2022

Therapist Self-Disclosure with Mandated College Students: A Case Study

Zachary Lattanzio

THERAPIST SELF-DISCLOSURE WITH MANDATED COLLEGE STUDENTS: A CASE STUDY

A DOCTORAL PAPER

PRESENTED TO THE FACULTY OF THE

GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY

OFFICE OF GRADUATE STUDIES

UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE

DOCTOR OF PSYCHOLOGY

BY

ZACHARY LATTANZIO, MA

JULY, 2022

APPROVED: _____

Shelly Smith-Acuña, Ph.D., Chair

_____

Jeff Nepute, Ph.D.

_____

Tracy Moran Vozar, Ph.D.

Abstract

Facing the stark reality of a disturbing mental health crisis present in the college populations of the United States, college counseling centers (CCC) must figure out ways in which they can utilize all of their available limited resources, especially regarding potential high-risk students who are unlikely to seek treatment and those that pose a danger to self or others. In certain cases, mandated treatment can potentially mitigate or eliminate crises, and may serve as an effective intervention to students whose risky behavior may be normalized within the culture of colleges across the United States. However, while this course of treatment may be a useful way to ensure that these high-risk students are connected to a therapist in their counseling center, mandating treatment does not guarantee positive treatment outcomes. In fact, this setting creates numerous, highly specific factors that serve as potential barriers to progress when compared with voluntary treatment.

In spite of these difficulties, proper and careful use of therapist self-disclosure (TSD) - the revealing of personal information, thoughts, or feelings to a client - has the potential to be a uniquely powerful intervention for college counselors, as it addresses many of the specific issues involved with mandated therapy directly. This paper aims to review the literature on the current state of CCCs, psychological perspectives regarding the overall effectiveness of TSD, proposed classification systems to help determine appropriate and inappropriate implementations of TSD, and how this information can be applied specifically within mandated settings. In addition, this will be followed by a case study that outlines examples of the use of TSD with mandated college students, reflecting some of the potential benefits and risks associated with the intervention. While TSD in these cases generally led to the accelerated building of a positive therapeutic relationship, there were also clear instances in which disclosure may have produced adverse effects. Thus, an examination of the current literature and the specifics of this case study highlights the importance of conducting additional research on the proper implementation of TSD when treating mandated college students. Additional research in this area should focus on providing college counselors with superior training regarding TSD and clearer guidelines with the aim of effectively and efficiently addressing the issues facing their students.

Keywords: Therapist self-disclosure, college students, mandated treatment, therapeutic alliance, case study

1. Introduction

As a result of the mental health crisis facing college populations, CCCs are increasingly becoming overwhelmed. In the 2019, according to the annual survey published by the Association for University and College Counseling Center Directors (AUCCCD), nearly 90% of CCC directors reported an increase in students seeking counseling (LeViness, Gorman, & Bershad, 2019), especially notable due to the fact that this was prior to the outbreak of the Covid pandemic. Leading up to the pandemic, it was not uncommon for students seeking individual therapy to be placed on 2-3 week waitlists in most CCCs (Bell et al., 2020). In order to alleviate the current high demand for mental health services, 47% of CCCs expressed that they either were

transitioning towards or had adopted a Stepped-Care System, (Gorman et al., 2021), nearly half of CCCs have session limits with an average of 12.6 sessions per academic year (Gallagher, 2013; LeViness, Gorman, & Bershad, 2019; Schwitzer et al, 2018), and 56% of CCCs are no longer able to provide weekly therapy appointments with the exception of high-risk students (Gorman et al., 2020; Gorman et al., 2021). All of these systematic changes resulting in reduced contact with students occurs as the rates of self-reported instances of non-suicidal self-injury (28.7%), suicidal ideation (36.7%), and suicide attempts (10.6%) have increased steadily for nine consecutive years (Center for Collegiate Mental Health, 2020, p. 13). In fact, suicide is now the second most common cause of death among college students with more than 1,000 students dying each year (Schwartz, 2006; Turner, Leno, & Kellar, 2013).

An additional threat to the health of students is the impact of alcohol and substance use on college campuses (Carey et al., 2015; Hingson, Zha, & Smith, 2017; Lawyer et al., 2010; Muehlenhard et al., 2017; NIAAA, 2020; SAMHSA, 2019; Turner, Leno, & Kellar, 2013). According to the most recent estimates by the NIAAA in a 2019 report, approximately 1,519 college students lost their lives due to alcohol-related unintentional injuries (NIAAA, 2020). Alcohol and substance use can have devastating consequences beyond fatalities. During their time in college, more than 1 in 5 women experience sexual assaults (Muehlenhard et al., 2017), the majority of which involve alcohol or other substances (Carey et al., 2015; Lawyer et al., 2010; NIAAA, 2020). More than 25% of students report experiencing negative academic consequences resulting from drinking (Carey et al., 2015; Lawyer et al., 2010; Muehlenhard et al., 2017; NIAAA, 2020). In fact, SAMHSA's 2015 national report on drug use found that 14.6% of college students met criteria for substance use disorder (11.2% alcohol use disorder) and 37.9% of students had engaged in binge drinking within the past month (SAMHSA, 2019).

Given these facts, in addition to the limited resources generally allocated towards college counseling, it is imperative to find methods in which to increase the efficacy of treatment in these mandated populations, both in terms of treatment outcome and resource usage. If this goal is not achieved, the current mental health crisis amongst the college population threatens to stagnate or even deteriorate further. One area that currently appears missing from the literature is the use of TSD with college students being treated in a University Counseling Center, particularly for students who are mandated to treatment due to substance use disorders and/or following a suicide attempt. The dearth of research on the topic and subsequent lack of guiding

principles fall short in considering the intersection of the following factors: involuntary treatment (Bernstein et al., 2017; Bitar et al., 2014; Carey et al, 2018; Kazem et al., 2014; Manchak, Skeem, & Root, 2014; Qi, 2014; Wild et al., 2016), reason for mandate (substance use or suicidality)(Bernstein et al., 2017; Hayes et al., 2019; Hill, 2018; Kazemi et al., 2014; Mastroleo et al., 2014; Milgram & Rubin, 1992; Schwartz, 2006; Weil & Holleran, 2006; Wild et al., 2016; Yurasek et al., 2017), age, professional role, utilization of brief or limited total sessions (Bernstein et al., 2017; Borsari et al., 2015; Carey et al., 2018; Hill et al, 1998; Mastroleo, 2014; Ziv-Beiman et al., 2017), and infrequently meeting (Gorman et al., 2020; Gorman et al., 2021; Manchak, Skeem, & Rook, 2014; Phillips, Fowler, & Westaby, 2018; Trotter, 2015; Qi, 2014; Wild et al., 2016). In spite of the fact that an analysis of general research on TSD seems to suggest that it could be particularly effective with mandated students in CCCs, the lack of specific studies on TSD that focus on this environment may indicate that it is currently being underutilized in CCCs.

2. Literature Review

2.1 TSD in Mandated Therapy

Universities are increasingly implementing policies that involve mandating mental health services (Bertolet, 2016; CCMH, 2020; Gorman et al., 2020; Gorman et al., 2021; LeViness, Gorman, & Bershad, 2019; Schwitzer et al, 2018). While many students who would not otherwise seek counseling services undoubtedly benefit from this system, there are significant drawbacks. Students frequently report that the mandate feels intrusive, inappropriate, unnecessary, and violating (Manchak, Skeem, & Rook, 2014; Phillips, Fowler, & Westaby, 2018; Trotter, 2015; Qi, 2014; Wild et al., 2016) often leading to resistance to treatment in session (Carey et al., 2018; Manchak, Skeem, & Rook, 2014; Mastroleo et al., 2014), no shows or cancellations of sessions (Schwitzer et al., 2018; Yurasek et al., 2017), lack of trust in the therapist, or even in the broader mental health system (Bell et al., 2020; Bernstein et al., 2017; Kazemi et al., 2014). There are numerous underlying issues that could cause suffering that would lead to substance use, suicidal ideation and suicide attempts. College aged students can often be unaware of or reluctant to talk about why they are suffering (Baumann, Ryu, & Harney, 2020; Kazemi et al., 2014; Qi, 2014; Trotter, 2015). Mandated treatment is often an additional barrier to their willingness to talk about these issues, making it difficult to actually address the factors that are motivating the behavior that prompted the mandates in the first place (Bell et al, 2020;

Kazemi et al., 2014; Phillips, Fowler, & Westaby, 2018). Based on literature regarding mandated therapy, there are several ways to overcome previously mentioned barriers, such as: building a strong rapport with client, lowering power differentials that are amplified in an involuntary situation, establishing therapist as distinct from the system that issued their mandate by highlighting the caring nature of therapist, conveying a sense of authenticity to client (Bernstein et al., 2017; Borsari et al., 2015; Carey et al., 2018; Kazemi et al., 2014; Manchak, Skeem, & Rook, 2014; Mastroleo et al., 2014; Milgram & Rubin, 1992; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015; Weil & Holleran, 2006; Wild et al., 2016; Yurasek et al., 2017). TSD is a powerful intervention with the potential to function as the ideal complement to mandated therapy, as its skillful implementation can address the unique barriers mandated treatment creates, leading to better outcomes in treatment.

2.2 Varying Therapeutic Perspectives on TSD

The potential risks and benefits of TSD have been widely debated for decades. While certain theoretical orientations are more intimately aligned with a particular stance – traditional psychoanalysis generally strongly opposes TSD, whereas humanism, feminism, and multiculturalism typically value TSD – over 90% of therapists report that they have self-disclosed with clients (Henretty & Levitt, 2010). Although research suggests that TSD can be a useful intervention (Baumann, Ryu, & Harney, 2020; Hill, 2018; Hill, Knox, & Pinto-Coelho, 2019; Knox & Hill, 2003; Miller & McNaught, 2018; Moody et al., 2021), it also demonstrates that there are always risks associated with self-disclosure and emphasizes careful deliberation prior to its utilization in treatment (Berg et al., 2020; Elliott & Ragsdale, 2020; Farber, 2006; Hill, Knox, & Pinto-Coelho, 2018; McCormic et al., 2019). Important factors to consider include client identities, learning history, focus of treatment, therapeutic alliance, function of the disclosure, stage of treatment, level of intimacy, how much detail, frequency, and how the disclosure is delivered and processed in session (Barrett & Berman, 2001; Farber & Nitzburg, 2015; Goldfried, Burckell, & Eubanks-Carter, 2001; Goldstein, 1994; Henretty & Levitt, 2010; Hill, Knox, & Pinto-Coelho, 2018; Knox & Hill, 2003; McCormic et al., 2019; Moore, Camacho, & Munson, 2020; Norcross & Lambert, 2019; Phillips, Fowler, & Westaby, 2018). Guidelines for using self-disclosure based on the results of several studies have been proposed, but they tend to sample general populations that present with differing issues, utilizing various treatment modalities over a wide range of sessions, etc.

