patients' diagnosis, personality traits, and presenting symptomology must be considered when debating using SD (Dean, 2010). Nonetheless, most therapists report they must consider SD irrespective of orientation and training and utilize caution before using SD with patients. MHPs with graduate-level degrees are more apt to view mental illness treatments involving SD. Overall, SD appears standard among therapists and is more readily indicated in newer training manuals as a therapeutic tool. However, using SD in more intimate content is not outlined in most training texts (Benko, 2018). To understand the use

of SD, the therapist must first understand what SD entails, the reasons behind using it, and how mental health professionals view mental illness.

Mental Health Professionals' Views of Mental Illness

Some studies reviewed by Benko (2018) introduced the notion that mental health professionals view those with mental illness in a more positive light when compared to those in the general population. Mental health professionals are less likely to label someone with a mental illness as dangerous, untrustworthy, or unpredictable when they compare their attitudes with those of the public (Kingdon et al., 2004). Furthermore, psychiatrists do not differ in their social distance measures between those with a mental illness and the general population. Psychiatrists offer a considerably high positive attitude towards the mental health community. They are less likely to disagree with the notion that mental illness is caused by a lack of self-discipline, leading to the development of a closer therapeutic bond between mental health professionals and patients (Benko, 2018).

Scholars de Vos et al. (2016) outlined the shift in the last two decades from a medical model of understanding clients as sick to a bio-psycho-social-spiritual recovery model with a therapist-led component, which leads to the therapist using their own experiences with mental illness to give patients insight into recovery. The attitudes toward those in treatment are higher than those not engaged in mental health treatment. Stull et al. (2013) found that members of a community treatment team reported an overall positive perception of those with mental illness, including the members' perceptions of good, trustworthy, innocent, and competent.

This optimistic view has led therapists and psychologists to endorse less social distancing and indicated some variability among professionals, even within the mental health community, regarding SD and defining closeness (Smith & Cashwell, 2011). Therapists and other mental

health professionals have a higher level of tolerance and acceptance for those with a mental illness when compared to members of the general population; these feelings include more willingness for inclusion, involving them in social circles, and even hiring them for a job (Covarrubias & Han, 2011; Granello & Gibbs, 2016). With this increased view of acceptance through training, mental health professionals may begin to endorse a changing attitude towards SD in therapy. Marino et al.'s (2016) research suggested that TSD of mental illness can benefit the therapeutic alliance by empowering and de-stigmatizing the mental illnesses's taboo.

The changing attitudes toward individuals in mental health treatment are shown in understanding, empathy, acceptance, and more adaptation to a strengths-based approach (Crowe & Averett, 2015). Furthermore, the change in attitude highlights that experience and training influence perceptions during treatment. In Dunne's (2015) conceptualization of the *Wounded Healer*, therapists and MHPs may choose to conduct therapy to address their mental health struggles and desire to help similar clients. The MHP who mirrors the client's symptoms may create a sameness in experience and intuitively finish their healing (Danzer, 2019).

Exposure to treatment modalities and those with a mental illness has been associated in other studies as interconnected. In Covarrubias and Han's (2011) study, exposure to treatment modalities and those with a mental illness was associated with a favorable attitude towards the patients. Master's and doctoral-level trainees tend to hold a positive attitude towards mental illness when they experience frequent contact with friends or colleagues who have a severe mental illness. However, Benko (2018) indicated that professionals in training do not consistently demonstrate these positive patterns.

Even among mental health professionals, SD and the social penetration approach are debated. For example, mental health professionals and trainees are more likely to endorse a less

tolerant or negative attitude when presented with the term mentally ill than when using the phrase people with a mental illness (Granello & Gibbs, 2016). This change in vocabulary shows that labels can change a mental health professional's perception, which can bring about the debate of using the term SD with those in treatment for a mental illness compared to the overall mentally ill population, alluding to the stigma and taboo among medical professionals seeing individuals with a history of psychiatric hospitalization as unpredictable and not safe. This nomenclature would affect SD views by inducing an undesirable view of using SD. There is a theory that gives more insight into how the use and idea of SD take place.

Social Penetration Approach to Therapist Self-Disclosure

In 1973, Altman and Taylor developed the social penetration approach, one of the most widely accepted theories of rational development that identifies SD as a driver of relationships and closeness (Carver, 2006). Moreover, this theory provides insight into how SD develops. First, before someone chooses SD, the thesis outlined how the discloser must mentally consider the threat of vulnerability and the discomfort of sharing against the costs and rewards of companionship and overall intimacy (Baldin et al., 2004). Part of the appeal of the social penetration theory is how direct it is regarding relationship development. Four primary considerations frame the social penetration theory according to Irwin Altman and Dalmas Taylor (1987):

1. Relationships progress naturally from a non-intimate to an intimate status,
2. Relationship development is systematic and often predictable,
3. Relationship development includes suspension and depenetration, and
4. SD is at the core of relationship development.

Within the social penetration theory, SD is formulated to encompass that personality is composed of layers, much like an onion. The top layers of nature are mainly superficial, and the innermost layers comprise personal information. The theory also identifies the two types of SD: depth and breadth (Carver, 2006). In this context, depth refers to the degree of intimacy within the disclosure. Breadth is defined as the number of topic areas disclosed. The social penetration process within the theory incorporates verbal, nonverbal, and environmentally-orientated behaviors.

The second tier of the theory outlines the use of costs versus rewards within relationships. According to Altman and Taylor (1987), people who engage in the social penetration process participate in maximizing gains while minimizing losses. The rewards result in timely penetration into deeper, more profound levels. The relationship's growth-related development or satisfying aspects outweigh the unfavorable ones. The social penetration theory emphasizes rewards as a motivational basis for relationship growth. Exchanges, such as communication and SD, occur if there is a mutual experience and a favorable reward or cost balance.

The therapist will decide whether to use SD based on the costs and rewards in this context. The level of SD will depend on the relational goals within the therapeutic alliance. SD is not only influenced by the predicted outcome but also by the situation and the closeness of the relationship. The discussion of the social penetration theory is helpful because SD is a cornerstone of the approach. Utilizing SD can have an intimate and profound effect and be therapeutic (Carver, 2006). SD can deepen the therapeutic alliance.

Self-Disclosure Levels and Frequency

Two considerations of SD, including the affective manner of presentation and flexibility of disclosure pattern, are essential to understanding the impact, especially when examining what

difficulties therapists face in self-disclosing (Chelune et al., 1984; Danzer, 2019; Dryden, 1990). Within SD, various levels impact the therapeutic relationship differently (Gibson, 2012). For example, an immediate disclosure is more likely to be seen in a positive light when compared to a non-immediate one. Therefore, an accurate definition of therapist SD is essential in research. Standardizing a definition of what comprises SD to fit all studies is impossible. These levels depend on what was disclosed and the nature of the relationship.

Some issues arise with the definition and modes of measuring therapist SD. The purpose of SD itself is broad and non-conclusive (Benko, 2018). The definition must first be simplified regarding SD outside of a therapeutic approach to identify the levels and frequency accurately. Knox and Hill (2003) reported that SD accounts for roughly one percent of a therapist's chosen interventions during a session. Other notable studies by Anderson and Mandell (1989) and Edwards and Murdock (1994) reported greater use of SD by therapists. This increase has occurred within the last 30 years.

According to Danzer (2019), therapeutic relationships explain a relatively high level of disclosure. Moreover, TSD becomes more conversational as the therapeutic alliance becomes robust. In the research, specific aspects of disclosure appear to happen frequently. Danzer's study indicated that not only does TSD happen, but it may be a growing preferred alternative to complete neutrality, distancing, and non-disclosure in many circumstances. Immediate or intratherapy is explored more often when compared with non-immediate or extratherapy (Henretty et al., 2014). Additionally, Levitt et al. (2016) estimated that 67.4% of TSD were from therapy, while 28.4% were from extratherapy, indicating that SD frequently occurs during sessions.

Danzer (2019) observed studies with SD being helpful when an MHP discloses harmful emotional content like the patient. Although previous quantitative studies may find difficulty in applying SD to individual cases, Moore and Jenkins (2012) and Rahman (2017) delineated more of a snapshot of SD with limitations of patient perspectives and experiences. While immediate and non-immediate SD have been seen as more helpful than nondisclosure during the therapeutic relationship, non-immediate disclosures were observed as most beneficial (Henretty et al., 2014). The one-sided exchanges of patients disclosing far more frequently than their MHP is a unique interpersonal pattern only seen in therapeutic alliances, which deviates from established societal norms and, therefore, may present a problematic interaction with patients who need human connection, especially within the trauma-based therapeutic alliance where patients often look for a link to process their emotions in a safe environment (D'Aniello & Nguyen, 2017). This concept brings into the discussion the rationale behind why a therapist might self-disclose during a session. Therapists and MHPs would benefit from being clear on clinical reasons for choosing SD and utilizing constructive wording (D'Aniello & Nguyen, 2017; La Porte et al., 2010; Sturges, 2012).

Reasons for Self-Disclosure

There has been abundant research on the factors of SD. The term SD was first credited to Sidney Jourard, a humanistic psychologist, in 1958. Jourard (1971) discovered the most potent reasons for SD to be the identity and the nature of the relationship between the two people in the exchange of SD. A currently accepted hypothesis suggests one party might disclose based on disclosure by the other, an assertion supported by research results (Strasburger et al., 1992; Watkins, 1990). SD in personal relationships is used to exchange information and receive confirmation, not necessarily to identify similarities (Reis & Shaver, 1988).

Furthermore, people's interpersonal motives are often influenced by satisfaction within the exchange. Research results model patients' learning to open up and expose themselves within the therapeutic relationship by imitating the therapist's disclosure. Additionally, social exchange models hypothesize the reinforcing nature of the therapist's and patients' mutual sharing as a beneficial norm guiding the therapeutic process (Fisher, 1990; Giovacchini, 1973). Knox and Hill (2003) hypothesized that therapists frequently make personal, direct SD to encourage their patients to follow suit and build rapport. Derlega and Grzelak (1979) outlined eight reasons people utilize SD:

1 Releasing pent-up emotions,

2 Clarifying personal opinions,

3 Receiving feedback,

4 Controlling the outcome of the relationship,

5 Obtaining advice,

6 Encouraging the other person to SD,

7 Gaining approval, and

8 Providing information to assist in getting to know one another.

Henretty and Levitt (2010) illustrated that patients reported more positive responses to SDs that were immediate and concerned feelings about the patient than non-immediate disclosures. Therapists might also use SD to validate the patient's perception of reality and show empathy and unconditional positive regard by granting a sense of normalcy to the patient's experiences, using SD as a bonding tool (Edwards & Murdock, 1994).

Audet (2011) reported that many patients do not expect their MHPs to disclose much and tend to view their MHP as a listener, often questioning and offering solutions. MHPs often

utilize SD more frequently when patients report to therapy with fewer mental health symptoms, disclosing less often to patients with more severe concerns, such as post-traumatic stress disorder (PTSD) and personality disorders (Benko, 2018; Henretty & Levitt, 2010). While studies by Benko (2018) and Hill and Knox (2002) indicated that MHPs disclose with some patients at certain times, it does not appear to be a frequently reported occurrence. Various reasons indicate that more SD correlates with improved therapeutic outcomes. Overall, the rationale behind therapist SD points to strengthening the therapeutic relationship by prioritizing personal communication.

Types of Self-Disclosure

There is a difference between deliberate, consciously intended SD, where the therapist chooses to disclose certain personal aspects, and the seemingly unavoidable self-revelations or nondeliberate SD that presents from the therapist's presentation, such as furniture or therapeutic interventions (Abend, 1995; Cozby, 1973; Fagan, 2018). Additionally, MHPs intentionally or unintentionally reveal much about themselves based on their office décor, wedding ring, attire, and how they respond during random or chance encounters with clients outside the therapy room. Therefore, unintentional TSD occurs frequently and appears in the literature for a good reason (Danzer, 2019). MHPs' self-disclosing statements are often divided into two main types: immediate and non-immediate (Benko, 2018). Prompt self-disclosure is referred to as disclosing something to a client during the session that often relates to the mental health professionals' feelings about something; for example, a clinical being frustrated when a client is consistently late to a scheduled session (Audet, 2011).

Furthermore, examining intentional versus unintentional SD parameters will give insight into SD's benefits and possible disadvantages (Bridges, 2011). Aran's (2016) psychoanalytic

paper showed examples of sharing feelings in real-time while in a group therapy context, demonstrating how self-involving TSDs can inspire a deeper therapeutic alliance and change. Deliberate non-immediate SD could entail disclosing anxiety or depressive symptoms to the client to build therapeutic rapport. For example, non-deliberate SD could include therapists' attire, body language, and nonverbal cues. Disclosure is often used either deliberately or non-deliberately for a variety of reasons. MHP reported using SD as a therapeutic tool to model patient behavior, increase the patients' perceptions of the MHP, and help patients feel connected and understood to increase the therapeutic alliance (Benko, 2018).

Another important distinction in SD is the notion of immediate versus nonimmediate TSD concerning treatment outcomes (Audet, 2011). Immediate disclosure involves the therapist discussing self-involving feelings and disclosing information regarding their education and professional approach (Benko, 2018). Non-immediate disclosure often relates to the therapists' experiences outside the treatment room, including coping skills learned throughout their therapeutic journey. Immediate TSD is increasing in the potential positive benefits and viewing the therapeutic relationship as a significant arena of change (Aron, 1991). Prompt SD is challenging to measure because these interventions are typically considered part of the therapeutic conversations. Comparatively, non-immediate SD is still taboo and less studied. Nevertheless, immediate SD is hypothesized to transpire more than reported, which raises the question: Is non-immediate self-disclosure tied to a greater acceptance of the MHP (Farber, 2006)?

Non-Immediate Self-Disclosure

Non-immediate SD often refers to therapists revealing personal information about themselves regarding life circumstances, history, beliefs, or values (Audet, 2011). A commonly

used example of non-immediate SD is when an MHP discloses their experience with anxiety, depression, or life events with a patient. An MHP using the therapeutic technique of SD about their mental health symptoms or history would be considered non-immediate disclosure (Benko, 2018). Sando (2014) identified non-immediate disclosure as therapists' sharing personal experiences with anxiety and other mood disorders and researching topics during therapy sessions. Non-immediate disclosure is often viewed as controversial and continues to threaten fundamental therapeutic practices (Henretty et al., 2014). Jourard (1971) highlighted the growing body of research on SD by examining the benefits, including trust and therapist credibility.

According to studies by Locke and Colligan (1986), SD positively affects physical health and the therapeutic relationship. Ramsdell and Ramsdell (1993) evaluated nonimmediate SD from a patient's viewpoint, finding that 58% of patients reported that the therapist disclosed personal details at least once during their sessions, typically viewed as part of the therapeutic dialogue between therapist and patient.

Therapeutic Alliance

The potential benefits of using SD are gaining in popularity. Benko (2018) and Elvins and Green (2008) denoted that SD may strengthen the therapeutic alliance when the relational aspects of the therapeutic relationship are regarded as independent from other treatment techniques or therapeutic approaches. Meta-analytic research reviews connected to the understanding of the therapeutic alliance corroborate that it consistently conveys therapeutic outcomes for all ranges of patients (Shirk & Karver, 2003). The MHPs' conduct often influences the therapeutic alliance. Patients seeing an MHP who does not disclose may view that MHP as cold, inaccessible, and even hostile and rigid, which can hinder the therapeutic alliance (Audet, 2011; Henretty & Levitt, 2010).

MHPs' understanding, openness, honesty, trustworthiness, warmth, empathy, and confidence are associated with favorable patient perceptions of the therapeutic alliance (Ackerman & Hilsenroth, 2003). Some of the procedural aspects of the therapeutic partnership include collaborative interactions or goal setting and interpersonal interactions between the MHP and the patient. Using SD can be a way for MHPs to convey meaningful connections to their patients, looking to associate significantly (Benko, 2018). A study by Henretty et al. (2014) showed that TSD significantly increased the patients' perception of the therapists' positive regard and attractiveness. Myers and Hayes (2006) found that therapists were viewed as experts when TSD was used within the therapeutic relationship. Vandenberghe and Silva Silvestre (2014) concluded that therapists view TSD positively in a study of 26 therapists' stances on sharing positive emotions when appropriate. Moreover, Pinto-Coelho et al. (2016) reviewed 185 TSD within 16 cases of psychodynamic therapy and found that TSD was correlated with a high client rating of the therapeutic alliance and a positive correlation between TSD and stronger therapeutic alliance.

Therapists' Self-Disclosure of Mental Illness

There is limited research into the therapeutic disclosure of personal information by the MHP related to their mental health. MHPs with a history of mental illness may be able to provide unique benefits in their work with patients, especially in the trauma-based realm (Benko, 2018). An example would be a therapist or MHP who has recovered from a traumatic event and can act as a role model and offer critical insight into treatment or healing and crucial insight into medicine, healing, and knowledge throughout the therapeutic alliance. An MHP with a history of mental illness and trauma recovery may also believe in the availability of healing and the notion

that recovery is possible. These MHPs might also have fewer stigmatizing and judgmental thoughts and provide an educated stance for patient advocacy.

