The dynamic shift in therapeutic relationships through counselor self-disclosure with military client: A case study

by

Ophelia M. Blackwell

B.S., Kansas State University, 2003
M.Ed., Virginia State University, 2006

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Special Education, Counseling and Student Affairs

College of Education

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Abstract

This qualitative case study is designed to explore how two participants described their role with their use of counselor self-disclosure in establishing and maintaining therapeutic alliance with military clients. Utilizing purposeful and criterion-based sampling, participants for this study were counselors who worked with the military populations, had independent practices, and believed that counselor self-disclosure was beneficial in building strong therapeutic alliances with military clients. Informed by Symbolic Interactionism, the participants' understanding of self-disclosure and its role in establishing and maintaining therapeutic alliance with military clients were explored through semi-structured, in-depth, open-ended interviews.

Counselor self-disclosure (CSD) is a technique that helps to establish strong therapeutic alliances and break down barriers that may exist between the military population and their counselors. Some military members experience mental health disorders following deployments. However, these military members experience barriers when seeking treatment and they commonly terminate treatment prematurely.

Findings indicate that when counselors use self-disclosure it inspires participants to open up and model their counselor's behavior. Moreover, military clients become aware of their own symptoms that were previously invisible to them, and find ways to relate and trust the counselor. Conversely, findings also indicate that CSD can be used improperly or even when used properly could have undesired effects such as causing ruptures in the therapeutic relationship due to a lack of clients' openness, or perceiving CSD unprofessional and an inauthentic way to elicit therapeutic alliance.

This study has implications for counselor educators and practitioners to consider training about relationally-oriented cultural practices that help to prevent ruptures in therapeutic alliances

with military clients. Another implication is about how CSD could be used in the preparation of students in counselor education training programs and how more inquiry could be conducted to document systematic data about the influence of CSD on therapeutic alliance. Finally, the study has implications about how CSD can facilitate support for military clients and critically understanding how CSD can aid in supporting retention or loss of treatment for military clients.

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Chapter 1 - Introduction

A primary objective for those in the field of professional counseling is the awakening of a desired change and/or growth within their client that results in a positive outcome from their therapeutic alliance or relationship (Hackney & Cormier, 2009). To that end, Sommers-Flanagan (2015) believes that mental health counselors should embrace relationally-oriented, practice competencies that promote such results. Unfortunately, the outcome of a therapeutic alliance is not always positive because counselors vary in the ways they integrate their clinical styles with specific treatment methods (Hackney & Cormier, 2009; Miller & Rollnick, 2002).

Sommers-Flanagan (2015) argues that relational acts and treatment techniques intertwine, making it difficult to recognize which of the two (practice or technique) is occurring. To ensure a positive outcome, he recommends a therapeutic approach that supports both relational acts and treatment techniques theoretically and empirically. Moreover, Ackerman, Benjamin, Beutler, Gelso, Goldfried, and Rainer (2001) have cautioned against overlooking the importance of a strong therapeutic alliance; such an approach, they believe, is inadequate and misleading.

Positive counseling outcomes may fail to occur when the therapeutic alliance involves a client and counselor of differing cultural backgrounds (Chang & Berk, 2009; Sue & Sue, 2003). Since the foundational domains of mental health counseling includes the principles of ethical practice and multicultural sensitivity, it is recommended that counseling techniques and theoretical perspectives both be modified to fit a client's culturally diverse needs (Sommers-Flanagan, 2015). Besides, as Ackerman et al. (2001) have argued, empirical evidence has demonstrated that counseling's effectiveness increases when counselors customize the relationship to meet the client's needs and characteristics.

Culturally diverse clients have reported experiencing barriers to mental health treatment in the form of stigmatization or lack of trust of their own counselors (Chang & Berk, 2009; Constantine & Kwan, 2003; Snowden, 2001; Terrell & Terrell, 1984). Historically, members of culturally diverse populations have been underserved in the United States, and this has created a disparity in the utilization of mental health services among culturally diverse groups (Substance Abuse and Mental Health Services Administration, 2011). According to Petterson, Williams, Hauenstein, Rovnyak, & Merwin (2009), African Americans and Latino Americans are less likely to seek mental health treatment as compared with Caucasian Americans, and are thus less familiar with the counseling process. Therefore, 50% of culturally diverse clients prematurely terminate counseling after experiencing difficulties in their therapeutic alliances (Sue & Sue, 2008; Terrell & Terrell, 1984).

Military members and their families represent a unique culturally diverse population in the United States (Strom, Gavian, Possis, Loughlin, Bui, Linardatos, Leskela & Siegel, 2012). For the last decade, 1.8 million military members have been deployed served continuously in Operation Enduring Freedom (in Afghanistan) and Operation Iraqi Freedom (Litz & Schlenger, 2009). Consequently, military members and their families have suffered from the psychological effects of war (Substance Abuse and Mental Health Services Administration, 2011), and multiple tours of duty away from home have led to the destruction of marriages and families. Yet, military members and their loved ones are still confronted with barriers to treatment. Like culturally diverse populations, active military members and veterans are underserved, and they are reluctant to seek professional mental health care in many cases (Blais & Renshaw, 2013; Leong & Kalibatseva, 2011; Kim, Britt, Klocko, Riviere, & Adler, 2011; Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009; Substance Abuse and Mental Health Services Administration, 2011;

Visco, 2009). When counseling services are sought, military members and their families often, report barriers similar to those endured by culturally diverse clients. Such impediments may include stigmatization, a feeling of being misunderstood, or a lack of trust in their counselors (Blais & Renshaw, 2013; Erbes, Curry & Leskela, 2009; Kim, Britt, Klocko, Riviere, & Adler, 2011; Leong & Kalibatseva, 2011; Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009; Visco, 2009, Vogt, 2011).

Because barriers encountered by military clients are similar to those experienced by other culturally diverse clients it is assumed that counselors may achieve positive counseling outcomes by applying the same empirically-supported therapeutic relationship principles with military clients. These principles -- such as the early establishment of rapport and the tailoring of therapy to match the needs of the client -- have shown to be vital and reliable predictors of treatment retention and outcome (Miller & Rollnick, 2002). Moreover, a strong therapeutic alliance will assist clients in placing trust in their counselors, thus enabling them to disclose and reveal difficult or embarrassing topics in sessions (Corsini & Wedding, 2008).

Counselors who engage in relationally-oriented, evidence-based practice assume the ethical responsibilities of gaining knowledge about diverse populations and becoming culturally aware by "providing (a) services in the client's native tongue, (b) using self-disclosure and "small-talk" to be more transparent, (c) obtaining a cultural consultation if needed, (d) providing services (e.g., childcare) that make it easier for clients to attend counseling, (e) aligning counseling goals with culturally-informed values, and (f) explicitly incorporating cultural content and cultural values into counseling" (Sommers-Flanagan, 2015, p. 99). Sue and Sue (2008) have asserted that effective treatment for culturally diverse clients consists of a wide range of skills, interventions, and tools designed to assist in establishing early connections. In adherence with

rationally-oriented, evidence-based practices and multicultural sensitivity, a specific technique known as *counselor self-disclosure* (CSD) may be essential in establishing and building rapport within the therapeutic alliance.

Counselor self-disclosure refers to a verbal revelation of personal information, made by the counselor to the client (Cashwell, Shcherbakova & Cashew, 2003). It has been described as an effective technique for building strong therapeutic alliances when working with members of culturally diverse populations (Sue & Sue, 2008; Burkard, Knox, Groen, Prez & Hess, 2006). Counselor self-disclosure has been effective in increasing mental health utilization participation and decreasing premature termination by members of culturally diverse populations (Cardemil & Battle, 2003). Furthermore, CSD models can encourage reciprocal disclosure from clients (Constantine & Kwong-Liem, 2003; Edwards & Murdock, 1994; Farber, Berano, & Capobianco, 2004; Simon, 1990).

Although CSD is effective with culturally diverse clients, there exists some controversy over the different definitions applied to the term. Counselor self-disclosure, in fact, has been described as the use of a "verbal statement that reveals something personal about a therapist" (Knox & Hill, 2003, p. 530). Similarly, Constantine and Kwan (2003) define CSD as verbal or nonverbal behavior that reveals information about a counselor to their client. According to Lee (2014), however, CSD from a counselor may consist of *nonverbal* transmissions of information that are unavoidable or inescapable self-disclosures. These forms of CSD may include a counselor in pregnancy or one who wears a wedding ring, as well as the counselor's personal appearance, attire, body weight, or skin color. CSD can be further explained by the *type* of information a counselor discloses. In fact, this verbal technique has been classified as one of two different types of statements: either self-involving or self-disclosing (Cashwell, Shcherbakova &

Cashwell, 2003; Lee, 2014). Self-involving disclosures are defined as information given about counselors' own cognitions and emotions during the therapeutic encounter; these revelations may refer to the client or the session -- and are communicated directly to the client (Hill, Mahalik, & Thompson, 1989). Similarly, Knox et al. (1997) defined instances of self-disclosing as disclosures communicated directly by counselors about themselves to their clients.

The use of counselor self-disclosure may bring about positive outcomes by helping to establish rapport and trust, while breaking down barriers that may prevent the success of a good therapeutic alliance with those of culturally diverse populations. This case study will focus on exploring the use of self-disclosure by counselors in therapeutic alliances with clients from the military population. Additionally, the study will examine the role that self-disclosure plays in discouraging premature termination while increasing mental health treatment utilization by clients in the military population.

Background

The military population represents an estimated 2.2 million military service members (including National Guard and Reserve) and 3.1 million immediate military family members (Substance Abuse and Mental Health Services Administration, 2011). As Hall (2008) has asserted, the United States military thus mirrors the demographics of culturally diverse populations of the country they serve. The U.S. Department of Defense (2015) reported that 31.3% (or 426,916) of active-duty military members identified themselves as culturally diverse (i.e., Black or African American, Asian, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islanders, multi-racial, or other/unknown). Military clients commonly blamed negative experiences on counselors' lack of cultural awareness. They also blame the counselor's use of incongruent theoretical approaches that were culturally inappropriate to their military

lifestyles and values – and therefore were a barrier to successful treatment (Leong & Kalibatseva, 2011; Visco, 2009). As a result, military clients expressed a lack of trust in counselors' abilities to understand and treat military clients (Visco, 2009). Hence, these clients experienced misunderstanding and stigmatization where mental health treatment issues were concerned (Blais & Renshaw, 2013; Kim, Britt, Klocko, Riviere, & Adler, 2011; Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009). Hoge et al. (2004) argued that this perception of stigmatization was high and disproportionately greatest among those who were most in need of mental health services. Hoge et al. (2004) conducted a longitudinal study examining the effects of combat on soldiers returning to the U.S. from deployments in Iraq and Afghanistan. Surveys were administered to participants three to four months after their return in order to evaluate symptoms of major depression, generalized anxiety, and the presence or absence of Post-Traumatic Stress Disorder (PTSD). Additionally, instances of alcohol abuse were measured alongside current stress levels as well as emotional and/or family problems. Participants were asked about their use of professional mental health services in the past month or year and about their perceived barriers to mental health treatment. Results from the study were that of those surveyed, 11-17% of military personnel may be at risk for mental disorders three to four months after returning from combat. However, only 23-40% of those who confirmed experiencing mental health disorders sought professional treatment, while 38-45% indicated an interest in receiving help.

An important issue to consider concerns the fact that barriers to treatment are not just limited to culturally diverse military clients; these barriers are reported by representatives of the military population as a whole. Vogt (2011) found that Caucasian American males in the military expressed a fear of public stigma and a mistrust or fear of the mental health system altogether.

Therefore, such barriers should be addressed since there are a significant number of service members returning from overseas who have experienced symptoms of either PTSD or depression, or have considered suicide – yet they are not seeking treatment (Kim, Britt, Klocko, Riviere, & Adler, 2011; Substance Abuse and Mental Health Services Administration, 2011). These psychological symptoms plague military clients and they contribute to the distress that can potentially break up their marriages and families (Blais & Renshaw, 2013; Kim, Britt, Klocko, Riviere & Adler, 2011).

According to Quillman (2012), CSD can facilitate and deepen clients' connections to their own affective and physical responses within the therapeutic alliance. As such, it is a strategy that would appear useful for a counselor working with members of the military, particularly those suffering from psychological symptoms such as PTSD. Quillman (2012) argued that CSD is powerful in several ways. First, CSD assists clients in establishing an enhanced awareness of their own body dynamics (or the physical self) by decreasing anxiety concerning the negative emotions brought on as a result of past traumatic events. Consequently, clients may infer that previously experienced negative emotions are actually less dangerous than initially feared. This realization leads to a greater sense of connection and safety when working in alliance with their counselors. Quillman (2012) thus concluded that CSD can aid in "increasing the transformational power of positive affect for self-regulation and reconfiguring of the client's internal world" (p. 2). In other words, CSD enables clients to learn how to self-regulate and to become self-aware.

Quillman (2012) further believes that self-disclosure "provides a deepened sense of connection between a patient and therapist by making explicit what the patient's implicit system is picking up (or misperceiving) from the therapist" (p. 2). For example, a counselor may choose

to use CSD with a client suffering from PTSD in order to verbally provide information to the client about how she or he is experiencing the client in the session based on her or his somatic (physical) sensations and body language (nonverbal communication). Therefore, CSD assists clients in recognizing and understanding how to manage symptoms of anxiety resulting from PTSD or other mental health disorders such as depression. According to Quillman (2012), self-disclosure, as used by the counselor, can enable the client to feel comfortable enough to reveal and solve instances of therapeutic discord that may occur in future sessions. In so doing, the chance that a client may prematurely terminate the relationship is significantly reduced. This type of self-disclosure is used in the moment and is useful when counselor shares or reports their affective (emotional) or somatic (physical) experience of the client while in session.

Burkard, Knox, Groen, Perez, and Hess (2006) recognized that there are several implications that favor positive counseling outcomes with the use of CSD. In their phenomenological study of counselors in cross-cultural therapeutic alliances, Burkard et al. (2006) identified five domains to consider when using CSD: (a) the counseling relationship, (b) the session antecedents to CSD, (c) the reason for using CSD, (d) CSD itself, and (e) the effect of CSD. Results from the study found that therapists who used self-disclosure improved the counseling relationships with their clients. Culturally-diverse clients reported feeling understood during the counseling process. Moreover, in using self-disclosure to reveal their reactions to their clients' experiences with racial or cultural issues, therapists were able to successfully build, enhance, and preserve their therapeutic alliances.

However, Burkard and his team found that the purpose for the therapist's use of self-disclosure did not match the *type* of CSD used with their clients. While the therapists felt the need to disclose after hearing their clients, the self-disclosure technique used by those therapists

did not match what was disclosed by their clients during a session. Thus, the researchers suggested that future studies should be initiated to explore a counselor's reasons for using CSD in relation to what is disclosed. Such research could fill what they perceived as a gap in understanding the use of CSD in therapeutic alliances with diverse clients

Kronner's (2013) study on self-disclosure focused on gay men who were in treatment with gay male therapists. He found that strong therapeutic connections occurred when counselors disclosed their knowledge and expertise in working with or being knowledgeable about the client's homosexual population. Additionally, Kronner (2013) reported that the clients' experiences in his study were supported when counselors disclosed they were gay which made them part of the population. Although his study explored the effect of CSD solely within a male-gay context, its results may be beneficial with understanding how counselors working with military clients understand the role CSD plays on the therapeutic alliance when they disclose that they are part of the culture and how this type of disclosure may make a therapeutic connection stronger.

Rationale for the Study

The goal of this study was to examine how two counselors made meaning of their role using counselor self-disclosure to establish and maintain therapeutic relationships with military clients. According to Litz and Schlenger (2009), 18% of military members who have served in Iraq and Afghanistan suffer from PTSD following deployment. Because service members are faced with many barriers to seeking treatment (Leong & Kalibatseva, 2011) and a large percentage of culturally diverse populations within the military have been identified as underserved (Substance Abuse and Mental Health Services Administration, 2011), these factors

create a need to understand CSD and how it may be beneficial during multicultural therapeutic alliances with military clients.

Research and clinical evidence exist to support the use of CSD with culturally diverse clients (Burkard et al., 2006, Chang & Berk, 2009, Sommers-Flanagan, 2015). CSD can result in positive effects as counselors assist clients in regulating and disclosing symptoms of distress (Quillman, 2012). Therefore, research in the area of CSD with the culturally diverse military population is warranted, specifically with those experiencing symptoms of distress from PTSD and other mental-health disorders. In addition, research into the area of CSD and the formation of therapeutic relationships with different culturally diverse populations like those of the military is needed to promote positive outcomes in therapy and increased client-retention (Kronner, 2013).

This study explores how counselors make meaning of the role CSD plays in multicultural therapeutic alliances with military clients. This study seeks to understand how the use of counselor self-disclosure can increase mental health professionals' awareness of how CSD contributes to treatment utilization and the reduction of premature termination of therapeutic relationships by service members.

Research Purpose and Questions

The purpose of this exploratory case study is to gain an understanding of how counselors make meaning of their use of self-disclosure when establishing and/or maintaining a therapeutic relationship with military clients. These questions will guide the study:

1. How do participants describe the role of their use of self-disclosure in establishing therapeutic relationships with military clients?

2. How do participants describe the role of their use of self-disclosure in maintaining therapeutic relationships with military clients?

Operational Definitions

In this section, acronyms and common terms that have special meaning are defined. The following definitions are presented to ensure uniformity and understanding of these terms throughout the study. I composed all definitions not accompanied by a citation.

• Counselor – A universal term in this study, used to represent licensed clinical professional counselors, clinical social workers, or clinical marriage and family therapists.

• Culture - A sum total of knowledge passed on by generations, which includes language, forms of art, religion, norms, and behavior. "Culture" also consists of all things individuals learn about what to do, believe, value, and enjoy within society. It is the total of the ideas, beliefs, skills, tools, customs, and institutions into which each member in society is born (Sue & Sue, 2008).

• Culturally diverse - the descriptor used in place of the word "minority" so that certain groups will no longer be viewed as "deficient" or "inferior" since society's primary objective is a recognition and celebration of alternative lifestyles (Sue & Sue, 2008). Different racial, ethnic, and linguistic populations or groups which make up the United States population (Paniagua, 2005).

• Establishing the relationship – An event occurring when a counselor establishes rapport with a client. The relationship includes such factors as respect, trust, psychological comfort, and shared purpose (Hackney & Cormier, 2009, p. 42).

• Intake interview -The first identifiable component of assessment. During this first counseling session, counselors are interested primarily in obtaining information about the range

and scope of the client's problems and about aspects of the client's background and present situation that may relate to these problems (Hackney & Cormier, 2009, p. 99).

• Maintaining the relationship - A continued action within the counseling process even after established relationships and rapport has been initiated (Hackney & Cormier, 2009). The goal is to develop relationships to decrease premature termination.

• Military clients – service members who are part of the military population consisting of individuals, couples and families.

• Military families - Families in which one or both parents are active duty service member, wears a military uniform and their children (Park, 2011).

• Military population - A culturally diverse group consisting of service members from the Army, Air Force, Navy, Marines, Coast Guard, Reserves or Guard and The Reservist. All members of the military service and their family members.

• Multicultural therapeutic alliance - A relationship bond between a counselor or therapist and a client from a different culture.

• Operation Enduring Freedom (Afghanistan; OEF) and Operation Iraqi Freedom (Iraq; OIF) (Litz & Schlenger, 2009). The beginning of the wars in Afghanistan and Iraq in 2001.

• Rapport - Refers to the psychological climate that results from the interpersonal contact between a counselor and client (Hackney & Cormier, 2009, p, 43)

• Service members - Army (soldiers), Air Force (airmen), Navy (seamen), Marines (marines), Coast Guard (members of the Coast Guard), Reserves or Guard (members of the guard and the reserve or Guard and Reserve personnel), The Reservist (reservists or soldiers or airmen depending on the branch of the reserves they are attached to); all members of the military service (Hall, 2008, pp. 31-32).

• Subgroup of culturally diverse – A group within a culture whose members share many of the values of the board cultures, but also have some values that differ from the larger cultures (Gudykunst, 2004).

• Therapeutic alliance or the therapeutic relationship - A working relationship between a counselor and client suggesting participatory involvement by both parties toward therapeutic goals and outcomes (Hackney & Cormier, 2009).

• Therapeutic goals - A set of conditions, a course of action, or desired outcomes to which a commitment has been made as part of the established therapist-client relationship (Hackney & Cormier, 2009).

Methodological Framework

This qualitative inquiry is designed to explore how two counselors describe their experiences with the use of CSD with military clients. A qualitative approach will provide an in-depth understanding of the ways counselors make meaning of their roles in using CSD with their military clients. Additionally, this study will explore the participants' reasons for using self-disclosure in a multicultural therapeutic alliance with the military population.

Qualitative studies are highly descriptive, often "filled with rich verbatim passages directly from study participants" (Kemparaj & Chavan, 2013, p. 93). Such inquiries should be naturalistic and emerging (Patton, 2003); moreover, they should assist researchers with making sense of phenomena, enabling a comprehension of the meanings the participants bring to the study (Denzin & Lincoln, 2008). Accordingly, this inquiry is grounded in the epistemology of *constructionism*, which accepts the supposition or idea that all knowledge is "constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty, 1998, p. 42). In this study, applying the principles of

constructionism will assist in the researcher's perception and understanding of the participants and what they reveal as existing within that "essentially social context," containing its own multiple realities to be interpreted and even re-interpreted (Crotty, 1998, pp. 55-56). Therefore, with reference to this particular study, participants will be asked to make meaning of their own experiences as well as their use of counselor self-disclosure during their relationships with members of the military.

This exploratory case study highlights the experience of two counselor's use of self-disclosure in multicultural therapeutic alliances with military clients. Yin (2009) described a case study as an empirical inquiry that investigates a current phenomenon within real-life situations. Further, a case study approach involves detailed descriptions from multiple sources (Yin, 2003). Hence, data will be collected to gain an in-depth understanding from multiple sources. The sources consist of interviews, observations, photo and object elicitation, reflective journals, and member checks. It should also be noted that case-study data analysis is an inductive process that works from the raw material to identify themes or patterns in order to create opportunities to explore additional questions (Hancock & Algozzine, 2011). Thus, a qualitative research design, such as a case study, will focus on the experiences of two counselor's use of self-disclosure in a multicultural therapeutic alliance with her or his military clients.

Theoretical Framework

Symbolic interactionism is the theoretical framework that informs this case study. It is based on three main premises (Blumer, 2004). The first premise is that human beings act toward things (a term that denotes objects or other individuals) on the basis of the meaning that the things have for them. The second premise is that the meanings of things are developed from human interaction with others. The third premise is that these meanings are an interpretative

process used by individuals interacting with the things they have encountered. Furthermore, effective interaction between people requires employing symbols. According to Blumer (2004), individuals' worlds are made up of objects that can be physical, social, or abstract. The object can be anything that has meaning to whomever it is an object. In addition, Blumer (2004) argued that people act on the basis of the meaning of objects, and it is necessary for the researcher to see the objects as the participants see them.

The symbols in this study are related to communication (the use of self-disclosure by the counselor). According to Blumer (2004), the word, symbols, denotes common words, along with gestures or indications made by individuals to each other, with meanings attached. Symbolic interactionism allows me to "understand culturally different interpretations of similar social experiences, explore meanings such as those of the members of undervalued groups, and attend to the social aspects of intense emotions" (Forte, 2004a, p. 391). In other words, a participant's perception of her or his military client's interpretation of experience within the social interactive process can provide significant meaning to the role CSD plays – particularly within a therapeutic framework where military clients who have endured intense emotional distress attempt to make meaning of those experiences. Symbolic interactionism views social interaction as an interactive communication process; therefore, the goal of this study is to gain an understanding of the role of counselor self-disclosure in multicultural therapeutic alliances between a counselor and her or his military clients. Additionally, the study is designed to gain an understanding of how counselors make meaning of when and what they disclosed with their military clients.

Problems and Potentials of the Study

This case study involves limitations with reference to the number of available participants who have worked with the military population. Moreover, the participants' possible lack of

willingness to share information limited the study. As such, the study can be only as rigorous as the participants' revelations will allow. Moreover, since I am in the mental health field in a rural area, the participants and I were familiar with one another. Because I was familiar with the participants, it allowed me to have a positive relationship in place. It should also be noted here that self-disclosure is used in my own therapeutic work, and I have a deep-seated belief in its effectiveness with military clients. However, as the researcher, I vowed to remain open to the participants' experiences in the study, even if their beliefs and ideas about disclosure differed from mine. Furthermore, in an effort to remain open-minded, I engaged in peer-debriefing sessions in order to process any conflicting emotions or interpretations in study.

Counselor self-disclosure results in clients feeling comfortable in the knowledge that their counselors are familiar with their cultural group, thus decreasing premature termination behavior. It aids in eliciting reciprocal self-disclosure from clients. Thus, CSD is beneficial for those who are experiencing symptoms of distress (Quillman, 2012). Yet despite the fact that CSD is documented as being effective in establishing rapport with clients, and has been specifically useful with those who are culturally diverse, there are few studies documenting its use with a military population.

This study contributes to understanding the reasons some counselors endorse the use of self-disclosure. Additionally, it clarifies how two participants made meaning of their role of CSD in establishing and maintaining therapeutic alliances with their military clients. This study can contribute critical knowledge to the multicultural counseling field in the areas of theoretical approaches and techniques by facilitating the improvement of multicultural therapeutic alliances as well as treatment retention of military clients. Additionally, this study contributes to understanding relationally-oriented practices by addressing how counselors interact with clients

using CSD in a way that is both transparent and collaborative. The participants in the study benefited by having the opportunity to add knowledge to the counseling field about treatment of military clients – who are still recognized as being underserved (Substance Abuse and Mental Health Services Administration, 2011). This study could potentially help to improve treatment utilization and decrease premature termination among those in the military population.

Chapter Summary

In this chapter, the nature of a therapeutic alliance was identified. An overview of barriers to positive counseling outcome and treatment utilization by the culturally diverse population and the military population was presented. In addition, CSD was identified as an effective technique when working with clients from both groups. The background and setting to the study were introduced, citing and describing a series of recent studies involving service members returning from overseas deployment in Afghanistan and Iraq, a large percentage of whom suffer from symptoms of PTSD and other similar maladies, in addition to experiencing the problems resulting from long tours of duty separating them from their families. Additionally, the rationale for the study, research purpose and questions were discussed – all designed around the theme of counselor self-disclosure (CSD) and its effectiveness in treating members of a culturally diverse military population, which will be the focus of this qualitative inquiry. Also, a list of operational definitions was enumerated and explained. Similarly, methodological and theoretical frameworks were presented, briefly presenting the main principles of constructionism and symbolic interaction and how these epistemologies will frame the study. Next, the limitations of the study were identified, particularly with respect to my concern about being open-minded during the study. Finally, the study's importance was discussed, along with the author's dedication of the

study to improving the availability of competent, sensitive, and ethical mental-health treatment for members of the military.

In the next chapter, a review of literature that addresses the use of counselor self-disclosure (CSD) will be provided.

Chapter 2 - Literature Review

A historical overview of self-disclosure is presented in this chapter along with the theoretical framework that informs the study, followed by a discussion and examination of past empirical studies on self-disclosure. And finally, this chapter will identify the military population as well as discuss the underutilization of services by this group and their mental health needs.

Self-Disclosure: A Historical Overview

The topic of self-disclosure in counseling and psychotherapy has been the subject of important examination over the past several decades (Cozby, 1970; Henretty & Levitt, 2010), some of which have generated controversy over its usage (Faber, 2006). These varying levels of support for the use of self-disclosure are based on divergent theoretical perspectives and therapy techniques, each emanating from different schools of thought concerning the way we may perceive the structure of personality. Corsini and Wedding (2008) argued that "what one authority considered psychotherapy may be completely different from how other authorities see the process" (p. 2). Hence, the bases of argumentative support for the appropriateness of self-disclosure will occasionally differ (Henretty & Levitt, 2010). This study will focus on self-disclosure from a humanistic perspective. Accordingly, in the following paragraphs, I will discuss the evolution of counselor self-disclosure as being borne out of the need to create a *different* kind of relationship between counselor and client – different, that is, from what was originally suggested a century ago.

Psychoanalytic/Psychodynamic Theory

The origin of the psychoanalytic school of thought began with Sigmund Freud (1912), who is recognized as being the father of psychotherapy, advanced the use of talk therapy (Halbur & Halbur, 2011) and established the first model of a therapist's behavior (known as the

therapist's stance) while engaging in a therapeutic alliance (Faber, 2006; Henretty, 2011). According to Freud as cited by Henretty and Levitt (2010), therapist should act as a blank screen, remaining neutral for clients. Psychoanalysts who followed this blank-screen concept did not share his or her feelings or experiences with their clients (Gibson, 2012). Hence, psychoanalytic therapists neither provided directions to those they worked with nor did they adopt the role of teacher during sessions (Henretty & Levitt, 2010; Lynn & Vaillant, 1998). The psychoanalyst's posture maintained anonymity, equanimity, and abstinence (Lynn & Vaillant, 1998). These strategies assured the creation of an interpersonal void between the psychoanalyst and client which allowed unconscious conflicts to emerge (Ziv-Beiman, 2013). Psychoanalysts have argued that this void allowed the client's internalized thoughts to manifest themselves, thereby bringing them into self-awareness. If the psychoanalyst shared his or her thoughts and feelings during consultations, this disclosure would result in an outside interference, and create an inadvertent suppression of the client's thoughts. The posture, role, and task of the psychoanalyst was to guard against such interference during treatment (Faber, 2006).

While Freud encouraged personal self-disclosure from the client, he advocated a policy of strict *nondisclosure* on the part of the psychoanalyst. He maintained that the psychoanalyst should remain opaque, similar to a mirror, where the psychoanalyst reflects to the client only that which is shown by the client (Freud, 1912). Classical psychoanalysts make the argument that self-disclosure deviates from Freud's original concepts of a therapist's ideal stance and the psychoanalyst runs the risk of *transference*, a situation arising during treatment where clients transfer feelings from the past onto their counselor (Faber, 2006). Although a classical psychoanalytical therapist argues that self-disclosure deviates from a Freudian idea of the therapeutic process, Freud improvised upon (and even deviated from) his own ideas about self-

disclosure and the therapeutic alliance. For instance, Freud self-disclosed when analyzing friends and family members. He chatted with his patients about politics, art, and religion and even presented them with gifts (Farber, 2007; Hill & Knox, 2002). Therefore, it could be argued that Freud broke his own rules about the therapeutic alliance and even though he was inconsistent in his teaching and practice of self-disclosure, his views regarding the therapeutic blank screen dominated psychiatry from its origins and on through the 1950s.

While classic psychoanalysts argued against self-disclosure, Freud's colleagues and students advocated its use, even during a time when the blank screen perspective was considered dominant. One such associate was Ferenczi (1932/1988), who advocated the idea that the therapist should be open and self-revelatory during sessions with clients. He argued in favor of mutual relationships with patients in order to ensure an unfettered communication of information, which acts as an essential component in the treatment of childhood trauma (Ziv-Beiman, 2013). Ferenczi provided the option of relating to clients openly and practicing a kind of therapy that gathered momentum in the 1950s and 1960s – a time when the *humanistic movement* began to grow.

Humanistic Theory

According to Gibson (2012), a general shift in how therapists related to their clients took place in the mid-twentieth century "across all major theoretical traditions" (p. 292) as a result of the person-centered approach, or Rogerian approach, advanced by Carl Rogers, recognized as the father of humanistic theory (Halbur & Halbur, 2011). The central assumption of the person-centered approach is that self-understanding and behavioral change come from within an individual (Rogers, 1951). Rogers' position on the therapist's stance was different from that of Freud. Rogers rejected Freud's original concept and did not believe that counselors should

present themselves as “neutral or remain a blank screen to their clients. Rogers (1967) believed that “many of the conditions, which were commonly regarded by psychoanalysts as necessary to psychotherapy are nonessential” (p. 103). These nonessentials included: (a) remaining a blank screen, (b) presenting an opaque front to the client, and (c) creating a void between therapist and patient. Rogers placed importance on the therapeutic relationship and how the therapist related to clients.