TSD when used properly, especially in a mandated setting, may be a powerful intervention to address these barriers; however, not all theoretical orientations share the same view on its use. Originally, traditional psychoanalysts were strongly opposed to TSD and were trained to be neutral and anonymous in therapy (Alfi-Yogev et al., 2021; Baumann, Ryu, & Harney, 2020; Buirski, Haglund, & Markley, 2020; Jackson, 2020; Kronner & Northcut, 2015; Norcross & Lambert, 2019; Patmore, 2020; Sunderani & Moodley, 2020; Wachtel, 2007). Freud believed that it was a therapist's job to analyze their client's transference, which is obscured if the therapist reveals anything about themselves (Alfi-Yogev et al., 2021; Buirski, Haglund, & Markley, 2020). Freud argued that self-disclosure increases resistance, transference becomes more difficult to analyze, clients become more interested in analyzing their therapist than themselves, and may become further invested in learning more about the therapist (Freud, 1912/1958). However, some modern psychoanalysts "have concluded that by embracing the technique of self-disclosure, the patient may feel the analyst's emotion, without which emotion an authentic analysis is impossible" (Billow, 2000, p. 62). Relational psychoanalysis, or intersubjectivity, emphasizes the importance of real relationships with two equivalent partners (Buirski, Haglund, & Markley, 2020). Their concept of relational authenticity underscores the crucial role that TSD has in therapy: the intersubjective relationship, developing from attunement (shared emotions), mutual attention and awareness, and congruent intentions, aims to help individuals grow together as authentic human persons (Buirski, Haglund, & Markley, 2020). While TSD remains contentious amongst psychoanalysts, it appears that some believe TSD serves a humanizing purpose, helping clients to view their analysts as regular humans with a full range of emotions, making them trust and reveal more to their therapists (Baumann, Ryu, & Harney, 2020; Buirski, Haglund, & Markley, 2020; Knox & Hill, 2003 Norcross & Lambert, 2019; Patmore, 2020).

Therapists that hold a humanistic orientation suggest that TSD demonstrates positive regard for the clients. "Since the 1950s, person-centered counselors have continued to argue that by modeling openness, strength, vulnerability, and the sharing of intense feelings cautiously, the counselor who uses therapy-relevant disclosures invites the client to follow suit and cultivates trust, perceived similarity, credibility, and empathic understanding" (Henretty et al., 2014, p. 1). They believe that TSD is essential in normalizing the issues their clients are facing, while also

reducing power differential in the therapeutic relationship (Baumann, Ryu, & Harney, 2020; Knox & Hill, 2003; Hill, 2018).

Feminist and multicultural traditions strongly advocate for the use of TSD in therapy (Alexandrova, 2021; Bennett et al., 2022; Brown & Walker, 1990; Hays, 2022; McCormic et al., 2019; McDonald, Rappaport, & Bates, 2022; Moody et al., 2021; Moore, Camacho, & Munson, 2020; Sue & Sue, 1999; Sunderani & Moodley, 2020). Mahalik, VanOrmer, and Simi (2000) have asserted that TSD is an intervention that is rooted in feminist values, cultivates client growth and change, equalizes power in the relationship, enhances the connection between client and therapist, reduces shame, and helps make the therapeutic relationship feel more genuine. Sue and Sue (1990) posit that it is especially beneficial to use with clients from different sociocultural backgrounds and may be necessary to demonstrate trustworthiness when therapists work with clients who do not hold similar identities. Additionally, Henretty et al. (2014) found that the research on therapists disclosing their own lesbian, gay, bisexual, or transgender identities to clients holding similar identities (a) helped "create a safe environment in which clients know they will not be judge[d] negatively (Hanson, 2005); (b) [created a model] for expressing appropriate actions and appropriate emotions (Cabai, 1996; Mathy, 2006; Riddle & Sang, 1978); (c) [assisted in] counter[ing] internalized hatred and shame (Satterly, 2006); and (d) [led to therapists being] viewed as a more credible source of help than counselors without an LGBT identity (Atkinson, Brady, & Casas, 1981; Cass 1979, as cited in Henretty et al., 2014, p. 4).

Cognitive behavior therapists view TSD as a potentially beneficial intervention, as it may increase motivation to change and enhance the therapeutic relationship (Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). Goldfried, Burckell, & Eubanks-Carter (2003) assert it can be used to "provide feedback on the interpersonal impact made by the client, enhance positive expectations and motivation, strengthen the therapeutic bond, normalize the client's reaction, reduce the client's fears, and model an effective way of functioning" (p. 559). They posit that TSD derives these benefits based on principles of reinforcement and modeling. Initially proposed by Bandura (1996), proponents of the cognitive behavioral perspective argue that modeling can be used to teach individuals to learn novel ways of thinking and behaving: teaching new ways of coping and altering unrealistically high personal standards, removing inhibitions that hinder the client,

encouraging inhibitions that help the client refrain from acting out inappropriately, motivating certain behaviors that the individual is capable of but does not perform because they lack incentive, and eliciting emotional reactions in individuals, which is especially relevant for individuals who struggle to identify and express their emotions (Bandura, 1996; Goldfried, Burckell, & Eubanks-Carter, 2003; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019).

Current literature is shifting focus to look beyond simply determining whether or not TSD works towards figuring out how and in what ways it does so, and then studying ways in which to maximize efficacy while minimizing risk (Alfi-Yogev et al., 2021; Bate et al., 2022; Baumann, Ryu, & Harney, 2020; Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Miller & McNaught, 2018). Functional analytic psychotherapists differentially respond to client's ineffective (CRB 1s) and effective behaviors (CRB 2s) (Kohlenberg & Tsai, 1991). By disclosing the impact that clients' responses have on the therapist, they can reinforce adaptive behaviors and punish or discourage problematic behaviors (Kohlenberg & Tsai, 1991). In Marsha Linehan's cognitive behavioral approach to treating borderline personality disorder (1993), she differentiates between therapists' disclosure of personal information and disclosure of their immediate reaction to the client within the session, both serving important functions (Linehan, 1993). As previously mentioned, within cognitive behavioral therapy the former type of disclosure is consistent with the principle of modeling and can help teach and encourage clients to adopt more effective ways of coping (Bandura, 1996; Goldfried, Burckell, & Eubanks-Carter, 2003; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). Within DBT, radical genuineness is a version of the latter form of disclosure in which one understands the emotion that the other is experiencing on a deep level and shares that experience as an equal (Linehan, 1993). This type of disclosure provides validation, normalizes the client's struggle, demonstrates similarity, builds trust, and can motivate client's disclosing in the future.

Nevertheless, nearly all researchers who support the use of TSD warn of the potential risks associated with its improper use. When not implemented skillfully, TSD can decrease clients' belief that their therapist can be helpful, shift the focus of the session or treatment overall from the client to the therapist, disrupt the client's growth, blur boundaries of therapy, contaminate transference, or cause the client to become overwhelmed, or anxious about their

therapist's wellbeing (Barrett & Berman, 2001; Berg et al., 2020; Billow, 2000; Elliott & Ragsdale, 2020; Geller & Farber, 1997; Hill, Knox, & Pinto-Coelho, 2018; McCormic et al., 2019; Tansey & Burke, 1989). While in agreement that TSD can be beneficial when used properly, and detrimental when not, different theoretical orientations have focused their research on different factors, leading to varying conclusions regarding their recommendations for effective TSD.

2.3 Factors Involved in Classification of TSD

As supporters of different theoretical orientations hold varying perspectives on the use of TSD, researchers also focus on different variables in their attempts to understand TSD and provide recommendations for clinicians. Henretty et al. (2014) focused on three distinctions of TSD: 1) intratherapy experience (i.e. thoughts/feelings about the client or therapy) vs extratherapy experience (i.e. past, present, or hypothetical occurrences in the therapist's personal life), 2) positive vs negative content valence, and 3) similarity or dissimilarity to the client. They concluded that TSD related to experiences of negative content valence that revealed similarities between the therapist and client, and TSD that related to intratherapy or especially extratherapy experiences led to more benefits for clients than nondisclosure. Specifically, this led clients to have a more favorable view of their therapist, strengthened the therapeutic alliance, increased clients' willingness to continue treatment with the disclosing therapist, and led clients to disclose in therapy more frequently (Henretty et al., 2014).

In Knox & Hill's (2003) research-based suggestions for practitioners, they examined the available research on TSD, focusing on how differences in the content, frequency and the level of intimacy of the disclosure alters the impact on the client and/or the therapeutic relationship. Based on their research, they suggested seven subtypes of disclosure that are based on a combination of content and function: disclosures of facts, feelings, insight, strategies, reassurance/support, challenge, and immediacy (Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Hill, Knox, & Pinto-Coelho, 2019; Knox & Hill, 2003).

With regard to content, a study conducted by Edwards and Murdock (1994) found that the 184 licensed, doctoral-level psychologists disclosed the following from most common to least: professional background (i.e. degree, therapy style, and training experience), successes and failures, interpersonal relations, attitudes, personal feelings, and sexual practices and beliefs (Edwards & Murdock, 1994). A second study conducted by Geller and Farber (1997) found the

following topics to be 1) most frequently disclosed: therapists' acknowledgement of mistakes or technical errors; 2) moderately frequently disclosed: reactions to clients' self-presentations, beliefs regarding the efficacy of therapy, personal information (i.e. whether they had children, location of a vacation, marital status, age, and ethnicity); 3) and least commonly disclosed: therapists' religious beliefs, birth date, and sexual orientation (Hill, Knox, & Pinto-Coelho, 2018; Knox & Hill, 2003). Knox and Hill concluded that "therapists evidently believe that disclosures of content-related professional background may be better received than those related to more personal areas of their lives (e.g. sexuality)" (Knox & Hill, 2003, p. 533). However, therapists that work from feminist or multicultural perspectives suggest that self-disclosure of more personal information is required in order for clients to have informed consent to work with their therapist (Bennett et al., 2022; McCormic et al., 2019; McDonald, Rappaport, & Bates, 2022; Hays, 2022; Mahalik, Van Ormer, & Simi, 2000; Moore, Camacho, & Munson, 2020; Moody et al., 2021; Sunderani & Moodley, 2020). This is in agreement with previously mentioned research, which demonstrated that therapist's disclosing their own LGBTQ+ identity to a client holding a similar identity had significant benefits in creating a safe environment without the fear of judgment, providing a model for expressing appropriate actions and emotions, countering internalized shame and hatred, and leading the patient to view the therapist as a more credible source of help than a therapist without an LGBTQ+ identity (Alessi, Dillon, & Van Der Horn, 2019; Baumann, Ryu, & Harney, 2020; Bjork, 2004; Chui et al., 2018; Cole & Drescher, 2006; Drescher, & Fadus, 2020; Henretty et al., 2014; Hill, 2018; Kronner & Northcut, 2015; Matsuno, 2019; Mizock & Lundquist, 2016; Moore, Camacho, & Munson, 2020; Shipman & Martin, 2019). Thus, it appears that while many therapists feel more comfortable and therefore disclose less personal information most frequently, research suggests that there are circumstances in which disclosing more personal information can, in fact, be more beneficial.