Benko (2018) and Fox et al. (1984) found that students rated therapists who practice SD as more attractive, likable, easygoing, responsible, flexible, cooperative, and mature than therapists who do not disclose. Undergraduates also rated MHPs who revealed previously experiencing similar symptoms to their clients as more sincere and warmer than therapists who did not disclose, that therapists who self-disclosed did not influence the perception of the therapist's ability to get along with or understand the client, no effect on the perception of the therapist's ability to attune to the patient's needs, and a more potent therapeutic relationship and anticipated a more favorable outcome in treatment (Somers et al., 2014). Although this study does provide some insight into the client perceptions of self-disclosing MHPs, how MHPs view the same disclosures has yet to be investigated, revealing a gap in the current literature (Benko, 2018).

Furthermore, there is a need for research into TSD of history with mental illness and how it may benefit the therapeutic alliance. The use of SD can increase trust between the MHP and the patient. Through SD, the MHP can present themselves in a humanistic and client-centered way to increase the bond and therapeutic alliance. These interactions are considered critical to the development of trust.

Trust and Vulnerability

Vulnerability is the basis of human connection. The foundation of vulnerability is the human willingness to own vulnerabilities and engage with the world from a place of acceptance within oneself and value one's worthiness (TED, 2012). Vulnerability is the bond that holds trust

together: trust in oneself and others. The rejection of vulnerability often comes from a place of fear. The patient may see the therapist as less than in the therapeutic alliance.

Brené (2012) defined vulnerability as emotional exposure to uncertainty and risk. SD is closely tied to vulnerability because each aspect presents a risk of luck in the outcomes. Like building a therapeutic alliance, vulnerability is based on boundaries and shared trust. Vulnerability, like SD, is about sharing feelings and experiences with others who have earned the right to hear them and help create trust.

Bottrill et al. (2010) discussed that a disclosing therapist and a patient receiving the disclosure might experience comparable feelings of vulnerability and openness. TSD can also decrease a patient's feelings of isolation and disconnection while increasing feelings of belonging and hope (Satterly, 2006). TSD may encourage clients to be more open and vulnerable and create a more intimate therapeutic alliance, as outlined in previous studies of progressive schools of thought (Knox & Hill, 2003). Therapists who respond to their patients' disclosures may assist with reframing negative experiences about how their own emotions and exposure might negatively impact the therapist and how a similar showing of vulnerability might be acknowledged by others (Simonds & Spokes, 2017). Trust and transparency are essential in the foundations of trauma-based therapy.

Self-Disclosure Ethics

Most of the studies did not delve into ethical details. Therefore, understanding the ethics of TSD is an important starting point for a more extensive discussion of the use of TSD (Danzer, 2019). Two discourses have developed from the previous literature on TSD. First, the ethics discourse renders disclosure as violating therapeutic boundaries and crossing the lines of patient and therapist roles. However, the previous studies were focused more on therapeutic efficacy and

less on the ethicality of SD as a boundary issue (Peterson, 2002). Second, discussions promote TSD as a practical therapeutic intervention, showing the importance of future research on TSD (Danzer, 2019).

Most MHPs, researchers, and theoreticians err on caution in favor of using TSD (Danzer, 2019). The therapist can SD or withhold personal information within the therapeutic alliance. The limitations of the current research should be examined regarding ethical implications related to SD. Recent research sought to identify moral questions regarding TSD. Many ethical concerns are connected to therapeutic boundaries between the therapist and the client, which should be defined using TSD. (Audet & Everall, 2010; Peterson, 2002; Smith & Fitzpatrick, 1995).

When used appropriately and considering the therapist's clinical intentions, SD can be viewed by the client or the governing body as boundary-crossing. A boundary crossing is a "departure from a commonly accepted practice that may or may not benefit the client" (Smith & Fitzpatrick, 1995, p. 500). A clear ethical boundary would be identified when the primary use of disclosure benefits the clinician's needs and risks serious harm to the client and the therapeutic process. Audet (2011), Knox and Hill (2003) raised concerns that too much SD may disrupt the boundaries of the professional relationship and cross over into a social one, distinguishing the therapeutic alliance. TSD conveys the MHP's humanity while developing rapport and trust with the patient. Even with strict ethical guidelines, TSD may still be appropriate (Danzer, 2019). The APA Code of Ethics (2022) has no clear definition or guidance on TSD, which is unhelpful in identifying ethical parameters surrounding TSD.

However, the APA did include SD under "promising and probably effective" therapeutic interventions (Ackerman et al., 2001, p. 495). Meanwhile, other studies reported positive effects on the therapeutic outcomes when the MHP uses SD (Barrett & Berman, 2001). The literature

suggested that the use of TSD and ethics move incrementally in a progressive forward direction and are increasingly recognized as a two-person therapeutic intervention with a neutral and professional component (Danzer, 2019). The therapeutic alliance moves from a historically secret subtlety to an uncharted level of vulnerability and intimacy using TSD (Bottrill et al., 2010). Therefore, along with concerns about the aspects, stories, and content of SD, the ethical trepidations pertain to degree and context.

Opposing views often counter the use of TSD as maleficence and that it crosses professional boundaries (Danzer, 2019). Thus, using TSD constitutes a dual relationship and should be avoided. The arguments against TSD suggest alternative interventions that MHPs should use to build a professional association with the patient, not a personal one. However, neither position is mutually exclusive. These views outline TSD as ethically appropriate and helpful, unethical and unhelpful, or a combination of both positive and negative. The context and practice relevance should be considered for reflection after determining if TSD is ethically appropriate.

One of the more critical aspects of TSD ethics is determining, before disclosing, that doing so is in the patient's best interest and is not a form of self-gratifying or self-indulgent behavior (Hill & Knox, 2002; Zur, 2010). Before using SD, it may be advantageous to reflect on how the disclosure may benefit the patient (D'Aniello & Nguyen, 2017). SD usage should be based on the MHP's understanding of the patient's previous history of personal connections and object relations (Ziv-Bieman & Shahar, 2016). There appears to be a fine distinction between what is helpful and potentially damaging regarding ethics. Therapists and patients diagnosed with PTSD should evaluate the reasons for SD.

Trauma and Therapist's Self-Disclosure

Trauma is a controversial topic, even among the mental health community. Much of the controversy is due to the definition variations, like TSD. Trauma is defined in the *Diagnostic and Statistical Manual of Mental Disorders* as exposure to actual or perceived death, serious injury, or sexual violation (APA, 2013). However, this definition leaves out trauma experienced from natural disasters and various forms of abuse, such as psychological, physical, and attachment. The broad definition also does not account for the complexity of abuse by those who may have authority or influence (Sanderson, 2011). However, it has been shown that traumatic events disrupt the internal balance, leading to lower self-esteem, confidence, and overall well-being, showing that trauma affects views of oneself (Friedman, 2015).

Trauma is prevalent in nearly half of all Americans. Friedman (2015) found that approximately 50% of Americans will be exposed to at least one of the following traumatic events in their lifetimes: physical or sexual assault, military combat, rape, industrial or vehicular accident, domestic violence, or natural disaster, making trauma and traumatic experiences an inevitable occurrence and product of life. Traumatic experiences can vary considerably from person to person. The outcome of many distinctive social and cultural factors and individual preferences can shape how a person processes and stores a traumatic experience.

The effects of trauma can produce intense emotional responses, including but not limited to extreme emotional instabilities, unhappiness, anxiety, depression, loneliness, anger, isolation, or irritability. Survivors may begin to question their environments. Visceral warning signs constantly bombard traumatized people, and to control these processes, they will become experts with their gut feelings and resort to numbing, which creates a disconnect between what is seen and what is felt (van der Kolk, 2014). Uhernik (2017) stated that the limbic system primarily

detects threats by interpreting sensory environmental data. Immediate SD can heighten or dull this awareness. These ecological cues can lead to hypo or hyperarousal states in the patient.

Prolonged trauma or repeated exposure to trauma can lead to the diagnosis of PTSD. High stress levels often lead to increased levels of cortisol, which results in decreased brain function and can affect the performance of the amygdala and hippocampus, often indicating a malfunction of the fear response and arousal (Gerhardt, 2004). This progression creates an internal environment where the survivor struggles with coping with extreme emotions and responses to trauma, resulting in avoidance. Some significant PTSD reactions are due to release, which can develop into a fear of attachments (Sanderson, 2013).

Seeking and maintaining a safe, healthy extension is universally hardwired into human beings (Ferentz, 2015). An individual's first attachment is with their primary caregiver. Attachment affects how someone self-regulates and develops into how they see the world. Passion occurs in communications with others through romantic or platonic relationships. Those who experience secure attachments will have few reports of worry and fear (Sanderson, 2013). The prominence of disordered passion and the prolonged expression of trauma-related disorders has a central role in the psychotherapy of these disorders, showing that the core of the treatment is in relationships within the treatment model (Chu, 2011). Validation of the survivors' emotions through TSD can assist with the patient's healing journey.

Post-Traumatic Stress Disorder and Therapist Self-Disclosure

Four symptoms are associated with PTSD: intrusive symptoms, avoidance symptoms, alterations in cognition and mood, and alterations in arousal. These symptoms present difficulties based on the patient's experience (Sanderson, 2013). Furthermore, this symptomology is often beyond the individual's conscious control. The symptoms can activate further and exacerbate the

PTSD responses. Intrusive components are the sign that is often activated during treatment. According to the *Diagnostic and Statistical Manual of Mental Disorders* (2013), the criteria for intrusive symptoms are as follows: intrusive distressing memories, recurrent distressing dreams, and dissociative reactions, such as flashbacks, loss of control of awareness of present surroundings, intense psychological distress, or exposure to internal or external cues that resemble the traumatic events. This hyperawareness and the presence of intrusive thoughts can lead to obsessions, which can exponentially agitate the individual (Tull, 2020). Those diagnosed with PTSD are often hyperaware of their environments, leading them to be attuned to their therapists.

In trauma-based treatments, the patient will likely be able to attune to the MHPs' suffering or affliction, mainly when the following occurs: the MHP is alongside the patient in a war zone or community of unrest, the MHP is outwardly declining in physical health, or the patient is outwardly progressively worsening in physical health (Danzer, 2019). The MHP often cannot remain entirely neutral in these circumstances. Pizer (2016) highlighted that the patient would not likely benefit from the therapist's refusal to acknowledge the obvious. In these situations, it would be expected for the MHP to move beyond the conservative choice of whether to disclose and would benefit from looking at the disclosure from a trauma-based lens, acknowledging that some forms of TSD could be ethically appropriate in the trauma-based treatment modalities. TSD in this arena would assist patients in being able to use introspection. Traumatized people chronically feel unsafe inside their bodies, making them uncomfortable with introspection (van der Kolk, 2014).

Rao and Mehra (2015) discussed their experiences as survivors and therapists who continued to practice during disasters, showing that MHPs felt a sense of duty not to abandon

their clients while using their own traumatic experiences to fuel their ability to assist others in traumatic situations. This sense of responsibility forms a bond between the therapist and the patient. The therapists' perception of the client and participation in the discussion of shared suffering assisted clients in progressing into a more profound sense of understanding. Broadbent (2013) found that therapists facing significant personal issues could form a deep connection with clients experiencing the same troubles. Adelman and Malawista (2013) presented a collection of essays on therapists who were either dying or working with dying clients, indicating a deeper connection and willingness to use TSD.

Pizer (2016) completed a psychoanalytic exploration of disclosing his blindness to his clients, outlining that initiating uncomfortable conversations with his patients about his blindness was difficult, which led to his motivation to explore TSD's usefulness. MHPs using TSD as a well-thought-out approach to grief, illness, and morality may assist the patient in addressing their anger, guilt, and abandonment while transitioning into personal issues of loss and reconnection. Pizer stated that disclosing a disability may significantly alter the treatment trajectory but can also assist the patient in growing their capacity for intimacy. Adelman and Malawista (2013) highlighted that using TSD in trauma brings awareness of fragility and unpredictability, which may bring the therapist closer to the patients' experience, showing TSDs being used ethically within a trauma-based treatment modality and forming a bond that furthers the healing journey.

Risks Versus Rewards

It is imperative to note that a therapist can no longer expect to remain completely anonymous in today's therapeutic arena. Even if the therapist has a limited online presence and lives a reclusive life, disclosure occurs through office pictures, décor, and how the MHP responds to patients' spontaneously asking personal questions in sessions (Daley, 2012). Watkins

(1990) reviewed over 200 studies identifying four central SD areas: disclosure of positive versus negative, sharing opinions about patient versus personal information sharing, conveyance of demographic data versus intimate personal details, and emotional reactions congruent to those of the patient versus different responses. Hill et al. (2018) examined seven subcategories of disclosure, reviewing biographical facts, feelings, insights, strategies the therapist has found to be effective in treatment, approval, challenges in the patient's thought process, and immediate thoughts or feelings within the therapeutic relationship to show how SD appears to have a more evident impact on the therapeutic relationship and MHPs' perceptions.

Even though the specifics of how SD is helpful are only sometimes consistent, it is a frequently used technique. Over 90% of practicing therapists will utilize SD during treatment (Henretty & Levitt, 2010). Therapists who continually implement SD are correlated with the patients liking them more (Barrett & Berman, 2001). Benko (2018) indicated that the MHP use of SD is associated with a patient rating the MHP as helpful, insightful, authentic, and human. Patients may also be willing to disclose their personal information to the MHP who uses SD due to feelings of deeper intimacy and connectedness, which leads to more research into the effectiveness of SD as a therapeutic approach (Benko, 2018; Henretty et al., 2014).

Henretty and Levitt (2010) noted that MHPs' SD does little to improve the patient's perception of the MHPs' trustworthiness, empathy, and overall esteem. Disclosure could even harm the client if a strong relationship does not exist between the MHP and the patient. Kelly and Rodriguez (2007) showed that SD had no impact or association with change in the working alliance between therapist and patient. SD has positive and negative results on the patient's perception of the therapeutic boundaries and the professionalism of the MHP, with an overall more positive outlook occurring when the disclosure is infrequent and limited in its intimacy

(Audet, 2011; Benko, 2018). So, while the previous research around SD may vary, the therapeutic relationship can benefit through MHPs' SD despite many unknown risks (Benko, 2018). TSD is a multifaceted and often complicated intervention with usage that is difficult to pinpoint (Pinto-Coelho et al., 2016). Nevertheless, there remains a variation in the previous studies surrounding non-immediate SD and its effectiveness in improving the therapeutic relationship in trauma-based therapy.

Therapist Self-Disclosure for Healing

When a therapist and a patient have similar personal issues, non-immediate disclosure may show boundaries and assist in developing a therapeutic alliance (Danzer, 2019). Building client rapport and creating a safe space to process their trauma is foundational for the therapeutic alliance. Therefore, shifting from a stoic and rigid approach and creating a warm, shared experience can lead to more remarkable healing. Nussbaum (2014) found equal amounts of positive and negative responses to disclosure, highlighting the unsettled view of TSD and its usage in the therapeutic alliance. The use of non-immediate SD is even less studied within trauma-focused care.

Summary

The effects of SD with clients have positive and negative impacts on the therapeutic alliance. The results of TSD on clients' perceptions of their therapists appear to be mixed. However, the most recent studies show that TSD is associated with an overall increase in positive perceptions of therapists regarding trust and warmth (Henretty & Levitt, 2010). In general, the research highlighted how well clients respond to disclosures made within the context of higher rapport and are seen by the clients as assisting with normalizing their experiences. Research also supported using TSD with clients who benefit from a levelized therapeutic balance

and would be necessary for specific groups. There are limited studies regarding the use of TSD within trauma-focused therapy. Furthermore, ethical literature suggested that TSD may be required for particular groups of clients, namely those with PTSD. Therefore, clients diagnosed with PTSD are more likely to undergo trauma-focused therapy.

Trauma-informed therapy is gaining popularity within the therapeutic community. Since COVID-19, immediate SD has been unavoidable as the treatment moved to telehealth. Nonimmediate SD has gained popularity due to the desire for human connection. Leveling the relationship between therapist and client shows the benefits of higher trust and openness within the therapeutic alliance. This use of non-immediate SD must be examined regarding trauma-based therapy and therapeutic outcomes.

Chapter Three: Methods

Overview

This qualitative case study examined the effects of non-immediate TSD on the therapeutic alliance. The existing research reviewed in Chapter Two included various circumstances in which SD can occur and types of disclosure to be considered for this study. Moreover, the issues around non-immediate SD are a heated topic among professionals (Bloomgarden & Mennuti, 2014; Ziv-Beiman, 2013; Zur, 2008). Overall, previous research resulted in mixed arguments for and against the impacts of non-immediate SD. Previous research indicated that non-immediate SD was predominately negative, and immediate SD consistently garnered more positive acceptance regarding the therapeutic relationship.

Some of the previous literature, including Knox and Hill (2001) and Henretty et al. (2014), suggested that the forms of SD could be less than therapeutic and seen as sharing personal experiences. In this context, SD could pertain to unresolved emotional issues for the therapist and not be used as a therapeutic technique to build rapport. This case study brought in the questions of ethics and the use of TSD regardless of timing. Other literature outlined that SD may be clinically helpful and productive in establishing a therapeutic relationship (Audet, 2011; Kelly & Rodriquez, 2007; Peterson, 2002). Some forms of non-immediate SD highlighted positively include modeling, empowering the patient by normalizing their experiences, and instilling hope (Buetler & Mitchell, 1981; Gelso, 2011). Therefore, the current studies on TSD and its various forms incited questions on the potential for therapeutic value and benefits. These studies show the importance of the need for additional and current research into this developing therapeutic technique and its impact on the therapeutic relationship. This study focused on non-immediate SD and its use within the therapeutic alliance.