According to Rogers (1957), certain conditions must be met in order for constructive change in personality to occur. He advocated the idea that counselors should be *congruent* or adopt an authentic, transparent, and honest role when using words and actions during sessions (Rogers, 1957). He placed emphasis on the acceptance of who the client is as a human being in order to help the client move towards his or her potential, thus gaining an understanding of his or her inner world. Rogers referred to this therapeutic strategy as unconditional positive regard for the client. He argued that counselors should have empathy for their clients and understand the client's internal frame of reference, thereby developing an ability to communicate these experiences for their clients. Rogers (1957) stressed that such conditions can exist when the counselor is genuine and forthcoming. Hence, based on Rogers’ humanistic framework, self-disclosure is considered appropriate if used for the well-being of the client, aiding in the therapeutic connection (Gibson, 2012). Corsini and Wedding (2008) asserted that “empathy and unconditional positive regard are not techniques, but they are the act of the person-centered therapist being real” (p.143). Therefore, person-centered counselors who practice self-disclosure can relate to their clients by moving them towards trust, growth, self-actualization, and self-awareness by revealing their thoughts and feelings in the here and now (Farber, 2007).

Following Rogers' (1967) advancement for unconditional positive regard and open, empathetic communication (self-disclosure) by counselors, other humanistic frameworks – such as family systems, intensive groups, and other schools of psychopathology – integrated his ideas and further expanded them (Farber, 2007). These ideas were augmented to include the importance of a therapeutic alliance (relationship) that emphasized attachment (or an emotional bond), relatedness, interpersonal engagement, genuineness, and disclosure. Moreover, therapeutic alliance has played a significant role in positive outcomes during treatment (Faber, 2007). An overview of the historical accounts of empirical studies following the expansion of Rogers' humanistic approach and other theories which support therapist self-disclosure is presented in the discussion that follows.

Self-Disclosure Research after Expansion of Humanistic Theory

Sidney Jourard (1954) is recognized as the first psychologist to use the term self-disclosure (Cozby, 1973). He is credited with advancing research into self-disclosure (Graff, 1970; Henretty & Levitt, 2010). During one study, Jourard and Lasakow (1964) examined the differences in self-disclosure as associated with race, sex, and aspects of self. The study revealed that Caucasian subjects disclosed more than African Americans and women disclosed more than men. There was a high self-disclosure rate from participants in the area of attitudes and opinions, tastes and interests, as well as work. There was low self-disclosure in the areas of money, personality, and body. The study reported that married subjects disclosed less to their parents and their same-sex friends than compared with unmarried subjects. Additionally, high self-disclosure was associated with positive feelings toward parents, while low self-disclosure correlated with attitudes of dislike toward parental figures. Jourard and Lasakow (1964) concluded that self-disclosure is measurable, and that the assessment developed by Jourard (1964) was valid. Their

research raised questions about why certain cultural groups disclosed less than Caucasian participants. Jourard conducted other studies into self-disclosure, and published books advocating its use in therapy. Jourard's research contributed to the importance of self-disclosure among different cultural groups (Jourard, 1971). Additionally, his work was influential in relationship-building and the reciprocating of self-disclosure on the part of clients during therapy, as other researchers have gone on to expand Jourard's work into clinical research in counseling and psychology.

Self-Disclosure and Modeling

Truax and Carkhuff (1965) believed that transparency or self-disclosure of the therapist enabled a greater degree of transparency and self-disclosure in clients. They conducted three correlational studies to examine their hypotheses about the relationship between therapist transparency, personality change, and self-disclosure. In these studies, ratings of self-disclosure were obtained from 14 schizophrenic patients seen in individual therapy from six months up to three and a half years. Results from the study confirmed a greater degree of transparency, self-disclosure, or self-exploration by the patients in the therapeutic encounter. Such transparency correlated to a greater change in the patients' lives and personalities.

Additionally, Truax and Carkhuff (1965) studied 306 participants (selected from 16 hospitalized cases) who had been in individual therapy for a period of time up to and including a period of three-and-a-half years. Results from this study revealed a significant correlation between the level of therapist self-congruence and the corresponding level depth of self-disclosure and intrapersonal exploration for the patients. The researchers found that therapist-transparency encouraged patients to become open and feel less anxious about the therapeutic encounter as well as gaining a deeper sense of self-exploration. This study provided evidence of

the importance of the use of self-disclosure and the need for the therapists to be transparent in their work.

Self-Disclosure Modeling with Different Populations

The use of self-disclosure by therapists was documented using several clinical populations in the 1970's in the area of therapist self-disclosure and modeling. Bundza and Simonson (1973) examined how clients rated their therapists as warm and nurturing. The researchers then correlated that rating to a clients' own willingness to self-disclose during therapy. Results revealed that nurturing therapist and client self-disclosure were directly related to positive psychotherapeutic outcome. These earlier studies were consistent with Rogers's (1951) ideas about positive therapeutic outcome among patients whose therapists are authentic, genuine, and open in the therapeutic alliance. Such therapists teach reciprocating behaviors of self-disclosure to their clients and, in doing so, provide a clinical foundation for what is known currently about self-disclosure.

In another study, Dies (1973) explored client's perceptions of therapists who used self-disclosure in group situations. Dies's (1973) study found that therapists who used self-disclosure were more positively perceived by their clients than therapists who did not disclose. Moreover, clients who attended a greater number of group-therapy sessions preferred therapists who practiced self-disclosure and were thus seen as more likeable, friendly and trusting. In contrast, clients who attended less group sessions preferred less self-disclosure from their therapist.

Self-disclosure Analogue Studies

Research into self-disclosure expanded further with the use of analogue studies, including the video- or tape-recording of therapists using self-disclosure with their clients. These studies began in the late 1970s and continued through the 1980s. Simonson (1976) conducted a study

exploring the effects of different types of disclosure used by a therapist. In the study, analogue tapes were used to compare the therapist's disclosure about past events using relatively impersonal information in relation to the same therapist's disclosure of past events using more personal information. The study found that participants who perceived their therapists as having a warm demeanor demonstrated greater disclosure than therapists who were perceived as having a cold demeanor.

Simonson (1976) argued that self-disclosure by warm demeanor therapists assists in facilitating patient disclosure; however, self dissclosure was found to be counterproductive if done early in the session. Simonson (1976) asserted that the client's perception of therapists is a significant variable in the therapeutic outcome and process. This study supports the value of developing a good therapeutic relationship before attempting to use self-disclosure because therapist self-disclosure may not be as useful early in sessions. Results from the study were consistent with previous studies (Bundza & Simonson, 1973; Dies, 1973; Truax & Carkhuff, 1965; Vondracek & Vondracek, 1971), which suggested that the therapists' ability to be transparent, open, and genuine assisted in developing a successful therapeutic relationship through increased self-disclosure by clients.

CSD and Family Therapy Theories

According to Faber (2006), cultural forces have influenced perceptions of psychotherapy over the past 30-40 years. Faber (2006) argued that the influx of women into the field of psychotherapy during the 1960's resulted in a more open attitude regarding self-disclosure. As a result, therapist disclosure was no longer seen as unnecessarily intrusive; instead, it was increasingly viewed as a tool toward enhancing positive, nurturing therapeutic relationships.

In more recent studies, some of the more relational therapies, such as those involving family therapy theories, have come to accept the practice of therapist self-disclosure. The use of self-disclosure varies among different family therapy theories (Gibson (2012) Yet, other researchers consider self-disclosure to be an effective tool in family therapy theories (Gaines, 2003; Robert, 2005). Gaines (2003) maintained that in terms of practicing from a relational or interpersonal stance, therapist self-disclosure is seen as a natural part of the therapeutic relationship. Gaines (2003) suggested that variations in the use self-disclosure do not negate "openness toward and a readiness for an open dialogue [which] is an essential part of the therapist's basic stance" within family therapy (p. 570).

Structural and strategic approaches are among the family therapy theories that support therapist self-disclosure but such schools of thought also harbored concerns about the actual use of self-disclosure. According to Gibson (2012), they opposed the use of disclosure except for the purpose of "joining with the clients" (p. 292), which is a way for therapists to begin to establish bonds with family members. Conversely, symbolic and experiential models permitted a liberal use of therapist self-disclosure (Gibson, 2012; Robert, 2005). Bowen family systems theory, narrative theories, and feminist theories are other family therapy theories which encourage therapist self-disclosure with their clients (Robert, 2005).

In family therapy literature, the term "the self as a therapist" was used to describe therapist self-disclosure (Cheon & Murphy; 2007, Watt-Jones, 2010). According to Watts-Jones (2010), the term self as a therapist, can be used differently. One use of the term may apply to when therapists have an awareness of themselves within both the professional and personal frameworks of the therapeutic process with families. Another use of the term refers to the

therapist "revealing a reaction to something that transpires in the therapy, or sharing an experience of her/his own that seems germane" (Watts-Jones, 2010, p. 405).

Narrative and feminist theories lend support to the practice of therapist self-disclosure. Narrative therapy explores stories that reflect a client's cultural perspectives and realities. Both narrative and feminist family therapists are encouraged to use self-disclosure to empower clients, normalize family problems, and assist families in realizing they are not different from other families who are experiencing distress (Lee, 2014; Nichols, 2010; Roberts, 2005). Narrative therapists encourage their clients to externalize their problem-saturated stories and reconstruct them into narratives that are more productive and liberating (Nichols, 2010). According to Mills and Sprenkle (1995), self-disclosure empowers clients when problems are reshaped and presented in the format of stories. Narrative therapists see their work as a way to alleviate feelings of oppression within clients and help them become active authors of their own lives which can result in feelings of empowerment. Therapist self-disclosure is supported within the family feminist perspective for its empowering effects in the therapeutic relationship (Enns, 1997). This theory is described as a set of values which consists of legitimizing clients, promoting egalitarianism, and aiding clients in their struggles towards sexual, social, and political equality (Bianco, 2007).

This section has provided the reader with past research of various examples of theoretical support for therapist self-disclosure. Nevertheless, the longstanding debate about self-disclosure persists, particularly with regard to ethical issues involving its appropriateness. Audet (2011), for example, conducted a qualitative study to examine therapeutic boundaries and professionalism with nine participants who had endorsed experiencing therapist self-disclosure with their counselor, psychologist, or psychiatrist. Results from the study revealed that participants

endorsed both negative and positive experiences from disclosure with three themes emerging from their interviews: (a) acknowledgement of boundaries and role distinctions, (b) perceptions of boundaries and roles prior to receiving therapist self-disclosure, and (c) perception of boundaries and roles after receiving therapist self-disclosure. Although positive qualities were reported, Audet (2011) found that two participants reported feeling that disclosure compromised therapy and blurred client-therapist boundaries. Other participants described disclosure as storytelling and felt that there was a role reversal occurring between therapist and client. Two participants even perceived their therapists as incompetent. Audet's (2011) study suggests that counselors must take issues of boundaries into consideration by becoming sensitive to the possibility that not all clients may benefit from therapist self-disclosure. Audet (2011) asserts that counselors should disclose similarly to their clients and that counselors may benefit from examining their role in the alliance before considering disclosing as it may alter (or reverse) roles in the relationship. Hence, counselors will benefit from examining the therapeutic relationship with particular attention paid to issues of clients' boundaries before choosing to use therapist self-disclosure.

Self-disclosure can increase intimacy and energy within a therapeutic space (Quillman, 2011). Therefore, novice counselors will benefit from using their supervisors to assist in difficult clinical moments and recognizing when self-disclosure should or should not be used. According to Quillman (2011), a counselor should avoid self-disclosure if they are experiencing uncontrollably intense feelings. In addition, counselors should avoid disclosing with clients who have a history of intrusive and invasive family members and with those who have been diagnosed as having tendencies toward schizophrenia. As a precaution, Quillman (2011)

recommends processing emotions before attempting self-disclosures with clients when counselors are uncertain about how their disclosures are perceived.

This historical overview offered compelling reasons why counselors or therapists may use self-disclosure. These reasons reflect therapist alignment with existing theoretical perspectives and practices. Ethical considerations were also considered with the use of therapist self-disclosures. Empirical research suggests that clients who respond well to self-disclosure may find themselves more at ease with therapists who do the same, thus resulting in the client being more likely to complete therapy successfully and experience a decrease in symptoms.

Theoretical Framework

The theoretical framework that informs this study is symbolic interactionism, a human process (Patton, 2002) wherein, according to philosopher and psychologist George Herbert Mead, people create meaning from their interactions with others to make sense of the world (Crotty, 2003; Blumer, 2004). These meanings are formed through cultural understanding, which deals with one's language, communication, interrelationships and community (Crotty, 2003) entities that play an important role in counseling and to this study. The counselor's communication (self-disclosure) aids in understanding the client's internal frame of reference. Crotty (2004) emphasized that the meaning of symbols can be understood through connections with others and is based on a person's cultural background and social interactions with others. For this reason, meaning is different for clients from different cultures because people have different cultural backgrounds and interact differently in their social connections. As such, perspectives will vary as they interact with counselors from either the same or a different cultural group.

Herbert Blumer (2004) composed a book consisting of forty years of notes from his mentor, Herbert Mead's teachings. Blumer is credited as causing a major impact in the area of sociology through Mead's thoughts and beliefs. Blumer (2004) identified Mead's three premises of Symbolic Interactionism:

1. Human beings act toward things on the basis of the meaning that the things have for them.
2. The meaning of things is developed from human interaction with others.
3. These meanings are an interpretative process used by the individual interacting with the things that are encountered.

With regard to the first premise above, White and Klein (2008) observed that "the most basic assumption in symbolic interactionism is that the explanation of human behavior is impossible without knowing the meaning such behavior holds for the actor" (p. 98). For instance, the meaning of the behavior must be understood from the person who exhibits that behavior. Unfortunately, Forte (2004) states that professional counselors are allowed to "impose definitions on client's circumstances" without considering what may be important to their clients (p. 397). However, a behavior can be understood only when the meaning of the behavior is known by the person or group

When working within the framework of symbolic interactionism, researchers understand that counselors who use CSD should be mindful of the client's definitions about counseling and other important facts about the client. Counselors should also be aware of what is needed in the therapeutic alliance. CSD is helpful when working with the military population because there are unique aspects of military clients that might not be revealed unless a trusting therapeutic relationship with their counselor is established, especially where culturally diverse clients may

require their counselor to disclose before feeling at ease to do the same (Burkard et al., 2006, Kronner, 2013). Furthermore, CSD aids in developing a strong alliance with clients from diverse populations (Burkard et al., 2006).

As pertaining to the second premise of Symbolic Interactionism, meanings of symbols and concepts are created through social interactions (Blumer, 2004). Individuals form meaning based on their perception of a situation (White & Klein, 2008). Sue and Sue (2008) have noted that counseling theories are often culturally inappropriate and antagonistic to the lifestyles and values of diverse groups in society. Therefore, what seems real for culturally diverse clients may not seem real for other clients. Consequently, a researcher working through the lens of symbolic interactionism must understand that interactions in a therapeutic alliance between a military client and his/her counselor may differ from traditional therapeutic alliances. Likewise, because counselors use CSD to help eliminate power differences with culturally diverse clients (Sue & Sue, 2008), it may assist military client to feel at ease as a result of their counselor's shared information.

Regarding the third premise of Social Interactionism, meanings are formed through an interpretive process based on the person's interaction with an object (Blumer, 2004). Because individuals make meaning through their interactions with objects, it is important to understand what constitutes an object An object can be classified as a symbol, a language, or a person Symbols are things that stand for (or represent) something else and are a major focus in symbolic interactionism due to their importance in communication. Symbols must be shared and agreed upon in order for communication to occur (White & Klein, 2008). According to Crotty (2004):

> An *interaction* [emphasis in the original]…is possible only because of the 'significant symbols' – that is, language and other symbolic tools – that we humans share and through

> which we communicate. Only through dialogue can one become aware of the perceptions, feelings and attitudes of others and interpret their meanings and intent (p. 75).

In other words, dialogue is needed in order to communicate in counseling and symbols are used to assist in the interaction between individuals. Hence, the only way to interpret the meanings of attitudes, feelings, and perceptions of others is through shared communication. Therefore, meanings will be different, based on how an individual interacts in different ways with a symbol. Counselor self-disclosure is a symbol in the therapeutic alliance, and a counselor will disclose information based on their interpretation of the interaction taking place in the session.

Symbolic interactionism is appropriate for this study because it enables counselors to frame their thinking around how clients make meaning of things through their interaction and communication in session. Because symbols have different meanings for different people, it will be important for counselors to understand those meanings when expressed by their individual clients. The understanding of the client's meanings assists counselors in facilitating change, thus establishing and maintaining a strong therapeutic alliance.

Current Research on Counselor Self Disclosure

Counselors who engage in relationally-oriented, evidence-based practice assume the ethical responsibilities of gaining knowledge about diverse populations and becoming culturally aware by (a) providing services in the client's native tongue, (b) using self-disclosure and "small-talk" to become more transparent, (c) obtaining a cultural consultation if needed, (d) providing services (e.g., childcare) that make it easier for clients to attend counseling, (e) aligning counseling goals with culturally informed values, and (f) explicitly incorporating cultural content and cultural values into counseling (Sommers-Flanagan, 2015, p. 99)

Therapeutic Alliance

Hackney & Cormier (2009) define therapeutic alliance, or working alliance, as a collaborative relationship between counselors and their clients where development of an attachment bond takes place and a shared commitment to the goals and tasks of counseling are agreed upon. This alliance is documented as having an important role in the therapeutic process with regard to the client's treatment outcome (Barrett & Berman, 2001). According to Blais, Jacobo, and Smith (2010), the therapeutic alliance is "one of the most robust predictors of positive psychotherapy outcome regardless of the type of treatment employed" (p. 387). Constantine and Kwan (2003) and Goldfriend, Burckell and Eubank-Carter (2003) maintain that the alliance in a therapeutic relationship is enhanced from therapist self-disclosure in psychotherapy. Rogers (1951) emphasized the importance of the therapeutic relationship when he wrote of its positive effect on treatment outcomes, regardless of the type of technique or intervention used. He also argued that positive therapeutic relationships aided in building trust between the two parties.

Bordin (1979) believed that deeper bonds of trust are developed when there is a working alliance between the client and the counselor. When considering alliances from the client's perspective, literature seems to be congruent with Bordin's (1979) research on bonding and therapeutic alliance. Typically, clients have described therapists who self-disclose as being more human or "real" (Knox, Hess, Petersen, & Hill, 1997; Nayman & Daugherty, 2001; Satterly, 2006). Clients also found such therapists to be trustworthy (Barrett & Berman, 2001), which made it easier for them to develop stronger trusting therapeutic relationships with their therapists. A study of self-disclosure conducted by Farber, Berano and Capobianco (2004) revealed that the client's decision to disclose is positively influenced by the therapeutic relationship. Furthermore,

clients reported that they disclosed more when they believed that their therapists would handle their disclosure in an affirming and caring manner. When counselors form trusting alliances with their clients, it allows their clients to feel free to reveal issues that may be sensitive or difficult to disclose.

In another study, Hanson (2005) found that participants believed that therapist disclosure contributed to a relationship that produced a sense of a deep understanding, connection, trust, and a decrease in alienation. As a result, the therapeutic relationship was enhanced by the therapists' disclosure of information about themselves or responses to their clients in session (Hanson, 2005).

Constantine and Kwan (2003) noted that counselor self-disclosure was a useful tool for developing and maintaining strong alliances in a multicultural therapeutic alliance. Counselor self-disclosure is documented as preserving the psychotherapeutic relationship after a client shared issues involving racism in the session (Roberts, 2005).

Burkard, Knox, Groen, Prez, and Hess (2006) conducted a qualitative study with eleven European American licensed mental health practitioners to examine therapists' use of self-disclosure in cross cultural counseling. Their study revealed that participants used therapist self-disclosure when their clients were coping with racism or oppression and as a means to enhance or preserve the therapeutic relationship. Burkard et al. (2006) revealed that therapist self-disclosure helped clients to feel genuinely understood. Therapist self-disclosure provided space to discuss intimate issues focusing on racism and normalized the client's experience in therapy.

Because the therapeutic alliance is considered an important factor in the counseling process, it makes sense to understand how CSD can assist clients from diverse backgrounds.

Research has acknowledged that CSD helps to establish rapport and that clients view counselors who use CSD as real or authentic. As a result, clients were open to discussing uncomfortable aspects of their lives with counselors who were from different cultural backgrounds.

Reciprocal Self-disclosure

Counselors endorsed self-disclosure for its reciprocal effect with clients (Simmon, 1990). In other words, clients may self-disclose after hearing their counselor disclose in session. Typically, counselors use self-disclosure to model a desired behavior from their clients in session (Edwards & Murdock, 1994). When CSD is used, clients learn the value of disclosure and how to use it in their interpersonal relationships (Faber et al., 2004; Simmon, 1990). Constantine and Kwan (2003) maintained that CSD helps to educate clients and acts as a model to demystify the therapeutic process and encourage self-disclosure with diverse clients in multicultural therapeutic alliances.

Studies have documented the reciprocal effects of CSD. Knox et al. (1997) found that CSD exerted a positive effect on clients. Therapists reported that clients felt encouraged to use self-disclosure more often in sessions when they recognized their therapists using the technique. The study also revealed that participants reported using disclosure in and out of therapy as a guide for their own thoughts, feelings, and behaviors.

Farber et al., (2004) reported that participants viewed counselor self-disclosure as a means of facilitating their own reciprocating disclosures with their therapists, as well as with their family and friends. Another study, conducted by Edwards & Murdock (1994) revealed that therapists endorsed using their disclosure, either to model appropriate behavior or to increase similar disclosure within the therapeutic relationship.

Simmon (1990) explored modeling as one of the strategies used by some therapists. The study found that self-disclosure "served as models of adult behavior by demonstration [of] problem-solving approaches, coping skills, self-acceptance and assertiveness" (p. 213).

Research demonstrated that counselor self-disclosure is recognized as effectively modeling acceptable behaviors and teaching clients to disclose in session. Clients have felt encouragement in disclosing sensitive issues with family members. Counselor self-disclosure can assist those who work with service members and their families – especially those in the military who are suffering from PTSD and other mental health disorders – to learn to use disclosure and encourage the divulging of sensitive matters to their counselors and family members.

Decrease of Premature Termination and Symptoms Distress

Counselor self-disclosure with diverse clients has been found to decrease symptoms of distress and premature termination of the therapeutic process by enabling counselors to make connections with their diverse clients (Quillman, 2012) and eliminate distrust (Constantine & Kwong-Liem, 2003). CSD makes it easier for counselors to break down barriers in a multicultural therapeutic relationship; it helps diverse clients to feel comfortable with the counselors they work with (Robert, 2005). For this reason, there are several worthy justifications for CSD in multicultural therapeutic alliances.

One such justification centers on culturally diverse clients who have prematurely terminated the therapeutic process after experiencing difficulties in relating to their counselors or therapists about cultural issues (Sue & Sue, 2008; Terrell & Terrell, 1984). According to Constantine and Kwong-Leimn (2003), culturally diverse clients are reluctant to speak about important cultural issues or may feel anxious after introducing these topics in session.

An article on transparency and therapist self-disclosure in family therapy, Roberts (2005) examined several therapists' use of self-disclosure in session. The study revealed that the use of therapist self-disclosure aided to "enrich and push the level of discussion in treatment about race and ethnicity" (p.55). Therapist disclosure allowed counselors or therapists to break down barriers and open discussions about race and diversity issues in multicultural therapeutic alliances (Barrett & Berman, 2001; Cardemil & Battle, 2003; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003).

Another justification for the use of counselor self-disclosure is that culturally diverse populations report feeling disconnected from their counselor due to mistrust (Cardemil & Battle, 2003; Quillman, 2012). CSD is well documented as an effective tool for counselors working with diverse clients because it assists in reducing mistrust in therapeutic alliances when race, ethnicity or other cultural issues are introduced into sessions (Burkard, Knox, Groen, Prez, & Hess, 2006; Knox & Hill, 2003). Constantine and Kwan (2003) noted the effectiveness of self-disclosure when addressing cultural mistrust attitudes with diverse clients in multicultural therapeutic alliances Quillman (2012) observed that therapist self-disclosure "provides a deepened sense of connection between a patient and therapist, making explicit what the patient's implicit system is picking up (or misperceiving) from the therapist" (p. 2). For example, Quillman (2012) suggested that CSD helps clients feel connected to their counselor and assures that the counselor's perceptions of their clients' symptoms are correct, thereby allowing them to feel at ease to reciprocate with their own disclosure during sessions.

A qualitative study conducted from the client's perspective assisted Audet and Everall (2010) to gain a better understanding of disclosure's impact on the therapeutic relationship. In the study, Audet and Everall (2010) examined non-immediate disclosure of personal information

in contrast to immediate exposure – disclosure about the client in the here and now. The study found that participants believed their therapist understood them and that they could relate to their therapist when the information the therapist disclosed was similar to their own experiences.

Additionally, participants in Audet and Everall's (2010) study revealed that interactions with their therapist assisted in developing a more human connection of two people working together rather than an impersonal and strictly "clinical" relationship. Therapists in the study were perceived as empathic and interested in the information their clients were sharing. As a result, participants formed an open therapeutic relationship as a result of their therapist's disclosure, which enabled clients to perceive their therapist as accessible. As Audet and Everall (2010) concluded, "the disclosing behavior [acts] as an invitation or permission to respond in kind" (p. 336). Clients reported hearing their therapists' past experiences, which encouraged them to feel better about disclosing their own issues (Audet & Everall, 2010). However, some clients in the study reported feeling that their therapists were behaving unprofessionally when they disclosed in session. Others reported feeling overwhelmed when disclosure differed from their values and beliefs and when disclosure was unwelcomed (Audet & Everall, 2010).

In another study, Kronner (2013) examined how often therapists self-disclosed to their clients and how connected each were to the other (patient-to-therapist or therapist-to-patient) in a sample of eight therapists and eight gay male patients/participants. The eight therapist-patient pairs (16 participants) completed questionnaires asking how often their therapists used CSD. Additionally, both patients and therapists were asked whether a counselor's use of self-disclosure led to a stronger therapeutic relationship. The levels of counselor self-disclosure were measured using a Likert scale developed by the researcher; moreover, the degrees of connection perceived

within each participant-pair (patient-to-therapist as well as therapist-to-patient) were assessed using the Barrett-Lennard Relationship Inventory (BLRI).

Results from this study revealed a positive correlation between the amount of CSD (as reported by patient-participants) and the patient-participants' perceptions regarding the level of connection. Patients who perceived that their therapists self-disclosed more often also reported higher levels of connection when compared with those who sensed a lower level of CSD used by their counselors. Counselors who used self-disclosure also conveyed an open acceptance of their patients. However, both therapist-participants and patient-participants were unsure as to what therapeutic qualities assisted in developing these connections. Kronner (2013) suggested future research examining counselors' choices regarding when to disclose, what to disclose, and why counselor decide to disclose.

Additionally, Kronner (2013) maintained that therapist self-disclosure allows connections to occur when counselors disclose their expertise in working with or being knowledgeable about a client's population. Moreover, clients' experiences were authenticated when the clinicians in study disclosed belonging to the same population.

Another significant justification for the use of therapist self-disclosure involves its effectiveness with decreasing symptoms distress. Knox et al. (1997) noted that therapist self-disclosure assists clients in decreasing symptoms distress and helps to dismiss the negativity toward disclosing symptoms. According to Quillman (2012), therapist self-disclosure provides an opportunity for counselors or therapists to normalize symptoms. Quillman (2012) further argued that counselors, when engaging in self-disclosure, will at the same time model such disclosure to their clients. Such modeling assists in decreasing their client's anxiety about any negative emotions with regard to their symptoms. Quillman's (2012) findings are consistent with

those of other studies centering on self-involving disclosure made by counselors or therapists when used in the here and now. Some therapists will use self-involving statements – in other words, shared reports about their affective (emotional) or somatic (physical) experience of the client in session through their language (spoken words). Clients are thus made aware of their symptoms through their counselor's or therapist's disclosure, and in turn these clients learn about their symptoms and become more familiar with their symptoms. Quillman (2012) argued that self-disclosure by counselors gives clients the ability to provide the counselor with accurate information about the symptoms they are experiencing without waiting for the client to disclose the information on their own.

The use of CSD, therefore, has been documented as having value with clients and counselors. Several worthy justifications include the developing of therapeutic alliance, the modeling of self-disclosing behavior for clients, and the reduction of symptoms distress. CSD with multicultural military clients and their families will allow counselors to model behavior when needed to assist clients who are unfamiliar with disclosing their symptoms. This form of practice may assist in reducing symptoms distress while offering counselors an effective way to establish and strengthen the multicultural therapeutic alliance.

In the next section I address the military population. This section will address some demographics of the population and the different dynamics that make the military a diverse subculture within the U.S. Additionally, I address the mental health needs of the military population.

Subcultural Population: Military Service Members and their Families

Members of the military and their families represent a distinct subcultural group within the culturally diverse populations in the United States (Strom, Gavian, Possis, Loughlin, Bui,

Linardatos, Leskela, & Siegel, 2012). This subcultural group is made up of an estimated 2.5 million military service members, including National Guard and Reserves and 3.1 million immediate military family members (Substance Abuse and Mental Health Services Administration, 2011). During the past decade, military service members have been constantly deployed to Iraq and Afghanistan (SAMSHA, 2011) with 37% of military members having been deployed at least twice (Litz & Schlenger, 2009). As a result, military service members report experiencing psychological distress from witnessing or personally experiencing traumatic events (Blais & Renshaw, 2013). Military service members also report experiencing psychological effects as a result of multiple separations from their families due to overseas deployments as well as service in stateside schools and while in training. These separations have led to the breakup of many marriages and families in the military. A review of the literature demonstrated that although military service members and their families are reluctant to seek treatment and are underserved despite experiencing negative effects from frequent deployments and other separations that are similar among other culturally diverse populations (Burnam et al., 2008; Hoge et al., 2004; SAMSHA, 2011). CSD may encourage military family members to remain in counseling and increase treatment utilization with the military population.

Military Culture

There are some factors that must be present in order for the military to be to be classified as a diverse subcultural population. Reger, Etherage, Reger, & Gahm (2008) documented a number of important factors that classify the Army as a subcultural population within a wider diverse population. They found that army language was one of the factors that classified the military and their families as a diverse population. Many acronyms are used by the military to assist in communicating procedures and processes. Such military jargon is important for military

members and their families because it is essential in understanding the organization and the unspoken dynamics of how to function properly within the population (Reger, Etherage, Reger, & Gahm, 2008).

Another factor of importance is the ranking system within the military, which influences relationships and the ways military members communicate with one another (Reger et al., 2008). Understanding the dynamics of rank in the military is an important part of this population's language. The Army consists of enlisted soldiers and commissioned officers who have different ranks, roles, and tasks associated within each group (Storm et al., 2012). Ranks are indicated on all service members' uniforms and are clearly recognizable. Reger et al. (2008) argued that although rank is visible and has power-authority and roles associated with it, the system can seem complicated to those who are not in the military. For example, although officers technically outrank enlisted military service members, the relationship structure and communication is somewhat different between a lower-ranking officer in the military for only 3 months than with an enlisted noncommissioned officer who has been in the military for 20 years or more (Reger et al., 2008).

Another factor that classifies the military and their families as a subcultural population involves certain systems of manners and behavior (Reger et at., 2008, Storm, 2012). To be more precise, there are clearly defined and expected behaviors and mannerisms within the ranks. Service members are expected to behave and socialize according to military standards. For example, according to Reger et al. (2008), a dress code is strictly enforced with clear instructions on grooming as it pertains to hairstyles and facial hair. Enlisted military members are expected to know when to salute officers, when to come to attention, and how to address officers. Hall (2008) discussed the separation of living arrangements among enlisted personnel and officers on

Army installations. Within this separation of rank, there exist distinctions in appearance, quality, and size of homes, all of which influence modes of behavior when enlisted personnel and officers socialize when off duty. Although this class structure may appear to carry social injustice implications, military members as well as family members are accustomed to living and working within these cultural norms (Hall, 2011).