Additionally, Knox and Hill (2003) found that different levels of intimacy of disclosures often significantly altered the impact of the intervention. High intimacy disclosures may cause clients to feel compelled to care for their therapist, intimidate the client, or may cause boundary problems in the therapeutic relationship; low to medium intimacy disclosures may serve to normalize clients' struggles, help the therapist seem more human to the client, and enhance the therapeutic relationship by increasing trust without revealing unnecessarily personal information (Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Hill, Knox, & Pinto-Coelho, 2019; Knox & Hill,

2003). Non-intimate disclosures, however, likely do not make the therapist appear more human nor demonstrate that the therapist trusts the client with information about themselves, which is in turn unlikely to normalize the client's struggles (Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Hill, Knox, & Pinto-Coelho, 2019; Knox & Hill, 2003). Thus, it appears that disclosures of low to medium intimacy are most likely to provide the most benefit while limiting the potential negative risks associated with intimate disclosures, especially those of a higher level.

It is important to consider the frequency that therapists utilize self-disclosure. Knox and Hill (2003) suggested that the potency of TSD may be derived from its being utilized relatively infrequently compared to other interventions. In fact, their research indicated that therapists who disclosed moderately occasioned more client disclosures and were viewed more favorably than those who disclosed too often or those who never disclosed or did so rarely (Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Hill, Knox, & Pinto-Coelho, 2019; Knox & Hill, 2003). Further, therapists who very rarely or never disclosed were often experienced by their clients as "distant, aloof, and impenetrable," (Knox & Hill, 2003, p. 533) which resulted in a weak therapeutic alliance. Clients who had therapists that disclosed too frequently often experienced their therapists as having poor boundaries and found that the focus of sessions would shift from the client to the therapist (Berg et al., 2020; Elliott & Ragsdale, 2020; Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Knox & Hill, 2003; McCormic et al., 2019; Miller & McNaught, 2018; Rosner, 2022). Therefore, therapists should consider the frequency they self-disclose with their client prior to deciding to use it as an intervention.

As previously mentioned, frequency, content, and intensity are all important variables that can influence whether TSD will be an effective intervention or negatively impact the progress of treatment. However additional factors include the timing of the disclosure and its relevance to the conversation/ client's experience, as poorly timed or irrelevant disclosures demonstrate a lack of understanding and weaken the therapeutic alliance (Baumann, Ryu, & Harney, 2020; Berg et al., 2020; Elliott & Ragsdale, 2020; Hill, 2018; McCormic et al., 2019). Moreover, immediately after self-disclosing, what the therapist does can significantly affect the effectiveness of the disclosure. Ideally, the therapist will follow the disclosure by bringing the focus back to the client, which can model how to disclose, normalize feelings or struggles, and/or provide insight (Baumann, Ryu, & Harney, 2020; Berg et al., 2020; Elliott & Ragsdale, 2020; Hill, 2018; McCormic et al., 2019; Miller & McNaught, 2018). Alternatively, not bringing the

focus back to the client by changing the topic, or not addressing the disclosure can cause the focus of the session to shift from the client to the therapist and blur the boundaries of therapy (Geller & Farber, 1997). Finally, therapists who self-disclose about their own ongoing issues risk co-opting the session to focus more on addressing their own needs rather than those of their clients, or they may not have enough distance from the experience to remain objective and be useful to their clients (Elliott & Ragsdale, 2020; McCormic et al., 2019). Therefore, it may be more beneficial for the therapist to disclose issues that have already been resolved (Elliott & Ragsdale, 2020; Goldstein, 1994; McCormic et al., 2019;).

2.4 Functions of Different types of TSD

Goldfried, Burckell, & Eubanks-Carter (2003) differentiated between types of disclosures based on the function the disclosure can provide for the client or therapeutic relationship. As previously mentioned, those include: providing feedback on the interpersonal impact made by the client, enhancing positive expectations and motivation, strengthening the therapeutic bond, normalizing the client's reaction, reducing the client's fears, and modeling an effective way of functioning (Goldfried, Burckell, & Eubanks-Carter, 2003). Without a strong therapeutic bond in particular, even the most skilled therapist utilizing the most effective interventions are unlikely to help improve their client's experience (Alessi, Dillon, & Van Der Horn, 2019; Alfi-Yogev et al., 2021; Bjork, 2004; Fuertes, Moore, & Galey, 2019; Hays, 2022; Hill, 2018; Henretty et al., 2014; Levitt et al., 2015; Manchak, Skeem, & Rook, 2013; Norcross & Lambert, 2019; Simonds & Spokes, 2017; Ziv-Beiman et al., 2017). Through effective use of TSD, such as disclosing having experienced similar issues that the client is currently experiencing, therapists can help their clients come to view them as human and enhance their therapeutic bond (Baumann, Ryu, & Harney, 2020; Goldfried, Burckell, & Eubanks-Carter, 2003; Johnsen & Ding, 2021; Solomonov & Barber, 2019). "The more the patients know the real person of the therapist, the more likely it is that trust will develop" (Fay, 2002, p. 154). This is particularly important when working with college students who are mandated to treatment, as they, more often than not, start treatment distrusting the intentions of the therapist and the purpose of treatment, feeling coerced and trapped (Bernstein et al., 2017; Borsari et al., 2015; Carey et al., 2018; Kazemi et al., 2014; Manchak, Skeem, & Rook, 2013; Mastroleo et al., 2014; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015; Wild et al., 2017) . Establishing trust in the relationship will be crucial for

the sessions to be useful and/or to leave the client feeling open to seeking therapy voluntarily in the future.

Numerous studies provide overwhelming evidence of the general therapeutic benefits of TSD when implemented effectively and for specific purposes. In alignment with Goldfried, Burckell, & Eubanks-Carter, Hill & Knox (2002) suggested that appropriate reasons to disclose include: to provide information, demonstrate similarities between therapist and client, model adaptive behavior, stimulate new ways of thinking and behaving, enhance the therapeutic alliance, or normalize and validate client experiences. Knox and Hill's (2003) research concluded that TSD in general has immediate positive effects: reassuring disclosures were rated by clients as more helpful and occasioned higher emotional experiences for the client than challenging disclosures; TSD facilitated insight for the client; TSD made the therapist appear more genuine, which improved the therapeutic alliance, normalized client experiences, and fostered feelings of reassurance, which in turn led to clients feeling better, demonstrating more openness and honesty in therapy. Barret and Berman (2001) found that therapists who disclosed in response to similar client disclosures (labeled reciprocal therapist self-disclosures) were liked more by their clients and their clients reported reduced symptom distress post-treatment. Knox et al., (1997) shared an example of TSD in which the therapist disclosed having spent summers at the shore during his childhood, like the client. The client reported that this intervention (a) provided insight for the client: reminding her of positive experiences in her youth, shifting her view of her parents from evil to ill, which allowed her to forgive them before they died; (b) made the therapist seem more real; (c) reduced client's experience of a power differential in the therapeutic relationship; (d) increased client's confidence in her therapist's ability to understand her due to their shared experiences; (e) increased client's sense of importance and esteem due to the trust she felt from her therapist. The findings of Sue & Sue (1999) emphasize the importance of therapist self-disclosure in cultivating trust in the safety of therapy when working with clients who hold marginalized identities that their therapist does not share.

2.5 TSD Usage Specific to Mandated Therapy

While there is not much research on the population this paper focuses on, research into therapeutic outcomes in other mandated settings have shown the strong benefits TSD can provide to address the unique challenges present in such environments. Mandated students often present to session with low motivation to change, lack of trust in the therapist and/or the overall

system, lack of hope that their situation could improve, poor insight into the factors contributing to their distress, a limited toolkit of healthy and effective coping strategies that can regulate their emotional experiences, and a lack of awareness of the impact of their interpersonal style (Bernstein, 2017; Borsari et al., 2015; Carey et al., 2018; Kazemi et al., 2014; Manchak, Skeem, & Rook, 2013; Mastroleo et al., 2014; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015; Wild et al., 2017). Some of these experiences may be due to a personality disorder, growing up in families that did not demonstrate appropriate and adaptive ways to cope, and/or in families where their reactions to their behavior were either not communicated or not normative (Kazemi, 2014; Linehan, 1993). Linehan (1993) suggests that for clients with these experiences, therapeutic modeling and disclosing the impact that the client has on the therapist personally can potentially be useful for clients, as therapists would be able to model more effective ways of coping and provide invaluable interpersonal feedback that hopefully will give the client a more realistic understanding of effectiveness of their interpersonal behavior. Moreover, many of the challenges related to clients' attitudes towards treatment may further be exacerbated by common constraints of a college counseling center: of primary concern being the limited numbers of sessions that sometimes occur once every two to four weeks (Borsari, 2015).

3. Method

This paper uses a case study methodology in order to provide examples of TSD use with mandated college students in a counseling center. This was done to provide evidence of such usage and the results in real-life contexts, especially as there is a lack of research relating to the unique population of students who are mandated treatment at CCCs (Yin, 2013). The author previously worked as both an advanced practicum student and a doctoral intern within the same CCC in a public university in the Rocky Mountain region of the U.S. With the help of a supervisor, he has deidentified the following cases by not including names and altering certain specific identifying information (Drotar, 2008; El-Gilany, 2019; Gagnier et al., 2014). As this is a case study with a limited number of described cases, these findings themselves are not be generalizable to other CCCs (Drotar, 2008; El- Gilany, 2019; Gagnier et al., 2014; Roberts & Steele, 2010); however, the data obtained through these cases do clearly demonstrate a greater need for the broader scientific community to further investigate the ways in which TSD can lead to better treatment outcomes without placing an undue increased burden on systems which are often already spread thin.

The following three case examples have been deidentified and are presented in order to demonstrate how therapists can use self-disclosure with mandated students in a CCC to positive effect, as well as provide a few examples of situations where TSD used did not achieve its intended purpose.

3.1 Case one: KF

KF identified as a white, non-binary lesbian (pronouns she/they), avid video game player who grew up in a town that held strong conservative values. They reported a history of abuse by their father, witnessed domestic violence prior to their parents' divorce and had no prior experience with mental health treatment. They were mandated to treatment following a suicide attempt that involved slitting their wrists and overdosing on a combination of pills. During the intake session, they were unwilling to talk about factors causing their suffering, which they revealed later was due to deep shame of the content of their intrusive thoughts.

With mandated students, I feel that it is important to use disclosure during the intake, in order to diminish differences in power, establish trust in the relationship through demonstrating that I am actively choosing to place trust in them, and, ideally, disclose aspects of experiences that share similarities to those of my clients (Bernstein, 2017; Borsari et al., 2015; Carey et al., 2018; Kazemi et al., 2014; Manchak, Skeem, & Rook, 2013; Mastroleo et al., 2014; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015; Wild et al., 2017). Typically, I will disclose my cultural identities, consistent with feminist theory findings, to provide my clients with informed consent around where my perspective and advice is coming from (Alessi, Dillon, & Van Der Horn, 2019; Alexandrova, 2021; Baumann, Ryu, & Harney, 2020; Bennett et al., 2022; Chui et al., 2018; Drescher, & Fadus, 2020; Kronner & Northcut, 2015; Matsuno, 2019; McCormic et al., 2019; McDonald, Rappaport, & Bates, 2022; Moody et al., 2021).