Design

A qualitative case study design allows researchers to explore individuals and organizations by analyzing complex interventions, programs, and relationships. Qualitative research methods can cut across disciplines and locate the observers in the design. This qualitative case study focused on determining the how and why of the research questions. Therefore, the qualitative case study approach was appropriate for this study to view the topic through multiple lenses, allowing various facets of the study to be identified and understood. Qualitative researchers set out to understand the specifics of the research findings within an ever-changing world by capturing the individuals' point of view through an observation lens.

Two foundational researchers guide the case study methodology: Robert Stake and Robert Yin (2010). These researchers found interest in the topics well explored to identify the phenomenon's essence. Both researchers based their approaches on a constructivist paradigm. Constructivists argue that truth is relative and dependent on each person's perspective. Furthermore, constructivism is built upon the social construction of reality. One of the advantages of using this approach for this study was to create a close collaboration between the researcher and the participants while giving the participants the freedom to tell their stories. By identifying these stories, the researcher better understood the participant's actions and choices, especially regarding using TSD.

This study aimed to explain how TSD affects the therapeutic alliance; therefore, a case study approach was appropriate. The behavior of those in the survey cannot be manipulated. This case study aims to determine therapists' decisions and the factors influencing their choices. It would be difficult for this researcher to have a clear picture of the therapist's decision-making

without considering the context in which decisions occurred. Therefore, creating a therapist-only focus group would be beneficial for gathering information.

Researchers used an exploratory lens to answer questions regarding the causal links in real-life interventions that may be too complex for a survey and have no clear, single outcomes (Stake, 2010). Therefore, this study was designed as a multiple-case study, allowing the researcher to explore differences within the cases. The purpose of using a multiple-case study design was to replicate the findings from the study across similar research. The researcher examined the decisions that go into the therapists' choices regarding environment and working conditions by looking at TSD under different environments using a multiple-case study approach, which allowed room to analyze each case's context settings. The other lens used was an instrumental outlook, which is used to gain insight and understanding of the use of TSD.

Research Questions

RQ1: How do therapists develop therapeutic relationships with their clients through self-disclosure as a trauma-based approach?

RQ2: What types of non-immediate self-disclosure do therapists use during therapeutic sessions?

Setting

Participants were gathered locally, including five to seven licensed therapists in the southern United States. The therapists were given links for the online survey to allow their clients to complete. The researcher also provided the link to the Counseling Department students at Liberty University to share to gather outside sources outside of the southern United States. Participants completed the interview on time and were scheduled for the in-person or virtual interview portions. Participants completed the interviews in the location of their choosing.

Participants

The participants were adults aged 18-65 in therapy for two or more years. The participants were from the southern United States. There was no limitation for gender, social status, ethnicity, or educational background. Participants were selected using theoretical sampling. Theoretical sampling occurs after data is collected to identify research questions and topics and gather a smaller sample for interviewing (Rachel, n.d.). The researcher analyzed the data and interviewed the selected participants based on the data gathered. Theoretical sampling allowed the researcher to move back and forth between sampling, data collection, and analysis until the data reached saturation. The sample size ranged from five to 10 participants.

The focus group of therapists was gathered from professional contacts. The sample size ranged from five to 10 participants. The participants were collected using convenience sampling. Convenience sampling is a method of collection by taking samples that are conveniently located around the researcher (Edgar & Manz, 2017). The samples were gathered from licensed therapists in the southern United States. The researcher had access to all licensed therapists in Arkansas and other southern states.

Procedures

The researcher was approved by Liberty University's Institutional Review Board (IRB, see Appendix A). Once IRB consent was received, the researcher emailed therapists. Potential participants were screened using a demographic survey to be sure they met the participant selection criteria (see Appendices B and C). Based on the responses and results of the demographic study, five to 10 participants were selected for the initial interview. Participants were interviewed either by phone or by Zoom. The researcher confirmed during the discussions

that the participant was in a private area. No interviews were conducted without the participant's written and verbal consent.

Note-taking or memo writing was utilized throughout the study. Both memo writing and constant note-taking were utilized to compare analysis and assisted with minimizing bias because these activities were reflective. Memos reminded the researcher to review their thoughts and helped differentiate ideas or thoughts that might be imposed on their personal views versus the theory that emerged from the data. Memos included topics, such as concerns about the study, thoughts, impressions, reflections from interviews, and categories that developed.

The Researcher's Role

The researcher's role in this study was to be an observer. Qualitative researchers seek to identify and utilize the social location of the researcher. The researcher recognized how using SD in private practice has shaped their outlook, personal perspective, and worldview. The researcher interacted with the participants and identified self-awareness and reflexivity. The researcher acknowledged the development of the research questions, the methods used to observe the phenomena, and how they were filtered through the researchers' knowledge, language, core values, and worldview. Subjectivity was embraced rather than objectivity. The researcher must know how their worldview could influence this research.

Data Collection

The researcher utilized semi-structured interviews for data collection. An interview is part of the social interaction between the researcher and the participant. Three screening questions were asked at the beginning of the interviews to evaluate whether the participants met the eligibility criteria, followed by participation consent. The inclusion criteria for the study were as follows: (1) live in the southern United States, (2) are above the age of 18, and (3) have

actively attended therapy in the last two years. The interviews had three questions related to SD. The use of multiple data sources enhanced the data's credibility.

The researcher used existing materials and focused on gathering a rich understanding of the studied phenomena by examining current research, such as personal documents of session notes and memos. The data was collected by a computer and by hand. Each interview was transcribed. Participants signed a non-disclosure form.

Interviews

The researcher announced a call to current therapists practicing in the southern United States via social media or university outlets to share the study with a range of patients with multiple diagnoses to broaden the research. This call extended previous research levels of TSD within the context of the nature of the disclosure (Kim et al., 2003; Smith & Fitzpatrick, 1995). When potential participants reached out for the interview portion, the researcher provided an informed consent document for the interview portion via email or postal service based on their preference. The researcher required that participants return this consent before scheduling the interview appointment.

The interview consisted of two meetings with the participants. The first meeting was an in-depth interview on topics surrounding TSD experiences. If the therapist was the one who reached out to be a part of the survey, they were asked to discuss reasons for SD and the nature of the therapeutic relationship, especially the length of time the patient had been in therapy and the amount of time the therapist had been in practice. The interviews lasted no longer than 30 minutes and were followed by a shorter discussion within one to two weeks. These second interviews lasted between five and 15 minutes. Zoom, phone, or another secure video platform

compliant with the Health Insurance Portability and Accountability Act was utilized to conduct interviews.

The focus group met via Zoom. There were two focus group sessions with the chosen participants. The focus groups were limited to 30 minutes. The researcher monitored the groups, allowing the therapists to freely discuss the use of TSD and other topics related to trauma-informed care. The focus group sessions were videotaped and transcribed.

In the first part of the interviews, the researcher used a semi-structured format with open-ended questions surrounding the following topics: personal perspectives on SD, their own experiences with SD, clinical work, licensure, their boards' views towards SD, and their clinical disclosure regarding mental illness. These questions were geared to open dialogue with the participants. Additional questions were asked or omitted depending on the progression of the interviews. At the end of the interview, the researcher asked the therapist group to outline their clinical diagnosis or disorder types in which they have more disclosure, years of practice, and type of licensure.

The rationale behind the second follow-up interview was to enable the participants to self-disclose reflections brought to light during the initial consultation, allowing the researcher to ask any follow-up questions for clarification that might have resulted from the interview or survey. The follow-ups developed a richer body of qualitative data for the researcher to review, allowing more time to observe the participants' answers. The second interview also allowed the researcher to clear up any confusion in the participants' responses.

These are the standardized open-ended semi-structured interview questions that were asked of participants.

1. Describe your experiences with therapy treatment and which trauma-based therapy you have received: DBT, EMDR, ERP, somatic experiencing, or other?
2. Ideally, the therapist would only use SD to strengthen the therapeutic bond. Has a therapist ever used SD during sessions? How did you feel about the SD?
3. What are some forms of non-immediate SD that you have encountered or used?
4. Thinking about the last time a therapist disclosed something personal, did it change how you viewed the therapist?

Each query was a knowledge question designed as a follow-up to their therapist's trauma-based treatment and overview. Knowledge questions are intended to be relatively straightforward and non-threatening and help develop rapport between the participant and researcher. The questions were adjusted as necessary for each participant based on the data included in each timeline. These questions allowed the participants to begin to outline their therapeutic experiences.

Question one discussed trauma therapy, allowing participants to share about their therapeutic alliances. This question enabled the researcher to gather more information about types of trauma-based treatments. Questions two and four invited the participants to reflect on their therapeutic history and experiences with SD in treatment. Question three was designed to develop categories of non-immediate SD used in treatment.

Question four was the first question that required a relatively high degree of vulnerability, so the researcher waited until the interview was underway to bring it up. Ideally, a good rapport was established by this time in the discussion. This question prompted the participants to develop their feelings toward SD and open dialogue about the impact on their treatment.

Demographic Questionnaire

Participants provided basic demographic information, including age, gender, race, and highest year of education. The participants not in the therapy professional sample group reported the number of years in therapy and choices of trauma-based therapeutic modalities, such as EMDR, ERP, and CBT. For the mental health professional sample group, participants were asked to provide information regarding the type of degrees, license status, year in practice, trauma-based training, type of treatment populations, and estimated hours they engage directly with clients in a week. The Demographic Questionnaires are in Appendices B and C.

Document Analysis

The interviews and questionnaires were kept in a locked personal file cabinet. The interviews were taped via Zoom, and the researcher received permission to film before the discussion. The Demographic Questionnaires were printed and kept for validation. Each interview was recorded and then transcribed by a software called Grain. The participants were asked for verbal and written consent to be interviewed before continuing the discussions.

Data Analysis

The coding of transcripts was completed in the same order as the interviews, which allowed the researcher to reflect and edit the interview questions as different theories emerged from the collected data. The researcher used coding to aid in identifying and understanding the perspectives of the participants and in analyzing the combined experiences with other participants. Codes were created throughout the research process to organize and analyze the data collected and to develop themes. Coding the interview transcripts allowed the researcher to break them into meaningful and manageable data, becoming a critical part of the data analysis.

Researchers utilize coding to prevent overemphasizing any aspect early in the study and ensure an accurate analysis of the entire interview (Stake, 2010).

The researcher utilized selective and theoretical coding. Charmaz (2006) stated that theoretical sampling and coding begin after categories in the research have emerged. Selective coding describes the process when codes relate to the essential core categories that start to develop throughout the study (Urquhart, 2013). A single selective code frequently becomes the theoretical code within the selective coding process. Furthermore, Birks and Mills (2011) believed theoretical sampling could begin during open coding when the initial data starts to unlock concepts that develop into potential theories or explanations of the researched phenomenon. Open coding allowed the researcher to go in-depth in every interview and use a few words to describe the data.

The researcher utilized theoretical coding to recognize categories, themes, and patterns that emerged during selective coding. Relationships between the themes identified the emerging theory or phenomenon. The use of memos facilitated constant comparative analysis. The researcher utilized a computer-assisted qualitative data analysis software, NVivo, to manage and analyze data. The software is designed to use query keywords for comparison along with manually coded categories and patterns. NVivo will not be used as the primary coding source but only in solidifying the data analysis.

Trustworthiness

Trustworthiness refers to the degree of confidence in the data and methods used and the interpretation of the quality of this study (Polit & Beck, 2014). In this study, the researcher established protocols and procedures to ensure the quality of the study by using two methods to collect data, with a follow-up interview to collect additional data and clarify information.

Researchers should establish safe and effective protocols and procedures for the study to be considered worthy of consideration by readers (Amankwaa, 2016). Since 2020, there has been a piqued interest in how therapy is conducted. Researchers are moving SD from taboo to the norm. Therapists and patients alike would benefit from understanding the use of TSD and its impacts. To increase trustworthiness, the researcher included direct quotes and had prolonged engagement with the participants through two interviews while ensuring the confidentiality of the participants. The research was reviewed by faculty members of Liberty University and the dissertation chair to ensure the study's validity.

Credibility

The credibility or confidence in the truth of the study is an important aspect connected to the internal validity of the research (Polit & Beck, 2014). The reader may ask whether this study was conducted using standard procedures. Consequently, this study aimed to answer that question with a resounding yes. The researcher addressed the study's credibility via prolonged participant engagement and peer debriefing. The researcher utilized two interviews to assist with examining the data several times to resolve any gaps in the research. Prolonged engagement was performed by meeting the participants in their native culture or the everyday world. The interviews were held via Zoom, allowing the participants to be in a relaxed and chosen environment, which assisted the researcher in identifying behavior and values within the participants' personal views.

Dependability and Confirmability

Dependability refers to the stability of the research and data over time and is relative to the conditions of the study (Polit & Beck, 2014). The researcher used a process log to maintain dependability, noting all the activities during the interviews. These activities focused on where

the participants chose for their interviews and the choice of trauma-based treatments. Confirmability is the degree to which the findings can be repeated. The researcher's methods to address this would be keeping detailed notes of all the decisions and analyses as the study progressed. The dissertation chair reviewed these notes to prevent biases.

Transferability

Understanding the results of this study may help others comprehend why and how SD happens. Transferability allows for temporary understanding. There are no absolute answers for the situations; everyone must determine their best practices. The readers must determine how applicable the findings from this study are to their positions (Polit & Beck, 2014). This study provided direction about the points readers may want to consider. Therefore, this study did not generalize the findings. Transferability allows the reader to develop their own opinion of applying the results outside of the contexts of this research design.

Ethical Considerations

The researcher stored the data in a locked filing cabinet. The electronic files were password-protected and saved under pseudonyms. The researcher assigned each participant a code to ensure anonymity. The recorded interviews were held in a password-protected Zoom profile, moved to a flash drive, and stored in a locked filing cabinet. Participants signed consent forms before completing the video interview portion. All participants were over 18 years old and met the set forth criteria of the study.

Meeting these criteria qualified participants for the study. The risks to human subjects during this study were minimal. All recorded material will be erased after five years, minimizing any future risks related to confidentiality and maintaining the integrity of the study. The screening questions that were asked before the scheduling of the interviews were geared toward

demographic identification. These questions covered disorders and clinical diagnosis, years in therapy, gender identities, and racial or ethnic labels. The researcher included these demographic questions to confirm that the current research does not commit the ethical errors of excluding populations or failing to document age group ranges and diversity.

Summary

Chapters 1 through 3 outlined the reason and purpose of this study. Chapter 1 introduced the information and rationale behind the study by stating the Problem and Purpose Statements. Chapter 1 included the Research Questions. Chapter 2 highlighted the past research conducted on SD. The goal of Chapter 3 was to outline the research methods used to address the research questions. This chapter outlined the Procedures, Participants, Criteria, Data Collection Methodology, Interview Questions, Ethical Considerations, and Data Analysis Procedures. The Theory and Research Questions were outlined. All matters related to Transferability, Trustworthiness, and Credibility were discussed.

Chapter Four: Findings

Overview

Over three months, the researcher gathered data from individuals and two focus groups of therapists. This data is presented in Chapter Four, along with the analysis conducted. The analysis steps were thought out and carefully constructed to establish congruence and validity to the study. This chapter is comprised of the results collected from the grounded theory case study conducted to answer the following research questions:

RQ1: How do therapists develop therapeutic relationships with their clients through self-disclosure as a trauma-based approach?

RQ2: What types of non-immediate self-disclosure do therapists use during therapeutic sessions?

This chapter also includes discussions presenting how the analysis was consistent with grounded theory methodology and how the current analysis correlates to the research questions. Furthermore, demographics and tables are included to present the summary and findings. The process used by the researcher to analyze transcripts from the six individual interviews and two therapist focus groups is detailed in this chapter, along with themes discovered throughout the data collection process. There were subsequently three levels of analysis conducted: (1) open coding, (2) selective coding, and (3) theoretical coding. During each level of coding and analysis, the researcher continued comparing the data until the final themes developed from the data set. Graphics and vignettes from individual and group interviews highlight vital themes, subthemes, and research questions.

Participants

Six individual participants were interviewed for this study. Two therapist focus groups with three to five participants were conducted. The sample represents two therapist licensure professions, with three (60%) licensed professional counselors and two (40%) licensed clinical social workers. The years in the profession varied among the five therapist participants sampled.

Those participants with over 10 years of experience represented 90% of the sample size. Those with less than 10 years of experience represented 10% of the sample size. Age ranges among the therapists were represented, with 60% falling within the 40-50 range, 20% within the 55 and older range, and 20% within the 30-40 range. Therapist gender was represented as 80% female and 20% male. The most widely used trauma-based approach was EMDR, with 80% and the remaining 20% identifying as retired and no longer in practice. Of the five therapists interviewed, four are currently in private practice in a clinical practice working with children at the beginning of their licensure. All demographic information about the therapists can be found in Appendix D.

Within the individual group sample size of six participants, age ranges and number of years in therapy were broken down. Four participants, or 80% of the sample size, were 25-40. The remaining two participants were in the 50-60 age range, accounting for 20% of the sample. Years in therapy varied among the individual participants: two participants were in therapy for two to five years (33.3%), two participants identified being in therapy for five to 10 years (33.3%), and two participants were in therapy for 11-23 years (33.3%). Among the individuals interviewed, 100% were female and self-identified as White; two participants (33.3%) had completed graduate degrees, two (33.3%) had completed college-level courses or degrees, and two participants (33.3%) had high school diplomas. Four different trauma-based approaches

were identified among individual participants, with 33.3% undergoing EMDR, 33.3% with DBT, 16.6% Art therapy, and 16.6% using CBT. All individual participants shared their race information, identifying as non-Hispanic White. All demographic information about the individuals can be found in Appendix E.