The military's belief system is also an important factor affecting personnel and their families as a subcultural population. Beliefs influence the way we think and behave, and there are many different belief systems within the military. According to Strom et al. (2012), expectations about the military begin the moment they enter the military. Typically, branches of the military have a basic training process where new recruits must learn basic values and beliefs. An important belief held by the military is that their mission is to provide national defense for the country (Reger et al., 2008). And to accomplish this and other missions, sacrifice, teamwork, leadership, loyalty, respect for the hierarchy, and obedience are expected and valued (Reger et al., 2008; Strom et al., 2012).

According to the U.S. Army (2016), there are seven core values in the military that soldiers learn during Basic Combat Training (BCT). They are as follows: loyalty, duty, respect, selfless service, honor, integrity, and personal courage. Soldiers are taught to live these values 24 hours a day, on or off duty, and to apply these values in everything they do. Loyalty is defined as allegiance to the U.S. Constitution, the unit, and fellow soldiers. Loyalty is expressed through the wearing of the uniform (U.S. Army, 2016). Duty is defined within the army as carrying out all assigned missions, tasks, and responsibilities. Duty means that soldiers will fulfill their obligations. Soldiers are taught to treat people with respect and trust that others will do the same. Selfless service is putting the needs of the country and the Army before oneself. It is important to

note that such values as those listed above may differ from those in the civilian world; but in the military, they are an everyday part of life. Honor can be found in soldiers' daily living and the choices they make. Integrity within the military is to do what's right, legally and morally (U.S. Army, 2016). The U.S. Army (2016) defines personal courage as confronting fear, danger, or adversity (physical or moral). Physical courage is both a matter of enduring physical duress and of risking personal safety. Facing moral fear or adversity may be a long, slow process of continuing forward on the right path, especially when taking actions that are not accepted by the mainstream.

CSD has been documented as an effective technique in working with culturally diverse populations. The military exists as a subcultural diverse group within the multicultural population. Therefore, it should be fair to assume that members of the military and their families can benefit from the use of CSD practices by counselors and therapists who work with those of this population.

Mental Health Needs of the Culturally Diverse

The Culturally Diverse Population

There is a disparity of mental health service utilization among culturally diverse groups (SAMHSA, 2011). Petterson, Williams, Hauenstein, Rovnyak, & Merwin (2009) found that African Americans and Hispanics receive less mental health treatment than other ethnic groups. Moreover, when professional mental health services are sought, they are 50% more likely to terminate counseling prematurely (Sue & Sue, 2008; Terrell & Terrell, 1994) due to the stigmatization associated with mental health as well as mistrust of mental health professionals and their lack of sensitivity toward cultural issues (Chang & Berk, 2009; Constantine & Kwan, 2003; Snowden, 2001; Terrell & Terrell, 1984).

Similarities between the military population and other culturally diverse populations found in CSD literature suggest several ways in which understanding other culturally diverse populations will assist in informing the study. First, counselors should develop an awareness of how CSD can actually benefit their efforts in establishing multicultural therapeutic alliances with military families. Second, cultivating an understanding of the culturally diverse population will assist counselors in increasing utilization of mental-health services and thereby decrease incidents of premature termination among the military/family population.

Stigmatization or embarrassment associated with seeking mental health care is documented as one of the main factors affecting mental health utilization by culturally diverse group members (Blais & Renshaw, 2013; Kim, Britt, Klocko, Riviere, & Adler, 2011; Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009). Regardless of the severity of their conditions, according to Corrigan (2004), most people feel marginalized by the idea of seeking counseling for their mental health simply because of the implied label that is often placed upon the term mental illness. Corrigan (2004) reported that people diagnosed with psychotic disorders are more harshly judged than those diagnosed with depression and/or anxiety. In a study conducted by Anglin, Link, & Phelan (2006), African Americans perceived individuals suffering from mental illness as dangerous. They believed people with schizophrenia were more likely to behave violently than someone with major depression. Additional research into attitudes held by members of culturally diverse populations have documented mistrust and perceptions of cultural insensitivity on the part of mental health professionals. Typically, clients are unwilling to disclose information about themselves when misunderstanding about their cultural issues is perceived during therapy. Ridley (1984) argued that non-disclosure by African Americans helps to protect a culturally diverse client's self-esteem and prevent the risk of oppression and racism

which resulted from negative past experiences where disclosure was misunderstood by counselors.

Resistance in the therapeutic relationship can result when negative experiences occur. According to Ridley (1984), African Americans disclose less information due to their mistrust of mental health professionals and other social factors. Negative experiences can result in a destructive influence on the therapeutic alliance, causing culturally diverse clients to begin missing appointments or showing up late for sessions, leading eventually to premature termination. Whaley (2006) found that African American men reported mental health professionals were unable to understand the challenges presented on a regular basis to those of culturally diverse members and thus willingly chose not to continue therapy.

Ridley (1984) stated that one of the reasons for this lack of trust among African Americans was due to traumatic experiences in the past with mental health providers. He stated that African American men received misdiagnoses erroneously from their counselors who, they perceived, lacked an understanding about them. Their counselors were unaware of the social and cultural issues with which African Americans are confronted with on a daily basis.

Military Population

Military members and their families are considered a subcultural population because of the specific language spoken within the group and for their distinct beliefs and values. As stated before, the military population has norms of behaviors which are different from those of the general public. Although the military is a subcultural population, there are many different culturally diverse groups represented within that population (SAMSHA, 2011), which makes it important to become knowledgeable about culturally diverse groups as well as the entire military. The use of multicultural diverse techniques such as CSD may be useful and may also

aid counselors in their work with members of the military. According to Hall (2008), the military mirrors the demographics of the culturally diverse populations in the country. The U.S. Department of Defense (2015) reported demographic information describing military service members and families in the military community. As I stated above, 31.3 percent or of active duty service members identified themselves as cultural diverse and these groups have experienced some of the same issues with insensitivity about cultural issues in their therapeutic alliances (Visco, 2009). However, this is not limited only to culturally diverse service members but, is common among military service members as a whole because military service members of all cultures prematurely terminate counseling (Erbes, Curry and Leskela, 2009). Similarly, culturally diverse groups within the military, along with the general military population, experience stigmatization and mistrust when the issue of mental health care arises. Such marginalization can serve as a barrier to mental health utilization in the same manner as with other diverse populations in the country. These barriers can deter service members and their families from seeking mental health services.

Another common barrier identified in the literature is the stigma associated with seeking mental health treatment. The military population reported feeling misunderstood and stigmatized about mental health treatment (Blais & Renshaw, 2013; Kim, Britt, Klocko, Riviere, & Adler, 2011; Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009). In a study of soldiers and marines returning from deployment in Iraq and Afghanistan, Hoge et al. (2004) documented that concerns of stigmatizations were high and disproportionately greater among those most in need of mental health services. Hoge et al. (2004) reported that only 23-40% of those who responded positively for mental disorders sought mental health treatment. Literature confirmed that barriers affect all the military populations as a whole. For example, a study conducted by Vogt (2011)

found that Caucasian men also expressed concerns about public stigma and a mistrust in the mental health system.

One common issue reported involved instances where health providers used incongruent theoretical approaches that were deemed culturally inappropriate to the lifestyles and values of the military (Leong & Kalibatseva, 2011; Sue & Sue, 2008, Visco, 2009). Visco (2009) found that military members expressed a lack of confidence in mental health professionals based on varying levels of experience and disappointing past experiences with counselors. In particular, many military members expressed a hesitation in seeking help from civilian personnel (those who had not served in the military) and most frequently cited "their inability to relate to the deployment experience as a barrier" (p. 249)

Erbes, Curry and Leskela (2009) found that Iraq and Afghanistan veterans had difficulty remaining in treatment. Vogt (2011) found that 42% of military members were referred for mental health services after deployment, but only 39% pursued follow up care six months later. Hence, it may be important to understand the barriers which prevent military clients from seeking treatment. Additionally, the use of interventions which are culturally aligned with the client will assist in retaining military clients. Therefore, more culturally competent awareness is needed among those who provide mental health services to the military population.

The barriers mentioned above are important to understand because of the number of returning deployed military members who are experiencing symptoms of Post-Traumatic Stress Disorder (PTSD), depression, anxiety, and other mental health illness. Additionally, there is an increase rate of suicide among these service members. These symptoms not only deter military members from carrying out duties but also threaten to break up marriages and families (Blais & Renshaw, 2013, Paul Y. Kim, Britt, Klocko, Riviere & Adler, 2011).

Counselor self-disclosure helps to decrease barriers in the therapeutic alliance with diverse clients and allows counselors to strengthen their therapeutic alliances (Sue & Sue, 2008). The use of self-disclosure decreases barriers by providing culturally competent techniques and creates space for discussions about culturally sensitive issues in the therapeutic alliance while modeling acceptable therapeutic behavior which the client may not be accustomed to. Moreover, the client's experience is validated when counselors disclose belonging to the same population or disclose their expertise in working with or being knowledgeable about a client's population (Kronner, 2013).

Symptom Distress

Many members of the military and their families are suffering from symptoms of distress due to deployments and other frequent separations (Blais & Renshaw, 2013; Hinojosa, Hinojosa, & Hognas, 2012; SAMSHA, 2011). CSD is one intervention that helps to educate the military population about symptoms and eliminates negativity around the symptoms they are experiencing (Quillman, 2012).

Castillo (1997) described symptoms as "a particular experience, a sensation, thought, emotion or behavior" (p. 33). Symptoms include an indication of illness which is common among the military population (Castillo, 1997). A considerable number of military members and their families suffer from symptom distress due to the general lifestyle of the military and the recent military conflicts. Conversely, as stated in the previous section, military members often are reluctant to seek mental health care. Similar to diverse clients, the military population may not be accustomed to counseling and may be unfamiliar with symptoms and how to report them during counseling. CSD assists clients with learning how to disclose symptoms through reciprocal behavior or modeling. This is can be done through psychoeducation and disclosing to

clients to build rapport in the relationship and to share about the importance of disclosure in their healing process. Additionally, CSD may assist clients with becoming aware of how they are being experienced by their counselors during the session.

The 1.6 million American men and women who served in the conflicts in Iraq and Afghanistan returned from their deployments and reported experiencing psychological distress from witnessing or personally experiencing traumatic events (Blais & Renshaw, 2013). Moreover, psychological distress may have developed from multiple separations from family members during deployments *without* traumatic experiences. According to Matthewson (2012) "the continuing hyper-alertness of a potential battle zone with a constant risk of being wounded or killed is harmful to the health of soldiers and their families" (p. 3). Everyday military training, as well as the various rigors and stress associated with the military, also add to psychological distress (Hall, 2008; Matthewson, 2012). Moreover, symptoms distress from lengthy deployments increase the risk of divorce and mental health issues (Hinojosa, Hinojosa, & Hognas, 2012).

Post-Traumatic Stress Disorder and Marital & Family Distress

Post-Traumatic Stress Disorder (PTSD) is one of the most commonly diagnosed mental health disorders experienced by returning deployed military service members (Sayers, Farrow, Ross, & Oslin, 2009; Vogt, 2011). The Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) classifies PTSD as a mental health disorder that is characterized by the re-experiencing of an extreme traumatic event which is accompanied by symptoms of increased arousal and avoidance of stimuli associated with the experience. Some military veterans reported witnessing life-threatening events such as combat firefights, live mortars, dismembered body

parts, and death (Tanielian, Jaycox, Adamson & Metscher, 2008). These experiences increase military clients' possibility of developing PTSD symptoms.

Sayers, Farrow, Ross, & Oslin (2009) reported that fifty percent of military members deployed to Iraq and Afghanistan were clinically significant for a diagnosis of PTSD. Although military members are screened for mental health disorders before post-deployment, they are reluctant to disclose symptoms (Tanielian, Jaycox, Adamson, & Metscher, 2008) and to utilize treatment. According to Leibowitz, Jeffreys, Copeland, and Noël (2008), disclosing trauma is essential in the treatment of PTSD. However, when treatment is sought, many military members fail to successfully complete that treatment (Seal, Maguen, Cohen, Gima, Metzler, Ren, Bertenthal, & Marmar, 2010, Vogt, 2011). As stated previously, CSD encourages military clients to reveal their experiences and disclose PTSD symptoms. Therefore, CSD enables clients to become comfortable with the therapeutic process and assists counselors with providing feedback about their clients' symptoms while in session (Quillman, 2012).

SAMSHA (2011) reported that approximately 18.5 percent of returning service members experienced PTSD. Unfortunately, military service members are at risk for developing other mental health symptoms such as depression, anxiety, anger, sleep disturbances, somatization, substance abuse, and sexual problems after returning from deployments. According to Goff, Crow, Reisbig, & Hamilton (2007), symptoms of depression and anxiety increase in individuals diagnosed with PTSD. Furthermore, the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) reported that individuals with a PTSD diagnosis are 80% more likely than those without PTSD to meet the diagnostic criteria for one of the other mental health diagnoses mentioned above. According to Hoge, Castro, Messer, McGurk, Cotting and Koffman (2004),

military members are at an 11-17 percent risk of developing mental health disorders three to four months after returning from combat deployment.

Seal, Maguen, Cohen, Gima, Metzler, Ren, Bertenthal, & Marmar (2010) found in their study on veterans deployed to Iraq and Afghanistan that from April 1, 2002 to March 31, 2008, 58.2 percent of veterans deployed were newly diagnosed with PTSD. Regrettably, only 10 percent attended at least one follow-up visit after their initial counseling session. The study revealed that a majority of the veterans in therapy failed to attend the recommended amount of sessions within the required timeframe for evidence-based treatment to take place (Seal et al., 2010).

Because PTSD symptoms can be debilitating and detrimental to the military family (Goff, Crow, Reisbig, & Hamilton 2007), assistance on several issues need to be addressed. According to Hoge, Terhakopian, Castro, Messer, and Engel (2007), impairment in functioning can be exhibited across a wide range of areas that include social, interpersonal, developmental, educational, physical health, educational, and occupational domains. The APA (2013) published results from a study of community veteran samples with PTSD. The study found that "PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success" (p. 279).

Open discussion about symptoms in the multicultural therapeutic alliance with those of the military population aids in educating clients about PTSD symptoms and helps clients to develop an awareness of their symptoms (Constantine & Kwong-Liem, 2003; Quillman, 2012). Hence, it may be useful for counselors to become knowledgeable about PTSD symptoms so that their clients will trust in their ability to help them and they may appear to be more competent and trustworthy by their clients (Barrett & Berman, 2001; Farber, Berano, & Capobianco 2004).

Leibowitz, Jeffreys, Copeland, and Noël (2008) conducted a study to gain better understanding of patients' trauma disclosure to health professionals. The study found that health care providers were essential in the disclosure process, with some clients disclosing trauma to their providers for the first time while a majority of clients "did not realize they had PTSD until provider identification occurred" (p. 102). Self-disclosure by counselors may help military members and their families feel secure in disclosing symptoms and allow providers to educate their clients about the symptoms of PTSD.

As stated previously, there are many debilitating symptoms which stem from PTSD. The APA (2013) reported that PTSD symptoms occur as a result of witnessing or being exposed to an actual or threatening event involving death, injury, sexual violence, or serious harm. These serve as requirements for diagnoses of PTSD. The events may have been witnessed in one of the following ways: (1) directly experiencing the traumatic event; (2) witnessing in person as the event takes place; (3) learning that the event occurred to close family members or close friends; or (4) experiencing repeated or extreme exposure to aversive details of the traumatic event. The person's response to the event must constitute intense fear, helplessness, or horror. A review of literature on the military population attests to the repeated exposure to these types of threats experienced by military members and their families indirectly (Blais & Renshaw, 2013; Matthewson, 2012; Tanielian, Jaycox, Adamson, & Metscher, 2008).

Trauma symptoms of this nature decrease the level of marital/relationship satisfaction. According to Goff et al. (2007), "high levels of trauma symptoms may make it difficult for soldiers to be emotionally available" (p, 352). Spouses of military members who returned from deployment often reported that their partner experienced symptoms of increased arousal and reactivity. Equally witnessed by spouses were irritability or outbursts of anger, reckless or self-

destructive behavior, hypervigilance, exaggerate startled response, lack of concentration, and difficulty sleeping (Goff et al., 2007).

The military population often struggle with reintegrating back into the normal roles and responsibilities of their marriages and families, due to symptoms of avoidance, detachment, and a decrease in previously enjoyed activities which are common symptoms of trauma (Allen, Rhoades, Stanley, & Markman, 2010; Goff et al., 2007). However, military members do not always associate their struggles with PTSD and commonly cite marital distress and re-adjustment to family life as reasons for seeking treatment (Leibowitz, Jeffreys, Copeland, & Noël, 2008).

PTSD symptoms experienced by deployed military members can significantly interfere with relationship satisfaction, relationship functioning, and normal marital processes such as positive communication and positive bonding (Allen et al., 2010; Goff et al., 2007; Hinojosa, Hinojosa, & Högnäs, 2012). In a sample of 45 male soldiers and their female partners, Goff et al. (2007) found that soldiers' trauma history and symptoms significantly predicted levels of relationship/satisfaction in soldiers and their spouses.

PTSD not only affects military members but also has a negative influence on spouses. Review of literature demonstrated that military spouses married to military husbands suffering from PTSD are at an increased risk for experiencing psychological and marital distress. Spouses reported experiencing some of the same symptoms as their military spouses (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005). Nelson, Goff, and Smith (2005) researched the effects of trauma on relationships and found that distress can have a reciprocal influence and can also affect overall relationship functioning.

Because many members from the military are suffering from PTSD and other symptoms distress, it is important that counselors are well-educated and understand how to identify positive

ways to work with this population. Moreover, an understanding of PTSD and how it affects military clients may be helpful for counselors consider when it is appropriate to use counselor self-disclosure as a model to educate and reduce symptoms distress.

Chapter Summary

In this chapter, I provided a historical overview of self-disclosure from the origin to the expansion of humanistic theories and past salient research. I then discussed symbolic interactionism which is the theoretical framework informs the study. Next, I examined empirical studies on the benefits of self-disclosure to include therapeutic alliance, modeling self-disclosure, and reducing symptoms distress. Finally, I identified the military as a diverse population and the barriers and stressor faced by the culture. Additionally, I discussed underutilization and retention of services by this group and their mental health needs.

Chapter 3 - Methodology

The purpose of this exploratory case study is to gain an understanding of how two clinical counselors describe their use of self-disclosure when establishing and/or maintaining a therapeutic relationship with military clients.

There were two research questions that this study addressed:

1. How do participants describe the role of their use of self-disclosure on establishing their therapeutic relationship with their military clients?
2. How do participants describe the role of their use of self-disclosure on maintaining their therapeutic relationship with their military clients?

Qualitative Research

A qualitative inquiry was selected for the purpose of providing in-depth detailed information about smaller groups of people or cases (Patton, 2002). Bhattacharya (2007) defined qualitative research as a systematic inquiry about an in-depth nature of human experience within the context in which the experience occurs. Lichtman (2013) described qualitative inquiry as an approach that is focused on words, themes, thick descriptions, and an understanding of the human experience that offers deep contextual meanings. Moreover, the data collection process is a naturalistic inquiry using multiple data sources for information. These pieces of information are then analyzed in small semantic units and then compared and contrasted against each other for the identification of broad patterns or themes within the data.

An in-depth inquiry into the process of the role of counselor self-disclosure in a therapeutic alliance with active duty military clients was explored in nuanced forms. Considering not all counselors practice self-disclosure in their therapeutic alliances, it is important to have a deep understanding of the reasons some counselors do choose to practice self-disclosure. To that

end, this study focused specifically on two participants' use of self-disclosure with military clients who valued counselor self-disclosure. The participants in this study used self-disclosure to establish rapport, build trust, and meet their military clients' therapeutic goals. Therefore, an exploratory case study was deemed an appropriate way to conduct an in-depth investigation of how a counselor understands her or his use of counselor self-disclosure in therapeutic alliances with military clients.

Methodological Framework

Qualitative research is often grounded in the epistemic framework of constructionism, which is the case in this study. Constructionists contend that meaning is constructed rather than discovered (Crotty, 2003, Stake, 1995). There are varied perspectives (Patton, 2009) on how constructionism is various types of qualitative research. According to Stake (1995), constructionists posit that individuals construct understanding from experiences of the world in which they live and work and through the process of interaction among individuals. Additionally, Crotty (1998/2003) stated that constructionism is based on a view that "[a]ll knowledge, and therefore all meaningful reality, is contingent upon human practice" (p. 42). In other words, human knowledge and reality are based on humans' experiences in a world which they inhabit. Likewise, human interaction through symbols assists humans in interpreting and understanding the meanings of others.

Within the epistemic framework of constructionism, a qualitative researcher usually chooses a theoretical framework that provides a lens to organize the substantive and methodological aspects of the inquiry. For the purpose of this study, that framework is Symbolic Interactionism. The three main premises of symbolic interactionism are:

1. Human beings act toward things on the basis of the meaning that the things have for them.
2. The meaning of the things is developed from human interaction with others.
3. These meanings are an interpretative process used by the individual interacting with the things that are encountered (Crotty, 2004).

These tenets of symbolic interactionism have an intersecting effect on understanding the subject matter of this study in addition to the ways in which, methodologically, this study is designed and the data are analyzed and represented. In other words, symbolic interactionism can ground how counselors symbolically understand and interact with concepts like self-disclosure, rapport building, establishing trust, maintaining a productive therapeutic relationship, and ability to help clients reach their therapeutic goals. Moreover, symbolic interactionism frames how the interview questions are designed, data analysis is conducted, and data are represented at the end of the study. These tenets inform the iterative nature of meaning-making around self-disclosure and the relationship between the client and the counselor. Crotty emphasized that an inquiry must be seen from the perspective of others, and the meanings of symbols and behaviors must be determined in terms of participants' meanings (Crotty, 2004). In this study, an identification of symbols around which meaning-making occurs is critical. These symbols include (but are not limited to) the language used in self-disclosure that informed and shaped communication between a counselor and his or her client. Another way in which symbols may inform the way a counselor and a client make meaning is how either party valued self-disclosure in building and maintaining a therapeutic alliance. Within this context, there could be values placed on affect, level of comfort, trustworthiness, and reciprocation in disclosure. How a client and a counselor interact with each other can shape and change the things that both parties value. This kind of

interaction can lead to multiple outcomes, including continuation (or discontinuation) of counseling. This study focuses on how counselors perceive the role of their own self-disclosure during counseling sessions with clients who value such relationship building.

For data collection purposes, the method used focused on the meanings and interactions around the common set of symbols in which the participants engaged (Patton, 2002). Data analysis aligned closely with evidence of the three tenets of symbolic interactionism in various data sources.

I chunked data for semantic units that reflected how participants acted toward various aspects of engaging a client through self-disclosure, how the participants explored the meaning of their therapeutic relationship as a result of engaging in self-disclosure, and how the participants reflected on their shifting understanding of the meaning of self-disclosure as they interacted with their clients. These analytic methodological strategies were consistent with the understanding promoted by symbolic interactionism – that "humans live in a symbolic world and our language structures the way we perceive and the way we think" (White & Klein, 2008, p. 98). Additionally, symbols are influenced by the way the participants consider their world. Hence, the study of the meanings of shared experiences and the influence of symbols helped shed light on what was important to the people involved as it related to an understanding of the symbols (Patton, 2004). With respect to making meaning through symbols, especially when neither the researcher nor the counselors could claim complete neutrality, a subjectivity story is offered to discuss how significant narratives of my life informed and shaped this study.

Subjectivity Story

According to Peshkin (1988) subjectivity affects all investigations and operates throughout the entire research process. There are several benefits to making subjectivity known

by the researcher. For one, it allows the researcher to take a "personal stake in the research" (Peshkin, 1988, p. 17). It also discloses who the researcher is in relation to the research (Bhattacharya, 2007). Our assumptions and values shape, transform, and may construe our research. However, disclosing personal qualities throughout the research allows readers to know what the researcher brings to the study and where self and the research participant may have merged. The narrative below discloses my assumptions and values as well as my personal and professional stakes in the study.

My first encounter with self-disclosure took place in 2000, as a military spouse stationed in Germany. At that time, I was a non-traditional student working as a paraprofessional in an American middle school my daughter attended on a military installation. In my work, I discovered that much of my time was spent listening to students' needs which routinely consisted of their personal, academic, behavioral, and family experiences.

Most of my relationships with the students were positive. However, there were some students who were a bit challenging. One of my students, who harbored a great amount of anger, challenged my authority every day in class. Typically, he was sent to the office at least two to three times a week and was on the verge of failing the 8th grade. As a result, I was displeased and frustrated with his behavior and his lack of respect in class. One day, however, after sending him to report to the office, I decided to walk out with him to discuss his behavior. I asked him what was wrong and to my surprise, he respectfully replied, "I'm angry because no one cares about me or what's going on with me. I have six brothers and sisters, and I am always ignored." He also shared his struggles with living in Germany and having a father who was absent most of the time due to his military career. I empathized with him about his struggles with the military because we had a very similar childhood. In that moment, we made a connection and I decided to

share with him my childhood experiences of missing my own father while he was serving in the military. In addition, I told of how I experienced him in the classroom and how I also believed he had the ability to change his behavior. From that point on, a new relationship between us developed. Moreover, his grades and behavior improved. This experience was a positive turning point in my life because at that time, I discovered how authentic and genuine relationships could begin a healing process and cause change in another individual's life. I believe my career trajectory changed after my relationship with that student, and I started my journey towards becoming a professional counselor. I continue to use self-disclosure in my practice as a counselor. Moreover, I have had the privilege of working in many different settings over the years (i.e. schools, corrections, military installations, behavioral-health military hospitals) where I continued to have positive experiences using counselor self-disclosure.

At the present time, I practice as a licensed clinical professional counselor. In that role, I have provided counseling for over 10 years. I have been married to my husband for more than 20 years while he has served our country on active duty in the Army. While my husband was stationed at Fort Riley, I started a private practice located in Junction City, Kansas. Seventy-five percent of the clients seen in the practice are active duty military service members and their family members. More than half of the military client I see in my practice suffer from PTSD, depression, anxiety and other mental health issues, including couples' distress.

In my work with military families, I have noticed a lack of disclosure of symptoms among active duty service members in their initial intake session. Often, spouses take the lead in marriage counseling when their active duty military spouse is unaware of his/her symptoms. However, there are times when spouses are guarded and provide little information for fear of "outing" their spouse. Typically, it can take three or more sessions before families feel safe

enough to share intimate issues about symptoms they experience in their relationships. According to Hackney and Cormier (2009), clients should begin to feel relaxed after the first session and should have a better understanding of the counseling process by the second session.

Another common issue I noticed in my practice with military families is premature termination of counseling services. This can sometimes happen when rapport is not established in the first couple of sessions, which is consistent with the clinical research of other underserved populations. In my experience, clients disclose when they feel safe and trust their counselors. Furthermore, I have found that clients will disclose after I disclose about my experiences as a military spouse. Additionally, clients will disclose when I share how I experience our counseling interaction while in session.

Counselor self-disclosure is important to me because I am a part of the military community. Moreover, I am a practicing clinician with the military population. My subjectivity shaped my perspective of the study, and I am aware that the military is a part of the culturally diverse population which has been underserved in the United States. I have experienced the situation personally, and I feel that the stigmatization associated with mental health counseling, the mistrust of mental health professionals due to cultural unawareness, and the lack of sensitivity about cultural (military) issues are all major problems. In addition, I believe many marriages and families have failed as a result of underutilization of mental health and counseling services.

From this study, a deep understanding of the role of counselor self-disclosure in strengthening the therapeutic practices of counselors and other mental health professionals was attained. Additionally, cultural awareness was gained from the participants' work with the military population.

Research Design

Yin (2009) stated that the research design is a logical plan that acts as a map to get from here to there with useful steps or components, such as the identification of the purpose of a particular case study or even if the case is important enough to study. The design of this case study is that of an exploratory study. A case study research is the study of an issue through one or more cases within a bounded system (Yin, 2009). According to Lichtman (2006), a bounded system can be a person, several people, a complex issue, or a place within real life. Lichtman (2006) further emphasized the importance of setting boundaries around what is to be studied while designing a case. Stakes (1995) argued that a case study design is selected for the purpose of understanding a case. Yin (2009) defined case study research as an in-depth investigation of a phenomenon in real life. Therefore, based on these descriptions of case studies, this study is a bounded case of the experience of two clinical professionals who use counselor self-disclosure in a therapeutic alliance with military clients. The participants were selected as individual cases. In addition, a cross-case comparison was completed to understand the similarities and differences in both cases. Case study research was an appropriate study here because it provided a deep understanding about counselor self-disclosure. It also captured rich descriptions and interpretations of the participants' experiences with using counselor self-disclosure. Furthermore, this case study research design provided data from multiple sources of information (Hancock & Algozzine, 2011, McLeod, 2011). This study is a multiple case studies design consisting of two cases. Multiple case studies provide an opportunity to go beyond a singular perspective with the option of comparing perspectives (Stake, 2006). In the following sections, I provide further details on the design of the case study.

Participant Selection

I used purposeful sampling to choose participants with a history of working with the military population. According to Merriam (1998) "Purposeful sampling is used based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned" (p. 61). The two participants I selected for the study provided insight about how counselors described the role of counselor self-disclosure in their therapeutic alliances with military clients. Furthermore, insight was provided by the participants' belief that self-disclosure played a critical role in establishing and maintaining alliances with their military clients.

In addition to purposeful sampling, I used criterion sampling for the study. I used criterion sampling because I had a list of predetermined criteria of importance (Patton, 2002). In the study, the criteria for the participants were as follows: (a) participants are licensed to practice by their state, (b) participants practiced counselor self-disclosure with military clients, (c) participants believed healing resulted from their practice of counselor self-disclosure, and (d) participants perceived their self-disclosure was a contributing factor to their military clients' successful completion of therapy. Figure 1 lists the participant selection process for the study.

Figure 3.1: Participant Selection

Figure 3.1. This diagram represents the process used to select participants for this study. Criterion and purposeful sampling were used to select the participants. Infographic by O.M. Blackwell (2017). *Participant selection* [Infographic]. Copyright 2017.

I selected two participants who provided detailed information about their experiences in using counselor self-disclosure with military clients who had successfully terminated therapy. The participants practiced independently and both earned PhDs. One participant has a background in the counselor education discipline and the other in the marriage and family therapy discipline.

The participant selection process consisted of my sending out emails to professional colleagues and professional organizations to solicit participation from counselors to be a part of the study please see (Appendix A). Two participants responded, met the criteria, and were

willing to participate in the study. I contacted the participants via email and by telephone to set a meeting time to discuss the study.

I answered all their questions about what was expected from the participants in the study during the first meeting. The participants were provided with other pertinent information about consent. I also informed the participants that their participation in the study was voluntary and they had the right to withdraw from the study at any time without any penalty to them. Additionally, I discussed information about confidentiality and non-identifiable information. I invited the participants to ask questions about the study. After speaking with my participants and answering their questions, I asked them to sign consent forms and return them to me to participate in the study.

Research Site

Stake (1995) posited that data collection is usually performed on the home ground of the participants and "procedures for gaining access are based on enduring expectation that permissions are needed" (p. 57). I was approved through the Institutional Review Board (IRB) before I gained access to the participants' sites please see (Appendix B). In my study, the participants' places of practice were the research sites. However, I collected data and gathered documents via email.

Researcher Role

As the researcher, I played an intricate role in gathering information to address the fundamental research questions (Hancock & Algozzine, 2011). Additionally, as the researcher, I was the primary instrument for observing, taking notes, documenting visual images, and conducting interviews (Merriam, 2009). Further, I played a vital role in making sense of the data. According to Lichtman (2006), the researcher's life experience, knowledge, skill, and

background influence the research. Therefore, my primary role as the researcher was to understand the use of counselor self-disclosure with the military population.