With KF, I shared that I identify as white, pansexual, non-binary (pronouns he, him, his), person who has male stimulus value, Italian-Irish American, high SES, was raised Catholic, but no current religious affiliation. After KF shared their identities, I also disclosed having a connection with video games and explored what games they enjoyed playing and how often they played. The aim of this disclosure of similarity was to: (a) create a safe environment; (b) make the therapist seem more real; (c) reduce client's experience of a power differential in the therapeutic relationship; (d) increase client's confidence in their therapist's ability to understand them due to their shared experiences; (e) increase client's sense of importance and esteem due to

the trust they felt from their therapist; (f) increase client's willingness to continue treatment with the disclosing therapist; and (g) lead client to disclose in therapy more frequently (Baumann, Ryu, & Harney, 2020; Chui et al., 2018; Goldfried, Burckell, & Eubanks-Carter, 2003; Henretty et al., 2014; Hill, 2018; Johnsen & Ding, 2021; Knox et al., 1997; Solomonov & Barber, 2019). The impact of this disclosure was immediately observable, as they started smiling, leaned-in, and excitedly shared some of the games they played. We found that we had a similar connection in that we played games in which we had the freedom to choose characters where we had more freedom to explore how we expressed our gender. This very specific shared experience relating to our gender identity and expression is consistent with the current literature on therapist's disclosing their own LGBTQ+ identity to a client holding a similar identity and the intention of the disclosure aligned with the significant benefits outlined in the literature: to create a safe environment without the fear of judgment, to provide a model for expressing appropriate actions and emotions, to counter internalized shame and hatred, and to lead the patient to view the therapist as a more credible source of help than a therapist without an LGBTQ+ identity (Alessi, Dillon, & Van Der Horn, 2019; Baumann, Ryu, & Harney, 2020; Bjork, 2004; Chui et al., 2018; Cole & Drescher, 2006; Drescher, & Fadus, 2020; Henretty et al., 2014; Hill, 2018; Kronner & Northcut, 2015; Matsuno, 2019; Mizock & Lundquist, 2016; Moore, Camacho, & Munson, 2020; Shipman & Martin, 2019). Capitalizing on the trust and credibility that was established, I shared that from my experiences, I differentiate between healthy and unhealthy gaming and asked if they felt that they had similar experiences. This established a framework for later discussions about dialectics that was rooted in their lived experience and helped teach them how reflect on their experience and differentiate between situations when they utilized gaming as an alternative coping strategy to self-harm that provided distraction from intense emotions, and when they used gaming as experiential avoidance, an escape from dealing with responsibilities, often leading to feeling overwhelmed, trapped, and shame.

I ask for feedback at the end of all my sessions to reflect on aspects of session that were useful and to increase client's willingness to share constructive feedback, as well as the opportunity to do so, by asking for it explicitly. At the end of our first session, KF shared that they felt excited to be working with someone who shared similar identities and felt that they could be more open with me than they were anticipating coming into the session. While they shared that they were not ready to talk about what had led their to their suicide attempt, they

were willing to acknowledge that they had omitted certain experiences during our intake and asked if we could talk about them during our next session. Consistent with literature regarding disclosures of similarity, my use of TSD served to begin to counter key obstacles established by their being mandated to treatment: creating a safe environment, reducing client's experience of the power differential within in the relationship, establishing trust through the authenticity of the therapist, increasing client's confidence in therapist's ability to understand them due to their shared experiences, and increasing client's willingness to continue treatment while disclosing their own experience more frequently (Baumann, Ryu, & Harney, 2020; Chui et al., 2018; Goldfried, Burckell, & Eubanks-Carter, 2003; Henretty et al., 2014; Hill, 2018; Johnsen & Ding, 2021; Knox et al., 1997; Solomonov & Barber, 2019).

Eventually, KF shared that they suffered from intrusive images that contributed to their social phobia and fueled their desire to escape in video games, as it provided them an outlet to be social without fear of hurting or being hurt by others. I disclosed how connected I felt to them as they became more open with their experiences and explored the shame that they experienced around having these intrusive experiences. Consistent with Goldfried, Burckell, & Eubanks-Carter (2003), disclosing the interpersonal impact made by the client served to reinforce their willingness to openly share experiences associated with shame, convey non-judgmental care for client, and build a stronger therapeutic alliance. They went on to share that they experienced panic attacks when they were around unfamiliar people, and they were unsure how others would react to them if my client needed to suddenly leave. While they were not willing to talk about the content of their intrusive images, they shared at the end of the session when I asked for feedback that they were surprised to hear that I felt more connected to them when they disclosed having those experiences, which was in line with my goals behind sharing my immediate experience. The reasons I chose to disclose my interpersonal experience were consistent with Hill, Knox, & Pinto-Coelho's (2018) conclusions regarding rationale and benefits of this form of TSD: improving the therapeutic alliance by making the therapist appear more genuine, and fostering feelings of reassurance, which in turn lead to clients feeling better, demonstrating more openness and honesty in therapy. I further shared that I was wanting to know more about their intrusive experiences and that I could tell that they held a tremendous amount of shame for having them. They started to cry and stated that they would eventually share, but the time did not feel quite right yet. I stated that I could relate with their experience and explained that I used to have

intrusive thoughts as I walked by strangers when my anxiety was high, which typically resulted in panic attacks, as I felt awful for having those thoughts and that it was completely out of my control. My understanding of my intrusive thoughts was that they were the worst insults I could think of in the moment in case the person were to attack me for my identities and through my own therapy, I came to understand them as a reaction to my experiences of being bullied in middle and high school for being different from other students. After disclosing so much, I ensured that I explored how my disclosure had landed for them and inquired as to whether their experiences were similar, after which she became tearful and shared that they were. Without knowing the specifics of her intrusive images, I had hoped to model that sharing shameful experiences in therapy was appropriate, normalize experiences they had in the past that caused them deep shame, inspire hope that therapy could help alleviate their suffering, and foster trust in our relationship. This type of disclosure is consistent with findings from Elliott & Ragsdale (2020) and McCormic et al. (2019), in which they discuss disclosing having experienced similar issues related to client's current issues and emphasize that it can have all of the positive effects previously mentioned, provided that the therapist is not still currently struggling with those issues and the therapist ensures to relate it back to the client.

KF started our next session by stating that they had been thinking about my experience since our last session and was curious about how I was able to stop having panic attacks and my intrusive thoughts. I was able to provide her with a mix of psychoeducation and disclosure of my personal experiences of the different types of exposure therapy I did in my own therapy: interoceptive cues exposure for panic, in vivo exposure for social phobia, and Exposure with Response Prevention (ERP) for the obsessive-compulsive pattern I had with my own intrusive thoughts. This type of disclosure is consistent with many previously mentioned researchers, especially those based on a CBT perspective, as the disclosure helps to serve as a model for client, normalize their experiences, and increase willingness to share their own experiences (Bernstein et al., 2017; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). KF shared that they were wanting to start some of this process on their own, but still were afraid to talk about their most intense intrusive images. They, however, agreed to honestly go through the Yale Brown Obsessive-Compulsive Scale (YBOCS) as long as they did not have to elaborate on anything that they still did not feel comfortable talking about. It became clear that their most distressing experiences centered on intrusive

images of hurting themselves, hurting others, incest, and sexual experiences involving minors. Still unwilling to further discuss these disturbing intrusive images, they were willing to start ERP for their contamination and checking experiences. At the end of this session, they shared that, had I given them the YBOCS at the beginning of treatment without disclosing my own experiences, that they would have been overwhelmed with shame and lied about their own experiences. This indicated that my previous disclosure had the desired impact (Bernstein et al., 2017; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). I disclosed how I was grateful that they felt they could trust that I would not judge them for having these experiences and that it made sense that they often escaped with video games because they wanted to avoid having these experiences. In making this disclosure, I hoped to reinforce their willingness to share deeply painful experiences with me and increase their motivation to do so in the future, reduce their shame, normalize their experience, and strengthen our relationship, consistent with Hill, Knox, & Pinto-Coelho's (2018) conclusions regarding rationale and benefits of this form of TSD.

In subsequent sessions, I disclosed how proud of them I was as they continued to share more vulnerably in session and take control of their relationship and responses to their fears by being more willing to approach rather than avoid triggering situations. KF continued to improve, reporting reduced urges to self-harm, less frequent and less intense intrusive images, less frequent panic attacks, and increased ability to engage socially outside of their virtual worlds. At the end of our treatment, KF shared that they would not have had the courage to share their true experiences with me had I not demonstrated that I trusted them with some of my most shameful experiences. For our relationship, I feel that my use of disclosure encouraged their willingness to disclose their experiences, increased their motivation to reverse their behavior and instead face their fears head on as opposed to avoiding them, strengthen our relationship, increase their hope that their symptoms would improve, model more effective coping strategies, normalized and validated their painful experiences, and provided them with insight about how their past experiences were influencing their current symptomology (Bernstein et al., 2017; Hill, Knox, & Pinto-Coelho, 2019; Manchak, Skeem, & Rook, 2014; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015).

3.2 Case 2: TC

TC identified as a heterosexual, cisgender male who had a white father and a Latina mother and was white-passing himself. He was homeschooled in a rural part of the country, which likely influenced the intense social phobia with which he presented. He was mandated to treatment following a suicide attempt during an intense panic attack in which he felt that he would never feel truly connected with others. During his intake session, he shared how his awareness that he was white-passing and did not speak Spanish prevented him from feeling like he was able to connect with his Latino culture. Instead of feeling a sense of inclusion, he instead felt like an outsider when interacting with people who were part of the Latino fraternity on campus that he wanted to join, but his fear of rejection prevented him from attempting to be accepted into said fraternity. I disclosed how I felt like I related to his experience by identifying as non-binary but presenting as male and how I used to feel that I would not be accepted by people within the LGBTQ community because of how I expressed my gender. Consistent with feminist, LGBTQ+, and multicultural literature, this disclosure of my identity and personal experience was aimed at cultivating client growth and change, equalizing power in the relationship, enhancing the connection between client and therapist, reducing shame, and helping make the therapeutic relationship feel more genuine (Alessi, Dillon, & Van Der Horn, 2019; Baumann, Ryu, & Harney, 2020; Bjork, 2004; Chui et al., 2018; Cole & Drescher, 2006; Drescher, & Fadus, 2020; Hill, 2018; Kronner & Northcut, 2015; Matsuno, 2019; Mahalik, Van Ormer, & Simi, 2000; McDonald, Rappaport, & Bates, 2022; Mizock & Lundquist, 2016; Moore, Camacho, & Munson, 2020; Shipman & Martin, 2019). At the end of the session, he expressed that he appreciated my sharing how I related to his experience and being willing to talk about my personal experiences.