Data Collection

The primary data was collected from the six individual interviews with six follow-up interviews and the two therapist focus groups. The demographic questionnaires were created to support the research data and notes taken from the interviews. After the first six initial interviews, the data collected was coded in the same order in which each interview was conducted to review emerging themes to assist the researcher in identifying follow-up questions for the next set of interviews. The researcher guaranteed that grounded theory was rooted throughout the data gathering of the research development by following this method. The interview protocol and initial questions did not change throughout the process (see Appendix F). The subsequent follow-up questions for individuals did change and are provided in Appendix G.

Data Analysis Process

All interviews were coded manually during open coding by reviewing each line of the transcripts. The first set of codes were analyzed in three batches, allowing time between analysis before moving forward. The researcher coded the three batches and analyzed each for categories and themes. Clarifying questions were added to the interview method following the conclusion of the first set of six interviews. These were included in the second batch, also labeled follow-up. These additional questions from open coding are listed in Appendix G.

The researcher recorded and transcribed each interview using Grain software with Zoom. The transcripts were then uploaded into the NVivo13 software for coding and analysis. The

individual interviews were initially manually coded, followed by using the software to discover themes. All six interviews, six follow-up interviews, and the two therapist focus groups aided the continual comparative analysis techniques essential to the grounded theory methodology.

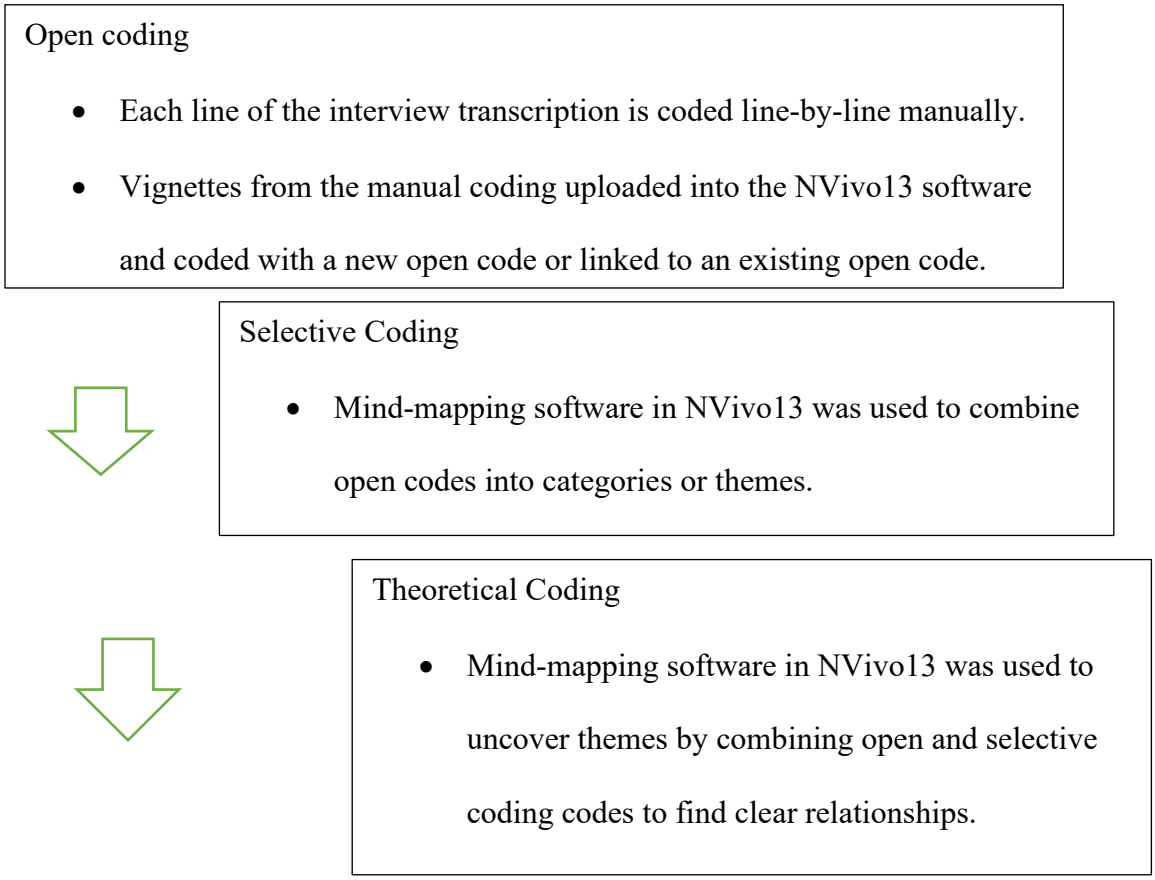
Using this case study approach, the researcher consistently outlined critical points during the coding process. The initial open coding results from the two therapist focus groups resulted in 36 themes from manual coding, as shown in Appendix H, highlighting the themes developed in the initial stages of the analysis process. These themes were essential in understanding the therapists' point of view within the study. Keeping the codes for therapists and individuals assisted in analyzing the differences between the groups.

The initial open coding results from the 12 interviews, comprised of the six initial and six follow-up interviews, resulted in 11 themes and are shown in Appendix I. These themes were unique to the individual participants in the study and showed common ideas and beliefs between the individual participants. The individuals in the research study shared their experiences with different therapists and therapy techniques.

The next step in the analysis process was selective coding. In this step, the researcher explored the initial themes to uncover categories or subthemes that developed from the similarities found in the open coding. All the vignettes and the open codes were mapped into a mind map using the mind-mapping software within NVivo13. Figure 1 outlines the summary of the data and the analysis process used for each step. The three data and analysis processes were open, selective, and theoretical coding.

Figure 1

Data and Analysis Process



Theme Development

The NVivo13 software provides word count queries and source code data, which allows the researcher to discover themes within the data set. The researcher's combination of the codes into themes permitted the depth and quality of the data to be examined. Grouping the initial codes into themes assisted in addressing the research questions. For the study, the researcher defined depth and quality as having five or more codes assigned to a theme, extending the theoretical coding from relationships within and across the open and selective coding. Relationships and connections were analyzed using sunbursts within mind-mapping software in NVivo13. The researcher built the mind maps or sunbursts, allowing each vignette to be linked

to a code and reviewed for significant relationships with other themes. Appendices J and K include the sunbursts for each subset of participants.

Some questions arose during initial interviews and were asked of some participants and not of others. Constant comparison between the individual interviews was exerted to ensure that any additional weight or bias was not added on a per-code basis. Utilizing note-taking during each interview allowed the constant comparison between cases. For example, every participant was asked questions about TSD and how they experienced non-immediate SD; however, not everyone was asked about using SD in trauma therapy. This question was only asked of those currently in trauma-based therapy because some participants identified in their interviews that they were not presently in trauma-based therapy. There were three distinctions within the selective codes: individual themes, therapist themes, and individual and therapist-dependent themes.

NVivo Analysis Results

A word frequency query was conducted using NVivo on the individual and therapist focus group interviews following the manual coding to check for any additional themes. Word frequency queries were performed at different ranges to see if any differences existed between the groups regarding queries that search for the same word, similar word groups, and frequency between the groups. Table 1 includes the results from the word frequency query. The word query search resulted in modifiers after excluding the word like and the researcher's name. The word know was the most frequently referenced word type in the query search for similar word groups, with it being said 513 times. The word therapist was the second most frequently used word, mentioned 298 times. The third most frequently used word, self, was used 253 times. The fourth most frequently used word, feel, was used 211 times. The last frequently used word, disclosure,

was referenced 209 times. Fifteen selective codes emerged from the manual coding and NVivo analysis, as shown in Table 2.

Table 1

NVivo Word Query

Exact	Between	Similar
Know	Know	Think
Therapist	Therapist	Therapy
Self	Like	People
Feel	Really	Want
Disclosure	Disclosure	Trauma

Table 2

Selective Coding Results

Individual	Therapist	Individual and Therapist
Experiences	Boundaries	Boundaries within Trauma-focused
Immediate SD	Changing views on TSD	
Non-immediate SD	Licensure/Teachings	
View of Therapist	Types of NISD used	
Therapeutic Bond	Therapist views on SD	
Therapist Bios	Trauma and TSD	
Trauma		
Vulnerability		

Individual Themes

A listing of the selective individual codes is located in Appendix L. Appendix M contains a sunburst of the selective individual codes.

Theme 1: Experiences

The word experiences was used as an umbrella term in this dissertation to include both positive and negative experiences identified by the individuals. This theme outlined the individuals' feelings and emotions towards TSD. All of the participants mentioned experiencing

TSD of some kind. Specific participants mentioned both positive and negative aspects depending on the situation and the therapist. Therefore, the umbrella term of experiences was appropriate.

Most of the individuals identified positive aspects of TSD. Three individuals were particularly enthusiastic about sharing their positive experiences with TSD. Each individual discussed and identified feeling validated when a therapist positively uses SD. The individuals identified that the sessions felt more like a conversation and less like a sterile doctor's office visit. Participants could point out the positive usage of TSD, stating it made the therapist feel more human and less robotic. The individuals discussed how therapy could feel unresponsive, and sometimes they feel lost within the therapeutic journey until their therapist used SD to relate to them.

When asked about trust towards a therapist who uses SD, two individuals had very positive experiences to discuss. These two individuals identified feeling increased levels of trust towards their therapist. One participant (DG) felt relief whenever her therapist could "drop the mask" and stated, "I know it's genuine and honest, not just blowing smoke."

There were examples of how TSD harmed some individuals. Four participants shared further details as to why they had negative experiences. All participants were no longer with the therapists they had negative experiences with and had moved on to new therapists. Multiple participants found their former therapists on Psychology Today, and one participant (KR) had the following to say:

> Our sessions were based on her experiences. It wouldn't just be like, you know, I've been through this, and there's a way out. It was more like a ping pong back and forth where it was both of us trying to get help for our situations. It turned me off therapy completely for a bit. Just because I felt like I was paying her to talk about herself with that therapist, I

> never really got anything off my chest. You know, I would say one point, and then it would immediately be a five-minute of her discussing her own issues.

Another individual (MJ) identified a negative experience due to the small town and college environment she was in at the time. The individual discussed how her college therapist was the only one she knew and their own relationships within the community. This participant stated:

> I felt like I couldn't say everything I felt because I realized she [the therapist] had a relationship with my ex-boyfriend, and it was a positive one. I didn't want to harm that because I respected my ex, and I didn't want to affect how she saw him since they often interacted. That kind of negative self-disclosure that I got from her really felt ineffective and made me feel uncomfortable.

Another individual (SF) discussed in length having a very negative experience with a psychiatrist. Although the researcher did not include this degree in the data collection, it felt essential to identify this negative experience concerning TSD. This participant went on to discuss the following:

> It was just a red flag from the beginning, but I was in crisis, and he told me how good he was and how he helped so many people. It was like he suffered from a God complex. He continued to tell me he didn't need my money, and he was so amazing and had checks he never cashed in his desk. I had another therapist who was going through a divorce, and she disclosed her financial trouble, and she would say you know you could sell stuff online. I had just rehomed myself with a friend, and everything I owned was in storage. And I'm living on a couch, and it was just something I didn't feel comfortable with discussing, and it was just very strange.

Theme 2: Self-Disclosure

Most of the participants were unaware of the definition of SD. Participants initially hesitated to discuss SD due to the lack of knowledge surrounding the topic. The researcher discussed the two different forms of SD with each participant. The participants were open to learning about the forms and could identify ways they had experienced each. The participants' responses mainly were on understanding TSD. The participants expressed excitement about learning about SD. The second individual participant (KR) interviewed emphasized feeling more apt to speak for the use of TSD:

> It's something that I could advocate for, like, with people that I'm encouraging to seek therapy. Whenever I'm talking about my therapist, it's something that I'll include to look for making the therapist more relatable…that I like about my therapist or what you might consider looking for in another therapist.

Another participant identified after the first interview that her views on SD were positive. The third individual participant found TSD to be helpful now that she understood what it was. This participant pointed out positive ways TSD has changed her view on therapy.

The two forms of SD were discussed with each individual participant, emphasizing their experiences with non-immediate SD. Many participants expressed positive and negative experiences with both forms of SD. Immediate SD was discussed and defined with each participant.

Theme 3: Immediate Self-Disclosure

Many participants were unaware of the immediate SD as a form of SD. Multiple individual participants discussed color schemes, decorations, and the wardrobe choices of their therapists. Some participants spoke about their preference for particular office décor and how

using immediate SD was comforting. The third individual participant (DG) interviewed spoke directly about her therapist's office and his use of immediate SD:

> Well, there's the thing: I'm very particular about my surroundings like things have caused me a lot of anxiety, but surroundings that shouldn't be there really activate my OCD. So, like, there was my first therapist, and when we started, there was a sand tray, and it always drove me nuts because there was sand everywhere. I couldn't concentrate, and we ended up having to switch rooms. My therapist now will let me know if there are any changes in the room before sessions. They also have a lot of pillows, and for some reason, it kind of helps me feel like I'm safe and shielded.

Other participants were asked about their views on immediate SD and how a therapist presents themselves, which affects their impression of the therapist. The researcher asked specifically about virtual therapy versus in-office therapy at the start of COVID-19, as the versions of immediate SD were affected. The second individual interviewed identified immediate SD with how therapists dress and present themselves. The fourth individual participant pointed out how COVID-19 caused changes in where the therapy was held. Most participants discussed being in the therapists' homes for telehealth appointments on Zoom due to therapy moving from office spaces to the therapists' personal spaces. The individuals identified that a different level of intimacy was developed during this change, and the details of immediate SD made them feel closer to their therapists during isolation.

Most participants stated they paid more attention to immediate SD and felt more at ease with their surroundings. The participants felt more comfortable with immediate SD, stating it feels warm and homey, and the ability to SD without verbalizing made them feel seen and valued. The fifth participant (SF) went in-depth, saying:

> With this current therapist, they are very important because they really don't know much about you, and as you build a relationship, you know more. My current therapist immediately made me feel comfortable with her surroundings and how she dresses. Always beautiful, just inside and out, and a salt lamp with essential oils. I knew we would connect.

Theme 4: Non-Immediate Self-Disclosure

Participants spoke about having experiences with non-immediate SD in different ways. Each individual participant discussed how this form of SD affected them and their views on therapy. The first individual participant (JR) discussed that her main goals for therapy were grief-related. She stated:

> There have been times where, like, my main reason for going to therapy is grief. My therapist has been through similar situations, and [in] some conversations, she'll bring up her past experiences. When she does this, I feel validated. Another time, I was having a bad time around the anniversary of my mom's death. But I wasn't like fully thinking about the fact that you know, it's been two years since she passed. I was just crying all the time and went to therapy, and my therapist validated my feelings and said she had been through the same thing.

The second participant (KR) directly stated that a therapist using SD to relate positively affected her by making the therapist feel human. The participants identified feeling relatable to their therapist when they expressed experiencing the same emotions or issues as the participants.

Most participants were unaware of non-immediate SD in previous therapy sessions. They discussed how they felt connected to their therapist when the researcher gave the definition and examples of non-immediate SD. The fourth participant (SC) stated:

> Me and my mom don't see eye to eye, and you know therapy isn't easy. I don't care what anyone says; you don't want to go to therapy. You go into that hour, and you're going to work, and a lot of times, you're not going to come out feeling any better than you did coming in because you just pulled all this stuff out of you. I didn't really want to talk about it, but my current therapist makes me talk about it in a way where you know you have to; you just need to. So, my therapist just helped me reframe and said: "You know I understand where you are coming from because I also struggle with my relationship with my mother." That was helpful. I felt seen, heard, [and] supported.

The third participant (DG) was quick to add that her therapist has used non-immediate SD, but it felt normal:

> There are things that I know about my therapist's life. Examples like, I know she's been divorced and that she has kids, and she will let me know if a kid is sick or something if we have to reschedule. There's never been more than that. Never been a line crossed; it's always been therapeutic. I know that when she [the therapist] uses self-disclosure, it's genuine and honest and not something more than just a connection to being human.

Participants also discussed how the non-immediate SD of their therapists' lives felt like it normalized the experience. They each identified appreciating the openness of their therapists in different ways. The fifth participant (SF) highlighted:

> I really appreciated that sometimes her kids or her pets would get in the video. My pets would also interrupt the video, and it was just nice to see that we both struggle with that aspect of life. I felt like those moments made me realize how human we both are and how my struggles are not far off from others.

Subtheme 1: View of Therapist

The participants spoke about how negative and positive experiences shaped their views. This vignette is related to both views of therapy and the views of the therapist. Most participants discussed TSD's impact on their views of a therapist after learning about the forms of SD. The participants outlined how their views of therapy have changed over the years regarding connection and the therapeutic relationship. The participants identified being able to connect with their therapists who have been in their shoes or can directly relate. By using SD this way, the participants felt more hopeful about their journeys.

Some participants talked about how their vulnerability levels depended on the TSD levels. The first participant (JR) stated:

> When a therapist is willing to be more vulnerable with me, it makes me feel more comfortable to talk about things that are harder to bring out. For example, with my current therapist, I think her level of self-disclosure has helped me feel a lot more comfortable and see her as more of a friend rather than a scary therapist. It kind of takes the fear out of it a little bit.

Other participants reflected on their experiences and views of their therapists after the first set of interviews. These individual participants were interviewed two to three weeks after the first interview, which allowed them time to discuss with their therapist if they wanted to and gave them time to process their experiences. In the follow-up interviews, many participants discussed how their views of therapy had changed. The participants echoed each other with the belief that their current therapists' usage of SD changed their view of the relationship in a positive way.