In the study, I assumed both the role of an insider and an outsider. As such, my role shifted depending on the activities I was involved in during the research process. In the role of insider, I identified as a researcher who had an inside status about the subject and as a member of the culture. My experience was as a clinical professional counselor who advocated the use of counselor self-disclosure. Moreover, I have been a military spouse for over 20 years. This gave me an inside perspective when making sense of the data. In contrast, I operated in an outsider membership role when I conducted research in the field. As an outsider, I was not familiar with the culture of the participants' locations. Additionally, I was unfamiliar with how the participants engaged with their clients and what their reasons were for using counselor self-disclosure. Additionally, I was an outsider when it came to understanding the culture of each participant's practice. Moreover, I operated as an outsider when I collaborated with the participants to understand their meaning-making of the world and how they described their role in using self-disclosure.

Data Collection Procedures

Case study evidence can come from multiple sources (Yin, 2007). Therefore, organization of raw data is important to a case study. Accordingly, I arranged a visual data chart to help provide an easy, accessible way to locate and identify the data in the study. Table 3.1 is a documentation of what was collected in the case study.

Table 3.1: Data Inventory

Data Source	Number of pages per event	Number of pages in total
3 (1-hour) interviews per participant (2 participants)	20 pages per one hour of transcription	60 x 2 = 120 pages
Member check	2 meetings per participants–5 page per member check session	5 x 4 = 20 pages
Participant photo or object elicitation	10 pages of elicitation	10x 2 = 20 pages
2 Peer Debriefing (1-hour)	10 pages of debriefing	10x2=20 pages
Journal reflections	10 pages per observation 5 pages per interview notes 6 interviews 5 pages per observations notes 5 pages photo 20 pages journal reflections	10 x 2 = 20 pages 5 x 6 = 30 pages 5 x 2=10 pages 10 x 2=20 pages 20x1=20 pages
Total pages		**280 pages**

Table 3.1. This table is an inventory of the data that was collected throughout this study. There were 280 pages of data from this data collection process. Infographic by O.M. Blackwell (2017). *Data Inventory* [Infographic]. Copyright 2017.

The data collection consisted of three one-hour interviews, member checks, participant photo reflections or object elicitation, and journal reflections. The data collection process spanned a period of 12 weeks.

Interviews

One of the most important sources of data which provided multiple realties of different perspectives came from the interviewing process (Stake, 1995). According to deMarrais (2004), an interview is a process between "a researcher and a participant engaging in a conversation focused on questions related to a research study" (p. 54). Qualitative interviews are used for their ability to provide in-depth knowledge from a participant's perspective about a particular experience (deMarrais, 2004). According to Patton (2002), the purpose of interviewing is to gain the participant's perspectives. Interviews are oral and typically conducted in person (Gay, Mills, & Airasian, 2006). Patton (2002) stated that asking open-ended questions assists researchers with gaining an understanding of the participant's world and to learn their terminology and their judgments about their experience. Therefore, establishing rapport is an important aspect of interviewing because it assists the researcher with gaining access to the participant's perspective (deMarrais, 2004). According to Patton (2004), clear, understandable questions facilitate rapport, and help participants feel relaxed and comfortable. The researcher's stance also assists in establishing rapport and creating a positive interview experience. Attention to maintaining active listening skills and positive nonverbal clues helps to insure an uninterrupted interview take place (deMarrais, 2004).

For the purpose of this study, semi-structured interviews were used that consisted of open-ended questions and possible probes that were consistent across all the conversations with the participants (Patton, 2002). Since qualitative research is an inductive, interpretive, and

relational process, the interviews were not similar in nature, nor were they conducted with the same sequence of questions. For instance, sometimes participants provided answers to the first question in such detail that it also addressed another question that was prepared but not yet asked.

Interviews were conducted via Zoom from the participants' clinical settings. Although I was seen by the participants as an outsider and an insider, I gained their confidence and trust through establishing rapport (Spradley, 1980) by participating in a preliminary conversation without any recording devices prior to conducting recorded interviews. This was an unscripted interchange where the participants and I engaged in informal bantering, asking each other questions as they arose. When the rapport-building conversation had ended, I scheduled formal interviews with the participants. The interviews were recorded and transcribed immediately within 24 hours of conducting the interview see (Appendix C) for a sample transcription. I provided an opportunity for the participants to meet on two different occasions to have a member-check conversation to review material for accuracy after each of the transcriptions was completed.

Spradley (1980) offers a guideline of how to frame interview questions in order for the questions to elicit deep, rich, thick stories, which was one of the goals for this study. These questions were of various formats. They were classified by type: "descriptive", "tour", "example", "structural", and "contrast" questions. Descriptive questions required the participant to describe an event, memory, interaction, in as much detail as s/he could remember. Tour questions required the participant to walk the researcher through a typical experience, which can be quite specific (a mini-tour) or broad (a grand tour). For example, grand tour questions describe the sequence of events within a particular setting or situation, whereas mini-tour

questions deal with a much smaller unit of an experience (Spradley, 1980). Example questions invited the participants to provide specific instances of what they were stating as analytical reflections. In this way, I gained insight into their narratives, their experiences, and their stories, all of which created certain analytical conclusions for me as the researcher. Structural questions were aimed to explore the structure of the experience. These questions look for what might be some of the salient components of certain experiences. Contrasting questions were asked for falsification purposes, to contradict, problematize, or complicate some preliminary pattern that emerges from the participant's responses. This was done to ensure that even if attempts to falsify were made, and the person's narratives remained stable, then there is rigor and truth in the narrative.

The interview questions are as follows:

1. Tell me about a specific experience that stands out to you in regard to counseling a military client in as much detail as you can.
2. Think of a time when you used therapist self-disclosure with a military client and tell me about it in as much detail as you can remember.
3. Walk me through a typical initial intake session with a military client where you used self-disclosure and found it to be helpful.
4. Walk me through a typical session once you established rapport with a military client where you used self-disclosure and found it to be helpful.
5. Can you think of a time when you might have interpreted self-disclosure to have enhanced a session preferably with someone from the military population? Please share in as much detail as you can.

6. Describe your relationship with one of your military families prior to your use of therapist self-disclosure.

7. Tell me about your relationship with one of your military families after using therapist self-disclosure.

8. Tell me about your process of successful termination with military clients after using self-disclosure in therapy.

9. Can you provide an example or detailed description of the military client before and after counseling/therapy using self-disclosure?

10. Can you tell me about a time when therapist self-disclosure wasn't as effective as you would have expected with a military client?

11. Is there something I haven't asked that I should have?

12. Can you provide a summary or advice for others who are considering using CSD?

Interviews are a relational process and are an important part of data collection for case studies. The interviews in this study represented the largest part of the data collection process. For that reason, I established rapport with the participants to gain in-depth knowledge from a participant's perspective which assisted in answering the research questions. I conducted interviews on three occasions with each participant to gain thick rich descriptions of their meaning of self-disclosure in alliance with military clients.

Participant Observations

Observations are a commonly used procedure for data collection in case studies. Observations aid researchers with capturing a good record of events, gaining additional information and a greater understanding of the case (Yin, 2009). Stakes (1995) argues that good observations reveal unique moments in a case that may be complex. Patton (2002) stated that

observations are used to describe the setting and allow the researcher to see and learn things that participants may not be willing to discuss in interviews. According to Patton (2002), observations take readers into the setting and allow the reader to make her or his own judgment about the nature and quality of the issue. In addition, observations allow the researcher to connect with the experience of the participant. The language of a setting, an understanding of the nuance of meaning, and an understanding of the participant's experience outside of their formal activities can be captured through observations as well (Patton, 2002).

According to Spradley (1979) researchers make descriptive observations whenever they view a social situation and then report what is seen. Descriptive observations are explained as activities that are engaged in without having any particular questions in mind except to answer the question about what is taking place in the moment (Spradley, 1979). Typically, the main features of most social situations involve the place, the actor(s), and the activities. There are six other features in a grand tour observation. These features act as a guideline for making observations (Spradley, 1979). For this study, six of the nine main features of Spradley's (1979) were utilized as a guide for the grand tour observations. I list the features and definitions below:

- Space – the physical place(s)
- Activity – a set of related acts people do
- Object – the physical things that are present
- Act – the single actions that people do
- Event – a set of related activities that people carry out
- Feeling – the emotions felt and expressed

Observations took place in the counselors' natural settings – the sites of their practice. I reserved 30 minutes of observation time when I gained access into the first participant's setting. I

reserved 30 minutes of recorded observations with my second participant via Zoom before our first interview. During the observations, I wrote notes that were descriptive and reflective, consisting of my thoughts and feelings about my experience in the setting. I observed the activities taking place with considerations for how employees interact with each other and with clients entering the practice. Observations of what was on the walls, on the desk, and how furniture was arranged in the participant's office was also documented. Additionally, how and what people were doing was observed. These observations focused on providing detailed descriptions about what I did, what I said, what people were involved, actions and events that were taking place, and personal feelings experienced while I observed.

Figure 3.2 Sample Observations

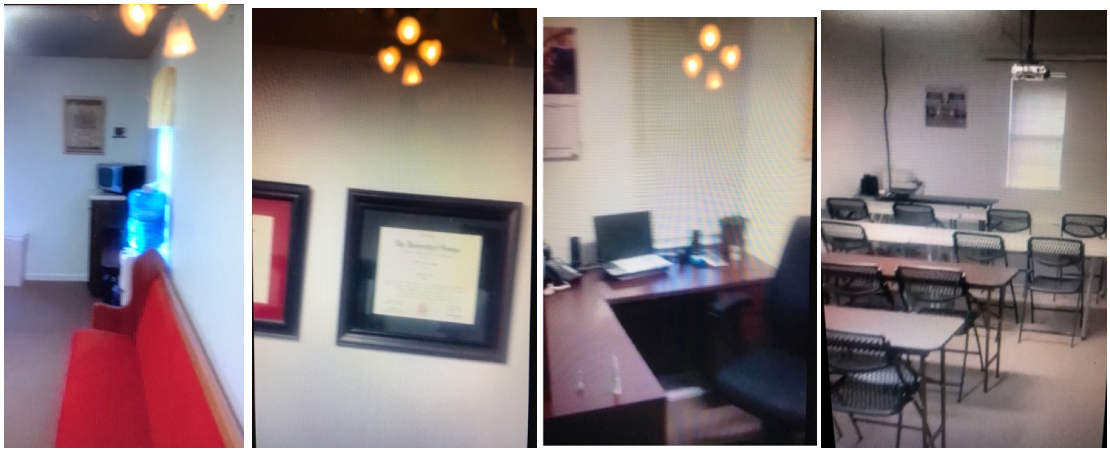

Figure 3.2. Observations of Dr. Tom's private practice. These are from Dr. Tom's private practice. Photo by O.M. Blackwell (2017). *Sample of observations* [Photograph]. Copyright 2017.

Photo Elicitation

A deep understanding about the story being told can be derived from visual data. Visual data provided nonverbal information (Harper, 2002). Keats (2009) argues that visual data, such as photographs, are useful when participants struggle with articulating their emotions,

impressions and other important aspects of their experience. Photographs are beneficial to the qualitative fieldwork because they are "worth a mountain of words" (Patton, 2002, p. 281). Therefore, photo elicitation is as an accepted form of participant-driven data collection. Photo elicitation is defined as visual inventories of objects, people, and artifacts that connect participants to experiences and are inserted into research (Harper, 2002). Lichtman (2006) notes that visual images can be used to enhance, embellish, and provide another avenue of meaning.

Photo elicitation was useful to this case study due to the symbolic aspects associated with participants making meaning of their own photos or artifacts (Harper 2002). According to Keats (2009), artifacts encourage new ways for participants to tell their stories and can hold deep meaning and importance to them. Artifacts are useful for their ability to "explore the relationship between visual objects and the developing narrative" (p. 191).

In this case study, the two types of visual data were artifacts and photographs. I asked participants to bring in artifacts or photographs that had specific meaning for them in terms of their therapeutic practice using self-disclosure. Participants described or interpreted their artifacts or photos of importance with an opening prompt from me that asked, "Tell me about this picture/object." The follow-up questions were generated from listening to the participant's responses and finding points to probe. The probes were guided by keeping the research purpose and questions in mind. These visual materials allowed the participants the opportunity to share their reality and produce invaluable information about the setting and atmosphere where sessions take place with military clients

Figure 3.3: Photo Elicitation

Figure 3.3. An artifact submitted by participant one that represents her symbolic meaning of self-disclosure use. Photo by O.M. Blackwell (2017). *Photo elicitation* [Photograph]. Copyright 2017.

Reflective Journaling

Keeping a reflective journal is common in qualitative research (Ortlipp, 2008). According to Patton (2002), reflexivity is an ongoing process of self-reflection and self-knowledge of a researcher during field work about their experiences. Lichtman (2006) defined journaling as a written self-reflection and self-knowledge about a researcher's process during the field work experience. The use of reflectivity through journaling, according to Janesick (1999), allows researchers to record their reactions and make interpretations about their inner thoughts, behaviors, beliefs and words. According to Morrow (2005), reflexivity allows researchers to understand their experience and how their ways of making meaning of the world affect the research process. In addition, reflective journaling can create a space to bring the disparate parts of the inquiry together to approach sense-making and triangulation while exploring the researcher's own relationship with the study (Janesick, 1999, Patton, 2002). Patton (2002) argues that a passive voice does not convey the subjective experience of the researcher; therefore, reflective journaling is a way for the researcher to speak in an active voice. Moreover, reflective journaling gives the researcher the opportunity to clarify and reinterpret their work (Janesick, 1999). According to Stake (1995), using personal logs or journals helps a researcher to stay

abreast with the progress of the study and to document any unanticipated events that may have meaning to the case (Stake, 1995).

For this study, I maintained a journal that reflects my thoughts around data collection methods, data analysis attempts, subjectivities, hunches, and other ways in which I formed understanding of the information gathered from multiple sources. I also used my journal as a space to make sense of the data collected and analyzed for the final reporting of data collection and analysis, and thus I was able to provide a detailed account of the processes. I shared this journal with a peer for debriefing and verification purposes.

Figure 3.4 Reflective Journal

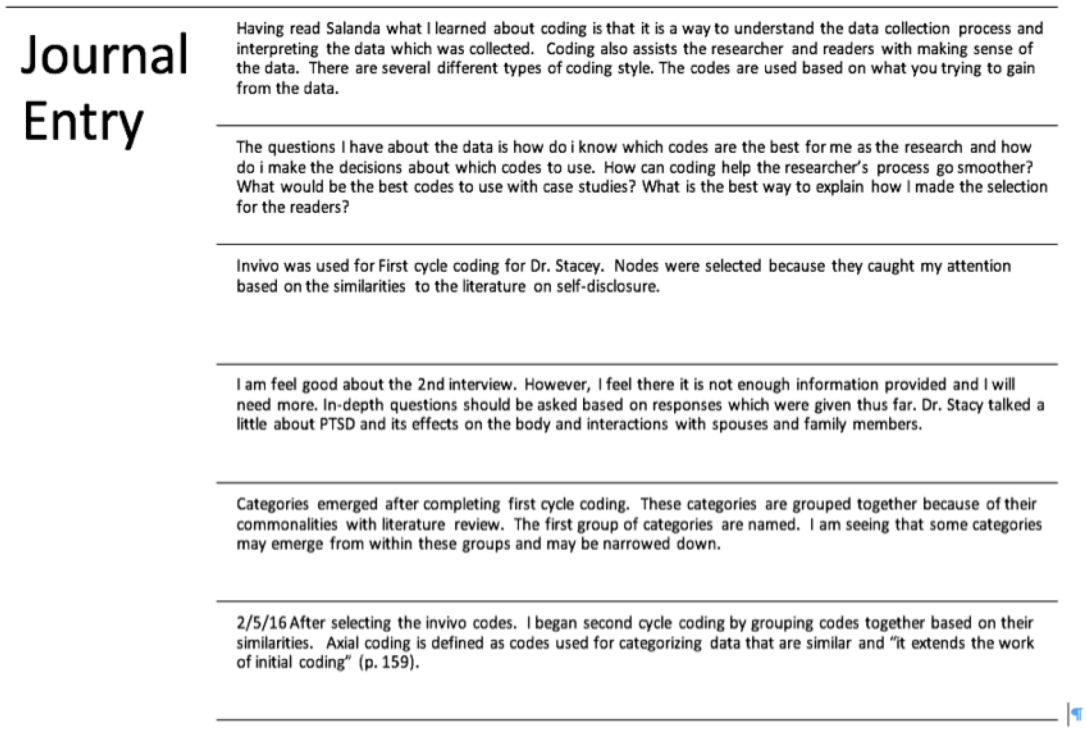

Figure 3.4. A sample of my journal entries that were written while conducting the data analysis process. These journals were of my thought and feels during the process and how I completed each step in the analysis process. Infographic by O.M. Blackwell (2017). *Reflective Journal* [Infographic]. Copyright 2017.

Data Management and Analysis

There is a large amount of data generated in qualitative research; for this reason, the organization of data is needed before analysis begins (Patton, 2002). According to LeCompte (2000), data analysis makes interpretation possible and should be organized in a way that assists in constructing an "intact portrait of the original phenomenon under study" (p. 147). The process of organizing data may "consist of examining, categorizing, tabulating, testing, or otherwise recombining evidence, to draw empirically based conclusions" (Yin, 2009, p. 126). In this study, a general sense of meaning was provided from the raw data that consisted of interviews,

observations, photos elicitation from participants, and journals. Therefore, a clear well-organized plan for the process is imperative.

Data Management

According to Patton (2002), analysis process begins with the inventorying of data. A useful tool for this procedure is NVivo software. QSR NVivo makes the collection, organization, storage, and retrieval of data manageable. QSR NVivo software is equipped with tools for classifying, sorting, and arranging information as it is collected and entered into the software. The software also assists with analyzing materials, identifying themes from codes entered, gleaning insight, and developing meaningful conclusions (Merriam, 2009). LeCompte (2009) asserted that "tidying up," which is the organizing of data, is the first step to analysis (p. 148). When considering organizing my data, I stored original raw data along with secondary copies of data as they were collected at my home office in a locked file cabinet. Raw data were transferred into electronic data and stored as mentioned above in NVivo. These electronic copies of data were backed up and saved on an external hard drive.

Analysis

Stake (1995) describes data analysis as a process of taking things apart. It is the act of making sense of the parts and how they are related to each other. In a sense, it is a discovery of the overall meaning and ideas of the participants. According to LeCompte (2002), analysis is a process of moving between the data collection and analysis. Therefore, the process of data collection and analysis is "integrative, iterative and synergistic" (Patton, 2002, p. 437).

Inductive analysis, which is a discovery of patterns, themes and categories, was used to help find core meanings in the content produced from this process. According to Bhattacharya (2007), an inductive analysis researcher "works up from all the sources of raw data, where the

researcher chunks the data into units of meaning (codes), then organizes the units of meanings (categories), and then answers analytical questions about the data to identify generalizable patterns (themes) across and within categories" (p. 88). In a like manner, I managed an inductive analysis, working from the raw data to first find meaning from codes, then categories, and then themes to understand meanings and ideas of the participants. See (Appendix D) for an in-depth look at the analysis process.

Figure 3.5: Inductive Data Analysis Process

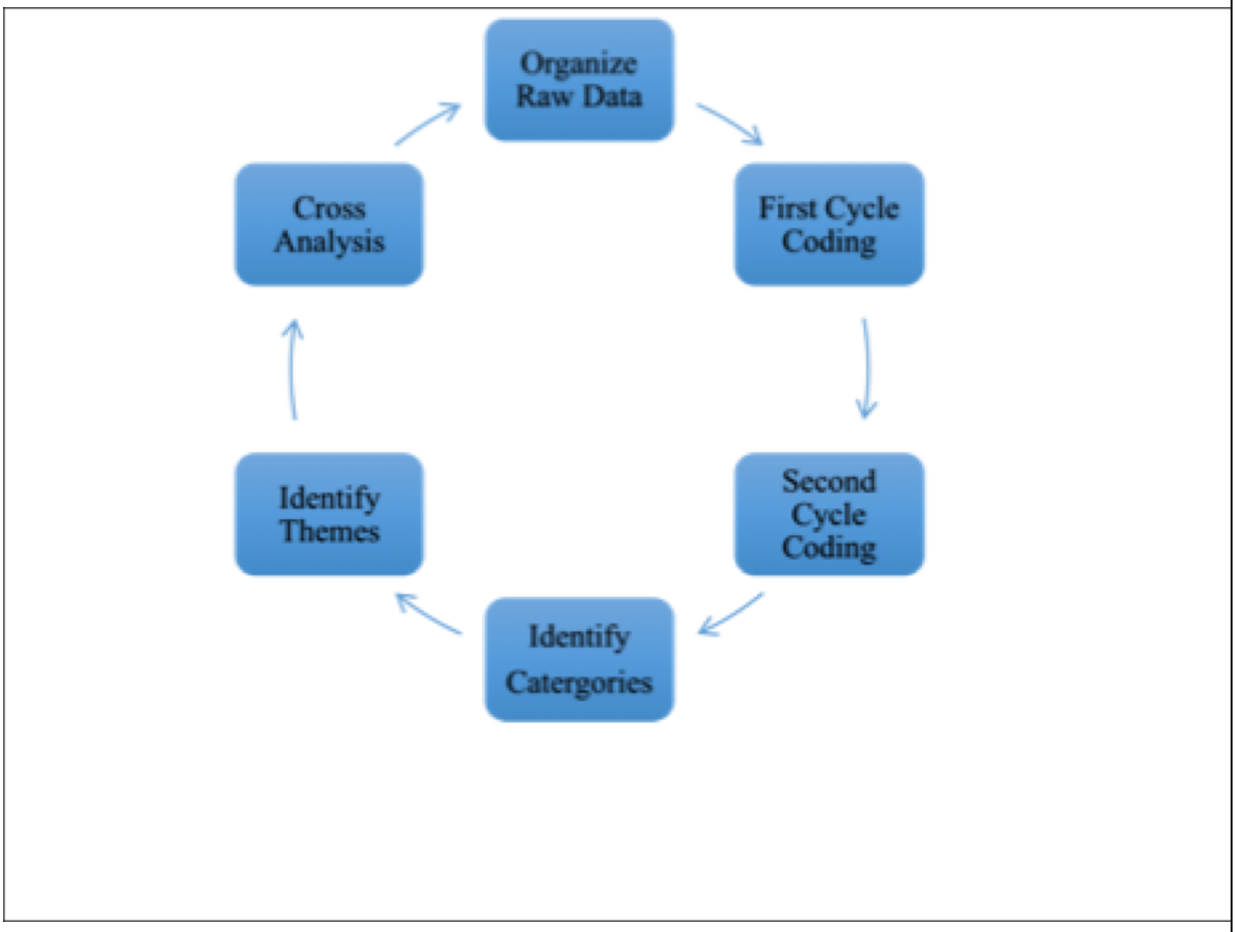

Figure 3.5. This diagram demonstrates the data analysis process used in this study. I used the suggested coding process by Saldana (2009) to analyze my data. Infographic by O.M. Blackwell (2017). *Inductive analysis process* [Infographic]. Copyright 2017.

I began inductive analysis when I conducted my first interview with participant one. I transcribed all participants' interviews immediately after the interviews were completed using Microsoft Word. I made pdf files of all the interview transcripts and placed them into NVivo as cases. I used Saldana's (2009) recommendation of first cycle coding by highlighting codes in NVivo for the initial analysis of raw data.

Figure 3.6: Interview Transcript

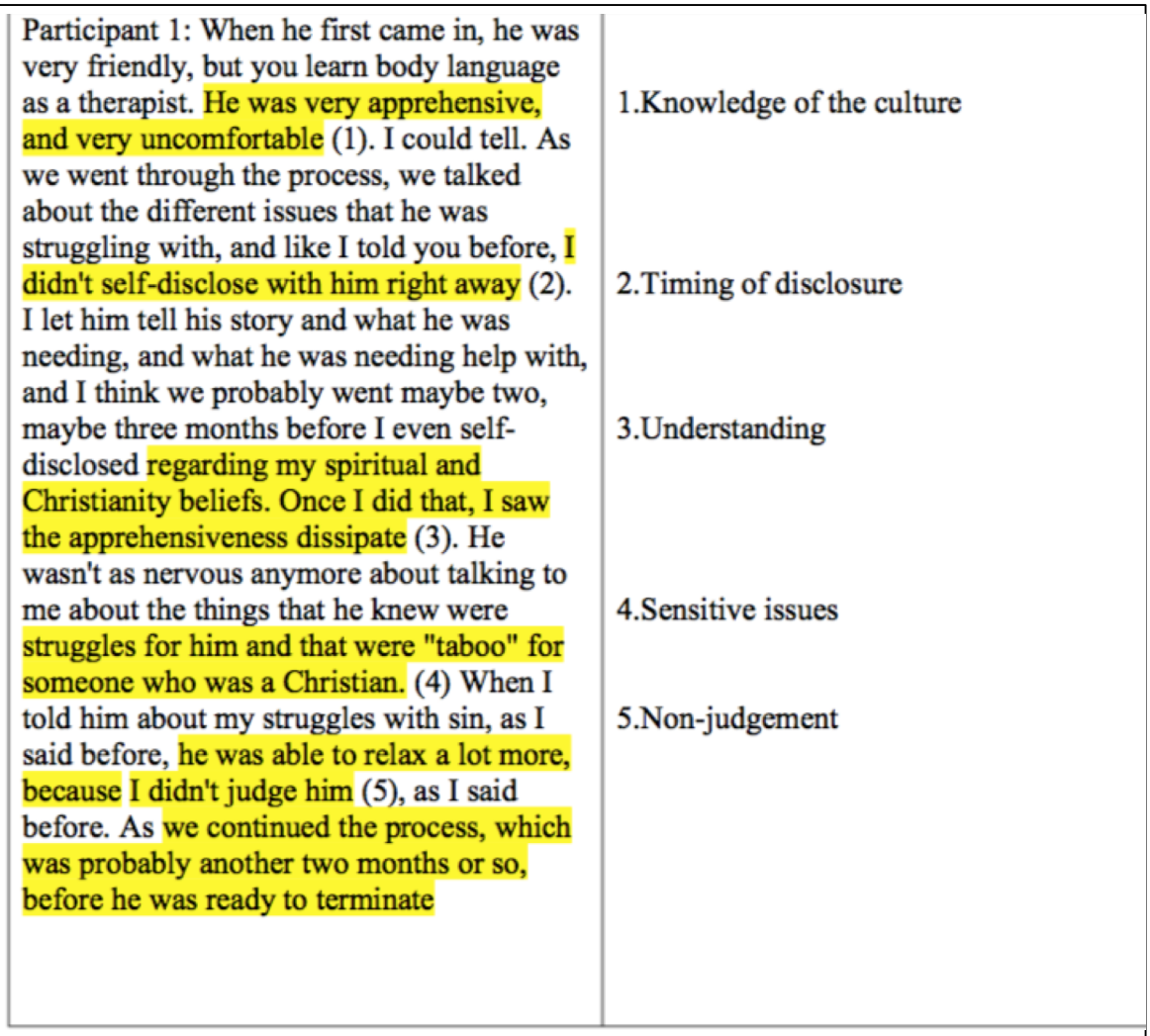

Figure 3.6. Sample of an interview transcript demonstrating the use of in vivo and descriptive coding to complete the first cycle coding process in this study. The highlighted areas represent passages coding using in vivo coding. Then descriptive coding was used to summarize the passages. Infographic by O.M. Blackwell (2017).

Saldana (2009) identifies several first cycle coding methods that are useful for the initial analysis process. Given that qualitative research was an emergent, inductive process, I provided a list of coding strategies that I used to look through the data:

- In vivo coding – meaning "that which is alive" (Saldana, 2009, p.74). Codes are actual quotes of the participants. In vivo codes are used for interview transcripts as a method to attune the researcher to the participant's language, culture, and worldview perspectives (Saldana, 2009, p. 48).
- Value coding – this "reflects the participant's values, attitudes and beliefs about their perspectives or worldview" (Saldana, 2009, p. 89).
- Emotional coding – capturing the participant's emotions, "recalled or experienced," and assist in "exploring intrapersonal and interpersonal experiences and actions of the participants" (Saldana, 2009, p. 85).
- Descriptive coding – defined as information summarized in a word or a short phase. It is useful for field notes, documents, and artifacts (Saldana, 2009, p. 48)

As I worked through the raw data, I initially used in-vivo coding to capture specific semantic units of meaning using the exact words and phrases stated by the participants. According to Saldana (2009), quotation marks with participants' quotes ensure codes are participant-inspired rather than researcher-inspired codes. In-vivo coding also assisted me with capturing "the essence of a portion of language" (Saldana, 2009, p. 33) retrieved from the participants' interviews and maintaining the word choices shared by the participants. So, there was little alteration in language when they described their experiences using self-disclosure in therapeutic alliances with the military population.

I used emotional codes to assist with capturing the participants' emotional experiences when making the decision to disclose and after disclosing. Additionally, because emotions are a part of all human experiences, emotional codes assisted in providing deep insight from the participant's perspective.

Likewise, value coding helped to understand the participants' values, beliefs, and actions regarding self-disclosure. Saldana (2009) states that each participant in a case study will apply a different meaning about what they attribute to an idea. That assigned meaning will reflect their attitudes and beliefs. Saldana (2009) further posits that value codes will assist in gaining an understanding of the participants' "cultural values and intrapersonal and interpersonal experience and actions in a case study" (p. 90).

According to Saldana (2009), descriptive codes are also called topic coding. Descriptive coding was used to assist with summarizing passages into one word. Descriptive codes were used to identify a topic about what is discussed. Saldana (2009) suggests the use of descriptive coding for the beginning researcher. In my case, descriptive codes assisted with the process codes from interview transcripts, reflective journals, and photos from the participants. Descriptive coding helped to find the answer to the research questions by asking about "what was going on" or "what was this about" in a passage (Saldana, 2009). Good descriptive coding makes second coding cycle method analysis easier which will be helpful because codes typically have to be re-categorized as more data is collected.

After coding all the first participants' interview transcripts using in-vivo coding and the other codes mentioned above, I continued to work through the data by shifting my focus to finding stronger patterns that could better assist in finding answers to the research purpose and questions. I used second cycling coding which provided a more advanced way of reorganizing,

re-analyzing, reducing and finding similarities in the data codes from first cycle coding (Saldana, 2009). I then began to combine similar codes from participant one to develop a list of categories that included: Types Of Counselor Disclosure, Reason For Using CSD, Things To Consider When Using CSD, How CSD Affects The Relationship, Timing Of CSD, Military Clients Reason For Seeking Counseling, Expertise About The Military Culture.