As we started treatment, he had a negative reaction to the idea of exposure therapy. At this point, I disclosed how I used to suffer from panic attacks and social phobia as well, and what helped me address these experiences was doing exposure in my own therapy. I shared how I was skeptical and afraid of the idea when it was originally presented to me. I realized that it would involve facing my worst fears and how, at the time, I felt that my relationship with anxiety was like I was treading water, using all my energy to simply keep my mouth above the water and not drown. The idea of exposure to me at the time was like I was adding 20lb weights to my ankles. This type of disclosure is consistent with many previously mentioned researchers, especially those based on a CBT perspective, as the disclosure helps to serve as a model for client,

normalize their experiences, increase willingness to share their own experiences, and increase willingness to try new behavioral strategies (Bernstein et al., 2017; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). I asked TC how he was feeling about exposure and how hearing my story was impacting him. TC explained that he already felt that he had weights pulling him down and that the idea of doing exposure was like someone was going to be pushing his head down, too. I validated how intimidating what I was asking him to do was and shared how my actual experience differed from my imagined experience: rather than exposure being weights tying me down, exposure helped me learn how to float on top of the water instead of fighting to not drown. Following this explanation, TC shared that he was open to trying to learn how to float but was still skeptical. Intratherapy disclosure (validating TC's nervous feelings) and extratherapy disclosure (past personal experiences relating to trying exposure therapy) were utilized to normalize client's concerns, strengthen the therapeutic alliance, and encourage client to try exposure therapy despite his concerns (Henretty et al., 2014). We designed an in vivo exposure exercise that involved telling his roommate and current best friend how he struggled to feel connected to his Latino identity because of how he is white-passing. At the end of the session, he shared how he was still nervous to try the exposure exercise but felt like hearing my experience provided him with hope that sharing his fears with his friend would actually help them connect on a deeper level rather than push him away.

At the beginning of our next session, he shared that he almost skipped our session because he felt ashamed that he was not able to follow through on our exposure target, as he became too nervous that his close friend would reject him. I disclosed how appreciative I was that he came to our session despite feeling ashamed and that I felt that I had messed up by assigning such an intense exposure exercise for him. In retrospect, I believe that his reaction to my story made me feel that he was more willing to try something new than he truly was and I shared this reflection with him. Intratherapy disclosure was made regarding the impact of previous TSD and how I miscalculated how much he was affected by the TSD when creating an exposure target, which is a potential risk when using TSD (Berg et al., 2020; Henretty et al., 2014). He was appreciative that I was not upset with him and that I had admitted to making a mistake. He went on to share how he felt that his experience of being homeschooled for so long combined with a feeling that he was neurobiologically different from other people made it so that he had deficits that prevented him from being able to connect with other people and for people to

feel connected to him. I shared how I could not speak for his experience, but I often have felt very connected with him, even knowing him for such a short period of time. TC expressed feeling similarly connected with me, but was surprised that I felt that way about him. Intratherapy disclosure about connection of relationship and demonstrated effects of TSD on strength of therapeutic alliance (Baumann, Ryu, & Harney, 2020; Goldfried, Burckell, & Eubanks-Carter, 2003; Johnsen & Ding, 2021; Solomonov & Barber, 2019).

We created a hierarchy of experiences that elicited anxiety for him and one stood out as a potential starting point: TC shared that there was a student in one of his current classes that he had been in three or four classes with already and they were assigned to be in a group project together. Although he was attracted to her and had been in so many classes together, he did not remember her name and was afraid to admit this to her. I shared how I would experience someone disclosing this information to me, especially if he shared that he wanted to get to know me better but felt like he ruined his chances by not remembering my name. After modeling how he could approach this situation, TC reported that he was leaving our session feeling confident in his ability to follow through on asking her for her name and sharing what had prevented him previously. TSD was used in order to provide a model for approaching a situation in a novel way and increase his willingness to try to confront a situation that induced significant anxiety (Bernstein et al., 2017; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019).

He arrived at our next session so excited to share how his experience went that he started talking about it in the hall between the waiting room and my office. I disclosed how happy I was to hear that his experience went well, but that I was even more thrilled that he approached a situation that caused him a lot of fear without knowing if it would end the way that he had hoped. Intratherapy disclosure regarding emotions in the here and now towards client and his reported experience (Henretty et al., 2014; Hill, 2018, Hill, Knox, & Pinto-Coelho, 2018). This one experience helped TC be able to experience how exposure could work and led him to be willing to continuously work his way up his hierarchy addressing his anxiety. By the end of our work together, he had joined the Latino fraternity on campus, he was in a committed relationship with someone he met doing an exposure exercise, he had joined the snowboarding club and was running for a leadership position, he had many friendships that he reported felt meaningful, and was not afraid of having another panic attack.

3.3 Case 3: LL

LL identified as a white, heterosexual, cisgender male from a high SES family, raised in a rural part of the United States and was the oldest child in his family. LL arrived at our session wearing a suit and shared during our first session that he had recently been charged with a DUI and that he was coming to treatment before the school mandated it in order to demonstrate good behavior for his trial, but that he did not believe that he had an issue with substances. LL reported that he believed that he was a psychopath due to relating to the main character of the movie American Psycho and from an online quiz he took in which he endorsed having wet the bed up until his early teens, he had killed animals throughout his childhood and he had set fires. Having shared all this information within the first five minutes of meeting him, I did not follow a typical intake and instead spent time exploring his claim. It turned out that he grew up on a farm and as the oldest child in the family, he was often asked to kill pests that were invading his family's crops and would participate in the butchering process of the animals they raised. Additionally, his fire setting was also connected to being the oldest on a farm, as he was often asked to burn trash and eliminate waste.

Less concerned about his being a psychopath, we spent the remainder of our first session discussing how to make our time together useful, what made life meaningful for him, and started to talk about his history with substance use. LL reported that he felt that the key to his happiness was making more money than his father had, and he planned to do so by working in finance on Wall Street. While I was very curious about the specifics of this comment and felt off overall from the abnormal structure of this session, I tried to build rapport with him by disclosing that my father had worked in finance on Wall Street so that I am familiar with the lifestyle for which he is striving. TSD of similarity was used to build rapport, create trust, and create a more authentic relationship between therapist and client (Bernstein, 2017; Borsari et al., 2015; Carey et al., 2018; Kazemi et al., 2014; Manchak, Skeem, & Rook, 2013; Mastroleo et al., 2014; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015; Wild et al., 2017); however, one of the risks that this disclosure took was not knowing the patient well enough to know how he would react (Berg et al., 2020; Elliott & Ragsdale, 2020; Hill, Knox, & Pinto-Coelho, 2018; McCormic et al., 2019). I did not think much of this disclosure until I received a call from my father stating that someone who claimed to be my friend had called him and stated that I had told him my dad would offer him a summer internship. I started the next session with him by

addressing this situation directly, explaining what I had intended by sharing that part of my background and how it felt to hear that he had used that information to reach out to my father directly. While this was an uncomfortable conversation to have, it allowed me to establish boundaries with him and let him know that I was willing to discuss the interpersonal impact his behavior had on me, which he shared was a very new experience for him as his family tended to avoid difficult conversations. We spent the remainder of this session talking about his relationships with his family. It seemed as though he consistently felt that his mom believed that he was not good enough and his dad only paid attention to him when he was being useful, which helped explain why he happily volunteered to do the farm related tasks that he worried was indicative of psychopathy. I disclosed how I felt hearing his experiences with his parents in order to validate the pain he was trying to push away and model how to identify and talk about his feelings. Consistent with Goldfried, Burckell, & Eubanks-Carter (2003), disclosing the interpersonal impact made by the client served to reinforce their willingness to openly share experiences associated with shame, convey non-judgmental care for client, and build a stronger therapeutic alliance.

Later in treatment, it appeared that many of his social relationships reflected versions of his relationships with his parents: with his male friends, he was often the person people relied on for a connection to whatever substance they were trying to find but not close with anyone; with his female relationships, he tried to present as the “perfect man” and would ghost them (cut off all communication immediately) when he believed that he had shown that he had flaws. He would constantly put people down, and it became apparent that he did so in order to minimize his feelings of loneliness and the fear of being unlovable that showed up when he learned of social events to which he lacked invitations. I provided him with feedback on the impact that he had on me whenever he made misogynistic or homophobic comments about people in his life and disclosed my identities with him. I shared that I was afraid of how he would react to me after having that knowledge, especially considering how he talked about other people in his life. I wondered aloud if this might also be how people in his life feel about sharing things with him due to how angrily and negatively he talks about people and behaviors that he does not like. This type of disclosure leveraged the strength of the relationship that we had already established, and utilized my experience of client within session to provide meaningful feedback regarding how client might be experienced by other people who share similar marginalized identities (Alessi,

Dillon, & Van Der Horn, 2019; Baumann, Ryu, & Harney, 2020; Bjork, 2004; Chui et al., 2018; Cole & Drescher, 2006; Drescher, & Fadus, 2020; Hill, 2018; Kronner & Northcut, 2015; Matsuno, 2019; Mizock & Lundquist, 2016; Moore, Camacho, & Munson, 2020; Shipman & Martin, 2019). After sharing this feedback with him, it was as if the wall he spent so much time fortifying suddenly collapsed and I was able to see the scared and hurt person that hid behind a critical and angry exterior.

LL was able to talk about how he used substances in order to feel connected with other people, to push away his insecurities, to reduce his feelings of loneliness, to feel capable in his classes, etc. but also how fleeting those experiences were and how he longed for a more permanent solution. He admitted that what he truly wanted was to be in a committed long-term relationship with someone who knew his flaws and still chose to be with him, but was terrified that no one would want to be with him if they truly knew him. I disclosed how connected I felt with him as he displayed vulnerability compared to how pushed away I felt in previous sessions when he focused on criticizing people in his life. Intratherapy disclosure utilized to help reinforce prosocial behavior and strengthen therapeutic alliance (Henretty et al., 2014; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019).

I eventually provided him feedback on how I experienced him during our first session when he shared that he thought he was a psychopath and how I thought about the function of his sharing that information differently after getting to know him better. I shared that in that moment, I was intimidated by him and unsure of what I could do. With his critical statements, I felt he was pushing me away. After getting to know him better, I felt that he wanted me to diagnose him as a psychopath, because then he could let go of the guilt he felt when he noticed differences between his current lifestyle and relationships and his ideal versions. If he was a psychopath, then he would feel he was excused from any responsibility to make improvements to his social relationships and his relationships with substances. TSD used with LL, while initially leading to a boundary violation, led to client and therapist becoming closer, allowing for therapist to provide interpersonal feedback that helped client feel safe enough to be vulnerable in session and help client realize his desire to be authentic in his relationships (Alfi-Yogev et al., 2021; Baumann, Ryu, & Harney, 2020; Buirski, Haglund, & Markley, 2020; Jackson, 2020;

Kronner & Northcut, 2015; Norcross & Lambert, 2019; Patmore, 2020; Sunderani & Moodley, 2020).