Subtheme 2: Therapeutic Bond

One therapeutic bond theme was a relationship with more than five vignettes. Additional open codes were bond with the therapist, TSD's effect on bond, and the selective code of trust in the therapist. One of the ways a participant expressed their therapeutic relationship was through the discussion of validating feelings. The first individual (JR) discussed her grief journey, and the therapist used TSD to validate her feelings:

> I feel like it strengthened our bond because I've always known we've been able to relate on certain levels. But, you know, it felt like a human connection instead of a business transaction. All in all, I feel it's been helpful because it makes you feel less alone when other people have experienced similar things as you, even if they're not similar situations that they've experienced.

Other participants articulated how TSD impacted their views of the therapeutic bond. One participant talked about how their therapist is personable, and when her therapist uses SD meaningfully, it gives her more confidence in the therapist's abilities by bringing them into a relatable partnership. The second participant (KR) discussed:

> I think it positively impacts our relationship. My therapist is more relatable. To know that you go to therapy and think these people are like have it all together and their life is perfect. But knowing the therapist has experienced the different things that I have just brings them down to [a] more conversational level.

Other participants were open about discussing how their current therapists use SD by referencing how their sharing about a similar situation made them feel less alone. One participant suggested that TSD has helped her understand her own emotions. The third participant (DG) stated:

> She [therapist] knows what she's doing. Basically, she will, you know, she might say something, but she'll never make an experience in her life seem like it's either more important than the problem I'm facing right now. Just like the other day, I had a panic attack for the first time ever during [a] session. I was just at that point where my mother had just had serious surgery, and I'm scared to death of losing my folks. I don't have anyone, and I started to get activated. She [the therapist] was able to teach me the depths within myself and sat with me instead of trying to turn it into something else. She [my therapist] literally had me dancing by the time the session was over because she said I wasn't alone, and she understood my emotions.

Participants were asked about their trust in their therapists and comfort within the therapeutic relationship. Concerning trust in the therapist and how the participants viewed their relationship with their therapists, the fourth participant (SC) shared:

> Really implicit trust, and she doesn't overshare. My previous therapist would overshare, and you know [like in] the movie *Overboard* with Goldie Hawn? That part in the movie when they get her back on the boat, and she's all rich again, and the husband is complaining, and the mama says we are not here for your therapy. That's something I say often to my therapist when I get off on whatever subject.

Some participants talked about their beliefs in their therapists' capabilities regarding connection. Most participants felt more at ease with a therapist who uses SD within boundaries. The second participant (KR) described her relationship with her current therapist as:

> [TSD] makes it more like an intimate relationship; you know what I mean? More in-depth conversation with your therapist because you're having to let them in where you don't normally let people in, and you have to have that confidence in them. So, you're

> having to work through that, and so, to me, that's where it's going to help strengthen the bond because you're having to come past all these hurdles with one another.

Subtheme 3: Therapist Bios

After the first set of interviews, a new theme emerged. The researcher discussed TSD in their bios with each participant to ascertain their views. Most participants supported therapists using some form of SD in their profiles. One participant expressed support for the therapist using SD in bios. Participants discussed how it would be easier to choose a therapist who is a good fit. By having small disclosures in their bios, individuals felt like the therapist would understand them better and where they are coming from if they have specific experiences.

Another participant expressed the importance of finding a therapist who meets personal needs. This participant pointed out how some people may hesitate to ask the necessary questions. The third participant (DG) discussed:

> I could see how it would be beneficial for people in the world who are hesitant to call somewhere. After working in the field, I understand that most people don't like to put themselves out there in that vulnerable situation. They would prefer to be able to do research on their own. So, I can see how [bios] would be beneficial for people as a whole. Doing so within a limit: not too much information but also making sure it's enough. I feel like if it were streamlined [and] bullet-pointed, it would be helpful.

One participant was indecisive about TSD in bios. The participant discussed fears about finding out too much about a therapist before building a therapeutic relationship. The sixth participant (MJ) stated:

> I think personally, if they did self-disclose in their bios, I don't know if they would, and I honestly don't know how I would feel about that. I think that would be mixed because

> this person has personal experience, so [that] they can relate, but this is my therapist, and do I really need to know that they are a survivor? If I read that they've gone through things that I've gone through, it might make me almost scared to see them because I don't want to get back in the same situation.

One participant discussed how her current therapist already uses SD on their website and how she found it helpful when she was looking for a therapist. The fifth participant (SF) stated:

> Things to look for on my therapist's website it tells you the methods and stuff that she utilizes. I remember looking back on my previous therapist's personal page, and I don't remember seeing any of that stuff…I can tell you what they specialized in, but that was it. I liked my new therapist having methods and [a] short bio, specifically on her website.

Some participants discussed how SD in bios would be helpful regarding trauma therapy. The first participant discussed how therapists typically have a generic bio, which all sound the same. This participant discussed how the generic profiles lack empathy. The fourth participant (SC) identified:

> I feel like therapist self-disclosing in their bios adds a personal touch and makes me more willing to reach out, especially within trauma therapy. I'd be more willing if somebody put more than just a generic "I want to help people" stuff and would give an extra level of empathy.

Subtheme 4:Trauma

The theme trauma had four vignettes. Some of the vignettes were related to trauma therapy, and some vignettes pertained to trauma related to reasons for TSD in therapy. One participant discussed their current therapist using SD to normalize their emotions during a traumatic event. The third participant (DG) stated:

> When something drastic happens next, and it was like this big thing that caused a lot of stress and emotions, I could not hold it together. I thought I had gotten worse because I could not hold it together. I couldn't stop crying, being angry. I couldn't function outside of being upset. I made an emergency session with my current therapist. He immediately was like this is okay; this is normal. It's okay to not be okay sometimes. I [my therapist] also have days where I can't function.

Besides normalizing emotions, other participants discussed how trauma led them to their current therapists and how their therapists handled their trauma work. Participants discussed how trauma therapy had assisted them in moving forward in their therapeutic journeys. One participant enthusiastically relayed a story about her therapist, who uses SD, creating a healing space for her to address a trauma she had been reluctant to address before in therapy. The second participant (KR) shared:

> I was just so shaken up, and it was the next week's therapy session. My current therapist gave me clay because I was very fidgety. So, as I talked, I just worked the clay in my hands while I was telling her the trauma I had experienced. After a while, she was like, "Stop [and] look at your hand." I had made a rose. I had made it with the clay without even realizing it. She [my therapist] said take a moment and recognize this is something you did. Then she said you can either save it or keep working with it. I was in such a place of trauma always happening, and like the rose, it had so many layers to it, which represented all these walls that were being built up to protect the inside. She [my therapist] told me that I created that beautiful piece from my trauma and that she, too, had been able to use art as a healing space, and it was really empowering to share that space with her.

Other participants were able to identify how the positive and therapeutic use of TSD empowered them to make more progress. Most participants were in trauma therapy and addressed it using EMDR or DBT. One participant identified making more progress in the last year and a half than they had ever made with any other therapist.

Another participant discussed how it felt less alone for her current therapist to use SD during sessions. All participants felt less alone and more connected when SD was used within boundaries. One participant shared more about how TSD has helped her move forward within trauma-based therapy. The fifth participant (SF) stated:

> We're in the trenches. We've all been in the trenches. Some of us had better trenches, and you were never taught to dig a trench. You were taught to just lay there and take the fire. My current therapist gets in the trench with me. She doesn't let me take the fire alone and helps me build defenses.

Theme 5: Vulnerability

The theme of vulnerability is related to openness, trust, and connection. Vulnerability was discussed by each individual participant while exploring their views of vulnerability regarding a therapist using SD during the therapeutic relationship. A sharing of vulnerability was discussed as being a part of the therapeutic relationship. There are two general ways that participants described vulnerability. One way was their personal vulnerability. The other was the vulnerability of the therapist. One participant pointed out how levels of vulnerability affect her experience, identifying that she is being vulnerable with her therapist, and the therapist is not as vulnerable as her; therefore, the therapist maintained a professional disposition, which allowed the participant to see the human in her.

Another participant described vulnerability in both immediate and non-immediate examples of SD. The second participant discussed that being in the office space presented vulnerability. The participant identified that having personal items in the office is also a vulnerability for a therapist because they put small pieces of themselves out there for judgment or acceptance without saying anything.

The other aspects of vulnerability explored were how the connection with the therapist affects their own levels of vulnerability. Whereas, if a therapist negatively were to SD, how would that impact the individuals' view of the therapist? Most participants identified that the negative experiences changed their views of that therapist and therapy. The sixth participant (MJ) stated:

> I guess sometimes positively and sometimes negatively. So, positively, I do feel like we're a team working towards goals for me, and that makes me want to share more and be more vulnerable. When I had that negative experience, it left a bad taste in my mouth about therapy, so I was closed off for a while.

Another participant pointed out how each individual has different experiences with therapy. This participant discussed how their level of vulnerability positively impacts their experience. The fourth participant discussed her connection to her therapist through vulnerability and allowing herself to release the stored trauma. The fourth participant (SC) stated:

> For some people, they go to therapy, and they'll have six or eight sessions, and they're done. But for people like me, it's simply for maintaining, you know, when something happens, and I'm not able to see my therapist, or something comes up, and we haven't had a session in a month by the time I see her, she can tell, and I can tell I needed that hour.

The individual participants could identify their insecurities and issues that brought them to therapy. These participants emphasized the importance of vulnerability within trauma therapy. One participant described her views on vulnerability about herself and her therapist, pointing out how trust is essential for both parties. The third participant (DG) stated:

> Because you're having to overcome so many insecurities, especially with this person in front of you, not only as a therapist looking at me as their patient but also as a human being that's had major trauma that they're having to overcome as well, that really shows vulnerability, in my opinion, to step into that ring for both the therapist and me. I'm trusting them to guide me, and they are trusting me to follow.

Therapist Themes

The sunburst of selective therapist codes can be found in Appendix N. These themes related to trainings, boundaries, reasons for SD, and open codes about therapists' views of TSD. Several therapists discussed how they have dealt with SD, what they see in clients' experiences with other therapists, and past usage of SD. All the participants identified boundaries needed within the framework of using SD as a therapeutic tool.

Theme 1: Boundaries for Deciding to Use Self-Disclosure

Most of the therapists' discussions revolved around choosing SD and the connection between the client and therapist throughout the therapeutic relationship. The therapists pointed out the code of ethics and the case-by-case basis concerning SD. The therapists discussed considering each patient and their journey when deciding whether to use SD. All the therapists pointed out that it depends on the person, the situation, and the therapeutic relationship.

Concerning that case-by-case basis, most therapists agreed that the root of the connection within the therapeutic relationship was the impetus behind using SD. Therapist One (LB) pointed

out the desire to evaluate the connection. She identified being able to work within healthy boundaries and identifying when those boundaries need to bend a little within a safe boundary to meet the client and build the connection. In order to bend, can the therapists continue working within the ethical boundary? All the therapists agreed that normalizing an experience was helpful to the client's overall therapeutic well-being. The third therapist (MS) spoke on this notion of normalizing within boundaries:

> To be able to have somebody that actually understands what anxiety is and how it affects a person doesn't mean that I'm going to trauma dump or tell the patient the source of my anxiety. But just what I've experienced and how I manage my symptoms. A panic attack is not a thing that I feel is a weird thing for a therapist to say they experience.

The therapists also discussed personal boundaries and the importance of expressing those to create a safe environment for the clients. Most therapists discussed how SD, to some degree, is warranted to assist the client in finding the right therapeutic fit. JH made the connection between what a client might want and using SD to assist them towards someone who fits that client's boundaries while working within an ethical frame. The second therapist (JH) pointed out:

> If someone were to come to me and say you know, prayer is really important to me, and I want to incorporate that part into therapy. I would say: "Yeah, I'm not your girl. So, let's find you someone else." I just think that being rigid in beliefs and not allowing yourself as a therapist to identify your own boundaries is not helpful. I am not rigid, but I also understand my boundaries within my own life and values.

The therapist group also pointed out that ethics and boundaries are not always black and white, as most schools teach. There must be a happy medium within the boundaries.

All the therapists discussed being mindful of TSD concerning immediate SD. All therapists agreed they had not known there were different types of SD and were conscious of immediate SD without knowing the subject just based on how they want their clients to feel during the therapeutic relationship. The therapist focus groups identified clear boundaries for the therapist and the usage of SD. The fourth therapist (AH) addressed the use of immediate SD within her own personal boundaries:

> I've always had a lot of this, not personal, but broad strokes of what I'm about and real clear indicators of that. But it's been an intentional thing. You know? I didn't have photos of families that were out and about or things like that. It was just very, very surface-level and intentional within my own boundaries.

Theme 2: Changing Times and Views of Therapist Self-Disclosure

The therapists discussed expanding the code of ethics, the new age, changing views of TSD, the therapeutic bond through SD, and therapists who choose not to use SD. One of the ways the therapists expressed the current code of ethics was by developing a new set for the ever-changing landscape and cultural norms associated with SD. The second therapist (JH) emphasized that the code of ethics may not be up to date on what is acceptable and what is helpful:

> I would say that's a beautiful guidebook [code of ethics], and of course, I'm ethical, but I also understand that there's a whole lot that is outside of the realm which occurs within the therapeutic relationship. This one thing [that the code of ethics] cannot necessarily be a one-size-fits-all for every single person and experience. So, we have to be able to look outside of that. Times are changing, and hopefully, the therapeutic relationship also has space for growth and opportunity to change as well. This needs to happen outside the

> realm of the rigidity that we are taught in graduate school. My views have shifted, so I would say there's a little bit more self-disclosure, but again, only if appropriate and helpful. I was definitely more fearful of self-disclosure as a baby therapist.

All therapists identified changing views from the beginning of their careers to where they are now. Three of the therapists expressed being terrified of doing anything that could be seen as unethical when first starting their practices. Two of those therapists identified not feeling as helpful by being so rigid. The level of SD also correlated with the population and work environment. The fifth therapist (ZB) discussed the differences in her levels of SD related to the work environment:

> In the beginning of my therapy work, there was not a whole lot of self-disclosure in any capacity. Just because of the severity of what the women I was working with were facing. It was a women's treatment center focused on what these women were experiencing. So, now, I would say it's completely shifted as I've now moved into working with strictly adults and trauma. Maybe because of this shift, I share more because we share similar experiences or more that I can speak to. I'm 15 years in at this point, so my mindset is also different. So, I just think that has sort of shifted based on the population that you are working with and the setting you are in, all that kind of shifts things, and I'm now more able to have the capacity for one-on-one working with trauma in adults. I'm not working with the seriously mentally ill or any population where self-disclosure would not be helpful.

Another therapist discussed how having a different career before becoming a therapist changed his views on SD. He expressed having pulled himself back from certain aspects of SD after learning about not using SD in graduate school. He discussed how his views have changed

over the years, and being in the field longer has helped him develop a different skill set. He hopes current and future views will change to incorporate SD as a therapeutic tool and less of a taboo subject. This fourth therapist (AH) stated:

> I had quite a few years of life not being a therapist. I started school like in my 30s, and so in my past life, I guess I was kind of a bit more, I would hate to say, about myself. So, as I got into school and learning about what we do now, I pulled back on talking about myself. We're talking like way back, probably too much. Now, I will use self-disclosure to kind of relate to the client. I usually wait a pretty good amount of time before I start. Unless someone is really hesitant or there is something embarrassing for them, and they don't want to talk. If I've experienced something similar, I will self-disclose in order to encourage them and normalize it for them to build that relationship. Relationships are the focus, and having solid relationships with people and part of that relationship does include a bit of self-disclosure. I have the privilege of teaching at a local college, and I teach mostly intro[duction] to psychology classes. My hope is that the curriculum and what's being taught now will change compared to the old views on therapist self-disclosure.

Subtheme 1: Licensure and Teachings about Therapist Self-Disclosure

The therapist groups comprised both licensed professional counselors and licensed clinical social workers, requiring a masters-level education. The therapists expressed having different classroom experiences, the curriculum surrounding SD, and its usage within the therapeutic relationship. One therapist talked about knowing that completely turning away from using SD would not help build the therapeutic relationship. The second therapist (JH) spoke about her experience in the social work graduate courses:

> In school, we were taught to not disclose, and I immediately knew that was nonsense. How do you create a therapeutic relationship without using any self-disclosure? We talked about countertransference, and I think it is different because I'm a social worker. So that was different because there was less focus on self-disclosure because there was more focus on countertransference and less based on self-disclosure as a tool.

All of the therapists interviewed were also trained in a trauma-based modality. They believed in the helpful use of SD within trauma-based therapy modalities. However, they did not remember SD being addressed directly. All of the EMDR-trained therapists discussed how there is SD throughout the training with other attendees. One therapist touched on the EMDR training and also discussed her experience within the licensed professional counselor graduate curriculum. The fifth therapist (ZB) said:

> I remember there being a little paragraph or something. But I don't necessarily remember us having any sort of actual conversation about it throughout the EMDR training. As far as my graduate course, there was definitely a class, and I feel like there was a whole class on it, but I don't remember discussing it. I vaguely remember it being a chapter in a book. I remember being taught a combination of both refer out if countertransference happens, but also, it's a reflective process of let's examine this and seek supervision.