Figure 3.7: NVivo Tree Map of Catergories

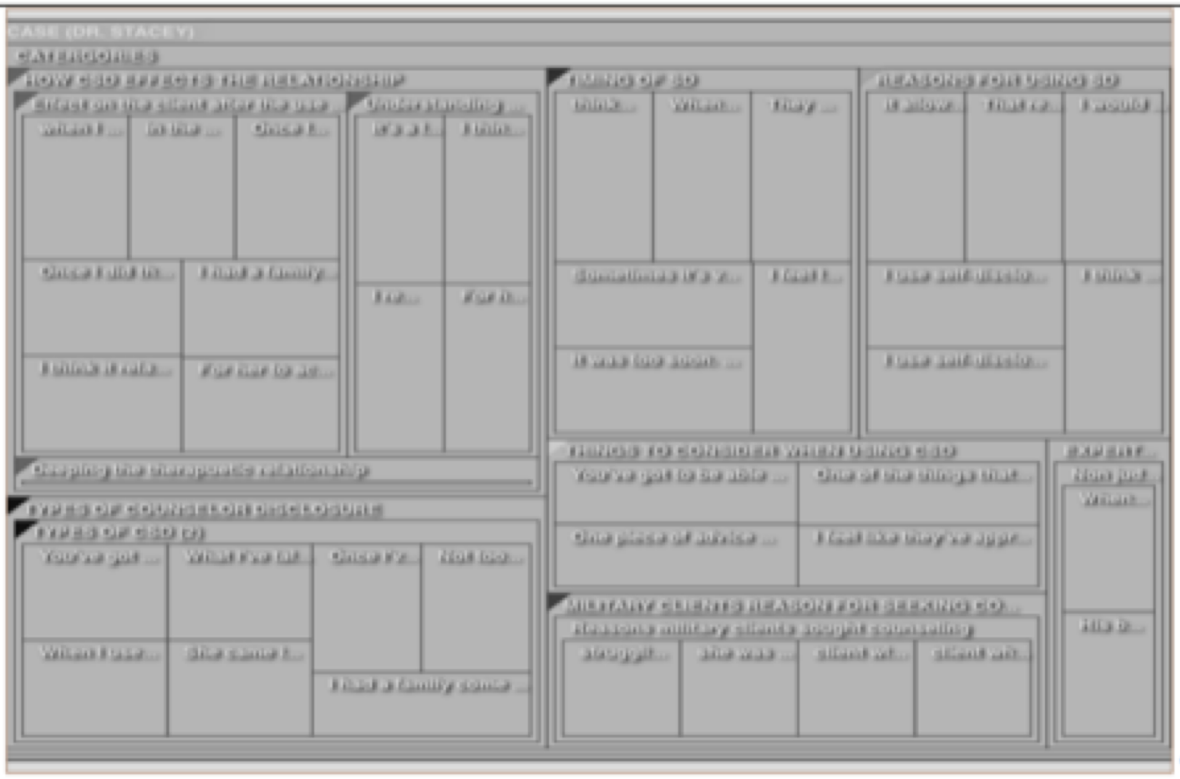

Figure 3.7 This diagram represent the process of second cycle coding used in this study. A tree map was created from NVivo data management system used through the analysis process of participant one's categories. Infographic by O.M. Blackwell (2017). *NVivo tree map of categories* [Infographic]. Copyright 2017.

Second cycle coding assisted in developing "a sense of categorical, thematic, conceptual, and/or theoretical organization" (Saldana, 2009, p.149). Saldana (2009) suggests axial coding and focused coding for developing categories in the second cycle process. I include below what coding strategies were used in the second cycle of coding.

- Axial coding is defined as codes used for categorizing data that are similar and "it extends the work of initial coding" (p. 159).
- Focused codes are used to identify the most "salient categories" (p. 155).
- Pattern coding are "explanatory or inferential codes" which help to pull everything together into a smaller, more meaningful and parsimonious unit (152).

These codes helped to fine-tune and answer questions about the role of counselors using self- disclosure with their military clients. For example, as I looked deeper into the data with the purpose of "narrowing down" (Patton, 2002), axial codes assisted in finding similarities in the codes from first cycle coding. Focus codes assisted in identifying major categories. Pattern codes in the second cycle coding process assisted in identifying major themes.

After, I conducted the same analysis process with both participants. I printed a copy of the color-coded categories from NVivo of both participants see (Appendix E). I then separated these categories from both participants and cut them out to assist me with identifying themes.

Figure 3.8: Color Coded Categories

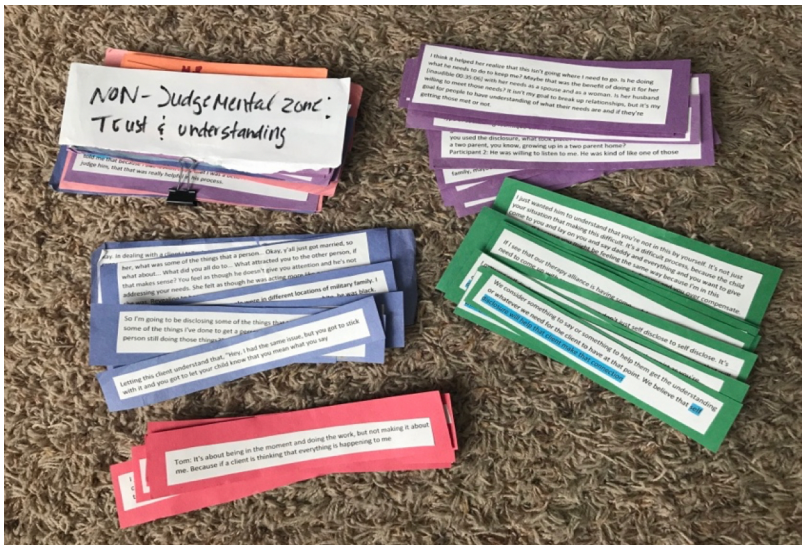

Figure 3.8. This is a photo of deconstructed color-coded categories from each participant used to identify themes in the data analysis process. Photograph by O.M. Blackwell (2017). *Color coded categories* [Photograph]. Copyright 2017.

Next, I answered the research questions for the first participant by placing the color-coded categories under each research question. Then, I chunked the categories into themes. Four themes were identified from both cases that addressed the unique findings in the study. These major theme identifications were part of the process in preserving the main research questions and added to the understanding of the case (Stake, 2006). Before completing the case cross-analysis process, I re-analyzed and found similarities in two themes from both participants which were merged together. I merged, I Use Self-Disclosure as A Common Practice and But One Piece of Advice from case one because it eased the flow of the themes. Likewise, I merged Benefits of Disclosure and There Are Things to Consider from case two for the same reason. This left each participant with three themes. See the diagram below showing original themes. The last two themes were merged together to form one theme for each which were I Use Self

Disclosure as A Common Practice: But One Piece Of Advice And Benefits Of Disclosure: There Are Things To Consider.

Figure 3.9: Themes for Cases

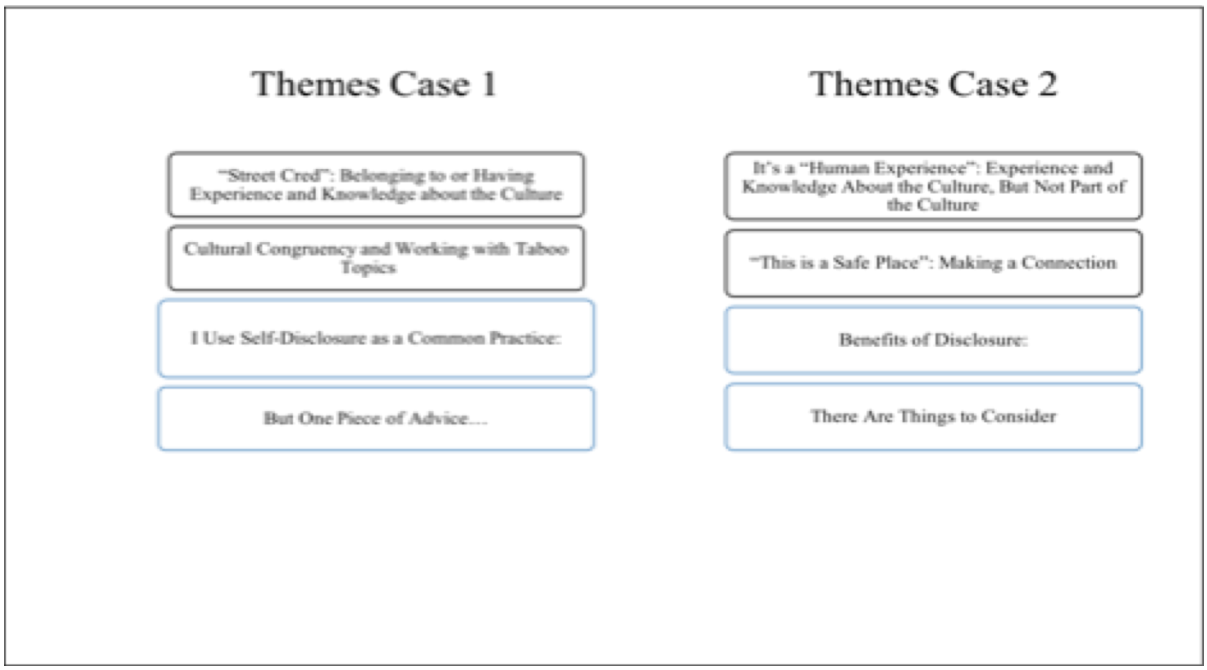

Figure 3.9. This a diagram represents the themes that emerged from participants in this study. Each participant was presented as cases to help compete the cross-case analysis. Infographic by O.M. Blackwell (2017). *Themes for cases* [Infographic]. Copyright 2017.

To complete the final analysis process, I conducted a cross case-analysis of the two cases in the study (see Appendix F). As Stakes (2009) suggested, I read through each case and its thematic narratives to identify similarities and differences between the two participants' experiences. I searched back and forth through both cases to identify uncommon information for closer scrutiny. Then, I sorted and merged the finding by their uniqueness and what might be helpful to highlight in light of the research purpose and question

Figure 3.10: Themes from cross-case analysis

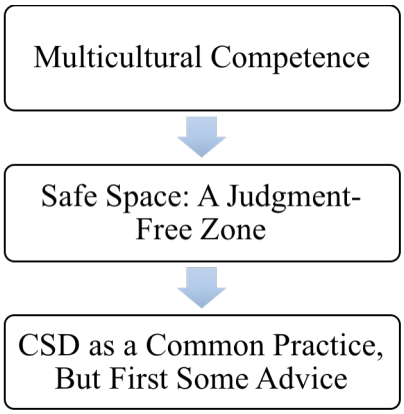

Figure 3.10. Cross-case analysis This a diagram represents the themes that I identified from cross-case analysis process. In this process, I identified the similarities and differences in each case. Infographic by O.M. Blackwell (2017). *Themes from Cross case analysis*. [Infographic]. Copyright 2017.

Despite the linearity of discussing my data management and analysis, this was an iterative process. The process consisted of moving in between coding processes that helped me to identify categories and discover themes that align with the research purpose and questions.

Data Representation

According to LeCompte (2000) data representation is credible when the theoretical drive is clearly articulated and results are meaningful to the readers (p.152). Due to the constructionist view of the study, data representation will be presented from the researcher's and the participants' perspectives. The constructionist view contends that knowledge is constructed from multiple realities and can change depending on circumstances (Golafshani, 2003). Freeman, deMarrais, Preissle, Roulston, and St. Pierre (2007) believe that "representing the multiple layers of human experience are a challenge" (p. 30). However, there are many ways data can be represented. Data representation will be presented from the perspective of symbolic

interactionism with the understanding that meanings of symbols (self-disclosure) and behaviors must be determined in terms of participants' meanings (Crotty, 2004). Riessman (2002) posits that narratives are the collaborative practice of telling about an experience. Case studies research typically uses narratives for its ability to provide thick, rich descriptions from multiple perspectives (Hancock & Algozzine, 2011). For this reason, I integrated thematic narratives in the participants' voices to demonstrate a shared understanding of counselor self-disclosure between the participants and the researcher. This representation form aligned with the ways in which the findings were discovered in the data analysis process and aided in depicting how the participants described their meaning of the role of counselor self-disclosure in therapeutic alliance with military clients. The interviews, photo elicitations and other data sources, which I selected, were influenced by my understanding of the research questions. Additionally, I selected findings as evidence to support the cultural context in establishing and maintaining therapeutic alliance. Likewise, I curated findings that focused on solving the problem of underutilization, increasing retention among military clients, and added to self-disclosure literature. I decided not to include some findings which already dominate disclosure literature.

Reciprocity and Ethics

Ethical concerns happen every day in research (Guillemin & Gilliam, 2004). Participants may or may not be influenced from taking part in the study, therefore decreasing the possibility of potential risks is essential (Patton, 2002). As I conducted research, ethical concerns about confidentiality, reciprocity, and risk to potential participants were addressed.

According to Patton (2007), confidentiality and anonymity have very different meanings. Confidentially is having information about something but not disclosing that information. Anonymity, however, is not having information. For example, a survey is considered to be sent

"anonymously" when there is no name attached to it. In an effort to maintain confidentiality, I did the following: as a licensed clinical professional counselor, I adhere to ethical codes of the American Counseling Association (ACA) which provide guidelines for conducting research. According to the ACA code of ethics (2014), "counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human research participants" (p. 16). Additionally, counselors are required to meet the regulations and standards of federal and state laws, as well as any university's regulations that pertain to conducting research. Therefore, I complied with state laws and procedural ethics, concerning the gaining of permission from the university's Institutional Review Board (IRB) before attempting to gain access to participants.

Informed consent with signatures from all participants was obtained before any information was received from participants. I accurately explained the purpose of the study and identified any procedures that would took place while conducting interviews and observations before requiring participants to sign consent forms see (Appendix G). I described all risks and any benefits or changes to participants or their organizations that may arise with their participation in the study. I disclosed appropriate alternative procedures that would be advantageous for participants and offered to answer any inquiries concerning the procedures.

As I conducted this case study, I protected the identity of the participants and, if appropriate, their clients, although I did not expect the participants to disclose identities of any of their clients. I used pseudonyms, selected by the participants, which they believed would represent themselves and their site in an effort to prevent possible recognition by the military community. I informed the participants of their right to voluntarily withdraw from the research at

any time they deemed necessary. I secured and protected all data collected in the study. I was responsible for decisions about how the interviews, transcripts, and all other data were stored. I also took responsibility for protecting the data and maintaining the confidentially of the participants. I protected and maintained the anonymity of participants' documents by masking names involved with the data and by gaining consent to use the documents. Member checks played an important role in the study as well. I provided an opportunity for participants to review transcribed material and transcripts for accuracy after each interview (Stake, 1995).

When considering reciprocity for the participants for participating in the study, I will not offer monetary reward. Patton (2002) notes compensation for participating in a study involves questions around ethics and using incentives other than cash that are just as effective. Consequently, reciprocity was not given in the form of cash for compensation but, the participants in this study were compensated in other ways.

Transcripts of interviews were provided to participants as member checks. I respected their sites and provided participants with feedback about what I observed if they requested me to do so. Finally, I offered my clinical experience with the military population through consultation, training, or professional support to each participant if they requested me to do so.

Trustworthiness and Rigor

Qualitative research is interpretive in nature, and therefore there is no absolute measure that can be taken that will be perceived universally as trustworthy and rigorous. Once the results of a qualitative endeavor are produced for the world, the researcher is aware that not everyone will see the value of the study the same way, despite measures taken to ensure trustworthiness and rigor. Thus, I must note that I am not able to assure that this study will be perceived as such by all who read it. Therefore, to maintain due diligence, I adhered to a variety of methods

suggested by Morrow (2005) for qualitative researchers in counseling psychology and Tracey (2010), who offers criteria of quality for qualitative research.

Tracey (2010) states that credibility is trustworthiness in research findings. Morrow (2005) believes that credibility is a way for researchers to ensure that rigor has been taken in the research process. Furthermore, credibility is achieved through activities such as observation in the field, peer de-briefing, prolonged engagement with participants, participant checks, and rich descriptions. Therefore, as one way to ensure the credibility of this study, a journal of observations in the field was kept. Morrow (2005) believes that self-reflective journals are valuable from start to finish of an investigation. As a researcher investigates, records of his/her experiences and reactions and emerging self-understanding can be examined and incorporated into the analysis.

Another activity which builds credibility is the use of peer debriefers, or those who act as a mirror from which the researcher can reflect their reactions to the research process and add an alternative interpretation about data analysis (Morrow, 2005). While I have my own subjectivities about counselor self-disclosure, I remained open to other perspectives. I documented my own subjectivities in my research journal to explore how they inform my perspectives. A peer debriefer was used to expand my insights on the study so that I did not become myopic as I collected, analyzed, and represented data.

Tracey (2010) suggests that researchers consider whether there is an adequate amount of data, time spent in the field collecting data, and the appropriate procedures used to ensure rigor in a study. As such, data provided meaningful claims, and time in the field assisted with achieving rich rigor (Tracey, 2010). For the purpose of this study, there was prolonged engagement through invested time spent in the field to gain insight and meaningful data. Here,

work in the field went on for 12 weeks. That work resulted in multiple interviews with the participants instead of just one. A literature review provided prolonged engagement with the subject matter and assisted in adding credibility and rigor to the study. I provided a literature review of empirical studies in the area of counselor self-disclosure and the culturally diverse makeup of the military population. I invested prolonged engagement with participants in the field, which assured that I provided an in-depth understanding of the participant's experience with the military population.

According to Tracey (2010), member checks or member reflections add credibility to the research. Member checks were used here to prevent misinformation or misinterpretation of meanings. Tracey (2010) argues that member checks produce new data and give the researcher the opportunity to collaborate with the participants and provide deeper and richer analysis. Therefore, participants were allowed to examine rough drafts of transcripts for accuracy during the member check (Stake, 1995). Member checks were used to assure that interpretations, observations and meanings were accurate (Tracey, 2010). Follow-up meetings with the participants were used to check for accuracy of preliminary and final data analysis.

Tracey (2010) argues that the most important component for achieving credibility in qualitative research is through the use of thick descriptions. For this reason, it was important that I provide readers with details that help them draw their own conclusions about meaning (Tracey, 2010). Thick descriptions were gained through the triangulation of multiple sources. Triangulation is the idea that multiple sources of data bring credibility to an investigation and assist in strengthening a case study (Lichtman, 2006; Yin, 2006). Furthermore, triangulation provided assurance that the interpretation of meanings is cross-referenced with a verifiable pattern across multiple data sources and participants. Theoretical framework, researcher

viewpoints and analysis, and multiple data sources allow the problem to be explored from different aspects. They also deepen understanding and provide consistent interpretation (Tracey, 2010). Using multiple sources of data, I provide rich thick descriptions of the findings in the next chapter that highlight the participants' experiences in ways that would not have been possible had I done a quantitative study.

Chapter Summary

In Chapter 3, I provided a rationale for the use of qualitative research and case study research design. I then, defined case study outlined along with information about how the process of case study analysis took place in the study. Next, I provided a brief summary of constructionism and symbolic interaction, the philosophical and theoretical frameworks for the study. I then provided a narration of my subjectivity story and followed it with a discussion of the research design with explanations regarding participant selection, the research site, and the researcher's role was discussed. Next, I offered detailed information about the data collection process which consisted of participant's interviews, photos or artifacts, observations, and field journals. I then addressed data management and the analysis process for the study. I followed up with a discussion of reciprocity and ethics, creditability, and trustworthiness and rigor. Finally, I provided an explanation of data representation for the study then ended the chapter. In the next chapter, I report the findings from the case study and the cross-case analysis.

Chapter 4 - Findings and Interpretation

This study is grounded in the theoretical framework of symbolic interactionism. There are three main premises of symbolic interactionism. First, human beings act toward something based on the meaning it has for them. Second, the meanings of things are developed from human interaction with others. Lastly, meanings result from an interpretative process used by individuals when interacting with things they encounter (Blumer, 2004). Because symbols are an important part of human interactions, an identification of symbols around which meaning-making occurs could offer critical insights. For the purpose of this study, these symbols can include, but are not limited to, the language used in self-disclosure that informs and shapes communication between a counselor and his or her client. In the therapeutic relationship, a counselor and a client could make meaning about how either party values self-disclosure in building and maintaining their therapeutic relationship.

The findings in this chapter provide information of two participants' attitudes, beliefs, values, and experiences about the role of self-disclosure in establishing, continuing, and meeting the goals in counseling for military clients who value relationship-building. This study was guided by the following research questions:

1. How do participants describe the role of their use of self-disclosure in establishing therapeutic relationships with military clients?
2. How do participants describe the role of the use of self-disclosure in maintaining therapeutic relationships with military clients?

In this section, findings from two participants are presented as cases. Drs. Stacey and Tom were selected for this study because of their experience using CSD as a technique in their counseling practices with military clients. For each participant, I provide (a) an introduction, (b)

a description of the participant, and (c) the research site in which we engaged. Then, I follow with thematic narratives of each participant's experience working in a therapeutic alliance with military clients. I conclude with a cross-case analysis to compare and contrast differences and similarities between the two participants.

Participants and Site Description

Participant: Dr. Stacey

Dr. Stacey is a 32-year-old, African American woman. She was selected to be in the study because of her background in working with the military population as a marriage and family therapist. She obtained a Master of Science degree in marriage and family therapy and a doctorate in family studies. She has practiced professionally for 10 years in different private practice settings. Dr. Stacey began working with the military population as an intern while completing her master's program.

Site Description

Dr. Stacey provides counseling services in a stand-alone building facing the traffic on a busy street in the business district of the city. The building where she provides services, consists of two suites (Suites A and B) on the right and left ends of the building. Her office is located inside of Suite A. There is a glass entrance to each suite, flanked by brick exterior. The entrance consists of two long glass windows on both sides of the doors. Dr. Stacey's clients enter the building into the waiting area, consisting of two counselor office spaces, a restroom, and a small storage area. The atmosphere is bright, due to the glare of the sun through the glass windows in the waiting area, which is filled with the odor of eucalyptus and spearmint. The sounds of Zen Spa (Nature Sounds), Ocean Waves, Water Sound Relaxation, Serenity Relaxation, Zen Garden, Healing Meditations, Chakra Healing, and other relaxing music fill the atmosphere. The sounds

of rain, thunderstorms, and waves from the ocean can be heard playing lightly in the background while clients wait to be seen. The sounds are played through a white noise machine which is used to help ensure confidentiality and privacy by filtering out noise in or out of the counselor's office. Gray and silver chairs are located around the walls in the waiting area. The carpet is sky blue, and all the walls are cream-colored except for one yellow-orange accent wall. There is a wall located between two counselors' offices. The accent wall has a large mirror and two paintings of blue peacocks on each side of the mirror. A glass table with business cards, magazines, and other important information is positioned directly underneath the mirror. On the opposite side of the entranceway in the waiting area is a wall with a large clock and a tall green plant growing to the ceiling. A copy machine and a small storage area are located next to the back door on the left side of the back wall. A hallway leading to the restroom is located on the right side of the back wall of the waiting area.

Dr. Stacey's clients can be seen stretching, reading books or magazines, and resting in their seats as they wait to see her. Her office is closest to the main entrance. The sky-blue carpet from the waiting area continues into Dr. Stacey's office. Her rectangular office is approximately 10 x 12 feet. There is a red futon couch for her clients to sit on during the sessions. It is against the long side of the wall next to the door entering the office. Directly in front of the couch is a large window with brown drapes flowing from the top of the ceiling to the floor. In front of the window is a big, comfortable red chair that Dr. Stacey sits in during sessions. A medium brown desk with a computer and a small copier is located directly in front of the doorway of the office. A small bookshelf with copies of the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition), *Trauma Counseling*, *Marriage and Family Counseling*, *Dialectical Behavior Therapy*, and other counseling textbooks are visible next to her desk against the wall. Her

degrees and professional license are displayed on the wall over her desk. Different pictures and a clock are on the cream-colored walls, which makes the area appear decorative, open, and airy. A standing lamp and a medium-sized table with a coffee machine and other knickknacks are located at the far end of the room. A white noise machine with sounds of rushing air is positioned on the floor next to the lamp. This allows her clients' conversations to remain confidential and unheard by others in the next office or the waiting area.

Dr. Stacey's Thematic Narratives

It Gives Me "Street Cred": Belonging to or Having Experience and Knowledge about the Culture

On various occasions during our interviews, Dr. Stacey shared about topics that were associated with multicultural awareness and culturally sensitive practice with military clients. She spoke extensively about how deeply she valued being culturally sensitive in therapeutic alliances with military clients. She explained how she gained cultural awareness and sensitivity through her work and life experiences with the military population, including those who are active duty as well as retired veterans and their families. Dr. Stacey described how disclosure about her knowledge and experience in working with the military earned her *street cred* – that is, being knowledgeable about a culture through actual involvement with that culture. Below, Dr. Stacey discussed how and why she used counselor self-disclosure to give her this credibility with her military clients.

> I use self-disclosure to make me appear down... on the same level... as they are. I have a degree and have a little bit more experience helping people, but I'm a human being, just like them, and I got into the field, because I wanted to help other human beings, just like me, who've been through similar things and other things as well. I think they feel some

> type of comfort, and they feel like they're being helped by somebody who can relate. And so, I feel like what I've experienced gives me space to be able to offer something real and not some of these examples out of a book or something like that. I think it also gives me "street cred." I've been through some stuff, so it gives me credit to be in the position that I'm in. I can actually help some people with stuff, as opposed to someone who's been maybe sheltered or not really experienced a whole lot of things in life.

Dr. Stacey discussed the importance of being able to relate to her military clients. She described how using self-disclosure helped her to form better connections and to appear human and "real" to her clients. She described how her self-disclosure about her life experiences helped clients feel comfortable in their therapeutic alliances. Moreover, her disclosure of working with other military members in the past gave her the *street cred* that could not be gained from books. She shared how that experience allowed her to appear more down-to-earth and humane. She valued being equal or being on the same level as her clients. This is not to say that Dr. Stacey was trying to be superior or to present herself as "better" than her clients; instead, she is describing the distance between book knowledge and lived experiences. For example, military clients follow a ranking system that carries perceptions about status based on education. Commissioned officers enter into the military after completing 4-year Bachelor of Science degrees and other required regulations (U. S. Army, 2006). Conversely, enlisted personnel do not typically enter the military with postsecondary degrees; however, some enlisted personnel have acquired postsecondary education. Therefore, some enlisted military clients may place their counselors (who are formally educated) in a position of authority. Unfortunately, this may cause enlisted military clients to perceive their counselors as unapproachable and out of touch with their everyday military life. However, Dr. Stacey is knowledgeable of the ranking system within

the military due to her extensive work with the military population from her college internship. She described her internship experience below:

> My very first experience with military clients was when I was in my internship. That was back in 2006. I've had pretty extensive work with military clients that gave me really immediate access to the soldiers. There were some issues of domestic violence that people were experiencing. We dealt with soldiers who were under a lot of stress and needed a place to talk about things. I had families there who really had a hard time being a family. Also, deployments for the soldiers, whether it was the wife or the husband, when they came back into the family system, they were needing to be reintegrated.

Dr. Stacey's internship was a major source for her experience with the military population, and she earned her *street cred* through her personal involvement. She shared how counseling active duty military members and their families exposed her to valuable clinical knowledge about the military culture (such as the ranking system, military jargon, careers within the military, etc.) that she would not have received if she had not interned on a military installation. The services she provided to military clients and their families in her internship gave her access to those who were experiencing many mental-health disorders. Dr. Stacey shared how she worked with clients and their families who had experienced the negative effects of multiple deployments. These deployments led to distress within marriages and families. In addition, active duty military clients who were reintegrating (or reuniting) into their marriages after multiple deployments described problems communicating after spending long amounts of time apart from their spouses and children. Some of those families also experienced emotional disconnection in their relationships. Additionally, active duty clients had to relearn how to deal with the rigors of adjusting to everyday life after returning from highly-stressed war

environments. This made it difficult for some to manage their stress, anger, and other difficult emotions. Likewise, Dr. Stacey worked with active duty clients who suffered from depression, anxiety, PTSD, and other serious mental health issues. Below, Dr. Stacey shared more details about her experiences as an intern.

> I learned a lot in my internship that has carried over into what I do now, and what I've done over time in my work with military clients who have come to me. Yeah, just learning the culture, that's been huge. I think the biggest thing is that I have an understanding of the culture. I know that everybody's job in the military is different, so there are different types of pressures. Some of them are on the front line. Some of them are back in the medic booth. Some of them are dealing with geo-spatial types of things, mapping, all of that kind of stuff. Some of them have been blown up and been in explosions. I had a client that has deployed four times. He has been in, probably, over ten explosions he said. So, I have an idea of what they're going through, and how they're struggling. What their needs are based on past experience.

Dr. Stacey's internship, along with years of working with the military population, has helped her to work confidently with military clients. She is knowledgeable about the language and the types of jobs her military clients perform. She is familiar with their mannerisms, norms of behavior, and the stressors and pressures they may be experiencing. Her internship experience gave her general knowledge of what her military clients go through daily and how to meet their needs from all the struggles associated with military life.

Dr. Stacey's principal tool for helping clients to feel comfortable happened when she demonstrated *street cred* through disclosure in the therapeutic alliance. This allowed her to position herself as an insider in the military culture. And as insiders, counselors are allowed to

position themselves as those who know, understand, and therefore can be trusted by those who are in the culture. Moreover, her position as an insider helped her to know what to disclose to help her clients feel secure, in addition to what and when not to disclose. For example, Dr. Stacey's credibility positioned her as an insider when she disclosed topics that were relevant and meaningful with her military clients. Her position as an insider is described below.

> I had an individual experiencing some PTSD issues. He and his wife are pretty much dealing with the aftermath of that. He deals with a lot of anger. He has some panic attacks. Sometimes they're just random, they just come up. He could be driving in the car… He says he could just have a panic attack right then. He said sometimes when he's driving at night, he's dealing with that because he'll go into a panic attack. Then, all he sees is Iraq and the war and the war zone. The use of self-disclosure in that sense is... I said, "Hey. I have an anti-anxiety medication that I use. It's really helpful for me. It helps me when I'm feeling anxious or when I'm feeling overwhelmed. I can take that, and it helps get me calm."

The passage above demonstrated how Dr. Stacey's position as an insider in the culture helped her to understand her client's symptoms distress, and she sensed her disclosure would help relieve those symptoms. She disclosed with her client that she used anti-anxiety medication when she became stressed. As an insider, she used her past experiences with her former military clients who experienced anxiety to assist her with understanding how difficult it was for military clients to share information about their symptoms of PTSD in session. Therefore, she realized that it was uncomfortable for her current clients as well. After she used disclosure, her client was surprised that she had an inside view of his problem not only as one who understood his military culture but, also as one who had an inside understanding of anxiety.

He looked at me, and he was like, "Really?" I was like, "Yeah. Sure do." I practice, what I preach. If I need it, I'm going to go get it. I'm not going to tell you to go get something, and then, I'm not willing to do it for myself if I need it. He really appreciated that. He told me that. He said, "Thanks for saying that. Thanks for telling me." He said, his wife has hers. He's going to go, and get medication for himself.

Dr. Stacey's military client shared how the information she disclosed helped him to feel comfortable going forward to get the additional help he needed to reduce his symptoms. Hence, Dr. Stacey's military client recognized, valued, and trusted in her ability to help him and her disclosure caused a shift in their therapeutic relationship. She shared how she believe there was a shift in the relationship below.

Yeah. Actually, he's one of those that has to call me when he's, you know, the schedule. He is working. He doesn't really know his schedule. He's in the civilian world now. He's retired. He doesn't know his schedule. Once he gets it, he has to call. He actually calls me and says, "Hey. I'm available on this day. Does that work for you?" I think that him making the effort to continue to come back, is how I feel like I helped with the therapeutic relationship. The things that he needed me to be able to provide for him. He trusts me. The call. It's on him. It really is. It's on him. He actually does call and schedule

In the passage above, Dr. Stacey believed her disclosure with her military client was successful due to her client's actions. Her self-disclosure about her anxiety shifted the relationship into one where she was viewed as trustworthy by her military client. Moreover, her disclosure is example of how some military clients value disclosure that models behavior. Hence, her military client felt safe to use medication to reduce his symptoms after she disclosed about her use.

In addition to Dr. Stacey's experience with her past military clients, she also demonstrated *street cred* and gained access with her military clients through what she referred to as her "warrior status." Dr. Stacey's necklace, which is similar to the identification tags that soldiers wear to identify themselves as members of the Army, occasionally helped her to gain access (see Figure 3.3).

Active duty military clients' identification tags have their names and social security numbers engraved on them. Dr. Stacey's necklace, on the other hand, had the words "love" and "fearless" engraved on two little coins and "warrior" on one tag along with a single cross. She stated that she wore her necklace daily, as it sometimes helped her to communicate about her experiences with military clients as well as the experiences she had personally overcome. Dr. Stacey explained about her warrior spirit below.

> I am the advocate in the room for the soldier, but also, I do not downplay the fact that they still are the "warrior." You know… I explain to them, whatever they're going through, if it's something that I've experienced or someone that I know has experienced it, then me being able to talk about that and talk about that person's warrior status or my warrior status as someone who's gone through something and made it through and is still standing strong is useful.