4. Discussion

As supported by the literature on self-disclosure and the clinical examples highlighted in the case study, TSD is particularly useful with mandated students in a CCC due to how it can enhance the therapeutic alliance (Alessi, Dillon, & Van Der Horn, 2019; Alfi-Yogev et al., 2021; Fuertes, Moore, & Galey, 2019; Hays, 2022; Hill, 2018; Henretty et al., 2014; Levitt et al., 2015; Manchak, Skeem, & Rook, 2013; Norcross & Lambert, 2019; Simonds & Spokes, 2017; Ziv-Beiman et al., 2017), overcome the negative aspects associated with being mandated to treatment (Bernstein et al., 2017; Borsari et al., 2015; Carey et al., 2018; Kazemi et al., 2014; Manchak, Skeem, & Rook, 2013; Mastroleo et al., 2014; Phillips, Fowler, & Westaby, 2018; Qi, 2014; Trotter, 2015; Wild et al., 2017), normalize/reduce client shame and fear (Alessi, Dillon, & Van Der Horn, 2019; Baumann, Ryu, & Harney, 2020; Buirski, Haglund, & Markley, 2020; Chui et al., 2018; Cole & Drescher, 2006; Drescher, & Fadus, 2020; Henretty et al., 2014; Hill, 2018; Kronner & Northcut, 2015; Matsuno, 2019; Mizock & Lundquist, 2016; Moore, Camacho, & Munson, 2020; Shipman & Martin, 2019), model effective ways of coping with negative emotional experiences (Bandura, 1996; Goldfried, Burckell, & Eubanks-Carter, 2003; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019), increase clients' willingness to disclose themselves (Bennett et al., 2022; McCormic et al., 2019; McDonald, Rappaport, & Bates, 2022; Hays, 2022; Mahalik, Van Ormer, & Simi, 2000; Moore, Camacho, & Munson, 2020; Moody et al., 2021; Sunderani & Moodley, 2020), and increase motivation to embrace change (Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). Due to the short duration of treatment, client resistance, and infrequent sessions, using moderately intimate disclosures at the beginning of treatment clearly helped to build rapport quickly, while subsequently reducing client resistance, as well. This allowed the author to provide treatment that addressed deeper issues within a fewer number of sessions, issues that may not have been addressed at all without TSD.

It appears that disclosures of similarity and immediacy are two of the more important types of disclosures for this population as they build trust, model effective responding and ways of communicating (Goldfried, Burckell, & Eubanks-Carter, 2003; Hill, 2018; Hill, Knox, & Pinto-Coelho, 2018; Johnsen & Ding, 2021; Solomonov & Barber, 2019). As previously

mentioned, without a strong therapeutic bond, even the most effective interventions might fail to be helpful to the client (Alessi, Dillon, & Van Der Horn, 2019; Alfi-Yogev et al., 2021; Bjork, 2004; Fuertes, Moore, & Galey, 2019; Hays, 2022; Hill, 2018; Henretty et al., 2014; Levitt et al., 2015; Manchak, Skeem, & Rook, 2013; Norcross & Lambert, 2019; Simonds & Spokes, 2017; Ziv-Beiman et al., 2017). Thus, focusing on strengthening the trust in the relationship is crucial in the first session. Meeting infrequently in a college counseling center makes it even more critical to build connections as clients have a tendency to forget what has been discussed in therapy if they do not believe that the therapy will be useful (Bell et al., 2020; Carey et al., 2018*;* Mastroleo et al., 2014; Yurasek et al., 2017).

Additionally, it is important that when disclosing their own experiences that therapists describe their thoughts and feelings in detail so that they can emphasize the struggles that they had in trying to cope with their experiences and how they ultimately overcame them. In doing so, the therapist is able to validate the client's emotional experience while simultaneously demonstrating a different approach to address the client's issues (Baumann, Ryu, & Harney, 2020; Berg et al., 2020; Elliott & Ragsdale, 2020; Hill, 2018; McCormic et al., 2019; Miller & McNaught, 2018). By modeling more effective coping mechanisms used by the therapist while dealing with similar struggles to those the client is facing, the therapist ultimately increases the likelihood that the client will attempt new and healthier coping mechanisms (Bandura, 1996; Goldfried, Burckell, & Eubanks-Carter, 2003; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019). In general, prior to self-disclosing, it is important to consider the motivation behind the disclosure and the impact that it will likely have on the client (Berg et al., 2020; Bernstein et al., 2017; Hill, Knox, & Pinto-Coelho, 2018; McCormic et al., 2019).

While this author recognizes many limitations regarding the generalizability of this paper's findings, additional research may demonstrate that a deep understanding of the functions that TSD can serve and a mastery of its skillful implementation may prove to be beneficial across a variety of different clinical settings. Due to the inherent nature of a case study approach, the narrow focus of treatment with a specific population under unique conditions, and the relative lack of experience of the author, the results can only provide suggestions towards the direction of future research rather than any formal conclusions. Of particular importance would be research centered on comparing the effects of TSD on the therapeutic alliance to other interventions such

as motivational interviewing techniques, differences in the impact that TSD has with voluntary and mandated clients, as well as differences on the impact TSD has on treatment that involve weekly, unlimited sessions and those that involve meeting once every few weeks with a session limit. This future research may also demonstrate that TSD can be used with other populations with similar challenges, such as clients who are mandated to treatment in forensic settings or voluntary college students seeking individual therapy within a CCC that utilizes any combination of session limits, a non-weekly model of therapy, and/or a stepped-care system.

The benefits of TSD are undeniable, yet the intervention itself often remains largely undiscussed within graduate programs and clinical practica. It is imperative that these clinical settings provide proper supervision and training on TSD and dismantle any stigma remaining from when it was regarded as a taboo topic for serious discussion. This concept is becoming increasingly relevant in a time where disclosures often occur either unintentionally and/or unavoidably. Patients may be able to glean personal details about their clinicians through something as simple as physical appearance, the accuracy of which can often be in question Baumann, Ryu, & Harney, 2020; McDonald, Rappaport, & Bates, 2022). Oftentimes this uncontrolled disclosure can go further, with new research showing that more and more clients are using the internet to obtain information on their therapists, thereby gaining access to a potential wealth of information through public social media or other sources (Farber & Nitzburg, 2015; McDonald, Rappaport, & Bates, 2022; Trub & Magaldi, 2021). This one directional disclosure of information can have multiple issues. Clients are likely to make inaccurate inferences regarding their therapists from this limited or cultivated information, which could weaken the therapeutic relationship if unaddressed. Even if the conclusions made by the client are accurate, dismissing or ignoring the issue altogether can prevent the formation of a more real and genuine connection.

If left unaddressed, therapists may even become suspicious, unaware of what information the client has accessed, undoubtedly impeding the building of trust. Thus, with better training and guidelines, well-prepared clinicians can use TSD to steer these instances of unintended disclosure towards the building of a superior relationship built on authenticity and trust. Such activity can provide an atmosphere of honesty and openness, as the client becomes more likely to share more frequently and vulnerably, consistent with the literature (Bernstein et al., 2017;

Goldfried, Burckell, & Eubanks-Carter, 2003; Hill, Knox, & Pinto-Coelho, 2019; Matsuno, 2019; Miller & McNaught, 2018; Norcross & Lambert, 2019).

5. Conclusion

Previous literature shows a clear benefit to TSD when used properly, and even appears to have an outsize effect in mandated sessions (Mastroleo et al., 2014, p. 321). TSD manages to directly address many of the specific issues involved in providing effective college counseling in mandated sessions. The data stemming from the case study and a review of the literature suggest that further research into its efficacy and proper use in such environments is warranted to develop guiding principles to inform clinical practice. The results of such a development will lead to more effective training so that clinicians are more comfortable in disclosing personal information in the best interest of their clients, encouraging their clients to more frequently disclose content of increasing intensity, which helps to establish a working relationship based off mutual authenticity- the ideal conditions to help client thrive as an authentic human being (Buirski, Haglund, & Markley, 2020).

References

Alessi, E. J., Dillon, F. R., & Van Der Horn, R. (2019). The therapeutic relationship mediates the association between affirmative practice and psychological well-being among lesbian, gay, bisexual, and queer clients. *Psychotherapy, 56,* 229– 240. http://dx.doi.org/10.1037/pst0000210

Alexandrova, N. (2021). Therapist self-disclosure of interpersonal trauma to client survivors [ProQuest Information & Learning]. In *Dissertation Abstracts International: Section B: The Sciences and Engineering* (Vol. 82, Issue 7-B).

Alfi-Yogev, T., Hasson-Ohayon, I., Lazarus, G., Ziv-Beiman, S., & Atzil-Slonim, D. (2021). When to disclose and to whom? examining within-and between-client moderators of therapist self disclosure-outcome associations in psychodynamic psychotherapy. *Psychotherapy Research*, *31*(7), 921-931.

Alwi I. (2007). Tips and tricks to make case report. *Acta medica Indonesiana*, *39*(2), 96–98.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice Hall.

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

Bate, Prout, T. A., Rousmaniere, T., & Vaz, A. (2022). Exercise 8. Self-disclosure. In Deliberate practice in child and adolescent psychotherapy. (pp. 99–109). https://doi.org/10.1037/0000288-010

Baumann, E. F., Ryu, D., & Harney, P. (2020). Listening to identity: Transference, countertransference, and therapist disclosure in psychotherapy with sexual and gender minority clients. *Practice Innovations, 5*(3), 246–256. https://doi.org/10.1037/pri0000132

Bell, D. J., Self, M. M., Davis III, C., Conway, F., Washburn, J. J., & Crepeau-Hobson, F. (2020). Health service psychology education and training in the time of COVID-19: Challenges and opportunities. *American Psychologist*, *75*(7), 919.

Bennett, E. A., Koelsch, L. E., Kuppers, S. R., & King Ash, S. (2022). #WeToo: Feminist therapist self-disclosure of sexual violence survivorship in a #MeToo era. *Women & Therapy*, *45*(1), 97–116. https://doi-org.du.idm.oclc.org/10.1080/02703149.2021.1971434

Berg, H., Bjornestad, J., Våpenstad, E. V., Davidson, L., & Binder, P. E. (2020). Therapist self-disclosure and the problem of shared-decision making. *Journal of Evaluation in Clinical Practice*, *26*(2), 397-402.

Bernstein, M. H., Baird, G. L., Yusufov, M., Mastroleo, N. R., Carey, K. B., Graney, D. D., & Wood, M. D. (2017). A novel approach for streamlining delivery of brief motivational interventions to mandated college students: Using group and individual sessions matched to level of risk. *Substance use & misuse*, *52*(14), 1883-1891.

Bertolet, C. L. (2016). *Examining changes in college counseling clients' symptomology and severity over an eight year span* (Order No. 10112691). Available from ProQuest Central; ProQuest Dissertations & Theses Global. (1800548436). https://du.idm.oclc.org/login?url=https://www.proquest.com/di, ssertations-theses/examining-changes-college-counseling-clients/docview/1800548436/se-2?accountid=14608

Billow, R.M. (2000). Self-disclosure and psychoanalytic meaning: A psychoanalytic fable. Psychoanalytic Review, 87, 61–79.

Bitar, G. W., Kimball, T., Bermúdez, J. M., & Drew, C. (2014). Therapist self-disclosure and culturally competent care with Mexican–American court mandated clients: A phenomenological study. *Contemporary Family Therapy*, *36*(3), 417-425.