Other therapists discussed how their graduate courses handled the discussions surrounding SD. Two therapists pointed out how SD was taught to be avoided at the beginning of their studies, and then SD was normalized later. The therapists discussed how SD was more normalized, as in it is going to happen, and the school should prepare them with various tools to handle those situations. The various tools focused on the therapists evaluating what is happening, how they can proceed without harming the client, or if a referral needs to be made to facilitate

that for the patient. All the therapists stated that current teachings should be a more reflective process versus being communicated as a topic to shy away from or avoid.

The therapists spoke about having different trainings but hoping for an updated viewpoint on SD within the therapeutic relationship. They each spoke about the struggles of staying stagnant in the beliefs of the older generations of psychological schools of thought and agreed with a move towards acceptance and education surrounding the benefits of SD. The fourth therapist (AH), who is a current professor, pointed out:

> I would hope that the curriculum and what's being taught would change. I also think that we talked about self-disclosure. It is obviously different from program to program, so I think what counselors are getting versus what social workers are getting is also different. So, my guess would be that it's shifting and changing between programs and universities. I try my best to educate the new students about real-life situations and not just the situations or examples in the textbooks.

Subtheme 2: Types of Non-Immediate Therapist Self-Disclosure Used

All of the therapists discussed and identified non-immediate SD. Several participants discussed being aware of this and the importance of how it has been used. Most therapists discussed the importance of non-immediate SD within the therapeutic relationship. The third therapist (MS) identified both immediate and non-immediate SD she has used in sessions:

> Non-immediate, like the surrounding spaces: I think [a] really important indicator is the office where I work. This is my backdrop for my day-to-day stuff, and I feel like if that kind of self-disclosure is really vital, especially right now. So, you know, that's part of the self-disclosure. This is not political; this is literally human, and I'm trying to make

> sure that's really clear. As far as like the direct or intentional self-disclosure, I feel like pairing with clients and sharing with clients increases credibility.

Another therapist added that he approaches SD without directly connecting it to his experiences. The second therapist (JH) stated:

> Even if there was an opportunity, it typically would not be about me, and I would say I have another client who has experienced something similar, or you know this is something that someone else had told me was helpful when they experienced this or something along that line.

Other therapists discussed using non-immediate SDs to add to the clients' perspectives and views of their struggles to build the connection and relationship. The therapist group spoke about the positive influence non-immediate SD had on their clients, particularly relating to common trauma diagnosis, which outlined how self-disclosing about their struggles with common diagnosis of anxiety or depression but only within the context of connecting to the clients built stronger therapeutic relationships.

One therapist discussed using her life experiences to connect with her clients. This therapist spoke about using her expertise and her trauma to assist clients with normalizing and working through their traumas. The second therapist (JH) discussed how she handles trauma and uses non-immediate SD to facilitate connection and healing. The therapist stated:

> Parent abandonment is one of my things. So, I guess I have shared that in terms of, like, with a college student who was experiencing that and was talking about how none of her friends or anybody else understands. I shared just in the understanding without going into detail that I do get where she was coming from, and I deeply understand the hurt with parent abandonment causes.

Theme 3: Therapists' Views of Self-Disclosure

This theme had seven subthemes ranging from credibility to views changing with experience. Some subthemes were evidence of relating to clients through different tools, whereas others leaned more towards why therapists might not use SD or feel comfortable exploring its usefulness. All therapists agreed that SD can be helpful if geared towards assisting the client with their journey. They all identified feeling like it is okay to use SD if it is designed to benefit the patient.

One therapist shared more details about how she has become more aware of her SD and how her views on being intentional are helpful for her clients. She also spoke about how years of experience have changed her viewpoint on SD. The second therapist (JH) stated:

> I've thought about not wearing certain things into sessions that I own because there could be some association to that, and it would indicate maybe that I wouldn't align with the clients. So, I have been more intentional about things, and still, even in a telehealth session, I'm super mindful about my backdrop and what I'm wearing. I would say [that] through the years, I've cared less, and if it's not aligned, then I'm not the right person for them.

The same therapist also addressed those who might not use SD and view it as an ethical boundary. The therapist pointed out that by being less rigid and more relatable, her practice is constantly full of clients who seek a different approach. The second therapist (JH) noted:

> It's fine because there's still therapists out there and patients that want rigidity, and there are plenty of therapists that still provide that, and then the other side of that is what keeps my practice bursting at the seams. So, it's a good problem to have, and I welcome

> conversation with every client at the end of the intake. And if I'm not the right match for you, let me help you find someone that is.

Another therapist outlined how her views on TSD have changed over the years based on the population she works with and moving from one modality to the next. The fifth therapist (ZB) indicated:

> I started off working with children for the first five to six years of my career. So, it's kind of this thing where you don't self-disclose because you're an adult, and they don't really care what you have to say as far as your life because they are teenagers. So, I steered clear from [self-disclosure] a little more. Now, working with adults, I don't self-disclose much unless I feel it's in the interest of validating their experience.

All the therapists agreed that there are different views regarding SD. They agreed that it is an ever-changing landscape with various viewpoints. The therapists discussed how training differs, and some therapists are less likely to stray from whatever they have been taught. They reiterated that there are therapists who can avoid using SD because that is what they were trained or taught to do. Adding these therapists might be fearful of anything outside of said training or may be new to the profession and scared of violating ethics without knowing.

Theme 4: Trauma and Therapist Self-Disclosure

Some subthemes were evidence of trauma therapy, and some vignettes leaned more towards the lack of adherence to the training on TSD within trauma-based modalities. One of the subthemes related to TSD being unavoidable. Trauma-based modalities included EMDR and DBT training, and all therapists agreed that some levels of SD are unavoidable. The therapists expressed flexibility as a determining factor when using SD during trauma-based therapy. One way flexibility was addressed was by identifying SD happening when choosing to specialize in a

trauma-based modality. One therapist described her considerations for SD when she became trained in EMDR and DBT. She shared that she was drawn to trauma treatment due to its nature of incorporating some levels of SD. This therapist also shared how some cultures may benefit from self-disclosure:

> I think that some people are very uncomfortable with a lot of the direct things that happen in self-disclosure from therapy. Those of us that are, like, really good at talking about trauma and things. I think that some people very much benefited, probably culturally [from TSD]. There are some lines along there about who would prefer to have somebody that was a lot more formal and withdrawn.

Most of the therapists were trained in EMDR therapy. All therapists echoed each other in the concept of SD within the training. In return, clients have some understanding of what is involved in EMDR training. One therapist described that she did not use SD unless the client struggled to accept their emotions and reactions or felt negative about themselves for their experiences. The second therapist (JH) stated:

> I don't disclose much unless I feel like it's in the interest of validating. My similar experience to theirs is a way to better relate to them to remind them they aren't the only one who has experienced something to normalize their reactions. Using therapist self-disclosure as a way to allow the patient to see these reactions may be typically associated with trauma. In EMDR, there is less self-disclosure in the treatment and more so in clients' understanding that, as therapists, we had to go through EMDR to become trained.

Another therapist (AH) pointed out how, as society has moved forward, so has his way of doing trauma-based therapy:

> I'm all about relationships, so when my client comes in, we're going to sit down, and it's just going to be a conversation. I don't follow the form like we did back in the day with the 40-page packet. I get my answers just by having a conversation with them and being relational as they work through trauma, especially using EMDR for trauma therapy.

Lastly, all five therapists agreed in different ways that SD is unavoidable. They discussed how SD is a part of any relationship, including the therapeutic one. They agreed that some trauma-based therapy has to include bits of SD to be effective. The second therapist (JH) solidified that notion:

> I am very relationship-focused and having a solid relationship with people. Part of that relationship does include a bit of self-disclosure. For me, I would say it's unavoidable. There will always be self-disclosure within the therapeutic relationship to some degree, not to a hurtful degree, always beneficial to the client. The therapist must always focus on the relationship.

Individual and Therapist Themes

All the individuals and therapists interviewed agreed that using TSD to compete with the client was harmful. The therapist focus groups also agreed that using TSD to create a power dynamic was harmful. Both groups discussed the importance of boundaries within the usage of SD. During the first focus group, the second therapist (JH) discussed her boundaries within SD:

> There's a lot of opportunity for self-disclosure in today's world of therapy models. So, making sure that I'm setting the boundary that it's helpful and not harmful is important. But also, one of the things I always keep in mind is [that] I have so many clients that come to be that have not had a positive experience with a therapist who did not form boundaries. So, I hear that a lot, and that makes me incredibly mindful of my boundaries.

> Most of my clients know that I have children, but they don't know their names. Some of them know I've been divorced, others don't. So, I think of self-disclosure in terms of validation of what the client is experiencing but also a deeper connection in terms of understanding. If I can speak to that, I speak from experience. Not necessarily making it like: "Oh well, that must be really hard that you're going through that; I have no idea how that feels." I set those boundaries to use self-disclosure to connect. Never using it to one-up the client.

The individual participants discussed how working within that boundary affected their journeys through healing. Most individuals pointed out how their current therapists were the first to use SD and the first they have felt connected with, which has increased their willingness to share and heal. The participants discussed how some of their past therapists just talked about themselves and had not given them homework or anything to work on outside the therapy room. They agreed that this felt nonengaging and unhelpful in their therapeutic journeys. All the individuals agreed that their therapists working within a healthy boundary and using SD to connect was more helpful than therapists who chose not to use SD and remained disconnected. For some participants, sharing emotions with their therapists helped them feel seen. The second individual participant (KR) shared her viewpoint on TSD within healthy boundaries:

> We can both share about how politics stresses us out. Again, there's a healthy boundary, and she [my therapist] makes me feel better that she's feeling it too. It's not just me telling my therapist stuff and her helping me through it. It's like us talking about our journey together and not just trying to fix me. It feels like we are fighting the thing together because we are allies.

Experiencing SD within the boundary helped others adjust to their experiences and emotions. One factor that helped some participants move forward in therapy was their therapist using SD after establishing the therapeutic relationship. They all described how they were unaware of how individually they were sharing an experience with their therapist until that point of SD. One individual participant (SF) expressed feeling like a light bulb moment, and it solidified her trust:

> There was one time where I really felt like a personal self-disclosure was helpful. I was beating myself up over being married and divorced multiple times. I guess I was really doing a number on myself in therapy because my therapist said I feel like you need to know I've been divorced twice, and immediately it hit me: after all these years, I didn't know that about her, and I felt seen in the moment.

Both groups discussed trauma-based therapy. The individuals gave their viewpoints on SD within trauma therapy. They each echoed the belief that more progress has been made with a therapist using SD. Individual participants defined the relationship as being in the trenches together, making the relationship one with trust and overall investment. The therapist group noted the same advantages of using SD. The connection and investment were increased during trauma-based therapy. The fifth therapist (ZB) noted:

> To me, I feel like you kind of invest more in a trauma-based therapy. It kind of becomes more natural and more emotionally involved in that person's well-being, too. So, I feel like [SD] becomes a not so much of a standoffish relationship.

The therapist group touched on trauma-based training regarding SD. They identified that some trauma-based training requirements are available to the public, and clients can see what is

required to complete, which led to the discussion of how EMDR requires therapists to do the work. The second therapist (JH) stated:

> When potential patients look up the trainings you've done as a therapist and see EMDR or another modality that requires you to do the work first, I think they understand without the therapist having to self-disclose that they [the therapist] are familiar firsthand with trauma.

Unexpected Themes

The following were unexpected codes that arose from the research. The two themes came from discussions between individual participants and the therapist focus groups. These themes were essential to the research by identifying possible outliers to the original research question and accounting for recent societal changes worldwide. The first theme was related to the COVID-19 pandemic and the sudden changes from in-office sessions to virtual sessions due to protocols and national emergency requirements from the licensing boards. The second theme encompasses therapist burnout.

Theme 1: Online Versus In-Person Therapy

During COVID-19, therapists suddenly had to work virtually with little preparation time. Individuals were also expected to adjust to this change rapidly. The open virtual vs. in-person therapy code had eight vignettes between both groups. The groups discussed how SD changed during this time. The second therapist (JH) discussed how her environment changed compared to being in an office setting:

> I think especially during those COVID times working from home. I have a cat on my shoulder, and the dogs barking in the background, and kids are coming in and out of the room. I have a computer facing a wall so nobody can see anybody, but like, yes, this is

> my life, here we are, you get it in full swing. I have children, I have cats, [and] I have a dog, so I think all of that self-disclosure was unavoidable and not something my education has ever prepared me for.

An individual participant voiced her support for virtual therapy and discussed how the privacy of being in her own home for therapy increased her level of SD. Participants echoed how virtual therapy increased their levels of trust and comfort. Each participant stated that virtual therapy made them feel safe to voice concerns or issues because they worry less about anyone in the waiting room overhearing them or being judged by office staff. All participants agreed there is a higher level of safety and security when using a virtual platform, which gave all participants a better view and a healthier environment for healing.

One therapist's perspective was that virtual therapy and COVID-19 were the first incidents the therapist and clients worked through together. This was the first time both groups were experiencing the same trauma and not knowing which way to go. The second therapist (JH) pointed out:

> I just think that it [COVID-19] was just one of the very first times that we walked with our clients through something at the same exact time. I think there was a bit more self-disclosure, and I think it had to be there, right? It's like, well, my kids have to hop on this Zoom call, and it's the middle of our session, and I still need to be present, but I also need to make sure this is happening, oh and my internet is slow because my kids are on it, and there was a lot that wasn't part of the therapeutic relationship prior to working telehealth through COVID-19. But I think the biggest thing with that is just the immediate because we are both in this same exact time and moment. So, as people are saying, "I am feeling so overwhelmed, or I'm feeling so alone," I am like, yes, I understand all of that, I hear

> all of that, and I feel that same way too. I feel like that time [COVID-19] was very different from anything that we've ever experienced. I think, personally, therapeutically, it was something that was so interesting.

Another therapist mentioned how some of her clients expressed being glad to return to in-person sessions after restrictions had been lifted. The second therapist (JH) discussed how she used SD to continue to build that relationship, transitioning from virtual to in-person again:

> So, I had a client, and we worked together weekly during COVID-19 because she was alone…we met every week because she was alone and depressed and anxious all the time. After we kind of moved a little bit out of the lockdowns, we returned to the office where we hadn't met in probably a year or so. [In] one of the first conversations, she said, "I'm just glad to get back to what our therapeutic relationship was before COVID-19." I told her you know, this is one of those times in history whereas therapists, we weren't prepared for this. We weren't trained for this, and we didn't know how to do it. This was one of the only times in history where we are walking side-by-side together and experiencing this at the same exact time. I said I definitely shifted the way in which I interacted and developed the therapeutic relationship, especially with self-disclosure. It was an interesting time.

Theme 2: Burnout

The unexpected theme of burnout developed from both therapist focus groups. The groups discussed how burnout could lead to therapists using SD negatively with clients. The therapists also addressed this theme by identifying that it could be the main reason clients have negative experiences with therapists. When asked why a therapist might not use SD as a helpful tool in therapy, the fifth therapist (ZB) pointed out:

> I would say, though, that part of it is burnout. My guess from what other people have shared with me is that most of the negative experiences from previous therapists were from seasoned, burnt-out therapists. That's what the trend has been that I've witnessed from my patients. It's the frequent cancellations. It's just a lot of things that my patients have shared when they've talked about negative experiences. They will say, "Well, this is who I saw before, and it's more based on [the] behavior of the therapist." I would be like, well, okay, that sounds like they were pretty burnt out and needed a break or whatever. I tell them I'm sorry that wasn't a good match for them.

Another therapist cited something specific about burnt-out therapists and referenced researching a client's previous therapist to gather information. The fourth therapist (AH) stated:

> The ones that I have tracked down have been seasoned therapists as well. People who've been in a lot longer than I have, and most of them were licensed longer. Some of them were newer, I guess, but burned out, just exactly as we all discussed. I think they were just tired of it and needing to do something different but not knowing how to proceed.

Another therapist explained why a therapist might have less negative SD by being rigid and less available to clients. One referenced her thoughts on being rigid and questioning how effective therapy can be. The second therapist (JH) stated:

> This is just my perception, and it could just be me being slightly judgmental, but I also think that people that are more focused or rigid in terms of ethics and rigid in terms of this modality that I'm utilizing and not straying from that suffer less burnout. These are the therapists that aren't returning text messages after office hours, not being available outside those hours, and being less accessible. So, I think that again, if it's more rigid and this is my role as a therapist, there's less self-disclosure. I feel like that leads to less

> burnout overall, but then how productive are you as a therapist? How connected and empathic can you be?

The therapist group addressed what could lead to burnout within the profession. Several therapists interviewed in this study experienced various levels of burnout throughout their careers. While these therapists have sought supervision or a trusted colleague to process their own experiences, not all therapists have these resources available. The therapists all identified limitations regarding therapist assistance. The fifth therapist (ZB) addressed burnout and imposter syndrome by stating:

> To be able to have somebody that actually understands what anxiety is and how it affects a person doesn't mean that I'm going to tell them my source of anxiety, but just telling them briefly what I've experienced to build the connection. Plus, I think it's still hard to seek help, even in our work as professionals in the helping profession. I see a lot of performative vulnerability, which is very different than actual vulnerability. But I'm not seeing a lot of people saying, "Look, I'm really struggling, and I don't know what to do about it." This leads to the burnout, the frequent cancellations, [and] the lack of boundaries in therapy. These therapists struggle with imposter syndrome a lot, too.

Theoretical Coding, Themes, and Summary of Results

Three theoretical themes emerged from the open and selective coding of the research through mind-mapping and NVivo analysis. The researcher used the mind-mapping software feature in NVivo to examine and understand the relationships between the open and selective codes about the research questions, which aided in discovering the theoretical theme. Relationships across the individual, therapist, and joint selective codes were analyzed within the data. The theoretical themes were formed from the selective codes with the most relationships.