Dr. Stacey used her necklace as a symbolic piece to help her advocate for her military clients. She stated that the necklace was a symbol of having a warrior spirit because she has persevered the experience of different trials and tribulations throughout her life. She believed that this demonstrated to her military clients that they could also withstand the challenges with which they were faced. Moreover, her necklace assisted her in gaining access by enabling her to

help clients feel free to talk without the need to waste valuable time explaining their military culture or jargon.

The military language consists of many abbreviations which are not common to civilians; if a military client, for example, stated that their MOS is a 92 Yankee in the military, then he or she is referring to their military occupational specialty or what they have been trained to do in the military. Consequently, military jargon is unfamiliar to most counselors and civilians who have not been in the military. Thus, counselors who are not culturally sensitive force their military clients to spend time explaining the meanings of commonly used military expressions instead of explaining what brought them into counseling in the first place. This cultural distance could lead some clients to refuse to return to counseling because most of their sessions were spent educating their counselors about their culture. Such a situation could cause clients to feel misunderstood. As a result, some military clients may perceive a lack of understanding. They suspect that their counselor may be unable to grasp what it is like to deploy, or to experience war and all other multifaceted areas of life within the military. Thus, having *street cred* helped Dr. Stacey as a counselor to appear more relatable and well-informed.

Dr. Stacey discussed another significant way positionality played a role in the therapeutic alliance. She revealed that she was in a relationship with an active duty military member which allowed her to have an inside view and gain access to her military clients as a member of the military culture. She shared that being a member of the culture helped her understand her military clients with a military related lens. Thus, she believed that her *street cred* was gained from her affiliation with the military. Dr. Stacey described times when she deliberately disclosed about being a part of the military culture, and about having firsthand knowledge of her military clients who were suffering with mental health symptoms. Below, she provides details about her

relationship with a military member who suffered from PTSD and TBI (Traumatic Brain Injury) and how she used her personal life to help one of her military clients.

> I've disclosed about not only the friend that I had who also struggled with TBI, but I also disclosed about being able to understand what was going on with him at times too, when he was dealing with his issues of PTSD, and not being able to remember. I think that counselor self-disclosure has been helpful in a sense. Once I've shared that, having a relationship with someone in the military who is struggling with some type of PTSD or some form of mental health issue that they feel ashamed about or aren't willing to confront right away, it allows a place of softening for them. They're able to feel more comfortable in the environment and they keep coming back. They come back on time, you know, they are not late. They confirm their appointments like a week ahead of time.

Dr. Stacey asserted that her experience helped her to bond with her military clients and that belonging to the culture gave her a deep understanding of the culture. She emphasized that she lived through what it was like to be in a relationship with someone who had suffered with TBI and had problems with memory loss. Likewise, she could relate to how her significant other suffered with PTSD and the shame he experienced from the illness. When she heard stories from her military clients that were similar to what she had gone through, it prompted her to disclose about her relationship in an effort to give her military clients or families hope. In addition, it was important for her to ease any apprehension with sharing about the symptoms or problems they were experiencing in their marriages and families. Subsequently, her clients were comfortable with talking in session because they were aware that she had lived what they were going through and this allowed her to gain real insight into their issues. Moreover, her military clients returned to counseling with her after she disclosed that she was part of the culture.

Dr. Stacey's disclosure about being in a relationship with a military member who suffered from PTSD and other mental health symptoms helped to reduce the shameful feelings her military clients experienced. She believes that shame not only prevents military clients from talking about having a mental health disorder in session, but it also prevents them from seeking treatment for these issues. For example, some military clients feel ashamed when they are unable to perform their jobs after experiencing trauma. They may feel alone if their comrades are doing well and are free of negative symptoms resulting from the same traumatic event in which they were all involved.

In addition, some military members may be reluctant to seek treatment and talk about symptoms to protect themselves from the possibility of losing their careers and lifestyle from a mental health diagnosis (Tanielian, 2008). Therefore, some military clients may choose not to seek treatment to avoid the stigma involved. And besides, some military members who are diagnosed with severe TBI and PTSD may be afraid of the risk of being medically chaptered out of the army, even if they are still capable of working. If this happens, there is the possibility that the loss will leave some clients with feelings of guilt, shame, and loneliness. Therefore, some may be skeptical about sharing their symptoms, feelings, and experiences with others due to stigma and fear. Nevertheless, Dr. Stacey created clinically safe environments from her *street cred.* This empowered her military clients to progress in their treatment goals. In addition, she revealed that it helped to soften discussions about mental health issues and create an environment that her clients were excited about and therefore eager to continue the therapeutic relationship.

Cultural sensitivity is vital in a therapeutic alliance with military clients. Therefore, counselors should gain as much experience working with the military population as possible. According to Dr. Stacey, cultural sensitivity does not come from book knowledge, but

knowledge and experience helps counselors to use more culturally sensitive practices that relate directly to that culture. Dr. Stacey's *street cred* positioned her as an insider with her military clients. Similarly, her relationship with a military service member gave her direct contact with the inner workings of the population. Her *street cred* was validated when she disclosed that she had worked with military clients in the past and that she suffered from anxiety. Additionally, Dr. Stacey's sharing about her real-life experiences in the relationship with someone suffering from PTSD and TBI had a major influence and shifted the therapeutic relationships in her military clients' treatment. Those military clients understood that she was a part of the culture as soon as she disclosed about her relationship and experiences they both went through due to his mental health issue. Dr. Stacey believed that when her military clients heard her stories, it made them feel unashamed about speaking about their symptoms of PTSD or other mental-health disorders in session with her. In addition, her disclosure provided a softening in the therapeutic alliance with her military clients. She shared that they felt comfortable within the counseling environment and they continued to return to counseling because of the climate she created within the alliance.

As a result of being a part of the culture and living with someone who suffered from the same maladies they were going through, Dr. Stacey noticed that her clients were confirming their appointments before sessions, showing up on time, while rarely being late – because they trusted in her ability to treat them. And since she had *street cred*, her clients were more confident in her ability and thus excited about attending counseling.

Cultural Congruency and Working with Taboo Topics

When counselors are unfamiliar with their clients' culture, judgmental views can be formed in the therapeutic alliance which can prevent their clients from revealing distressing issues. Typically, such views form when there is the expectation that military clients will have

similar characteristics and behavior akin to their civilian counterparts. Perhaps some counselors may be unaware of the shame associated with the discussion of certain topics in the military. For example, some active duty military clients may not be willing to discuss their symptoms due to the fear of being medically discharged, thus ending their careers. Some counselors who are unfamiliar with the military culture may feel it is more rational for people to stop working if they are sick. Moreover, some counselors may pass judgment on their clients' choices to even serve in the military. They may feel that their military clients made the choice to deploy, and hence they were aware of the possible dangers to themselves, their marriages, and their families when they made commitments to the military. Some may also expect military clients to take responsibility for how they contributed to negative issues in their lives by choosing to serve. Consequently, conflicts and impasses may develop in the therapeutic relationship due to military clients' distrust of their counselors' ability to understand their culture. For this reason, counselors' congruency with a specific understanding of the military culture is vital in a therapeutic alliance with those clients.

Because cultural congruency is such a significant component in the therapeutic alliance, it may need to be cultivated before military clients will feel secure in sharing sensitive issues. As a consequence, military clients may cover up symptoms or avoid certain topics when there is that lack of congruency. Thus, important parts of their lives are omitted from discussion during sessions; and as a result, counselors may not acquire an accurate picture of their military clients' experiences. For example, some military clients will not ask questions about what should happen in the session for fear of appearing uninformed or sounding unintelligent. Moreover, communication about their major issues may not be disclosed if military clients feel uncomfortable or open to judgment. When this happens, it perpetuates their fear of sharing what

they consider taboo topics with mental health professionals as a means of self-protection. By contrast, however, when military clients trust their counselors' ability to be culturally sensitive, they may be more open about sharing such issues, which are then exposed and explored in session.

According to Dr. Stacey, counselor congruency is not merely about being able to relate with the military culture. Nevertheless, being congruent *is* about relating when used as a means of gaining trust and demonstrating an understanding – not only of the trauma of their military clients' experiences but also of the cultural context in which the experience occurred. Counselor congruency is also about the healing possibilities when someone chooses to stay in the military while dealing with mental health issues. Therefore, a combination of cultural understanding and cultural context in which things are taking place is important in a therapeutic alliance with military clients.

Dr. Stacey discussed how the military clients she has worked with typically return to sessions because they trust her as a culturally competent counselor. In the excerpt below, she described how her military clients have bonded with her.

> They keep coming back, and they come back on time, you know? They are not late, you know? They confirm their appointments like a week ahead of time. So yeah, they keep coming back. I think they feel some type of comfort, and they feel like they're being helped by somebody who can relate.

Dr. Stacey asserted that her clients' desire to continue counseling demonstrated enough trust to maintain the therapeutic relationship. As discussed earlier, the stigma associated with counseling (as well as the fear of what might be reported), coupled with the fear of not being fully understood, may render some clients reluctant to continue counseling. Therefore, unless a

counselor demonstrates cultural congruency through self-disclosure while resisting the impulse to adopt a judgmental attitude through having a deep awareness of military culture, such clients may opt out of the therapeutic relationship altogether.

Dr. Stacey emphasized that cultural congruency is communication-driven, especially to the extent that she endorses the practice of self-disclosure, starting from the first session. Below, Dr. Stacey provided an example of one of her initial intake sessions with a military client.

> We sign the necessary paperwork, the informed consent, those types of things, and then we dive right in: "What made you feel like you needed to come in and receive help?" Then we talk through that. I look through their intake forms and we walk through the different types of issues that they've been having, and we talk specifically about those. Then, I've had some that had things that they feel ashamed of on their intake form. They've written it down, but they don't want to talk about it, and I obviously point to everything. I don't leave anything out. When they seem skittish about that, I explain that I've had many other people or I myself have experienced those types of things, so I understand the embarrassment, and I understand the reluctance that you may have to discuss it, but this is a judgment-free zone, and if you need to talk about it, we can talk about it, and I can understand it from my perspective from things that I've experienced, but I want to understand it from your perspective as well.

Dr. Stacey was sensitive to the fact that there is stigma associated with military clients attending counseling. For this reason, they need to feel understood within their cultural context, and this is imperative from the outset. If understanding is not established early, even as early as the first meeting, the client may not return. So beyond being non-judgmental and empathetic, a culturally congruent counselor would have to demonstrate their shared cultural understanding to

inspire the client's return. Likewise, counselors need to be aware of culturally sensitive details and may need to share their knowledge and understanding of those details in the first meeting, so that the military client does not feel like s/he has to explain basic information to even get to the point where they can discuss where they need help. For example, Dr. Stacey's approach differs with new military clients because she realizes they are somewhat reluctant to discuss issues with which they feel shame or discomfort. Culturally congruent counselors will focus on such clues and address sensitive issues. They may disclose how they have worked with other military clients concerning certain difficult-to-discuss topics. Similarly, a counselor who, like Dr. Stacey, is part of the culture may talk to the client about her knowledge and awareness of the difficulty in revealing personal and sensitive information, because they may have experienced it as well. This may help to alleviate awkwardness and demonstrate a counselor's familiarity with the military culture.

Dr. Stacey and I talked in-depth about how her military clients responded to her after she disclosed. She insisted that her military clients were open and shared more about personal military issues when she disclosed in session.

> I had a family come in and their struggle was communication. He's getting ready to deploy, he's not really communicating the way he needs to. It's one of those things where I'm getting ready to leave, so I don't want any emotional issue to come up. I talked about when I left my family, and moved to another state. I had an aunt who was the same way. When I would go visit, she would pick a fight with me, and we'd leave angry and all that type of thing. What she did was project onto me the anger and frustration that she was feeling about me not living there anymore.

She reported that the therapeutic relationship between herself and the couple changed after she disclosed about her issue with a family member when she moved away from her home town. She described what happened after counselor self-disclosure was used below:

> He was like, oh. She was like, mmm. Okay, that helped them to open up the lines of communication and really be able to talk about the deployment and talk about how long he was going to be gone and how they were going to be able to cope with it emotionally and those types of things. I really feel like it opened the door for him, in particular, because he was the one that was shut down, and she was wanting to facilitate change.

Dr. Stacey described how counselor self-disclosure helped to facilitate change in the alliance and allows client to feel open to disclose about topics which may be difficult to share about.

Trust and understanding are key components in being culturally congruent with military clients. Dr. Stacey stated, "If you develop a relationship with them, then they can trust you." Hence, a strong therapeutic bond consisting of trust and understanding is critical for culturally congruent counselors. As stated above, clients' sensitive issues are difficult to share in sessions with counselors who do not demonstrate the ability to understand their clients' culture. Yet, when trust is present, clients are more willing to bring these issues to light because their counselor understands their experiences and is nonjudgmental about the cultural context in which their stories are being told. Below is an example of how Dr. Stacey's client trusted her and discussed a sensitive issue pertaining to her life as a woman in the military.

> There was a client with self-image issues. She was really trying to come into her own as a member of the military, and she had dealt with some sexual harassment, that type of thing, but also has insecurities. Very beautiful woman, but still has those insecurities, which cause her to act out in certain ways. What I've talked with her about is some of the

> similar struggles that I've had, and not going into detail, but saying, “Hey, I understand. I understand the struggle is real, and I've been there myself.” And she talked about having some issues of depression, and I said I've been there too. I remember her saying, “Wow! That makes me feel much better that I know that it's not just me, and I know that you can be trusted with this information, and you can understand from your own personal standpoint.” That really helped in the process of joining with her. We've been able to do some great work together because of that.

This client suffered from a negative self-image, sexual harassment issues, and depression. Dr. Stacey discussed her client’s insecurities revolving around her identity as a military soldier. She recognized that this client was unique because not many military women are as open about discussing such issues because she, like many others of her gender, did not want to be looked upon as “weaker” than their male counterparts. Therefore, some military clients may be influenced by the core values of the military, and those beliefs are drilled into their thinking from the time of basic training. One of those values is that sexual harassment is neither tolerated nor should it occur within the organization.

Unfortunately, there is the possibility that a soldier will experience sexual harassment. And if it does happen, it would not be a topic that military clients may choose to openly discuss within the military. Therefore, Dr. Stacey demonstrated an understanding of her client’s military culture; as a result, her client disclosed intimate details as their bond within the therapeutic alliance grew strong. Her client revealed that she suffered from depression, information she had not disclosed early on in their relationship. Yet, her military client trusted in Dr. Stacey’s ability to understand her culturally, despite the taboo imposed on the discussion of such topics as depression, PTSD, and other disorders in the military.

However, some military clients may be reluctant to even seek counseling and when they do, it is difficult for them to talk about uncomfortable experiences, occurring as they did within the context of the military. Dr. Stacey's shared what it was like for one of her military client's initial session.

> He came in and we did the intake, and I asked questions, just to get to know what's going on and what's happening and why he felt like he needed to come in. That's when he told me my commander said there's something wrong with me, so I need to come in. I said okay, what's going on? He said I'm in the military. I said, okay.
>
> Why did you join the military? He said, "Honestly, when I first joined, I thought I'd be able to do it, but now I'm in it, and it's getting real." He said, "I can't do it." He said like I'm not mentally unstable. I'm not saying that I'm crazy, but what I'm saying is I don't feel comfortable pointing a gun at somebody and pulling the trigger. He said would you please tell that to my chain... I said yeah. I'll let him know if that's okay with you. Sign this form, for full disclosure. I only met with him once, and gave the information to his commanding officer and that was it. I think he got maybe... He was discharged, but I don't know if it was... I don't know what type of discharge

Dr. Stacey's military client requested a release of information about the session with his chain of command. Although she shared that he was not unstable, the military client was chaptered out of the military due to other information that was disclosed in the session about feeling uncomfortable with shooting his weapon. Hence, some military clients may be reluctant to share in session due to hearing about incidents like this one shared by Dr. Stacey. As a result, some issues are difficult for clients to talk about, specifically with reference to military clients who do

not want to risk hindering the advancement of their careers by being unable to attend schools, being promoted, or getting chaptered out of the military involuntarily.

Dr. Stacey was perceived as culturally congruent by another one of her military clients who was struggling with his sexual orientation and spirituality. Her experience with that client is the subject of her revelation below.

> I had one client who was in the military, but he was struggling with some sexuality issues. He was really wanting to have a place for him to come and talk about that, as well as the struggle with him was also spiritual, because he was definitely identifying himself as a Christian. Those backgrounds pretty much say that you can't have homosexuality as a practice. He was working through those things, and we were talking through things, and when he made mistakes, meaning he gave into temptation and had sexual relations with men, he struggled mightily with that within himself. I think we probably went maybe two, maybe three months before I even self-disclosed regarding my spiritual and Christianity beliefs. Once I did that, I saw the apprehensiveness dissipate. He wasn't as nervous anymore about talking to me about the things that he knew were struggles for him and that were "taboo" for someone who was a Christian. When I told him about my struggles with sin, as I said before, he was able to relax a lot more, because I didn't judge him. “That's a part of who we are, and God knows that.” For him to hear that, he was like, “Thank you. Somebody at least understands what I'm feeling.”

In the passage above, Dr. Stacey sensed apprehension in her therapeutic alliance with her Christian military client who struggled within himself about what he considered as mistakes. She discussed how he had a difficult time talking about those issues when he first entered counseling. However, after sharing the information that she too was a Christian, the apprehension dissipated.

He became comfortable enough to risk communicating with her about issues considered taboo in the military. She noted that the shift in the relationship and bonding began right after her revelation about her own spirituality. Her client responded that he did not feel as though he was being judged, and he thus felt understood. Therefore, cultural congruency with the client assisted her in recognizing early the barrier within their therapeutic alliance. Dr. Stacey provided an excellent example of how a counselor can use cultural congruency to assist in removing that barrier. Additionally, she demonstrated how essential a judgment-free environment is to a strong therapeutic alliance. Her client relied on and trusted her understanding of the Christian culture because she was a member. He also believed it felt good to have another Christian to talk to – someone who understood his feelings. Subsequently, because she was congruent and nonjudgmental, her Christian military client completed counseling and was able to have the needs of his treatment met. According to Dr. Stacey, "We terminated with him saying it was so helpful to have that Christian perspective and not feel judged in the process."

On the other hand, some military clients may not be fond of culturally congruent counselors in session. These military clients may find such counselors overbearing, rude, and offensive. For example, the counselor's disclosure about her familiarity with a culture may cause the client to shut down in session and later decide not to return to counseling. There are times when military clients are not open to suggestions about their culture. Dr. Stacey shared an experience that she believed resulted in a negative outcome as a result of her disclosing with the client. She stated:

> I had a couple, and they came in with some domestic violence issues, and she was pregnant, and he was very…You could tell he was very controlling. She couldn't say much when he was there in session, but they would come in together. He came the first

> time, we talked through things, and she said very little. He was saying, “My commander said I need to come and we needed to come for therapy” or whatever. In a session alone with the wife, she was telling me all kinds of things that her husband was doing to her, and she was pregnant. He was throwing her up against the refrigerator, choking her out, stuff like that, and he had early on hit her in her stomach when she was pregnant. I talked with her about some of the abuse that one of my aunts had gone through, and it was not pretty. The ending was not pretty. I said, “You’ve got to decide right now, what is it that you're going to do to protect yourself and your unborn child. Right now, he's showing you that he doesn't care about you or your unborn child.” She was like, "I know, I know, but I don't know what I'm going to do." I said there are lots of options for you. I said, “I'll be right back.” I came back with a list of different options that she could use. I said, “You can utilize these the next time.” And they never came back.

In the above excerpt, Dr. Stacey’s client revealed that her husband was abusive and she was experiencing domestic violence in her relationship. Dr. Stacey was particularly concerned about the abuse within the marriage due to her client being pregnant. During their session, the client shared the graphic details of how her husband had hurt her several times in the past. This caused Dr. Stacey to think about her safety. As she attempted to gain the client’s trust and provide support, Dr. Stacey made the decision to share information about her aunt who had been involved in an abusive relationship that ended tragically. She shared that she disclosed that information because of her previous work with other military clients who had experienced abuse, and it may have been the only opportunity she had to prevent further spousal abuse and to protect her unborn child. Although Dr. Stacey never saw the couple again, she stood by her decision to disclose because she was culturally sensitive to the situation. Dr. Stacey shared that she

understood this to be an example of when self-disclosure was not helpful in establishing a strong trusting therapeutic alliance.

Dr. Stacey is culturally congruent with her clients, and they, in turn, have discussed sensitive topics in session with her. Her military clients trusted her and valued her knowledge about the culture. She convincingly influenced her clients' treatment process and helped them to feel comfortable enough to disclose information concerning sensitive topics. Additionally, Dr. Stacey's sessions with her military clients were effective because she related to her clients' experiences. Her clients opened up about difficult issues and they terminated counseling successfully after hearing how aware she was about their cultural issues.

Dr. Stacey did share one experience above that did not have a positive outcome. This instance may serve to highlight the caution needed in the practice of self-disclosure and its role in developing therapeutic relationships. In other cases, however, Dr. Stacey's cultural congruency allowed her to develop successful therapeutic alliances with her military clients. Within those alliances, she demonstrated her deep understanding of military culture, the stigma associated with seeking help, the fear among clients about being reported to ranking superiors, and further fears of being judged. While self-disclosure here did demonstrate cultural congruency, another characteristic important enough to be paired with *self-disclosure* would be the quality of *self-awareness*. This was seen when Dr. Stacey interpreted her disclosure as not having the outcome she had hope for with the client who responded negatively to her disclosure concerning domestic violence. Unfortunately, her client did not return to counseling and may or may not have remained in a violent relationship. Her inclination to self-disclose in that moment may have been caused by Dr. Stacey's need to protect her client and to use self-disclosure as a teaching tool. However, Dr. Stacey may have been unaware of how raw the memory of her aunt

was. Additionally, it may have been a touchy area in which Dr. Stacey needed more healing. Hence, counselors are not always making the best decisions with the use of self-disclosure. Therefore, timing, awareness of self, and how counter-transference can enter into an alliance are crucially important factors for counselors to consider before making the decision to disclose. Although self-disclosure can be a method for developing cultural congruency, Dr. Stacey's experiences emphasize the idea that such disclosure requires a strong coupling with the idea of self-awareness – almost to the point of a counselor understanding where her own wounds might exist, thereby insuring that a client's pain, anxiety, or fear may not intensify to the point of forcing the client to make a decision that s/he might not be ready to make.

I Use Self-Disclosure as a Common Practice, But One Piece of Advice…

In our interviews, Dr. Stacey mentioned on how beneficial disclosure was to her counseling practice with military clients. Although she advocated the use of self-disclosure, she stated there are considerations to be weighed before counselors use disclosure in their clinical work with members of the military. Hence, she provided guidance for other counselors who may find self-disclosure beneficial. Dr. Stacey shared one of the benefits of using self-disclosure below:

> Counselor self-disclosure relaxes them. I think it makes them see me as a therapist, as a human being, and not somebody perfect trying to help other people do stuff because I'm perfect.

Dr. Stacey's goal in her therapeutic alliance with her military clients is to help them feel relaxed so that they can share their stories. Hence, being perceived by her clients as a humane individual is vital. She discussed how difficult it is to form connections with someone who may come across to a client as cold, stoic, and seemingly "perfect," regardless of the type of

relationship, therapeutic or otherwise. Such a relationship might fail due to lack of warmth and connection. Therefore, it is likely that the same feelings may apply in a therapeutic alliance with military clients. Those who engage in sessions with one who is perceived as a fellow human being with problems similar to his/her own may have an easier time developing and maintaining therapeutic relationships and staying connected.

Additionally, Dr. Stacey believes that disclosing in session helps to normalize the counseling process for the client. She stated that self-disclosure helped her to create an atmosphere that consisted of two people sharing with each other. Such a strategy enables the counselor to set the stage in helping along the healing process for her or his clients. Dr. Stacey stresses the importance of creating the right tone for the therapeutic alliance, and this allows her military clients to feel at ease when speaking with her. In addition, she found that the practice of disclosing made her appear down-to-earth, genuine, and authentic. She describes how she used self-disclosure in detail.

> I use self-disclosure to make me appear down on the same level as they are. I have a degree and have a little bit more experience helping people, but I'm a human being, just like them, and I got into the field because I wanted to help other human beings, just like me, who've been through similar things and other things as well.

In allowing herself to be perceived in these ways, Dr. Stacey wanted her clients to make a therapeutic connection with her. Moreover, she wanted them to return for further treatment so that their needs would be met. She stressed that although she was “the professional or the one with the formal psychological training, she did not want her clients to feel that she was better than them. Therefore, her sharing of her experiences with military clients provided a comfort zone. This is important because it is difficult for military clients who are unfamiliar with the

process of counseling to share their life experiences with someone who appears to be a "know-it-all." But Dr. Stacey discussed yet another advantage:

> I use self-disclosure as a common practice…for one, it keeps me grounded. That's for one. For two, it allows me the opportunity to join more effectively with the client.

She describes "being grounded" as not being viewed as someone who is "better" than another person. She prefers to be seen as someone who is in a therapeutic alliance to facilitate change and healing. Hence, if disclosing about her own life experiences – those similar to her military clients' experiences – causes change and healing to take place, then she considers self-disclosure a beneficial tool, especially when considering how common it is for those in the military to enter therapy with skepticism. Thus, she shared how disclosure helped her relate more effectively with her clients.

Dr. Stacey likes to use the term "joining her clients" when she talks about her self-disclosure practice with families. This is a term that comes from Dr. Stacey's training in the marriage and family therapy program. The act of *joining* connotes "being part of one team." The concept of *joining* allows counselors a better understanding of the family and enables them to integrate into a family to help facilitate change as an insider or as an equal. Hence, Dr. Stacey is viewed by the family as an honorary member, allowing her to speak frankly and openly as a member of that family and not as an outside stranger. Therefore, Dr. Stacey made an active, self-aware decision to *join* with her clients, and perhaps if done successfully, then becoming one of the members of her clients' family will help her "to do some great work together" with her clients. Moreover, her disclosure about her life experiences also helps her to normalize the counseling process. She is able to create a comfort zone within the therapeutic alliance by disclosing how other military clients have experienced counseling in their therapeutic alliances

with her. Also, she has provided examples to her clients about what to expect, thus assisting them in understanding the counseling process.

Although Dr. Stacey endorsed the use of self-disclosure with military clients, she offered advice for counselors to consider before they attempt to disclose or joining with their clients.

> One piece of advice would be know yourself. Know that you're a work in progress, but also know that if it's something that's so tender for you that you wouldn't be able to see past the fact that it's not about you in the session, then don't use self-disclosure. Don't do it. It's not the proper time.

Dr. Stacey also shared that if the self-disclosure is used too early during counseling, it may be received by clients.

> They may not be receptive to it. You got to know them, and sometimes it takes a little bi to figure it out, and sometimes it takes a little bit for you to be able to get to a place where they accept what you're saying.

Additionally, Dr. Stacey shared "being able to gauge it" – that is, with reference to the timing of self-disclosure, knowing when or when *not* to use it is important. Therefore, a client might not respond well to self-disclosure early on in a session because the client is still trying to sort out her feelings before she is ready to hear her counselor's similar experiences.

The client might also feel overwhelmed by having to deal with her own situation while at the same time listening and allowing space for the counselor's struggles. This was evident in Dr. Stacey's conversation with a client to whom she had disclosed her experience with a domestic violence situation involving her aunt. That client never returned. While it is not known whether self-disclosure was the reason for the client's failing to return, it is still suspected that this was

the most likely cause. It is still not known whether self-disclosure at that time was the best therapeutic decision for that particular client's well-being.

According to Dr. Stacey, "as a counselor, you must know yourself too." In that respect, she discussed the importance of knowing oneself personally as a counselor. She ranked this quality as important as understanding how to gauge the timing of self-disclosure. She considered these to be critical pieces of advice for assisting counselors with their use of self-disclosure in their multicultural therapeutic alliances with military clients. Dr. Stacey stated:

> One piece of advice would be to know yourself. Know that you're a work in progress, but also know that if it's something that's so tender for you that you wouldn't be able to see past the fact that it's not about you in the session, then don't use self-disclosure. Yeah, I think there is a boundary that must exist as well, and that's first and foremost.

Dr. Stacey's advice in the above passage is primarily useful for novice counselors. Similarly, it is useful for counselors who are not experienced with using disclosure and are looking for ways to get their clients to reveal more information in sessions. Her advice is especially critical for novice counselors who lack experience. Dr. Stacey suggested that they avoid disclosing about things they haven't worked through personally because of unwanted strain and damage that can be caused in the therapeutic relationship. Disclosing unresolved issues can trigger unwanted feelings to surface in the novice counselor. It can also cause clients to be concerned or burdened about their counselors' mental state in session. Moreover, the client may perceive the counselor as unstable, which could lead clients to distrusting their counselors' ability to help them. Therefore, measures should be taken to avoid disclosure of things that are difficult or unresolved. In addition, boundaries around what is disclosed by counselors must be in place. Personal issues which are not client-focused should not be used as a means to force a bond that does not exist.

Therefore, counselor self-disclosure should only be used when it is relevant to the situation being discussed by the client during session.

The last piece of advice given by Dr. Stacey is critical in counseling as well as other clinical professions because it is one of major reasons why some counselors choose not to use counselor self-disclosure as a tool to strengthen therapeutic alliance. Dr. Stacey stated:

> One of the things that I feel like is helpful, after having done the self-disclosure, is to not keep doing it, saying, "I did" or…"What I'm saying is…" because it's not about you, and at that point, you make it about you. If you can find that balance of "I've experienced that, but let's talk about what your experience is," I feel like they've appreciated that so much more than me constantly telling them, "I remember I did…" If you make it about *them*, and you keep it about *them*, it makes it a little bit easier for you to develop that deeper relationship.

Dr. Stacey believes that knowing how to balance counselor self-disclosure is important. In essence, counselors should not continually disclose about themselves. This is significant because it shifts the focus off the client and onto the counselor. Additionally, clients may not feel that they are being heard or they may feel challenged because they have to compete to get a word in during the sessions. Equally, military clients may become annoyed with hearing about their counselors' experiences when they have paid to seek help for their own personal issues.

Although there are many benefits and considerations with any technique used in counseling, Dr. Stacey shared experiences that she deemed important in her practice with the use of counselor self-disclosure. She learned what worked and what did not work through trial-and-error in over a decade of therapeutic alliances with military clients. She found her use of self-

disclosure beneficial to her military clients because she appeared human, trustworthy, and competent enough to help them.

In a therapeutic alliance, the client and counselor often engage in reflection and projecting. In other words, a client could project her emotions onto the counselor if the counselor behaves in ways that could trigger the client. The counselor, if not unaware of her tender spots, could also project on the client, even in self-disclosure, and could enter into a reciprocal relationship of reflection of emotions and projecting on each other. This process is called transference and counter-transference. Counter-transference can be detrimental to the client's progress and healing. Therefore, a counselor should know where her wounds are; and if she is disclosing, then the disclosure should only be to the extent that it can be used to refocus on the client's issues instead of causing the client to hold space for the counselor to share her experiences. There has to be a clarity of intention and balance from the counselor's perspective when using self-disclosure.

Dr. Stacey's advice for novice counselors to consider before disclosing with their military clients in session consisted of counselors "knowing themselves", especially in situations where some topics might be too fresh for them to share in session with their clients. She asserted that counselors need to have worked through unresolved issues before disclosing about those problems because clients may perceive their therapists as behaving unprofessionally. Additionally, knowing when to disclose is important. According to Dr. Stacey, counselors should learn how to gauge when to disclose and when *not* to disclose while balancing how much information to share with a client. She further emphasized that this may help counselors to maintain professionalism while keeping their clients (and sessions) focused.

Participant: Dr. Tom

Dr. Tom is a 39-year-old African American man who was selected to be in the study because of his background. He has worked with the military population as a licensed professional counselor. Dr. Tom obtained a Master of Science degree in counseling and psychology, an Education Specialist degree in guidance and counseling, and an Ed.D. in counselor education and supervision. Dr. Tom has practiced professionally for 8 years. He has worked with the military population since 2008. In sharing how he began working with the military, he stated, "I think Tricare was one of the organizations I became credentialed with when I got fully licensed." Afterwards, he began receiving referrals for military clients. He revealed that military clients came from Tricare, the Department of Family and Children's Services, and Military One Source.