Bjork, D. (2004). Disclosure and the development of trust in the therapeutic setting. *Journal of Lesbian Studies, 8,* 95–105. http://dx.doi.org/10.1300/ J155v08n01_06

Borsari, B., Apodaca, T. R., Jackson, K. M., Mastroleo, N. R., Magill, M., Barnett, N. P., & Carey, K. B. (2015). In-session processes of brief motivational interventions in two trials with mandated college students. *Journal of consulting and clinical psychology*, *83*(1), 56.

Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy: Theory, Research, Practice, Training, 38*, 21–30.10.1037/0033-3204.38.1.21.

Brown, L. S., & Walker, L. (1990). Feminist therapy perspectives on self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 135–154). New York, NY: Plenum Press. doi:10.1007/978-1-4899-3582-3_10

Brown, R. T. (2004). A General Approach to Publication in the Journal of Pediatric Psychology: From the Process of Preparing Your Manuscript to Revisions and Resubmissions. *Journal of Pediatric Psychology*, *29*(1), 1-5.

Budgell B. (2008). Guidelines to the writing of case studies. *The Journal of the Canadian Chiropractic Association*, *52*(4), 199–204.

Buirski, P., Haglund, P., & Markley, E. (2020). *Making sense together: The intersubjective approach to psychotherapy*. Rowman & Littlefield Publishers.

Cannity, K. M. (2022). Therapist disclosure to combat COVID-19 vaccine hesitancy: a narrative review. *Journal of Behavioral Medicine*, 1-10.

Carey, K. B., Durney, S. E., Shepardson, R. L., & Carey, M. P. (2015). Incapacitated and forcible rape of college women: Prevalence across the first year. *Journal of Adolescent Health*, *56*(6), 678-680.

Carey, K. B., Merrill, J. E., Walsh, J. L., Lust, S. A., Kalichman, S. C., & Carey, M. P. (2018). Predictors of short-term change after a brief alcohol intervention for mandated college drinkers. *Addictive behaviors*, *77*, 152–159. https://doi.org/10.1016/j.addbeh.2017.09.019

Center for Collegiate Mental Health. (2018, January). 2017 Annual Report (Publication No. STA 18-166). https:// sites.psu.edu/ccmh/files/2018/01/2017_CCMH_Report-1r3iri4.pdf

Center for Collegiate Mental Health. (2020, January). *2019 Annual Report* (Publication No. STA 20-244).

Center for Collegiate Mental Health. (2022, January). *2021 Annual Report* (Publication No. STA 22-132)

Chelvarajah, R., & Bycroft, J. (2004). Writing and publishing case reports: the road to success. *Acta neurochirurgica*, *146*(3), 313–316. https://doi.org/10.1007/s00701-003-0203-2

Chui, H., McGann, K. J., Ziemer, K. S., Hoffman, M. A., & Stahl, J. (2018). Trainees' use of supervision for therapy with sexual minority clients: A qualitative study. *Journal of Counseling Psychology, 65,* 36–50. http://dx.doi.org/10.1037/cou 0000232

Cole, G. W., & Drescher, J. (2006). Do tell: Queer perspectives on therapist self-disclosure—Introduction. *Journal of Gay & Lesbian Psychotherapy, 10,* 1– 6. http://dx.doi.org/10.1300/J236v10n01_01

Dogan, T. (2018). Problem Areas of Students at a University Psychological Counselling Centre: A 16-Year Analysis. *British Journal of Guidance & Counselling, 46*(4), 429-440. https://doi.org/10.1080/03069885.2018.1437255

Drescher, J., & Fadus, M. (2020). Issues Arising in Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Patients. *Focus (American Psychiatric Publishing)*, *18*(3), 262–267. https://doi.org/10.1176/appi.focus.20200001

Drotar D. (2008). Editorial: thoughts on establishing research significance and preserving scientific integrity. *Journal of pediatric psychology*, *33*(1), 1–5. https://doi.org/10.1093/jpepsy/jsm092

Drotar, D. (2000). Writing research articles for publication. In *Handbook of Research in Pediatric and Clinical Child Psychology* (pp. 347-374). Springer, Boston, MA.

Edwards, C.E., & Murdock, N.L. (1994). Characteristics of therapist self-disclosure in the counseling process. Journal of Counseling and Development, 72, 384–389.

El-Gilany, A. H. (2019). An overview of writing a case report. *Asploro Journal of Biomedical and Clinical Case Reports*, *2019*(1), 1.

Elliott, M., & Ragsdale, J. M. (2020). Mental health professionals with mental illnesses: A qualitative interview study. *American Journal of Orthopsychiatry*, *90*(6), 677.

Failoni, V., Passarella, T., Inchausti, F., Popolo, R., & Dimaggio, G. (2019). L'autosvelamento del terapeuta alla luce della formulazione del caso = Self-disclosures and case formulation. *Rassegna Di Psicologia*, *36*(3), 47–56.

Farber, B. A. (2003). Self-disclosure in psychotherapy practice and supervision: An introduction. *Journal of Clinical Psychology, 59*, 525–528.10.1002/(ISSN)1097-4679

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

Farber, B. A., & Nitzburg, G. C. (2015). Young adult self-disclosures in psychotherapy and on Facebook. *Counselling Psychology Quarterly*, *29*, 76–89. doi:10.1080/09515070.2015.1078286

Fay, A. (2002). The case against boundaries in psychotherapy. In A.A. Lazarus & O. Zur (Eds.), Dual relationships and psychotherapy (pp. 146–166). New York: Springer.

Freud, S. (1958). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 109–120). London, England: Hogarth Press. (Original work published 1912)

Fuertes, J. N., Moore, M., & Ganley, J. (2019). Therapists' and clients' ratings of real relationship, attachment, therapist self-disclosure, and treatment progress. *Psychotherapy Research*, *29*(5), 594-606.

Gagnier, J. J., Kienle, G., Altman, D. G., Moher, D., Sox, H., Riley, D., & CARE Group (2014). The CARE guidelines: consensus-based clinical case report guideline development. *Journal of clinical epidemiology*, *67*(1), 46–51. https://doi.org/10.1016/j.jclinepi.2013.08.003

Gallagher, R. P. (2013). *National Survey of Counseling Center Directors.* Alexandria, VA: International Association of Counseling Services.

Geller, J.D., & Farber, B.A. (1997, August). Why therapists do and don't self-disclose. Paper presented at the annual convention of the American Psychological Association, Chicago.

Goldfried, M. R., Burckell, L. A., & Eubanks-Carter, C. (2001). Therapist self-disclosure in cognitive-behavior therapy. *Journal of Clinical Psychology/In Session, 59*, 555–568

Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal, 22*, 417–433.10.1007/BF02190331

Gorman, K. S., Bruns, C., Chin, C., Fitzpatrick, N. Y., Koenig, L., LeViness, P., & Sokolowski, K. (2020). Association for University and College Counseling Center Directors (AUCCCD)

Annual Survey: 2020. Retrieved from https://www.aucccd.org/assets/documents/Survey/2019-2020%20Annual%20Report%20FINAL%204-2021.pdf

Gorman, K. S., Bruns, C., Chin, C., Fitzpatrick, N. Y., Koenig, L., LeViness, P., & Sokolowski, K. (2021). Association for University and College Counseling Center Directors (AUCCCD) Annual survey: 2021. (AUCCCD) Annual Survey: 2020.

Gorman, K. S., Bruns, C., Chin, C., Fitzpatrick, N. Y., Koenig, L., LeViness, P., & Sokolowski, K. (2022). Association for University and College Counseling Center Directors (AUCCCD) Annual Survey: 2021. Retrieved from https://taucccd.memberclicks.net/assets/2020-21%20Annual%20Survey%20Report%20Public%20Survey.pdf

Hayes, J.A., Petrovich, J., Janis, R.A., Yang, Y., Castonguay, L.G., & Locke, B. D. (2019). Suicide among college students in psychotherapy: Individual predictors and latent classes. *Journal of Counseling Psychology*. Advance online publication. https://doi.org/10.1037/cou0000384

Hays. (2022). Creating a positive therapeutic alliance. In Addressing cultural complexities in counseling and clinical practice: An intersectional approach (4th ed.). (pp. 109–132). https://doi.org/10.1037/0000277-006

Henretty, J. R., Berman, J. S., Currier, J., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology, 61*, 191–207. doi:10.1037/a0036189

Henretty, J., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*, 63–77. doi:10.1016/j.cpr.2009.09.004

Hill, B. S. (2018). Treating LGBT veterans with substance use disorders: A gay psychiatrist's experience. In E. C. Ritchie, J. E. Wise, & B. Pyle (Eds.), *Gay mental healthcare providers and patients in the military* (pp. 125–138). Cham, Switzerland: Springer. http://dx.doi.org/10.1007/978-3- 319-66026-4_12

Hill, C. E., & Knox, S. (2001). Self-disclosure. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 413.

Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35*, 222–233.10.1037/0022-0167.35.3.222

Hill, C. E., Knox, S., & Pinto-Coelho, K. G. (2018). Therapist self-disclosure and immediacy: A qualitative meta-analysis. *Psychotherapy*, *55*(4), 445.

Hill, C.E., & Knox, S. (2002) Therapist self-disclosure. In J.C. Norcross (Ed.), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 255–265). Oxford, England: Oxford University Press.

Hill, Knox, S., & Pinto-Coelho, K. G. (2019). Self-Disclosure and Immediacy. In Psychotherapy Relationships that Work (pp. 379–420). https://doi.org/10.1093/med-psych/9780190843953.003.0011

Hingson, R., Zha, W., & Smyth, D. (2017). Magnitude and trends in heavy episodic drinking, alcohol-impaired driving, and alcohol-related mortality and overdose hospitalizations among emerging adults of college ages 18–24 in the United States, 1998–2014. *Journal of studies on alcohol and drugs*, *78*(4), 540-548.

Jackson, D. (2020). The therapist's dilemma: Tell the whole truth?. *Journal of Clinical Psychology*, *76*(2), 286-291.

Johnsen, C., & Ding, H. T. (2021). Therapist self-disclosure: Let's tackle the elephant in the room. Clinical Child Psychology and Psychiatry, 26(2), 443–450. https://doi.org/10.1177/1359104521994178

Kazdin, A. E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. Oxford University Press.

Kazemi, D. M., Levine, M. J., Dmochowski, J., Angbing, I., & Shou, Q. (2014). Personality risk factors and readiness to change in mandated and voluntary college students enrolled in an alcohol intervention program. *Substance Use & Misuse*, *49*(1-2), 154-165.

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

Knox, S., & Hill, C. E. (2016). Introduction to a special issue on disclosure and concealment in psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 1-6.

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

Kohlenberg, R.J., & Tsai, M. (1991). Functional analytic psychotherapy: Creating intense and curative therapeutic relationships. New York: Plenum Press.