The three theoretical themes included: (a) therapists strengthen the therapeutic relationship by using SD as a connection tool to validate the client's experience and emotions by normalizing their traumatic responses; (b) therapists use examples of other unnamed clients' experiences and their own experiences, boundaries, and beliefs as types of non-immediate SD in developing the therapeutic bond; and (c) clients feel safe and unjudged when the therapist uses SD positively. All the therapists interviewed agreed that SD should only be used within boundaries and in a case-by-case manner. The individuals interviewed also expressed that TSD can be helpful in connection and validation. Both groups identified negative and positive examples of non-immediate SD. The individuals discussed how non-immediate SD has been helpful in their healing journey when the SD was used in moderation.

These three theoretical themes resulted from reviewing the data and the relationships between the open and selective codes. These three themes focus on the therapist and individual experiences with TSD. The themes have a direct tie to the selective codes of boundaries and experiences and were developed to support the research questions:

RQ1: How do therapists develop therapeutic relationships with their clients through self-disclosure as a trauma-based approach?

RQ2: What types of non-immediate self-disclosure do therapists use during therapeutic sessions?

Summary

This chapter contained the analysis process, the analysis results, connections back to the research questions, and an outline of the internal consistency of the analysis with the case study methodology. Six individual participants and five therapist participants were interviewed for this case study. The semi-structured, open-ended interview questions were designed to explore

factors contributing to TSD and the types of non-immediate TSD used during therapeutic sessions. All the individual participants were women with a minimum of two years of experience in trauma-based therapy. Four of the therapist participants were women, and one therapist participant was male. All therapist participants had at least eight years of experience in providing trauma-based therapy.

Steady use of the grounded theory, with three levels of analysis, guided this case study's analysis. There were three levels of analysis, open coding, selective coding, and theoretical coding, utilized in this study. Constant analysis was utilized via the mind-mapping software within NVivo to discover the selective codes that emerged from the open codes. Additional comparison analysis was used to discover the relationships between and within the selective and open codes, which led to the theoretical themes and subthemes. The three theoretical themes resulting from this study are as follows: (a) therapists strengthen the therapeutic relationship by using SD as a connection tool to validate the clients' experiences and emotions by normalizing their traumatic responses; (b) therapists use examples of other unnamed clients' experiences and their own experiences, boundaries, and beliefs as types of non-immediate SD in developing the therapeutic bond; and (c) clients feel safe and unjudged when a therapist uses SD positively.

Chapter Five: Conclusion

Overview

The purpose of this qualitative case study was to examine the effects of non-immediate TSD on the therapeutic alliance. This chapter discusses the significant findings related to the literature on TSD in trauma-based therapy, motivating factors as to why therapists use SD, and types of non-immediate SD used throughout the therapeutic bond. This chapter concludes with a discussion of limitations found in the study and capacities for future research. This chapter encompasses a discussion of future research opportunities to address the following research questions:

RQ1: How do therapists develop therapeutic relationships with their clients through self-disclosure as a trauma-based approach?

RQ2: What types of non-immediate self-disclosure do therapists use during therapeutic sessions?

The research resulted in three main themes: (a) therapists strengthen the therapeutic relationship by using SD as a connection tool to validate the client's experience and emotions by normalizing their traumatic responses; (b) therapists use examples of other unnamed clients' experiences and their own experiences, boundaries, and beliefs as types of non-immediate SD in developing the therapeutic bond; and (c) clients feel safe unjudged when a therapist uses SD positively. These factors contribute to using SD as a therapeutic tool and point to how non-immediate SD can be hurtful and helpful within the trauma-focused treatment modality.

Interpretation and Discussion of the Findings

While there are multiple reasons why a therapist might use SD or shy away from it, it was discovered that the age-old thought of not using SD at all is outdated. All of the therapists

interviewed identified that SD in any form is unavoidable. The researcher sought to answer why a therapist might use SD and the types of non-immediate SDs used in trauma-focused therapeutic modalities. These two themes were dynamic regarding how the views of non-immediate SD have changed over time and what was essential to the therapeutic bond.

Therapists Strengthen Therapeutic Relationship via Self-Disclosure

This study concluded that using TSD as a connection tool within boundaries and ethics was essential to assisting clients in developing trust, safety, vulnerability, and the therapeutic bond. There may still be a division between a therapist who reveals too much and one who tells too little (La Porte et al., 2010). Each therapist must use their judgment and knowledge of the client in deciding whether to use SD. While one therapist can use SD as a therapeutic tool, another may choose not to use non-immediate SD. Depending on the foundation of the therapist's training, SD has different meanings and levels of importance. Newer therapists have a favorable view of the importance of TSD within the therapeutic alliance as the teachings and society have evolved (Ziv-Bieman, 2013). While some therapists disclosed learning little about SD in their licensure tracts, they each acknowledged the importance of boundaries and their involvement in using SD.

All the individual participants described both positive and negative experiences with TSD. Participants cited that using SD as a connection tool and not as a way to develop a competition allowed them to develop a sense of connection and trust. In this study, the individual participants identified TSD as a way to feel like they were being heard and valued and like it was a shared experience. Carl Rogers stressed the benefits of this form of therapist transparency (Benko, 2018). Throughout most interviews, the individuals expressed their experiences with SD regarding vulnerability and trust. While some individuals expressed negative or imbalanced

experiences with SD, participants felt balanced and vulnerable within a healthy boundary of TSD.

There was a difference in individuals who experienced a harmful use of SD. These participants stated feeling withdrawn and even running away from therapy. The therapists also identified having multiple referrals of clients stating their last therapist only talked about themselves. The clients who identified the negative experiences expressed feeling heard and less stressed when encountering a therapist who used SD within boundaries and as a connection tool. All participants identified TSD as a tool to humanize therapy. Humanizing therapy aligns with the humanistic approach of promoting an authentic therapeutic bond to build a foundation of trust (Rogers, 1951). Trust was essential in the client's levels of vulnerability with themselves and their therapist.

Therapists Non-Immediate Self-Disclosure to Develop Therapeutic Bonds

While all the therapist participants expressed not being aware of the differences between immediate and non-immediate SD, they could identify forms of non-immediate SD they have used in the past or are currently using. The therapists identified using everything from vague examples to direct shared experiences. Much like Danzer (2019) expressed that MHPs mirror the client's symptoms to create a sameness, the therapists identified using non-immediate SD as a way to normalize and connect, which connects back to Caver's (2006) social penetration theory that highlights self-disclosure as a drive of relationships. The therapists identified using stories, emotions, and even points of view to establish connections and reach those who might be closed off during sessions. Specifically, the results of this study included the following sentiments: (a) walking with the client helps the client be open, (b) having a therapist discuss shared experiences

does not diminish the client's experiences, and (c) all experience life and should embrace that familiarity.

This study's emphasis on non-immediate SD was consistent with the literature regarding relationships and therapeutic bonds. Following the four primary themes in the social penetration theory, TSD aligns with relationships progressing naturally, with SD being the core of development. The therapists discussed the different levels of SD, echoing the literature regarding immediate SD being seen in a more positive light when compared to non-immediate SD. All the therapists agreed that the level of non-immediate SD depended on the relationship's nature and what was being disclosed.

This study was consistent with the literature discussing commonly used non-immediate SD examples. The therapists pointed out disclosing their experiences with parenting, absent parents, anxiety, and depression with patients, which aligned with Audet's (2011) discussion on the commonly used definition of non-immediate SD. The therapists in this study stressed that using non-immediate SD as a connection tool must be within boundaries, and after developing a relationship with the client, operating within these boundaries fosters trust and an environment for healing.

This study's conclusion emphasizes the importance for both therapists and individuals to examine their boundaries and reasons for using SD with the understanding that each person's needs are unique. Understanding that some clients will not benefit from SD aligned with the literature showing that while immediate and non-immediate SD has been growing in popularity compared to non-disclosure, the one-sided exchanges of the patients deviate from established societal norms (Henretty et al., 2014). Understanding the individual needs within a trauma-based therapeutic alliance, the therapists agreed that patients often look for a connection to process

their emotions and increase vulnerability for healing. This form of connection appears to be strengthened when using non-immediate SD to normalize the patients' experience. The individual participants expressed increased vulnerability to release pent-up emotions or process through an event when they felt more connected to their therapist. One of the noticeable differences in the results of this study, as compared to existing studies, was the emphasis on non-immediate SD in online therapy. All participants identified experiencing non-immediate SD in the current state compared to previous therapies.

Clients Feel Less Judgment and More Vulnerability

Judgment and vulnerability were motivators in the foundation building within the therapeutic alliance to foster an environment where patients feel safe to disclose. This study's results highlighted the desires of the individuals and how they have changed over time and how the views of TSD have changed, which was echoed in Benko's (2018) and Henretty et al.'s (2014) literature showing that TSD significantly increased the patients' perception of the therapists' positive regard by conveying a meaningful connection to their patients. The individual participants also pointed out how they felt like their therapist was more connected to what is happening in the real world when they used SD as a connection tool. The individual participants expressed feeling more seen and heard when their therapist used SD instead of just nodding their heads and asking how they felt. This finding correlates with the study from Myers and Hayes (2006) that found individuals viewed their therapists as more of an expert in their fields when TSD was used positively.

The individual participants wanted a warm, friendly connection instead of apathetic, cold, and withdrawn exchanges. The literature emphasized the importance of vulnerability and trust within the therapeutic alliance. Two studies showed a positive correlation between TSD and an

improved therapeutic alliance. The results of this study support those examples. The therapist and individual participants discussed negative examples of TSD and how those negative experiences affected the patients' ability to be vulnerable and develop trust.

The participants in this study agreed that their vulnerability levels generally depended on their level of comfort and trust in their therapist. The literature highlighted vulnerability as the foundation for trust (Brown, 2012). Furthermore, rejection of said vulnerability often stems from fear and distrust. The individual participants discussed adverse reactions to TSD that created power dynamics, pointing out how competition with their therapists caused them to withdraw from therapy and distrust the therapeutic process.

Regarding trust and transparency, vulnerability was shown to be the most critical factor in the foundations of trauma-based therapy. The therapists agreed that for a patient to be open to healing from trauma, various levels of vulnerability from both the therapist and the patient are needed. The results of this study align with the literature regarding the importance of TSD and vulnerability in developing a positive therapeutic alliance. Knox and Hill (2003) outlined that TSD may encourage clients to be more open and vulnerable, creating a more intimate therapeutic alliance. Bottrill et al. (2010) echoed this belief by outlining the corresponding process of TSD, and a patient receiving the disclosure could experience positive feelings of vulnerability and openness. If vulnerability and trust are critical to creating a positive therapeutic alliance, perhaps it is time to rethink how TSD is approached and taught for every therapist, making the therapeutic relationship a step closer to humanizing on a more consistent plane.

Implications for Theory and Research

The Literature Review in Chapter 2 outlined several motivation models for this current study, including the humanistic or existential view, social penetration theory, and non-immediate

SD used in trauma-based approaches. These motivating factors were the foundation for this study.

Humanistic or Existential View

While older theories and schools of thought were against using SD, the humanistic and existential schools of thought showcase TSD as a more critical therapeutic intervention (Ziv-Bieman, 2013). This view of TSD aligns with the newer societal viewpoint of therapist transparency and the usage of congruence as it occurs when a genuine interaction happens between the therapist and the patient. Furthermore, the humanistic approach focuses on the therapeutic bond as the foundation of trust between the two parties. The results of this study aligned with the literature and suggested that using TSD to promote an authentic bond is crucial to the relationship and the patient's healing. The humanistic approach teaches that disclosing personal information, such as feelings and experiences, may increase the therapists' level of authenticity, allowing the patient to develop a stronger sense of self (Benko, 2018). The results of this study aligned with those teachings.

The results of this study confirmed that identifying boundaries when deciding to use SD is necessary. The boundaries align with existential schools of thought that utilize the idea that therapists should maintain congruence and transparency with their patients (Benko, 2018; Carew, 2009). This study emphasized the importance of the therapists' awareness of burnout and boundaries and reason for self-disclosing while acknowledging that some forms of SD are unavoidable. This thought process aligns with most contemporary schools, highlighting TSD as inevitable (Benko, 2018). The therapists in this study agreed that trying to avoid all forms of SD was impossible and created an environment that was disengaging and unreflective of healing.

Social Penetration Theory

When comparing the current study's results to the social penetration theory (SPT), similarities within the foundations exist. This study and the social penetration theory identified TSD as a drive of closeness. Furthermore, the SPT outlined how the one who chooses to disclose must consider the threat of vulnerability and discomfort compared to rewards (Baldin et al., 2004). The therapists all identified the self-reflection process they complete when choosing what, when, and how to self-disclose, accounting for the risks and the rewards in terms of creating a safe space, giving the patient room to unpack uncomfortable feelings, and generating an environment of trust. These risks and rewards echo the four primary considerations in the SPT framework.

Looking at the primary considerations for the SPT, according to Altman and Taylor (1987), such as (1) the natural progress of relationships from non-intimate to intimate, (2) development is systematic and often predictable, (3) development includes suspension and depenetration, and (4) SD is at the core of relationship development, it is evident throughout this study that these factors are essential to both the individuals as well as the therapists involved in this study. SPT identified two types of SD: depth and breadth (Carver, 2006). Depth is defined as the degree of intimacy within the disclosure. The individuals in the current study identified feeling more connected with their therapist when SD was used to relate to their experiences. In this sense, depth within non-immediate SD is one of the foundations of vulnerability.

Breadth was described as the number of topic areas or examples disclosed. Both therapist groups in the current study identified using SD sparingly and only if appropriate for the patient's experience. The individuals identified some past therapists using too much SD as a negative impact. Much like the SPT, therapists in this study weighed the risks and rewards of using SD;

maximizing the positives while minimizing the negative experiences was the key to successfully using SD. The results of this study confirmed that the essential aspect of healing is the therapeutic bond, which is especially evident within trauma-focused modalities.

Non-Immediate Self-Disclosure Within Trauma-Based Approaches

Previous literature's arguments led to non-immediate SD being viewed as something to be avoided or harmful, whereas immediate SD consistently gained more affirmative approval among clinicians. The results of this study indicate that non-immediate SD is gaining popularity and acceptance. The therapists in this study pointed out how some forms of non-immediate SD were more efficient in developing a relationship. The results of this study confirmed what the previous research by Knox and Hill (2003) hypothesized: therapists will make personal, non-immediate SD to encourage their patients to open up and build rapport.

The results of this study highlighted the reasons for SD. These deliberate non-immediate SD ranged from sharing anxiety symptoms to relating to a patient on relationships, echoing Benko's (2018) notion that the patient's perception of their therapist is influenced by how connected and understood they feel during the sessions and furthering Farber's (2006) research of non-immediate SD being connected to an overall acceptance of the therapist. A few individuals in this study discussed how sitting across from a therapist who did not use SD heightened their anxiety and felt cold. This viewpoint is aligned with Audet's (2011) study, which outlined MHPs who do not disclose as being seen as uninterested, disconnected, and inaccessible to the patient. All of the individuals in this study were critical of the foundations of feeling connected and shying away from clinicians who were impersonal or cold.

Regarding PTSD and trauma-related treatment, feeling connected and understood ranked high on all the participants' needs for therapy. Trauma is growing in diagnosis, and in 2015,

Friedman asserted that 50% or more of Americans have been exposed to at least one traumatic event. With the aftermath of COVID-19, all Americans, including patients and their therapists, have experienced a collective traumatic experience. The therapists in the study identified that this was the first time in their careers walking with their patients through a traumatic event. It is widely understood that the effects of traumatic events often lead to anxiety, depression, and isolation, all of which were seen in the wake of COVID-19. The participants in this study suggest that using non-immediate SD in the event of a collective trauma creates a healing environment.

Implications for Practice

In a study by Henretty et al. (2014), non-immediate SD was viewed as threatening the therapeutic practice. However, the results of this study point to non-immediate SD as a factor in strengthening the therapeutic alliance and humanizing the patients' experiences. Fear of ethics may be undermining the usage of TSD. Today, society and psychological schools of thought are more accepting of TSD when compared to the past. As worldviews change, individuals must also change their training and ethics to fit the current societal landscape.

The results of this study imply that using TSD in a positive, boundary-abiding, non-comparative way holds an advantage regarding creating trust and vulnerability when compared to non-disclosing environments. Perhaps this imbalance between strict measures to not self-disclose against the benefits of using SD needs to be changed. There appears to be a healthy balance between boundaries and SD. Therapy could benefit from a better understanding of how SD aids in healing. The stigma that SD should not be utilized and avoided is outdated. Studies have shown that over 90% of practicing therapists will SD (Henretty & Levitt, 2010). The results of this study support that number and even increase it to 100% within the therapist focus group. The results of this study imply that education and training in how to use SD in a healthy way

would benefit the therapeutic community and their patients. Non-immediate SD is not the threat, but a lack of education surrounding the proper use is the threat.

Delimitations

The researcher chose only to include participants over 18 to focus on how SD affects those with a more developed understanding of therapy. The therapist group also had limitations of being in practice for two or more years to eliminate newer therapists who did not have experience in real-world situations and primarily only worked with children. As pointed out by one of the therapists in the focus group, SD happens less when working with children due to their comprehension and the overall therapeutic relationship. The individuals in the study were also filtered by years in therapy to examine how the individuals experienced SD over a longer course of treatment. Those new to therapy might not have experienced SD or had a comparison between therapists.