Site Description

Dr. Tom's research site is a mid-sized stand-alone brick building on a busy street. Before entering the center, cars can be heard traveling down the street. Christmas music can be heard playing in the background as clients enter the center through a white door with the name of the center on it. The waiting area is large. A sliding glass window is on the left side of the waiting area as clients walk into the front door to check in for appointments. A wooden door next to the check-in window leads clients into the back offices. A table with children's books and mental health brochures are located next to the door which leads into the back offices. Above the table is a message board with more information about groups and activities offered in the community. Pictures are mounted on all the walls. A microwave and a water dispenser are located in the far corner of the waiting area for clients. There is a desk with a chair on the other corner of the back

wall. Live plants are in the waiting area as well. Two windows provide natural light into the waiting area.

The wooden door leads to a wide hallway where the counseling offices are located. The restrooms are located in the hallway along with a water fountain and a computer with a desk. A couple of steps to the right of the water fountain is a large classroom with 6 tables. Two tables with a set of two chairs are placed side by side, lengthwise and wall to wall, with a space between each set. There is a small window in the front of the room that provides natural light. A stand is located in the front of the room where presentations are given. There is a computer and a printer on the opposite side in the front of the room. The counselor's offices are located across from the restrooms.

Dr. Tom has a medium-sized office with white walls and beige carpet. An L-shaped desk takes up an entire corner and two walls of his office. He has a calendar over his desk on his right side. His desk is very neat and clean with a few items on it: a phone, computer, desk-top computer speakers, and a small decorative container. Along the entire wall on one side of the office is a bookshelf that is attached to his desk. A window is located on the other side of the wall. Nearby are three picture frames containing his degrees. The office is arranged with seating directly behind the desk. His chairs are leather. There is also a small table and lamp.

Dr. Tom's site also contains another counselor's office right next to his office. This office appears to be used for counseling with children. When entering the office, a couch and a clock are on the back wall. A four-shelved bookcase containing children's books is located next to the couch. A small desk with a few items on it is directly in front of the couch on the opposite wall. Two crates of toys are next to the desk.

Dr. Tom's Thematic Narratives

It's a "Human Experience": Experience and Knowledge About the Culture, But Not Part of the Culture

Dr. Tom talked extensively about his experiences working with the military population, which began after he received full clinical licensure from his state. He stated that most of the referrals of his military clients came from the community and from insurance companies that he is credentialed with. Furthermore, Dr. Tom's counseling center provides services for a mixture of clients who are a part of the military population and are civilians in the surrounding community.

According to Dr. Tom, barriers sometimes exist in his therapeutic alliances with military clients when they were not confident in his ability to understand their culture. He reported that barriers within his therapeutic alliances prevented them from utilizing services. For this reason, Dr. Tom's goal in his therapeutic alliances with military clients was to understand their struggle and to connect with them on a human level. He asserted that he used self-disclosure to help his military clients to understand him as a human being who had experiences that he could share with them to ease the counseling process. Moreover, counselor self-disclosure helped him to connect with these clients – even as someone who knew little of the military.

> Although I have never been in the military and I do not plan on getting in, it's part of the human experience. When you can help, the person understands that it's the human experience. Then it takes away titles and brings them back to "you're human," living in America, or living in the world. As a person living in the world, you deal with issues. We all got to work to do the best we can.

Although Dr. Tom may not have been a soldier, he believes that this does not mean that he cannot help or understand his military client's lifestyle. He insisted that he formed

connections with his clients even though he has never experienced the military or war. He used common human experiences to connect with his military clients. He discussed the human aspect – how they are human beings living in the world in which we, as humans, all deal with problems in life. Therefore, his military clients may possibly connect with Dr. Tom as a counselor with the understanding that they both have experienced issues in life that may require counseling to help them through.

Forming connections from shared human experiences was vital for Dr. Tom. He asserted that the connections he established made the difference in alliances with members of the military. He stated that he used the same perspective that everyone is human and deals with problems to address major adversity or trauma. Thus, Dr. Tom disclosed portions of his personal experiences with these clients to assist in forming human connections. He shared an example of self-disclosure that he used with one military client when he was attempting to establish rapport. He told the client:

> Yes, I have to work through things too. You're living the human experience and I am too. And although I am trying to help people work through their human experiences, I have to deal with things too.

Dr. Tom further revealed to the client that he has had to work through adversity and trauma in his life; and this made him more open to understanding his clients' trauma. He shared that he wants his clients to understand that they are not alone in dealing with trauma.

He found that he typically used self-disclosure when his clients said they felt alone, isolated, or mistreated by other professionals in the past who were supposed to help. Some civilian counselors may not understand what it is like to be deployed to a foreign country or to fight in a war. Moreover, they may not know what it feels like to lose a comrade in war or even

to come home from war and lose your spouse and family. Likewise, some military clients may feel as if they are being mistreated and misunderstood if they have been experiencing those feelings at the time of the session. However, Dr. Tom is sensitive to these issues and elaborated in more detail below.

> People may be in a situation where they feel they're being mistreated. Or they feel that they're having problems and it's just unique to them. So, I believe some intents of self-disclosure is to help the person to realize that it's not just you. And I've been through adversity too, and I overcame it. Understand that there has been a time where I've been in that situation where I felt that way, and I overcame. For instance, my father died. And I didn't have the best relationship with him…. However, you work through those feelings of grief or regret. We all lose people and we all grieve in different ways, but loss is not unique to just you. We all lose people and things. How can we process that? So I guess sometimes people think counselors are perfect and they're not human. So being able to say "Yes, I'm human too" is the intent.

Dr. Tom used an example of how self-disclosure could help his military clients understand that they were not alone in their struggles with loss. His example is a way to think about approaching the topic. The sharing of his loss could help to ease a client's feeling of being alone in that experience. For example, loss is universal and it is not an emotional state that is unique only to military clients. Dr. Tom shares how disclosure could help him to connect with his military clients and expose his clients to the fact that grief and loss is a process that we all must experience at some point in life. Clearly, people experience and process grief and loss in different ways. However, at some time, it is universal that individuals will experience some form of loss or grief.

Dr. Tom's disclosure about suffering from the loss of his father to form connections in the therapeutic alliance with his military clients was successful. He used this form of disclosure to teach them about the universality of grief and loss. According to Dr. Tom, self-disclosure was beneficial in many different scenarios such as this, where his military clients found it difficult to talk about painful losses they experienced while on deployments to war or throughout their careers.

In addition, Dr. Tom believed that counselor self-disclosure stripped away titles in the therapeutic alliance which helped his military clients to trust him and begin to confront real issues. For example, some military clients may have a hard time trusting their doctors with information regarding symptoms or just difficult issues they may be experiencing. Intimate problems are difficult enough to discuss with a spouse and even more difficult to disclose with a counselor who appears to live a perfect life. However, when self-disclosure is used, it allows military clients to experience their counselor as a human being just as they are, and the client can establish a connection with another human in the therapeutic alliance.

Dr. Tom relied on disclosure involving personal experiences to help him gain the trust of his military clients. In fact, there was one instance where he provided services to a veteran who was mandated to counseling by the Department of Family and Children Services (DEFACS) because his son's teachers had concerns about his disability. They were concerned that this disability would render him unable to raise his two children alone because he suffered from constant pain resulting from an accident where his bones had been crushed during deployment. Dr. Tom stated that clients who are mandated to counseling typically do not want to be there and this makes it difficult to establish rapport. But as Dr. Tom has stated, "I believe in using self-

disclosure to help break the ice with them and to understand them." And he explains how he used counseling disclosure with his veteran client to help break that ice:

> "I'm not here to hurt you. I'm here to help you and get you through the process." This was one of the things I found helpful with him and others in this position. I shared there have been times where I didn't want to do things, but I just went through it. "I'm here to help you out; I'm not here to hurt you." So I presented examples in life, where I had to comply with DEFACS's investigation or comply with situations that people threw in front of me.

Dr. Tom used examples in his life to help break the ice with his skeptical veteran client. He shared with him about how he had to do things in life that he did not like to do. His disclosure helped his veteran client to trust him. This eventually led to the client disclosing about the trauma and pain he often suffers. Regarding the client's condition, Dr. Tom explained:

> I used self-disclosure to share that I've had a couple of bone issues in my life. When you have pain and when you have chronic pain and your mobility is an issue, sometimes you really don't want to do things or move unnecessarily. I've had leg operations. I've had arthritis-type issues where I didn't want to move.

It was important that Dr. Tom reveal his own health issues because this allowed him to gain the trust of his client. He disclosed how he still deals with chronic pain. He also described the operations he had to endure and how his pain keeps him immobile at times. Dr. Tom disclosed this information with his client because he did not want his veteran client to feel that he was alone in his own suffering. Additionally, he wanted the client to know he understood him and that he could relate to his being unable to move around with physical ease while taking care of his children. Although Dr. Tom did not make a connection with his client through his military

affiliation or through his trauma from war, he did connect through the similar experience of suffering chronic pain.

Determining what to disclose with his clients is another situation Dr. Tom finds important in therapeutic alliances with military clients. He determines what to disclose by paying close attention to what his clients are saying in session. He explained that he discloses based on his intuition and interaction with his clients. In the case of his veteran military client, more problems began to surface after Dr. Tom revealed similar health issues. Dr. Tom's veteran client revealed that he received 100% veterans' disability but had little or no resources and support. Moreover, his veteran client disclosed that his wife had left him. As a result, he alone was raising their two boys under the age of five. Moreover, he owned a large piece of land with horses that he also cared for alone without any assistance. Dr. Tom was familiar dealing with this type of stress, and he recognized the stressors. Therefore, he disclosed to the veteran about how he deals with stress and how he relies on members of his family for support and assistance while getting necessary tasks accomplished.

> I explained the purpose of having support systems. I revealed to him how in my daily life, I depend on my family members to help me out. For instance, my sister's my office manager. I look toward my mom to help me keep my house clean and/or iron some clothes for me, if you would, and cook dinner for me. There have been times where I come home and I don't feel like cooking, but if my mom could handle that for me, that would make my life easier. I pointed out to that client the benefits of using your resources and connections to help you because you don't have to be at it all alone.

Dr. Tom's disclosure about things that were relevant to what his veteran client was experiencing helped him to make the needed changes in his life. There are some veterans with

disabilities who are in need of support, but they may not know how to ask for it or they may feel shameful in asking. Additionally, veterans with disabilities may be unfamiliar with the vast amount of resources available to them. Therefore, veteran clients may find self-disclosure about this information extremely useful in the therapeutic as well as in their healing processes. Moreover, self-disclosure in this case was used to educate and model how to find and use resources. The sharing of his personal life experiences helped to educate his client and modeled how to ask for and receive help.

Dr. Tom found counselor self-disclosure beneficial with military families. He disclosed his personal life experiences with military families to make connections on a human level as well. He discussed one opportunity to disclose information about his childhood with a troubled teenage boy in a military family.

> I had a client that came in with her son. They have a blended family. She wanted help for their relationship. I had a good relationship with the mom, but I didn't have a good relationship with the son. The son was very intelligent and he would try to talk down to you. For me, it was like a tug of war, if you would, with him. The mom wanted counseling, but the child was trying to do everything he could to get out of it. The mom was invested in the process because she had her own therapist and she wanted to have a therapist to do family counseling because when he came to visit from his dad's house to the new blended family, the whole dynamics of the house would change and he influenced his two younger siblings. I disclosed how family life is; I gave him some insight into how my relationships was with my parents. I was very close to my mom, but I wasn't as close to my father. At that time, my father had passed, so helping him understand that family means something. I used self-disclosure to talk about the

relationships I had growing up, because I grew up in a two-family household and explained how you could use those opportunities to your advantage. I believe it put him in the mindset that, this guy is really here to help us out and I can bring my guard down. I don't have to have my guard up.

According to Dr. Tom, the situations faced by blended families are difficult, and they are even more difficult with those in the military. He discussed a military family who had a son who exerted negative influence. Dr. Tom used self-disclosure in session with the son. His purpose was to help the family when he came to visit his mother because the teenager's mother remarried and had other children who lived with her and her new husband on a full-time basis. The teenaged son lived with his father and was having difficulties adjusting to the changes that had occurred in his life. His mother sought help for her family. Unfortunately, the teenager was strongly against counseling, and he did everything in his power to make the counseling sessions unproductive – that is, until Dr. Tom disclosed information regarding his own childhood and the similarities he shared with the teenager's experiences. Afterwards, he saw a change in the teen's behavior after this disclosure. It was then that the teenager let his guard down and began to share his thoughts about his parents' divorce and living in a two-family home. Dr. Tom believed their encounter was successful because the family continued in therapy, and the teenager finally made successful changes and adjusted to blending with his family.

It is important to note that Dr. Tom disclosed about similar topics in the case concerning the veteran client and the case involving the military son. In the latter example, he disclosed about experiencing divorce and the difficult relationship he had with his father. His disclosures with the teenager in the blended military family and his disclosure with the veteran dealing with pain from his illness allowed Dr. Tom to make human connections based on his past experiences.

The basic premise of "It's a human experience" is that everyone can find a connection on a human level. Dr. Tom's disclosure gave insight about his knowledge and understanding of the military culture, and this allowed his clients to trust the therapeutic process. Dr. Tom found that he did not have to be a part of the military culture to make connections with his clients; and when he disclosed about similar issues in his own life, his military clients responded – because he had personally experienced what they had been through and they were aware that he understood because he had gone through the same issues personally. Moreover, Dr. Tom modeled and taught reciprocal behavior (as defined in chapter 2) for the benefit of helping his military clients to get through the counseling process and to put trust in his ability to help them. He modeled through his disclosure. This benefited his clients tremendously. Finally, Dr. Tom's work with the teenaged client helped repair discord in the blended family. Dr. Tom's past helped the teenager to experience him as one he could trust; and this allowed him to mend and develop a better therapeutic relationship with his counselor and to blend with his family. In this way, Dr. Tom's human side assisted him with forming connections with his military clients even as a counselor who was positioned as an outsider in the military population.

"This is a Safe Place": Making a Connection

Establishing trust with military clients is important for building real therapeutic connections. However, when trust is absent, it becomes difficult to establish and maintain therapeutic alliances with military clients. For this reason, counselors may want to attempt to provide a place where clients feel secure and understood. According to Dr. Tom, the concept of *a safe place* has symbolic meaning. It means more than providing a room for counseling to take place. He interpreted it as sense of security or trust to share information about one's individual self in the therapeutic alliance. For instance, He does not consider a counseling session safe if it

ends with a military client feeling judged about their thoughts, feelings, or behaviors. Hence, he interpreted a safe place as an emotional state of being where clients feel validated about what they disclose with their counselors. Moreover, they continue to disclose in session with their clients because they trust them. According to Dr. Tom, trust carries special meaning as part of the therapeutic relationship.

> Trust is always a barrier that comes up with clients in therapy. You're also dealing with humiliation. I guess that ties in. You got to make them understand this is a safe place. I'm not here to judge you. I'm only here to help you. I can't fix you, but I can help you recognize what things you can do to help fix yourself.

Because some military clients feel humiliated about needing counseling, and they may feel judged after disclosing in session to their counselors it important to make them feel safe. According to Dr. Tom, humiliation is an emotion that is frequently mentioned by military clients and is one of the main reasons military clients and their families underutilize counseling services. Therefore, Dr. Tom creates opportunities with his military clients where they feel neither judged nor stigmatized about receiving help. Dr. Tom asserted, “It's not about me. It's about the client.” Dr. Tom focuses his energy on gaining the trust of his military clients and combatting the false concept among members of the military who consider participation in counseling as a sign of weakness. He has often shared with his clients that counseling is not for the weak; instead, it is for those who are motivated and ready to do the work and get well. His intention is to educate and grow through his therapeutic connection with his military clients. Below, he expressed his thoughts and feelings about his military clients’ reluctance to trust counselors along with the counseling process.

> Some military clients see themselves as tough. They see counseling as a weakness or

> deficiency. I've had this issue with military and non-military. I try to help people understand going to counseling means you're strong. That it's a strength to be able to go and talk about something and actually to work on it. It's being passive if you ignore it until it gets to the point that you're either forced out of your job, or it's affecting you on the job, or you're going to get kicked out.

Dr. Tom instilled hope in his military clients to help them trust him and to decrease their feelings of weakness and stigmatization that are often associated with the seeking of counseling. He disclosed his thoughts and feelings with his clients to offer them an alternative perspective about counseling. Additionally, he concentrated on the benefits of counseling.

It was important for Dr. Tom to address his military clients' needs and provide them with necessary tools. He stated that he wanted his military clients to be stabilized before they were forced out of their careers. He asserted his main goal was to help his clients to focus on the strength and courage it takes to ask for help before negative outcomes arise. As a result, Dr. Tom improved his military clients' cognitive abilities by aiding them in rethinking the counseling process and validating their stories.

> The therapeutic alliance always needs to be in the mind of the therapist as you're working with the client. As I stated previously, the goal of self-disclosure is to help the therapeutic alliance and get the clients to a place where they're able to share willingly and feel understood to remove barriers.

Dr. Tom's disclosure enabled his clients to feel more comfortable revealing their individual personal stories. He validated their struggles, allowing his clients to feel understood. He listened to his military clients' stories, and this helped him to develop strong bonds with him as well as others. Dr. Tom acknowledged that what he disclosed made the difference. Often, he would use

disclosure to make a connection when he recognized that the client felt insecure. However, at times he had reservations about how self-disclosure should be used. Dr. Tom asserted that he did not use self-disclosure if he did not have anything relevant to add to the session or if the clients did not speak. He stated that he would never use disclosure to soothe any insecurities and suspicions on his own part, as if to say to himself, "Okay, the client doesn't trust me, so let me tell him something about myself." Disclosing about irrelevant things to gain the trust of his military clients is not something that Dr. Tom considers suitable. He insists that using disclosure in this manner works against the authenticity of the therapeutic alliance. According to Dr. Tom:

> We don't just self-disclose to self-disclose. It's because it's going to be a vital key to what's going on during the session that will help the client in a certain way. We bring it out as we listen to the client and we empathize with them. We consider something to say or something to help them get the understanding or whatever we need for the client to have at that point. We believe that self-disclosure will help that client make that connection.

Using self-disclosure correctly is important to Dr. Tom because this is what creates connections and shifts the therapeutic relationship. If military clients are not sharing with their counselor, then that means there is nothing to make an assessment from in the session. Likewise, being mindful of disclosing in the context of what is going on during the sessions is important. For instance, a counselor's disclosure should be pertinent or similar in nature to what the client is sharing during sessions. According to Dr. Tom, disclosure is appropriate or correctly used when it provides a better understanding for his military clients.

Counselor self-disclosure holds different meanings for each counselors. Dr. Tom compared his process of using self-disclosure to a Jack-in-the-box that comes out when needed

to make a connection and to establish rapport in a therapeutic relationship with his military clients. Below is the photo of a Jack-in-the-box that Dr. Tom submitted to represent what counselor self-disclosure means to him

Figure 4.11: Photo Elicitation

Figure 4.11. Dr. Tom submitted this photo which represents his symbolic meaning of counselor self-disclosure. *Scanned Photo* [Photograph]. Copyright 2017.

Dr. Tom described his reason for submitting the above photograph:

> I decided to submit that because self-disclosure is like winding up the jack-in-the-box as I'm listening to the client. As the clinician continues to listen to the client, it provokes the clinician to consider using self-disclosure. Once the clinician hears enough from the client, as you wind the jack-in-the-box, then the jack comes out the box, that's the self-disclosure coming out of the box.

Dr. Tom indicated he discloses only after hearing what his military clients were experiencing. Additionally, he is mindful about what he hears from his military clients because this is what guides the session, just as it also guides when and what information he discloses.

While in session with military clients, body language is important for Dr. Tom. He asserted that he observed his military clients' body language to gauge whether there were any impasses in the therapeutic relationship. Furthermore, he used it to gauge the existence of clinical issues that were being avoided by the client. Dr. Tom described how he used self-disclosure to help him understand his clients' body language in the excerpt below:

> So, you know, I always check in with people when I talk to them. I ask them, does that make sense? Or I'll look at their facial expressions. I'll ask them, "So tell me about your facial expressions. Because I don't know what you're thinking, I don't know what you're feeling. All I know is how you behave. And I need you to help me understand because if you're making a facial gesture and I don't know what that means, I just need you to tell me what's going on." Counselor self-disclosure makes them feel more secure with me. I think it's very important to be authentic and to be in the moment so the person understands if you're relating to them, you know? As a counselor, you've got to pay attention to the non-verbal – and respond to it in time. Not, you know, later on. It's just you have to be in the moment and dealing with your gut feelings and using your professional guidance when you need to self-disclose.

Counselor self-disclosure helped Dr. Tom understand his clients' body language. He used disclosure to help him educate and explain how he experienced them during sessions. According to Dr. Tom, his military clients are often unaware of what they are expressing in their bodies. In addition, some military clients do not know how to express what they are feeling. Hence, they may not know how to describe what they are experiencing. Dr. Tom asserts such disclosure is appropriate because it helps to inform his military clients about paying attention to what is happening to them physically. Moreover, he described how his military clients' verbal language was not aligned with what their body language was presenting in session. For instance, some military clients like to assert that everything is going well and there are no problems in their lives. However, their body language presents a different scenario. Hence, studying body language assists the counselor to get at serious problems rapidly.

According to Dr. Tom, insecurity is another issue that some military clients deal with in

counseling. When military clients first come into a counseling session, it is unlikely that much sharing of information about their insecurities will occur while in session. Thus, Dr. Tom uses disclosure about what he senses from his clients, and when they have difficulties sharing their symptoms, feelings, and thoughts. Such disclosure may include predictions about what he senses from them. After such disclosures, Dr. Tom asks whether his predictions will turn out correct. Moreover, if Dr. Tom has disclosed correctly, his military clients will begin to disclose about other things they may have been experiencing.

Professional guidance is also important. Dr. Tom stated that it helped him to know when (or when not) to disclose. Additionally, he argued that his interactions with his military clients are important. He would follow his "gut feelings" about what he was experiencing and sensing from his clients. For example, as stated above, military clients may enter into counseling with insecurities, and it is important for Dr. Tom to help his clients to feel secure while in the counseling space. By contrast, if military clients harbor insecurities and feel unsafe while in session, it is likely they may not return to counseling. However, if the military clients are read incorrectly, the same result may occur. Thus, Dr. Tom considered counselor self- disclosure as a intricate intervention technique. He commented:

> I see counselor self-disclosure as a double-edged sword. I have to look at it based on what I'm getting from the client, if I'm reading my client correctly. They may not be in the right temperament. I got to pay attention to how they are responding, if they are heated. A person may be like, "Well, I don't care about hearing about you right now and your feelings." It would not be appropriate to use self-disclosure when a person is not into receiving that. A client has to be in a space where they're willing to receive information. If we're at a place where the client may not be willing to receive or perceive

me as the model, then I need to help them see me in that stance or to normalize behavior. Although I'm a professional, I have issues, too, or I've had situations where it didn't work best for me. The key is that I need for clients to understand. I need to normalize the behavior in a sense, or I need to be able to bridge it.

According to Dr. Tom, an accurate reading of military clients during the counseling session is critical because there are times when self-disclosure is not appropriate. Hence, he considered counselor self-disclosure "a double-edged sword" because it can be either useful or ineffective. For example, it may not be an advantageous strategy when practiced with military clients who do not have the right temperament while in session. Likewise, the same can be said for those clients who are not in the mood to hear about their counselor's life. Additionally, because some military clients may be new to counseling, Dr. Tom stated that they may not even know what the counselor's purpose is or what is to be expected of clients during the session. For this reason, Dr. Tom expressed his concerns about how significant it is to educate and normalize the counseling process for new military clients. Moreover, he stressed that modeling disclosure behavior in sessions is useful to help new military clients understand the process of counseling as well. Nevertheless, according to Dr. Tom, refraining from the use of self-disclosure when military clients are upset is important because in such cases, their emotional state takes precedence over disclosure.

Creating a safe space and encouraging trust and understanding from clients is important for counselors in their therapeutic alliance with military clients. Dr. Tom uses counselor disclosure in his sessions to help his military clients feel understood. Additionally, the therapeutic alliance is nonjudgmental, and Dr. Tom's clients' thoughts and feelings are expressed freely after he discloses. Moreover, Dr. Tom's disclosure reduces insecurities within the alliance

and provides awareness to his military clients. His disclosure provides opportunities for Dr. Tom to model, educate, and inform his military clients about their symptoms, knowledge of which is exposed through body language. Vital information about when to refrain from using counselor self-disclosure with military clients and why learning to read clients carefully was also addressed.

Benefits of Disclosure: There Are Things to Consider

According to Dr. Tom, there are several benefits to using counselor self-disclosure with active duty military clients. He sees it as a helpful intervention when working in multicultural therapeutic alliances, especially with active duty clients. Yet Dr. Tom asserts that considerations need to be taken into account before disclosure is practiced. In this section, he expounds on the benefits he sees from practicing counselor self-disclosure. He shares an example of what he saw in session after once using counselor self-disclosure with one military client: "I noticed that clients were willing to disclose more information. When clients come in they don't always tell you the truth or they don't always tell you everything."

Again, Dr. Tom has described how his military clients revealed more information in their sessions after hearing him self-disclose. His military clients were not always willing to disclose everything about what they were truly experiencing in session. Dr. Tom discussed how counselor self-disclosure modeled and demonstrated openness and honesty. His client's behavior changed about disclosing after seeing it modeled in session. Here, it would be appropriate to recall the disabled veteran client profiled earlier, who was mandated into counseling. He shared in-depth information that he had not previously told anyone – about his life and family. He did so after hearing Dr. Tom disclose.

> After using self-disclosure, I noticed that clients were willing to disclose more information. When clients come in they don't always tell you the truth or they don't always tell you everything.

This client shared information about the status of his wife, about how she was addicted to prescription pain medication and how she had left him and the children. Additionally, he shared issues of distrust that resulted from the loss of his wife.

> The male disabled veteran that had their own little boy. He was willing to tell me more about the status of his son's mom. He disclosed information that she was addicted to medicine, or pain medicine or on drugs and she just up and left them. That caused him to have trust issues with people. This was an instance like okay, so now that I feel a little bit more open to you, I could tell you some things that I normally would not tell a person, you know.

Dr. Tom gained an alternative perspective of his veteran client and why he didn't trust people. Moreover, self-disclosure provided insight about a important problem in the veteran client's life. Furthermore, it assisted Dr. Tom with meeting the needs of his client. Additionally, it helped Dr. Tom to assist his veteran client in the process of healing from the breakup of his marriage and trust issues that resulted from the relationship.

Another benefit of counselor self-disclosure, as experienced by Dr. Tom, is how disclosure opens the line of communication in the therapeutic alliance so that actual conversations begin to take place in the sessions. According to Dr. Tom:

> It opened a door so that we could actually begin to talk because initially he had the idea of, "You're not smarter than me, and I'm smarter than you." So, when I'm talking to him,

he's thinking that I'm trying to trick him, or I'm trying to use some type of counseling technique on him.

Dr. Tom's disclosure helped his clients to open up. Recall the adolescent teenaged boy in the blended military family. Dr. Tom stated that the teen began to talk more meaningfully after Dr. Tom disclosed. The teenage boy shared his private feelings about his relationship with his father after his parents divorced. Dr. Tom reported that this was an important turning point in their therapeutic alliance because his client had been experiencing a hard time adjusting to living between two homes after his parents divorced. Dr. Tom's disclosure involved the feelings he underwent as a child after his parents divorced and about how his relationship with his father changed after the divorce. In addition, Dr. Tom informed his teenaged military client about how he was raised in a two-family household and the advantages he experienced at that time in his life which was similar to his. After Dr. Tom's disclosure, his teenaged military client related to him and he felt understood.

According to Dr. Tom, self-disclosure helped his military clients to acquire a sense of self-awareness as to their own feelings, motives, and desires. He confided that it is important for his military clients to gain such awareness because it can act as a catalyst toward a positive outcome. This is why Dr. Tom claims, "I see myself as an intervention." He described what he sees in this alliance after disclosing:

I've seen awareness. They don't know that I may use my past behavior, feelings, or thoughts to help them out. Some people are surprised, and they say, "Like, for real? You had the same type of situation?" But I don't want that to overwhelm them to where they don't see the whole picture. I don't want them to be so focused on me and my issues. I want them to recognize I've had those times, too.

Clients are often surprised to hear that Dr. Tom has experienced real-life issues. He stated that he is a vehicle for some of his military clients to experience "A-ha!" moments during the therapeutic alliance. Likewise, Dr. Tom asserted that his disclosure with his military clients acts as a guide during sessions. For example, Dr. Tom's disclosure to his military clients gave them an opportunity to see him as someone they could trust because he demonstrated sharing about his real life with them. Therefore, when he disclosed, it may have been easier for his military clients to do the same. Dr. Tom stated that this is when self-disclosure enables his military clients to become more aware and venerable to disclose. Consequently, he gained more awareness about them. He explained that when his clients disclosed, it helped him to understand them better and allow him to discover who they were as people.

According to Dr. Tom, counselor self-disclosure is beneficial for both counselors and military clients because it enables them to become more aware of themselves and each other. The benefits stem from the amount of trust military clients place in their counselors after he or she has openly shared information about their personal experiences. Trust also results from hearing their counselor's reflections on what they have stated. Dr. Tom described such experiences:

> Reflection. That's the process that's going on. As clinicians are getting clarity and everything, he or she is listening to the client and getting a better awareness of what's going on with the client and their process of the situation. We're trying to fill in the gap.

Reflection is a frequent technique used by Dr. Tom and many other counselors. He maintains that military clients feel understood correctly when their counselors provide reflection or mirror words and feelings. That way, what they have heard in the session is clarified. Dr. Tom uses self-disclosure as a way to provide information to his clients, to see if he understands them correctly, and to assure them that he is actively listening. During a disclosure, let us say Dr. Tom

recalls an experience that was related to what his client has just finished discussing; therefore, his reflection in session is an interpretation of his military clients' disclosure, which he offers through a story or narrative to demonstrate understanding.

Dr. Tom further describes reflection as a process that fills in gaps regarding any symptoms and/or issues his clients are experiencing. He credits his disclosure with allowing him to close those gaps, thus strengthening the therapeutic alliance. Clients may then entrust themselves to his care and feel better understood.

There are many benefits for the use of counselor self-disclosure and although Dr. Tom is a strong advocate for its use, he shares these ideas for counselors to consider before practicing self-disclosure with their military clients: "I don't have to self-disclose, but if I do, I'm going to think that's probably one of the best ways for my client to understand." If he discloses to his military clients, he does so because it is the best intervention at that time for him to gain an understanding of his clients and to help them realize that he understood them.

Another piece of advice from Dr. Tom is to consider whether disclosure is practiced with the expectation that military clients would benefit from it: "I would say they need to have a complete understanding of the situation with the client and use self-disclosure only when it could benefit the situation." Counselors should fully understand a military client's situation before deciding to disclose. To put it another way, Dr. Tom believes that a counselor should also consider how disclosure will serve the client's ends. By contrast, counselor self-disclosure is not appropriate for counselors to use as an informal mode of conversation. For instance, a counselor should not share basic information about the self if it does not pertain to their client's well-being. Furthermore, the use of disclosure as an ordinary way to communicate with military clients in session should be avoided.