Kronner, H. W., & Northcut, T. (2015). Listening to both sides of the therapeutic dyad: Self-disclosure of gay male therapists and reflections from their gay male clients. *Psychoanalytic Social Work, 22,* 162–181. http://dx.doi.org/10.1080/15228878 .2015.1050746

Lawyer, S., Resnick, H., Bakanic, V., Burkett, T., & Kilpatrick, D. (2010). Forcible, drug-facilitated, and incapacitated rape and sexual assault among undergraduate women. *Journal of American College Health*, *58*(5), 453-460.

LeViness, P., Gorman, K., & Bershad, C. The Association for University and College Counseling Center Directors Annual Survey: 2019.

Levitt, H., Minami, T., Greenspan, S., Puckett, J., Henretty, J., Reich, C., & Berman, J. (2015). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly*, *29*, 7–28. doi:10.1080/09515070.2015.1090396

Linehan, M.M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

Lund, S. (2019). *A Comparison of College Student-Athletes with Attention-Deficit Hyperactivity Disorder (ADHD) and Nonathletes with ADHD: Academic Adjustment, Severity of Mental Health Concerns, and Complexity of Life Concerns* (Order No. 22618559). Available from ProQuest Central; ProQuest Dissertations & Theses Global; Social Science Premium Collection. (2306288619). https://du.idm.oclc.org/login?url=https://www.proquest.com/dissertations-theses/comparison-college-student-athletes-with/docview/2306288619/se-2?accountid=14608

Mahalik, J. R., Van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 189–201). Washington.

Manchak, S. M., Skeem, J. L., & Rook, K. S. (2014). Care, control, or both? Characterizing major dimensions of the mandated treatment relationship. *Law and Human Behavior*, *38*(1), 47–57. https://doi-org.du.idm.oclc.org/10.1037/lhb0000039

Mastroleo, N. R., Magill, M., Barnett, N. P., & Borsari, B. (2014). A pilot study of two supervision approaches for peer-led alcohol interventions with mandated college students. *Journal of Studies on Alcohol and Drugs*, *75*(3), 458-466.

Mastroleo, N. R., Oakley, W. C., Eaton, E. M., & Borsari, B. (2014). Response of heavy-drinking voluntary and mandated college students to a peer-led brief motivational intervention addressing alcohol use. *Journal of substance abuse treatment*, *47*(5), 321–328. https://doi.org/10.1016/j.jsat.2014.06.005

Matsuno, E. (2019). Nonbinary-affirming psychological interventions. *Cognitive and Behavioral Practice, 26,* 617–628. http://dx.doi.org/10.1016/j .cbpra.2018.09.003

McCormic, R. W., Pomerantz, A. M., Ro, E., & Segrist, D. J. (2019). The “me too” decision: An analog study of therapist self-disclosure of psychological problems. *Journal of Clinical Psychology*, *75*(4), 794-800.

McDonald, M., Rappaport, A., & Bates, A. (2022). How do I work with fertility loss as a pregnant therapist? A case study and discussion about pregnancy self-disclosure in the oncology setting. *Journal of Psychosocial Oncology*, *40*(2), 263-266.

Milgram, D., & Rubin, J. S. (1992). Resisting resistance: Involuntary substance abuse group therapy. *Social Work with Groups*, *15*(1), 95-110.

Miller, E., & McNaught, A. (2018). Exploring decision making around therapist self-disclosure in cognitive behavioural therapy. *Australian Psychologist*, *53*(1), 33-39.

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity, 3,* 148–155. http://dx.doi.org/10 .1037/sgd0000177

Moody, K. J., Pomerantz, A. M., Ro, E., & Segrist, D. J. (2021). "Me too, a long time ago": Therapist self-disclosure of past or present psychological problems similar to those of the client. *Practice Innovations*, *6*(3), 181–188. https://doi-org.du.idm.oclc.org/10.1037/pri0000151

Moore, K. L., Camacho, D., & Munson, M. R. (2020). Identity negotiation processes among Black and Latinx sexual minority young adult mental health service users. *Journal of Gay & Lesbian Social Services, 32,* 21–48. http://dx.doi .org/10.1080/10538720.2019.1677542

Muehlenhard, C. L., Peterson, Z. D., Humphreys, T. P., & Jozkowski, K. N. (2017). Evaluating the one-in-five statistic: Women's risk of sexual assault while in college. *The Journal of Sex Research*, *54*(4-5), 549-576.

NIAAA. Underage drinking. 2020. https://pubs.niaaa.nih.gov/publications/UnderageDrinking/UnderageFact.h…. Accessed December 8, 2020

Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work: Vol. 1. Evidence-based therapist contributions*. New York, NY: Oxford University Press.

Patmore, J. (2020). Therapist self-disclosure in the treatment of eating disorders: A personal perspective. *Journal of Clinical Psychology*, *76*(2), 266-276.

Phillips, J., Fowler, A., & Westaby, C. (2018). Self-disclosure in criminal justice: what form does it take and what does it achieve?. *International journal of offender therapy and comparative criminology*, *62*(12), 3890-3909.

Pinto-Coelho, K. G., Hill, C. E., & Kivlighan Jr, D. M. (2016). Therapist self-disclosure in psychodynamic psychotherapy: A mixed methods investigation. *Counselling Psychology Quarterly*, *29*(1), 29-52.

Platt J. R. (1964). Strong Inference: Certain systematic methods of scientific thinking may produce much more rapid progress than others. *Science (New York, N.Y.)*, *146*(3642), 347–353. https://doi.org/10.1126/science.146.3642.347

Qi, D. (2014). Predictors of motivation to change in mandated college students following a referral incident. *Psychology of Addictive Behaviors*, vol. 28, no. 2, 2014, p. 524.

Ramsdell, P.S., & Ramsdell, E.R. (1993). Dual relationships: Client perceptions of the effect of client–counselor relationship on the therapeutic process. Clinical Social Work Journal, 21, 195–212.

Roberts, M. C., & Steele, R. G. (Eds.). (2010). *Handbook of pediatric psychology*. Guilford Press.

Rosner, B. (2022). Therapist self-disclosure: Process and insights [ProQuest Information & Learning]. In *Dissertation Abstracts International: Section B: The Sciences and Engineering* (Vol. 83, Issue 3–B).

SAMHSA, Center for Behavioral Health Statistics and Quality. 2019 National Survey on Drug Use and Health. Table 6.21B – Types of Illicit Drug, Tobacco Product, and Alcohol Use in Past Month among Persons Aged 18 to 22, by College Enrollment Status and Gender: Percentages, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHD…. Accessed December 8, 2020.

SAMHSA, Center for Behavioral Health Statistics and Quality. 2019 National Survey on Drug Use and Health. Table 6.23B – Alcohol Use Disorder in Past Year among Persons Aged 18 to 22, by College Enrollment Status and Demographic Characteristics: Percentages, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHD…. Accessed December 8, 2020.

Schwartz, A. (2006). Four eras of study of college student suicide in the United States: 1920-2004. Journal of American College Health, 54(6), 353-366. doi:10.3200/JACH.54.6.353-366

Schwitzer, A. M., Moss, C. B., Pribesh, S. L., St John, D.,J., Burnett, D. D., Thompson, L. H., & Foss, J. J. (2018). Students with mental health needs: College counseling experiences and

academic success. *Journal of College Student Development, 59*(1), 3-20. doi:https://doi.org/10.1353/csd.2018.0001

Shipman, D., & Martin, T. (2019). Clinical and supervisory considerations for transgender therapists: Implications for working with clients. *Journal of Marital and Family Therapy, 45,* 92–105. http://dx.doi.org/10.1111/jmft.12300

Simonds, L. M., & Spokes, N. (2017). Therapist self-disclosure and the therapeutic alliance in

the treatment of eating problems. *Eating*

Disorders, *25*(2),

151-164.

Solomonov, N., & Barber, J. P. (2018). Patients' perspectives on political self-disclosure, the therapeutic alliance, and the infiltration of politics into the therapy room in the Trump era. *Journal of Clinical Psychology*, *74*(5), 779-787.

Solomonov, N., & Barber, J. P. (2019). Conducting psychotherapy in the Trump era: Therapists' perspectives on political self-disclosure, the therapeutic alliance, and politics in the therapy room. *Journal of Clinical Psychology*, *75*(9), 1508-1518.

Sternberg, R. J., & Gordeeva, T. (1996). The anatomy of impact: What makes an article influential?. *Psychological Science*, *7*(2), 69-75.

Stiles, W. B. (1995). Disclosure as a speech act: Is it psychotherapeutic to disclose? In J. W. Pennebaker(Ed.), *Emotion, disclosure, & health* (pp. 71–91). Washington, DC: American Psychological Association.

Sue, D.W., & Sue, D. (1999). Counseling the culturally different: Theory and practice (3rd ed.). New York: Wiley.

Sunderani, S., & Moodley, R. (2020). Therapists' perceptions of their use of self-disclosure (and nondisclosure) during cross-cultural exchanges. *British Journal of Guidance & Counselling*, *48*(6), 741-756.

Tansey, M. J., & Burke, W. F. (1989). Understanding countertransference: From projective identification to empathy. Analytic Press, Inc.

Trotter, C. (2015). *Working with involuntary clients: A guide to practice*. Routledge.

Trub, L., & Magaldi, D. (2021). Secret powers: Acts of Googling in the therapeutic relationship. *Journal of Clinical Psychology*, *77*(4), 968-985.

Turner, J. C., Leno, E. V., & Keller, A. (2013). Causes of Mortality Among American College Students: A Pilot Study. *Journal of college student psychotherapy*, *27*(1), 31–42. https://doi.org/10.1080/87568225.2013.739022

Wachtel, P. L. (2007). *Relational theory and the practice of psychotherapy*. New York, NY: Guilford Press

Wallander J. L. (1992). Theory-driven research in pediatric psychology: a little bit on why and how. *Journal of pediatric psychology*, *17*(5), 521–535. https://doi.org/10.1093/jpepsy/17.5.521

Weil, W., & Holleran, L. K. (2006). Working with Involuntary, Substance Abusing Clients in the Criminal Justice System: An Interview with Wendy Weil.

Wild, T. C., Yuan, Y., Rush, B. R., & Urbanoski, K. A. (2016). Client Engagement in Legally-Mandated Addiction Treatment: A Prospective Study Using Self-Determination Theory. *Journal of substance abuse treatment*, *69*, 35–43. https://doi.org/10.1016/j.jsat.2016.06.006

Yin, R. K. (2013). *Case study research: Design and methods*. London, England: SAGE.

Yurasek, A. M., Merrill, J. E., Metrik, J., Miller, M. B., Fernandez, A. C., & Borsari, B. (2017). Marijuana use in the context of alcohol interventions for mandated college students. *Journal of substance abuse treatment*, *79*, 53–60. https://doi.org/10.1016/j.jsat.2017.05.015

Ziv-Beiman, S., Keinan, G., Livneh, E., Malone, P. S., & Shahar, G. (2017). Immediate therapist self-disclosure bolsters the effect of brief integrative psychotherapy on psychiatric symptoms and the perceptions of therapists: A randomized clinical trial. *Psychotherapy Research*, *27*(5), 558-570.