Limitations and Recommendations for Future Research

A limitation of this study was the individual participants' gender. All the individual participants were female, which created a weakness across gender experiences. There were also limitations to ethnicity because all participants and therapists were White. From a racial perspective, this study lacked the diversity of the participants, which created a limited scope of comparison among the population. Several areas for future research on targeted demographics could add to the findings of this study and further the research by using a broader demographic lens.

Another limitation was the participants' location. All participants were from Arkansas, which could limit the experiences of those from other states due to differing ethics and licensing boards. Several states have differing boards and govern therapists. Another quantitative study

could help expand this study's findings by using a more extensive and diverse population. Comparing northern and southern states could potentially add to the findings. A broader demographic of participants and therapists may give more insight into the use of TSD and its acceptance in practice.

While the researcher asserted that qualitative research was the correct choice for this study, a larger sample could be utilized if this study was coupled with quantitative research. As interviews are not explicitly designed to capture hard facts, a survey designed for quantitative research along with a statistical analysis may offer a more evidence-based strength component to the data discovered in the study. Therefore, a mixed-method design could give a clearer picture of how TSD is used and received.

Summary

The older beliefs and teachings that TSD should be avoided and that non-immediate SD is an ineffective therapeutic tool were generally rejected in this study. Although ethics regarding SD are often unclear, there is still evidence of negative bias towards SD. Motivating factors for therapists mirror the motivating factors for patients seeking therapy. One exception is the emphasis on healthy boundaries when using SD in a trauma-focused treatment modality. If therapists continue not utilizing SD as a treatment tool, they are missing a key component in building trust and vulnerability, as shown by this study.

The results of this study suggested that there were three themes related to TSD: (a) therapists strengthen the therapeutic relationship by using SD as a connection tool to validate the client's experience and emotions by normalizing their traumatic responses; (b) therapists use examples of other unnamed clients' experiences and their own experiences, boundaries, and beliefs as types of non-immediate SD in developing the therapeutic bond; and (c) clients feel

safer and less judgment when a therapist uses SD positively. SD can be utilized as a connection tool to normalize experiences and decrease unhealthy emotional responses, essential to the patient's best interest. For therapists, identifying the types of helpful non-immediate SD can strengthen the therapeutic bond and the therapist's understanding of the patient's experience. Developing an environment where the patient feels safe is vital to the therapeutic process.

A mutually respectful, trusting, and open environment promotes healing for the patient. This environment includes the therapists identifying their areas of work and healing to prevent burnout. A reciprocally beneficial therapeutic relationship consists of trust and vulnerability. SD is a fundamental element in growing those factors. SD is no longer avoidable and should be evaluated for its contribution to the therapeutic process, which perhaps is a recognition of the opposite of a sterile relationship where the therapist is disconnected and unavailable. Continuous acknowledgment of the factors leading to SD can extend understanding of the importance of the therapeutic relationship to patients. The individuals in this study emphatically voiced their support for wanting to feel seen and heard.

While the therapists in this study expressed that they shared the importance of unconditional positive regard, it was somewhat disheartening to hear that the training has been negative regarding using SD. The therapist participants in this study presented themselves as ethical, competent, and experienced therapists who genuinely loved their work. They spoke of their careers with high regard and generally viewed their approaches as satisfactory. They each echoed the understanding that the overall SD viewpoint must change. Some even used the word outdated to describe the educational stance on SD, especially regarding ethics.

Societal views are ever-changing, and the therapeutic relationship must be able to move forward. Past teachings no longer apply to life after a collective trauma. The use of SD has a

place in healing. If a therapist chooses whether or not to use this technique, it should be their decision. Advancing therapeutic skills by utilizing every facet of healing will only propel the foundations of healing into the future. By not using SD, the therapist could miss reaching a patient and appear cold and disinterested, which can have more significant consequences on the patient and deter them from continuing therapy. The results of this study show how beneficial TSD can be when used within healthy boundaries and guided by ethics. Hopefully, the therapeutic community will start to understand SD through a non-biased lens, moving away from outdated teachings into the current worldview by accepting TSD.

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Appendix A

Institutional Review Board Approval

IRB #: IRB-FY22-23-401

Title: CLINICIANS' SELF-DISCLOSURE WITHIN THE THERAPEUTIC ALLIANCE WITH A TRAUMA-RELATED

DISORDER

Creation Date: 10-8-2022

End Date:

Status: Approved

Principal Investigator: Jenna LaMaster

Review Board: Research Ethics Office

Sponsor:

Study History

Submission Type Initial Review Type Limited Decision Exempt - Limited IRB

Key Study Contacts

Member Jenna Lamaster Role Principal Investigator Contact xxxxxxxx@xxxxxx

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Member Jason Ward Role Co-Principal Investigator Contact xxxxxxxx@xxxxxx

Appendix B

Demographic Questionnaire: Patients

1. Are you currently, and have been for at least two years, in therapy?
2. Do you live in the southern United States?
3. Are you over the age of 18?

   Please provide an email or phone number for the researcher to reach you to schedule an interview.

All participants will provide the following items:

1. Age (in years)
2. Gender
    a. Male
    b. Female
    c. Non-binary
    d. Other:
3. Race or ethnic identity?
    a. White
    b. African American or Black
    c. Hispanic or Latino
    d. Asian
    e. Native Hawaiian or Other Pacific Islander
    f. American Indian or Alaska Native
    g. Bi or multi-racial

4. Level of education (LOE)
    a. High school
    b. College
    c. Graduate

Appendix C

Demographic Questionnaire: Mental Health Professionals

Please provide an email or phone number where you can be reached to schedule the focus group.

1. Type of Degree (Master or Doctoral)
2. License type (LPC, LMSW, PsyD)
3. Years in Practice
4. Primary trauma-based treatment
    a. EMDR
    b. ACT
    c. CBT
    d. ERP
    e. DBT
    f. Other (please specify)
5. Type of treatment population
    a. Private
    b. Inpatient
    c. Community mental health
    d. College counseling center
    e. Other (please specify)

Estimated hours of direct client contact a week?

Appendix D

Demographics for Therapists

THERAPIST	AGE	LICENSURE	GENDER	YEARS IN PRACTICE	TRAUMA-BASED TX	POPULATION	HOURS OF DIRECT CARE A WEEK
1	45	LCSW	F	10+	EMDR, DBT, Energy work	Adults	40
2	45	LPC	M	10+	EMDR	Adults	40
3	65	LCSW	F	20+	Retired	Retired	Retired
4	45	LPC	F	15+	EMDR, DBT, Energy	Adults	40
5	35	LPC	F	10+	EMDR	Adults	40

Appendix E

Demographics for Individuals

PARTICIPANT	AGE	GENDER	ETHNICITY	EDUCATION	YEARS IN THERAPY
JR	28	F	White	Graduate	2.5
KR	30	F	White	Graduate	11
DG	37	F	White	College	23
SC	50	F	White	High School	5
SF	50	F	White	College	7
MJ	30	F	White	College	10

Appendix F

Interview Questions

These are the standardized open-ended semi-structured interview questions that will be asked of participants.

1. How would you describe your experiences with therapy treatment, and which trauma-based therapy you have received: DBT, EMDR, ERP, Somatic experiencing, or other?
2. Ideally, the therapist would only use self-disclosure to strengthen the therapeutic bond. Has a therapist ever used self-disclosure during sessions? How did you feel about the self-disclosure?
3. What forms of non-immediate self-disclosure have you encountered, such as therapist disclosing similar experiences or details about their journey?
4. Think about the last time a therapist disclosed something personal. Did it change how you viewed the therapist?
5. I want to ask you a question that will prompt you to put everything together. Reflecting on your time in trauma-based therapy, do you feel that using self-disclosure was helpful or hurtful to your healing journey?
6. Imagine that you are in a therapy session, and the therapist discloses they, too, deal with the same mental health struggles. How does that impact you?

Appendix G

Follow up with Group A

1. Would the level of TSD affect your vulnerability in therapy?
2. What are your views on virtual therapy regarding immediate TSD?
3. What are your views on therapists disclosing in their bios?
4. Has your view of therapy changed now that you better understand TSD?

Appendix H

Initial Open Therapist Codes

Code	Number of References	Aggregate Number	Items Coded	Aggregate Number
Vulnerability	29	29	10	13
SD / TSD	18	18	11	11
View of Therapist / Therapeutic Bond	15	15	9	9
View of Therapist	14	29	10	13
Experiences / Positive	13	13	7	7
Experiences / Negative	12	12	6	6
Vulnerability/ Bios	9	9	7	7
Trauma / Trauma Therapy	6	6	5	5
Trauma / Non-Immediate	4	4	2	2
LAC Teachings on TSD	4	4	1	1
Changing Times & Views Towards TSD	3	3	2	2
Moving to Virtual	3	3	1	1
Relationship & Connections	3	3	2	2
SW School Teachings	3	3	1	1
Therapeutic Bond Through TSD	3	3	2	2
Boundaries	2	2	1	1
Connection Between Therapist and Client	2	2	1	1
NISD from Therapist	2	2	1	1
Relate to Clients through TSD	2	2	1	1
Trauma and TSD	2	2	2	2
Views Change with Experience	2	2	1	1
SD	1	19	1	11
Trauma	1	11	1	8
Burnout	1	1	1	1
Choosing a Therapist	1	1	1	1
Choosing to SD- Therapist	1	1	1	1
Credibility	1	1	1	1
Current Views of TSD	1	1	1	1
Differing Therapists	1	1	1	1
Expanding Code of Ethics	1	1	1	1
Helpful TSD	1	1	1	1
Immediate TSD	1	1	1	1
Knowing Limitations	1	1	1	1
Line within TSD	1	1	1	1
Mindful of TSD	1	1	1	1
Non-SD Therapist	1	1	1	1
Past Experiences from Clients	1	1	1	1
Previous Negative Experiences	1	1	1	1
Reason for TSD	1	1	1	1
Reason Therapist Do not TSD	1	1	1	1

Therapist Immediate SD	1	1	1	1
Therapist Views of SD	1	1	1	1
Trauma Therapy SD	1	1	1	1
TSD in Today's World	1	1	1	1
Unavoidable	1	1	1	1
Vulnerability	1	1	1	1
Experiences	0	25	0	9

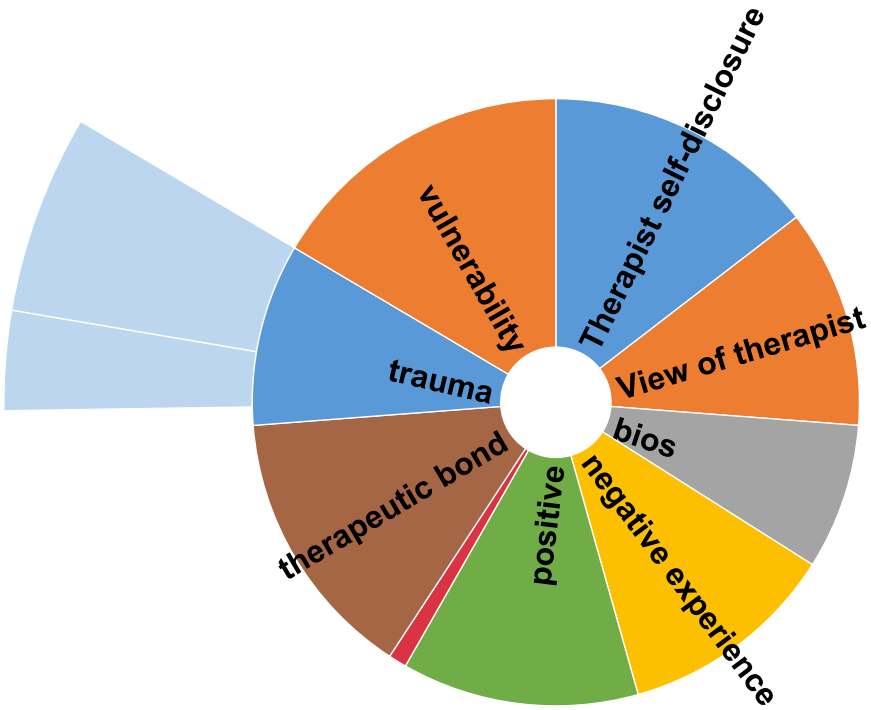
Appendix I

Initial Open Individual Codes

Code	Number of References	Aggregate Number	Items Coded	Aggregate Number
Bios	8	8	7	7
Negative Experience	12	12	6	6
Positive	13	13	7	7
SD	1	1	1	1
Therapeutic Bond	15	15	9	9
TSD	15	15	10	10
Trauma	1	10	1	7
Trauma / Non-Immediate	3	3	1	1
Trauma / Trauma Therapy	6	6	5	5
View of Therapist	12	12	9	9
Vulnerability	17	17	9	9

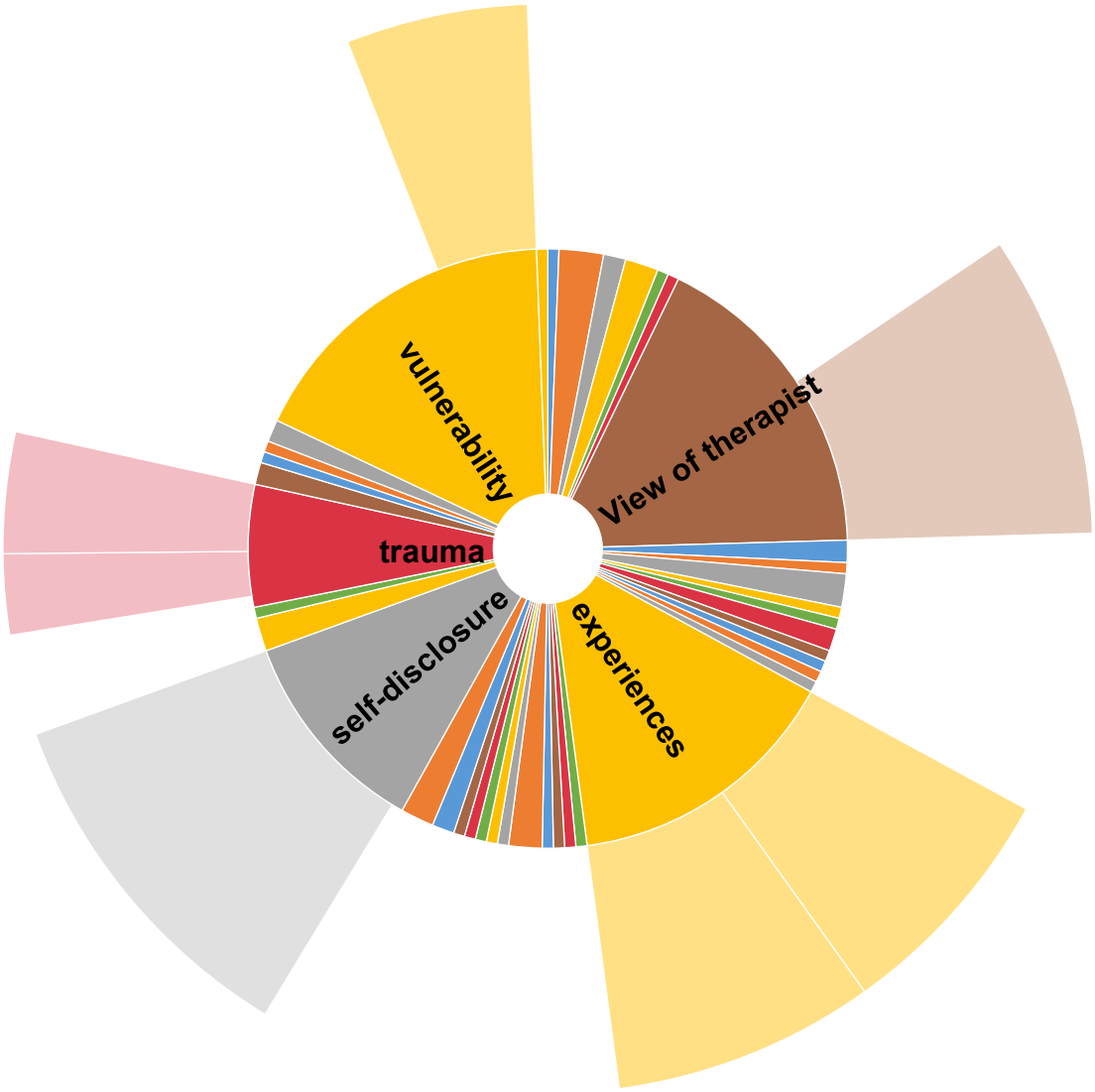
Appendix J

Sunburst of Initial Open Individual Codes



Appendix K

Sunburst of Initial Open Therapist Codes



Appendix L

Selective Individual Codes

Code	Number of References	Aggregate Number	Items Coded	Aggregate Number
Experiences	0	25	0	9
Experiences / Negative Experience	12	12	6	6
Experiences / Positive	1	19	1	11
SD	1	19	1	11
SD / TSD	18	18	11	11
Trauma	1	11	1	8
Trauma / Non-Immediate	4	4	2	2
Trauma / Trauma Therapy	6	6	5	5
View of Therapist	14	29	10	13
View of Therapist / Therapeutic Bond	15	15	9	9
Vulnerability	2	0	29	10
Vulnerability / Bios	9	9	7	7

Appendix M

Sunburst of Selective Individual Codes

Appendix N

Sunburst of Therapist Selective Codes