The decision-making process involved with considering disclosure requires that counselors are attentive during sessions. They must have the ability to make quick decisions about disclosure after hearing from their clients. Dr. Tom emphasized, "As the clinician continues to listen to the client, it provokes the clinician to consider using self-disclosure." According to Dr. Tom, counselors must make quick rational decisions and utilize their active listening skills in the decision-making process. Consequently, before counselors consider disclosing in session with their military clients, it is important that counselors have a good understanding of (and experience with) using basic counseling skills. For example, he asserted that active listening skills, reflection, paying attention to body language, tone, asking open ended questions, paraphrasing, summarizing, and note-taking are all basic counseling skills which counselors should attain before practicing self-disclosure. Moreover, Dr. Tom believes that paraphrasing allows him as a seasoned counselor to repeat what he believes he heard from his military clients. This form of "summarizing" helped him to understand the main points of a client in session. Dr. Tom stressed that he could not make an informed decision without these essential counseling skills. Therefore, he questions whether unseasoned or novice counselors, should consider using disclosure at this early juncture. As he says, "You have to be in the moment and you have to deal with your gut feelings and use your professional guidance when you need to self-disclose."

> In other words, counselor self-disclosure requires counselors to respond according to the situation in a timely manner. Consequently, counselor self-disclosure may not be appropriate So if you're gonna use self-disclosure, you've got to be very particular about how is it going to fit in and if a person could rebut, how would you respond to it?

> Because they may say you may not see the world in the way that I see the world. And when you're working with clients you've got to see the world through their worldview. If you're gonna use self-disclosure, and it may not be taken well, you gotta be prepared for that. You gotta be able to have a relationship with the client. You gotta be mindful and intent of how self- disclosure is being used

Therefore, novice counselors may be unaware of what could inadvertently affect clients emotionally. Hence, self-disclosure may be a better intervention for those who have developed and practiced using basic counseling skills for some time.

In this section, Dr. Tom offered advice for counselors before disclosing with them in session. He shared the importance of counselors having basic counseling skills before disclosing with their clients. He stressed how disclosure may not be appropriate for novice counselors until they are equipped with those basic skills. Nonetheless, counselor self-disclosure is appropriate when counselors are in the moment and carefully gauging their interaction with clients in session. In Dr. Tom's case, he documented the benefits of disclosure. Moreover, his use of disclosure helped him to connect with his clients on a human level and provided a judgment-free environment where his military clients were secure to disclose intimate details about their lives. This safe space ultimately brought about self-awareness in his therapeutic alliances with military clients.

Cross Case Analysis

I present a cross case analysis in this section to compare similarities and differences between the two participants. An analysis of the cases revealed that the two participants are similar in their thinking about their use of counselor self-disclosure. Both participants found the practice of counselor self-disclosure useful when working with the military population. In

addition, the two participants asserted that counselor self-disclosure was a vital instrument in helping to establish therapeutic alliances with their military clients. Although both participants praised the practice of counselor self-disclosure, they had different thoughts about their use of counselor self-disclosure. Additionally, other differences are noted and discussed below. Assertions made are done so with the clear assumption that participants' interpretations inform said assertions.

Multicultural Competence

Multicultural competency is defined as a counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups (ACA, 2014). Drs. Stacey and Tom are competent in their practice with military clients. They both asserted that multicultural competence is important in their work with the military population. Our interviews revealed that both participants defined multicultural competence as having experience with clients from culturally diverse populations. Additionally, Drs. Stacey and Tom acknowledged that their competence was developed from having extensive knowledge of the military culture through years of treating military clients. Dr. Stacey asserted that her experience was gained from working and belonging to the military population, while Dr. Tom's experience was gained only through his work with the population. Although, both participants gained cultural competence through their work with the population, neither of the two are part of the military culture at this time. Below, I address each participant's competencies in further detail.

Counselor self-disclosure was used by both Drs. Stacey and Tom as a culturally sensitive activity to provide effective treatment to assist in meeting the needs of their military clients. When Dr. Stacey and Dr. Tom experienced difficulty in their therapeutic alliances with military

clients, they had similar beliefs that using self- disclosure would help to shift their therapeutic relationships. For instance, Dr. Stacey disclosed about her extensive work as an intern with her military clients. She used counselor self-disclosure to gain access and respect. In doing so, she positioned herself as an insider in the military. Based on what she disclosed about herself, her military clients perceived her as a cultural expert. She found that her clients were willing to share information related to certain topics that might be considered taboo in the military. Dr. Stacey's internship with the military was a critical factor in how she continues her work with the military population to this day, given that it helped to develop her understanding of the culture and the clients she works with presently.

Although, Dr. Stacey disclosed about her extensive work with the military population, Dr. Tom did not. He chose to position himself as an outsider in the culture. He took the opportunity to know his military clients as persons and not just as members of the military. This strategy helped him to gain access into his military client's world. For example, he had to learn to connect with his clients in other ways than through military affiliation because he was not part of the population. Therefore, Dr. Tom found other commonalities in his alliances with military clients and he disclosed about those experiences.

Dr. Stacey discussed her disclosure that she belonged to the military culture and how this influenced her therapeutic alliances with her military clients by positioning her as an insider in the culture. Her disclosure signaled that she was already conversant and knowledgeable about military jargon and culture. Moreover, her past military affiliation gave her *street cred*, which is important because it helped her to establish trust. Dr. Stacey asserted that her military clients viewed her as more trustworthy and relatable and her interpretation was that this was a great combination for establishing strong therapeutic relationship.

Both Dr. Stacey and Dr. Tom agreed that multicultural competence is important in their work with the military population. However, Dr. Tom does not believe he has to be a part of the military to be culturally competent. He stressed that his years of experience working with the military population was enough of a qualification. His use of counselor self-disclosure with military clients was vital because it helped him to make important personal *human* connections with his clients. A human connection for Dr. Tom meant that he connected with his clients on the basis that "we are all human" *regardless* of our culture. He established connections through his disclosure that all humans experience some form of pain or trauma, despite one person's military experience and another's lack of the same.

A human connection with military clients is important to Dr. Tom and is critical to how he positioned himself in establishing the therapeutic alliances with them. For example, because he is viewed as an outsider by the culture, it is important that he is culturally competent about his military client's needs. Being culturally competent about the needs of the military population gives him an advantage in knowing when and what he should disclose in the alliance. For instance, Dr. Tom typically disclosed about things which he learned about from his personal interaction in the therapeutic relationship with his military clients. He shared that he was mindful and was attentive to his military client's body language and was familiar with their language, work, and behaviors. He also gauged barriers in the therapeutic relationship and whether the relationship needed repair after any ruptures. Additionally, he evaluated clinical issues with his military clients to determine if what he was seeing with one client could be generalized across the population when dealing with mental illnesses. Consequently, Dr. Tom educated himself in his therapeutic relationships with the military to become culturally sensitive and component. He

chose to develop relationships with his clients as a human being and not make assumptions about what he thought he knew about his clients' military culture.

Regardless of how the two participants gained experience, either from working with the culture or belonging to the culture, they both agreed that cultural competence helped them to use counselor self-disclosure to position themselves in a way to gain access and insight in establishing and maintaining therapeutic alliances. Although both participants are culturally competent in their work with the military population, their thoughts about the use of counselor self-disclosure to make connections and gain understanding about their clients is different. Likewise, Drs. Stacey and Tom's multicultural sensitivity and awareness about the military culture guided their use of counselor self-disclosure. As a result, both doctors demonstrated how counselor self- disclosure is a relationally-oriented practice, useful for establishing and maintaining therapeutic connections with military clients.

Safe Space: A Judgment-Free Zone

Providing a space where military clients feel safe to share about difficult times, uncomfortable situations, symptoms, and any other embarrassing issues in their therapeutic alliances was important to Drs. Stacey and Tom. A safe place was defined by the counselors as space where their military clients felt comfortable in disclosing intimate details of their lives or topics considered taboo by the military to discuss openly. Additionally, a safe space was typically developed through establishing trust, understanding, and maintaining a non-judgmental approach. A safe space is also an emotional state within the therapeutic alliance where both counselor and client are allowed to be vulnerable and open.

Dr. Stacey's military clients disclosed about taboo topics in their therapeutic alliances because they were in a safe space where vulnerability was permitted. Typically, her military

clients disclosed about taboo topics only after she self-disclosed about another similar topic they may have had in common. For example, her military client, who suffered from depression and experienced sexually harassment in the army, disclosed about sexual harassment only after hearing Dr. Stacey disclose how she once coped with her own bout of depression. Dr. Stacey's client was not used to sharing about depression for the fear of stigma associated with having mental health issues in the military – nor would she discuss sexual harassment in a military environment due to the rigid, core belief systems held by the military. Therefore, Dr. Stacey's disclosure modeled vulnerability in the alliance and taught her client that no topics were considered off-limits in their safe space. Likewise, she modeled self-disclosure to the client. Dr. Stacey believed another reason her clients were motivated to disclose about sensitive topics was because they were able to identify that they were not alone in their experience. When clients hear their counselors disclose about some experience that is similar to theirs, it diminishes their feeling of being alone. In a sense, it helps them to normalize the issue and realize that they are not the only person who has experienced the problem. For example, there was the client who found her disclosure about her religious beliefs helpful, and it motivated him to disclose about his sexual orientation and his being in the military without feeling judged. In addition, he began to openly disclose how his sexual beliefs brought him much distress because they contradicted his religious, moral, and military beliefs.

According to Dr. Tom, a safe space is not just a place where counseling takes place. On the contrary, it is an emotional state. It is a nonjudgmental and trusting place where disclosure occurs between both counselor and client. Dr. Tom wanted his clients to feel safe to disclose. He stated that his clients were motivated to disclose after hearing him discuss his own experience with some of the same issues they had experienced. Additionally, his disclosure about similar

symptoms or life experiences which did not pertain to his military client's experience helped them to feel understood. For example, Dr. Tom's disclosure about the pain he has to deal with daily as the result of various past maladies enabled his veteran military client to disclose intimate details about his life. The veteran client revealed that his wife was addicted to pain medicine and left him and the children. This information would have not been divulged without the presence of that trusted space where his client was rendered free from judgement.

According to Dr. Stacey, her military clients trusted in her ability to understand their problems. She discussed the importance of providing a safe space and a non-judgmental zone for her military clients to disclose information and stories related to uncomfortable situations and shameful symptoms, some of which came about as a direct result of their being in the military.

Both Dr. Stacey and Dr. Tom provided a safe space for their military clients and they both argued that it was important for their clients to feel safe in their therapeutic alliances. Being able to provide a non-judgmental zone and establish and maintain trust within the therapeutic relationship were of significant importance for Dr. Tom and his clients. By the same token, helping to model vulnerability and disclosure via the use of counselor self-disclosure was important for both Dr. Stacey and her clients.

CSD as a Common Practice

Counselor self-disclosure is a common practice used by both participants in their work with military clients. Dr. Stacey and Dr. Tom shared how disclosure was beneficial in establishing and maintaining their therapeutic alliances with members of the military. Both participants discussed their reasons for practicing self-disclosure with military clients.

There were several things about disclosure that Dr. Stacey and Dr. Tom had in common. Primarily, Drs. Stacey and Tom practiced counselor self-disclosure to make connections or to

"join" with their clients. They argued that disclosure was one of the main reasons it was possible to make connections in their therapeutic relationships with military clients. Furthermore, both participants used disclosure in session because it helped them appear more empathetic. Dr. Stacey shared how her military clients perceived her as "more human" when she disclosed. Additionally, her clients thought she was down-to-earth. Likewise, Dr. Tom also practiced counselor self-disclosure because it helped him to connect with his military clients. He emphasized that forming connections on a person-to-person level was an important factor in any therapeutic alliance, since all counselors may not be fortunate to make connections through cultural membership. He believed that he has to depend on that human connection because he has never been in the military and he has never experienced deploying to fight in wars. Yet, Dr. Tom was still able to reveal to his clients that he could relate human experiences that were similar to theirs. This connection assisted his military clients in trusting him more because some of his military clients did not trust him prior to his disclosures. He used similar strategies with the teen-aged boy from the blended military family, discussed earlier in this chapter. His military clients began to reveal his feelings more openly after Dr. Tom shared about experiencing his parents' divorce when he was a child.

Both participants credit disclosure as enabling their military clients to openly disclose regarding taboo topics and various sensitive issues. For Dr. Stacey, disclosure encouraged her clients to freely share about things more in-depth after she discussed her own sensitive issues in session. Moreover, when Dr. Tom disclosed, it facilitated the sharing of more important information from clients. In earlier sessions, his military clients would not talk. However, those sessions changed after he disclosed.

The participants also revealed differences in their practice of counselor self-disclosure. Dr. Stacey used counselor self-disclosure to relax her military clients. While, Dr. Tom disclosed in order to help his clients gain awareness and understanding from his disclosure. Additionally, it helped him to remove barriers in the therapeutic alliances when his military clients were aware of what was taking place in the counseling process. Similarly, Dr. Tom gained a better awareness of what was happening with the client and their processing of the situation after he disclosed.

Each participant found their use of self-disclosure beneficial; however, they offered advice for other counselors to consider before practicing disclosure. Dr. Stacey suggested that counselors should know themselves. She argued that counselors are a work-in-progress and if they have certain unresolved personal issues, then they should not disclose anything about them in session. Equally, Dr. Tom provided advice for counselors. He urged them to maintain a good understanding of (and experience with) basic counseling skills. He stated that it may be important for counselors to pay attention to verbal and non-verbal cues. Additionally, counselors may want to know how to read their clients correctly and respond appropriately. Therefore, basic counseling skills such as active listening, attentiveness to body language, asking open-ended questions as a way of gathering more information, paraphrasing, or restating what was heard and summarizing – these are important to practice continually before attempting to use counselor self-disclosure.

The timing of disclosure was also mentioned by both participants. Drs. Stacey and Tom stated that timing is vital. Dr. Stacey expressed concerns about being able to gauge when it is the right time to use self-disclosure. She stressed that timing is essential because it can affect the therapeutic alliance if it is used too early in the relationship. One thing she found helpful to combating the problem was to listen more frequently and to talk through issues with her military

clients. She stated that she typically disclosed based on what clients revealed they were experiencing in their lives. By doing this, it helped her to decide if and when she should disclose. Dr. Tom shared advice about the timing of self-disclosure with military clients as well. He discussed "being in the moment" and to avoid making the disclosure about himself. He asserted that counselors should make self-disclosure about what is happening with their military clients. He argued that disclosure should be used based on what the counselor is hearing from the client during the session. In addition, Dr. Tom maintained that counselors may need to have a complete understanding of their military clients' situation and disclose only when it benefitted the military client or the therapeutic alliance.

Dr. Stacey and Dr. Tom both provided advice for counselors about using disclosure in a purposeful way. Dr. Stacey believed that counselors must be mindful of how often they continue to use self-disclosure with a military client. She also cautioned against disclosing too often. Dr. Stacey emphasized the importance of finding balance with disclosure and the military clients' experiences. She argued that her military clients appreciated disclosure when it related directly to the clients and what they were experiencing. According to Dr. Tom, purposeful self-disclosure is vital in forming therapeutic alliances. He argued that self-disclosure should only be used when it benefits the situation. He believed that counselors may not want to self-disclose without a good reason. Moreover, disclosure should only be used to help military clients in a way that helps them feel understood. He also suggested that counselors pay attention to their disclosure. He advised that they may not want to disclose merely for the sake of disclosing. He stressed that it is important to use it only when it is appropriate – i.e., when it pertains to the client's experiences.

The participants may have differed in their respective approaches to how and when counselor self-disclosure should be practiced. But one clear factor is that counselor self-

disclosure assisted them both with establishing and maintaining therapeutic alliances with their military clients. They were confident that disclosure enabled their clients to trust them more openly and to bring relevant, sensitive issues into the sessions. Most importantly, however, self-disclosure appeared to be a useful technique in assisting counselors with their military client's mental-health needs.

Chapter Summary

In this chapter I presented the thematic narrative of two participants' experiences of their use of self-disclosure in a therapeutic alliance with military clients. In these narratives both participants address cultural competency, provide s safe for military client to share sensitive topics, and the benefits of disclosure. Next, I provided a cross- case analysis of the similarities and differences in the findings of the two participants. In the next chapter, I provide the conclusion and implications to the findings.

Chapter 5 - Conclusions and Implications

As a practicing clinical professional counselor in therapeutic alliances with military clients, I am aware of the underutilization of mental health counseling by the military population as a whole. Moreover, in my experience, when military clients enter into counseling, they may prematurely terminate due to the stigmatization associated with mental health counseling and several other underlying issues. For this reason, I practice counselor self-disclosure in my therapeutic alliances with military clients in order to establish and maintain relationships, increase treatment utilization, and decrease termination rates among the military population. I believe mu clients trust me because of my own military experiences and being a spouse of someone who has served in the military.

In chapter 4, I presented two participants, Drs. Stacey and Tom. Both were selected because they met the preselected criteria through purposeful sampling. Additionally, their ability to provide in-depth perspectives from their experiences practicing counselor self-disclosure in therapeutic alliances with military clients influenced my selection of them. The study is epistemologically grounded in constructionism so as to examine how a counselor and a military client make meaning of the value and the role of counselor self-disclosure in building and maintaining their therapeutic alliances. In this chapter, I will start by responding to the research questions, using the theoretical lens of symbolic interactionism identified for this study. Next, I will discuss how the findings of this study contribute to related fields, and then I will discuss the implications of this study.

Responding to Research Questions

In qualitative research, often a response to one question overlaps with the response to another question. Therefore, it is common practice to respond to multiple questions

simultaneously. In the section below, I respond to both the research questions simultaneously, as they are entangled. The response will be preceded by the theoretical orientation to the study. The theoretical framework will help orient the response to the research questions.

This study was guided by the following research questions:

1. How do participants describe the role of their use of self-disclosure in establishing the therapeutic relationship with military clients?
2. How do participants describe the role of the use of self-disclosure in maintaining the therapeutic relationship with military clients?

Symbolic interactionism is the theoretical framework guiding the study and it plays a dual role in the study. First, it bears the responsibility of helping to make sense of how participants describe their roles in the use of counselor self-disclosure. The interaction around a significant symbol in this study is counselor self-disclosure and how it created a shift in the therapeutic relationship after it was used by the participants with their military clients. Additionally, this study demonstrates and symbolizes how I view counselor self-disclosure as an entangled interaction in building a strong trusting therapeutic relationship. Below, I respond to the research questions integrated through the theoretical lens of symbolic interactionism.

In this study, meanings formed from two participants' disclosures in therapeutic alliance with military clients demonstrated how disclosure created a change in their therapeutic relationships. This change helped the participants in this study, to either establish or maintain therapeutic relationships with their military clients. One of the ways participants use self-disclosure to that created change was through disclosure that modeled vulnerability to their military clients.

As a practicing clinical counselor, I identified counselor vulnerability as being valuable to the study because the participants interpreted their disclosure as helping their military clients to form the meaning that disclosing information on sensitive topics was acceptable. Additionally, the participants believed that their clients' meanings were developed through their interactions with counselor self- disclosure in session. For the participants, the purposely used disclosure to modeled vulnerability and invited their military clients to become even more open to share about senstive topics. In one instances, Dr. Stacey's military client disclosed details regarding sexual harassment only after Dr. Stacey shared that she too had suffered from depression.

Likewise, Dr. Tom shared how the son from the blended military family, while unaware of the cause of his emotional state, gained awareness in their therapeutic relationship. Tom. Dr. Tom interpred the meaning to this client's decision to disclose about the conflicted feelings he was experiencing from his parents' divorce as a dynamic shift in thier relationship. He considered the shif in the therapeutic relationship as sucessful because the son disclosed only after Dr. Tom disclosed about his own experiences as a child during his parents' divorce. Therefore, Dr. Tom's modeling of vulnerablity helped him in working with his military clients to establish and maintain a trusting therapeutic relationships with his military client.

Another of Dr. Tom's military clients disclosed important information about his wife's addiction and the fact that she had left him and their children with no support after Dr. Tom had modeled vulnerability through his disclosure with the client. Dr. Tom disclosed about how he had used his family for support due to problems involving his own health. Therefore, Dr. Tom's believed his disclosure assisted the client in making meaning of his own need to ask for help and support. The interactions between the participants and their military clients might therefore be seen as interpretive processes based on (a) the participants' disclosures of personal and intimate

information from their own pasts, followed by (b) their clients' responding with disclosures regarding *their* topics and instances of vulnerability.

Counselor vulnerability presents multiple implications beyond simply modeling the behavior. For example, as previously stated, counselor disclosure involves an educational component where counselors can educate their clients with regard to psychosomatic or self-induced symptoms in order to improve their clients' awareness about what they may be experiencing physically. Perhaps prior to self-disclosure, some military clients were unaware of the ways in which their symptoms appeared and were thus apprehensive about counseling in general, let alone the idea of how self-disclosure affected them. The process of making sense of their well-being came from an awareness of what their symptoms were based on their interactions with their counselors as they modeled and engaged in disclosure. Therefore, the therapeutic relationship became an ongoing, iterative, interpretive process of awareness of the self, awareness of symptoms, and furthermore, awareness of the possibilities of healing.

Both participants determined the value of interpreting how they believed thier military clients respond to self-disclosure through a series of interactive processes wherein they gauged the client's reaction through their own past experiences of failures and success with the technique. Moreover, both participants were aware that counselor self-disclosure could be inappropriate in different scenerios. Therefore, understanding the timing of self-disclosure lends value to the study. Using counselor self-disclosure too early, for example, could jeopardize the therapeutic relationship if military clients react negatively. Dr. Stacey described how self-disclosure may be inappropriate when counselors have not spent enough time beforehand interacting with clients to make meaningful connections. Likewise, perhaps counter-transference may occur, where the counselor projects their own issues on the client, thus altering the

interpretive meaning of self-disclosure for both parties. This may have been the case for Dr. Stacey in her therapeutic alliance with a pregnant military spouse who was in an abusive marriage. Although Dr. Stacey held reservations about the timing of disclosure and her client's decision to terminate, she felt that she made the right decision at that time. Still, she was left to wonder whether her client's premature termination was due to the disclosure or because of something else. Consequently, Dr. Stacey formed meanings about her client's decision to terminate counseling, without any direct communication from the client. She wondered whether the intensity of her disclosure had inadvertently intimidated her client through the exposure of more details than needed – or perhaps that she chose to intervene in a domestic-violence situation too quickly. As such, there was no way for her to know exactly what reasons contributed to the termination, and this left her to question the appropriateness of self-disclosure and consider certain cautions for its future application.

In contrast, Dr. Tom discussed how self-disclosure could be perceived as dangerous when used by a novice counselor. He argued that an honest intuitive awareness, acquired through experience over time, creates the interaction that allows for self-disclosure to be authentic and helpful. A seasoned counselor, by instinctively knowing *when* to use self-disclosure, will thus enable the technique to assist in establishing connections with clients. According to Dr. Tom, the timing of self-disclosure will be based on how clients express themselves verbally or non-verbally, assisting him with recognizing when the situation is appropriate. He further asserted, however, that self-disclosure will not work simply because a counselor decides to use it for its own sake. Instead, he explained that disclosure needs to be organic – in other words, an interactive experience where paraphasing, active listening skills, and attention paid to verbal and non-verbal cues (body language) are used. For example, Dr. Tom decided not to disclose with

one patient, the teenaged boy from the blended military family, because he recognized the teenager's sadness, pain, and anger and his hesitation to speak freely. The hesitation also resulted in an incongruence between his verbal communication and his non-verbal communication. Therefore, Dr. Tom waited until he was able to conclude that his client felt secure within the therapeutic relationship before he would engage in disclosure. When he did disclose about himself after he assessed the teen's verbal and nonverbal language were congruent and that his client was at a place where the client could receive Dr. Tom's disclosure without being further distressed. Overall, both paticipants provided caution for the use of self-disclosure but considered it appropriate when forging valuable connections with miltary clients. Hence, it was evident that Drs. Stacey and Tom both have a sense of connection and meaning-making associated with their practice of self-disclosure.

In Dr. Stacey's case, self-disclosure is not just a stand-alone concept that can be universally applied to all clients, but it is instead used to understand how her miltary clients make meaning of their cultural experiences. So for Dr. Stacey, meaning-making is culturally situated, especially with regard to the kind of self-disclosure she engages in. It thus exists as a therapeutic strategy that is far more specific in terms of meaning than anything general that might relate to the human experience of pain or of suffering.

For Dr. Tom, though, self-disclosure must have some meaning for both client and counselor in order to have value. However, where Dr. Stacey determined meaning through a cultural lens, Dr. Tom made meaning through a shared human experience and interaction lens. In other words, Dr. Tom used disclosure to share about pain resulting from broken bones, losing independence due to injury, and having conflict with family, because he assumed that these were shared experiences for which his clients would make similar meaning.

Therefore, in responding broadly to the research questions, I show that self-disclosure has been used by the participants for the purpose of establising strong therapeutic alliances with their military clients, where counselors used self-disclosure to either relate culturally or simply relate with shared human experiences. Both particapants explained the role of self-disclosure as beneficial in their practices through modeling vulnerablity and openness in therapeutic alliances and enabling the counselor to be seen on the same plain as theirs – an equal human being, and not as someone hierarchically superior, thus allowing the client not to feel judged by the counselor for their own pain and suffering. However, both participants cautioned against the improper use of self-disclosure when a situation might instead call for other ways of relating to clients in order to gauge their needs accurately. Otherwise, self-disclosure might result in military clients prematurely terminating alliances before their therapuetic needs can be met. This could cause further harm to befall military clients, thus perpetuating the decrease in utilization of mental health services by military clients. For both participants the moment of self-disclosure, if used correctly, caused a dynamic shift in their therapeutic relationship with their clients, leading to effective mental health care.

Furthermore, both Drs. Stacey and Tom described self-disclosure as a technique that influenced the relationship between their clients and themselves with several caveats. Self-disclosure, while helpful in creating a shift in the relationship, connection, credibility, trust, modeling vulnerability to disclose sensitive issues, bringing awareness to symptoms for a mental health disorder, and demonstrating cultural competency, is not without its own cautions and problems. Both participants described these cautions and problems from their own experiences. Dr. Stacey's experiences could be used to argue that self-disclosure can sometimes be too heavy for the client to receive, especially if the client is lacking clarity of her own situation. In those

cases, even modeling self-disclosure does not bring clarity. Instead, it could potentially terminate a therapeutic relationship and cause additional trauma, while the client is expected to hold space for the counselor when the counselor is disclosing. Dr. Tom's experiences highlight the timing and gauging of the clients' readiness to receive self-disclosure as a connector and a helpful therapeutic intervention. His experiences could be used to argue that self-disclosure cannot be used as a gimmick, or to force connection if a counselor is struggling to establish connection. Further, Dr. Tom's experiences could be used to argue that perhaps novice counselors should exercise extreme caution before engaging in self-disclosure, because the potential to make mistake in gauging when it is appropriate to use self-disclosure could be high. Additionally, while gauging the appropriateness for self-disclosure, counselors need to be fully present in the therapeutic relationship to know when there is an appropriate opening for self-disclosure, instead of reflecting on a session and then choosing to plan to disclose in a future session. In other words, self-disclosure requires appropriate understanding of the clients' needs, being fully present during a session, and knowing how and when to use it, instead of forcing it as a therapeutic intervention based on existing research and its perceived benefits.

Contributions to Literature

When considering the contributions to literature on self-disclosure in assisting counselors to establish and maintain therapeutic alliance, recall that the findings from the cross-case analysis are divided into three parts: Multicultural Competency, Safe Space: A Judgement Free Zone, Counselor Self-Disclosure as a Common Practice. In this section I use these patterns from the cross-case analysis to discuss the contributions to the literature.

Multicultural Competency

The definition of multicultural competency is a counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups (ACA, 2014). Because multicultural competency is an ethical mandate for counselors, it is recommended that counselors engage in relationally-oriented practices when working with clients from culturally diverse backgrounds. Counselors can achieve this by adapting culturally sensitive activities, such as using counselor self-disclosure and small talk to be more transparent (Sommers-Flanagan, 2015). According to Sue and Sue (2008), it is difficult for diverse clients to establish rapport. Therefore, effective treatment for culturally diverse clients should be comprised of a wide range of skills, tools, and interventions that contribute to establishing early connections. Existing literature indicates that military clients commonly blame negative experiences on their counselors' lack of cultural awareness and use of incongruent theoretical approaches that were culturally inappropriate to military lifestyles and values (Leong & Kalibatseva, 2011; Visco, 2009).

This study contributes to multicultural competency literature by demonstrating how counselor self-disclosure assisted both participants in providing relationally oriented counseling. Both participants in the study adapted culturally responsive techniques that illustrated cultural awareness and sensitivity. Their military clients valued their disclosure in session, and this contributed to establishing alliances that produced connections and decreased feelings of alienation. Therefore, the participants' therapeutic alliances with their military clients were enhanced from the counselors' disclosure in session (Hanson, 2005).

In addition, the participants' use of self-disclosure helped their positionality as counselors. Recall that Dr. Stacey used self-disclosure often to inform clients of her past

experiences with the military. She disclosed on occasion about her relationship with her significant other who was in the military. In doing so, she demonstrated her knowledge, awareness, and sensitivity about military culture. Likewise, she positioned herself as an insider and a relative expert on that culture. Dr. Stacey's positionality thus aided in establishing strong therapeutic connections with her military clients. This allowed her military clients to trust her as a counselor and enabled them to reveal difficult or embarrassing topics in sessions (Corzine & Wedding, 2008). Thus, this study contributes to current literature in that counselor self-disclosure was not only beneficial, but critical in establishing connections in therapeutic alliances with clients from the military population. Had Dr. Stacey not disclosed her prior experiences with the military and her cultural insider status, her clients would have suspected her ability to help them and may not even have entered in a therapeutic relationship with her, or might have prematurely terminated the relationship. Dr. Stacey's disclosure about her knowledge and expertise working with the client's military culture was similar to the findings in Kronner's (2013) study, where a gay counselor disclosed his sexual orientation to his clients, who were also gay. Additionally, her disclosure about belonging to the military culture validated her military clients' experiences and assisted them in disclosing. Findings from this study also answer Kronner's (2013) call for conducting similar studies with other cultural subgroups. In this instance, the cultural subgroup was the military, which is known to have strong norms and protocols that often become a contributing factor to how those within the military seek mental health help, if they seek that help at all. In this regard, the clients treated by this study's participants are similar to the gay clients in Kronner's (2013) research who do not feel comfortable sharing their experiences unless they think that the counselor could relate as a

cultural insider, and for this reason often remain apprehensive about seeking mental health help and disclosing about their sexual orientation.

On the other hand, Dr. Tom did not rely on self-disclosure about his past work with military clients. Moreover, he was not a part of the military culture. Although, he demonstrated awareness and expertise through his work with clients from the military population, his disclosure did not position him as an insider in that culture. However, his disclosure did allow him to make connections on a human level (Audet & Everall, 2010). Dr. Tom used disclosure specifically with military clients to establish a human connection. He considered this connection to be two people working together because he was an outsider and did not want to come into his alliances with any preconceived assumptions. Dr. Tom's use of counselor self-disclosure in this way supports Audet and Everall's (2010) study where 16 clients interviewed, all reported a positive disclosure experience from their therapist use of disclosure. Clients in the Audet and Everall (2010) study reported that their therapists added a human dimension to the therapy when they disclosed in session. Additionally, these clients reported that their therapists were more human and it felt as if it were two humans connecting and working together in the session, oppose to their "therapists exerting superiority within the relationship" (p.334). Subsequently, Dr. Tom provides a counselors' perspective of his use of counselor disclosure in this study, which corresponds with the clients reports about their therapist who used disclosure in the Audet and Everall (2010) study.

Recall Dr. Stacey and Dr. Tom's military clients described them as being more human or "real" from their disclosure (Knox, Hess, Petersen, & Hill, 1997; Nayman & Daugherty, 2001; Satterly, 2006). Additionally, their military clients described them as trustworthy (Barrett & Berman, 2001), which made it easier for them to develop stronger trusting therapeutic

relationships with their therapists. In this study, both participants illustrate how their disclosure assisted them in establishing and maintaining strong therapeutic alliances with their military clients. Dr. Stacey valued having the ability to relate to her military clients. Her self-disclosure enabled her to form better connections, while appearing human and real to her military clients. Dr. Stacey's military clients valued her use of self-disclosure in their therapeutic alliances. Additionally, military clients viewed her as trustworthy enough to continue attending sessions, scheduling appointments in advance, and showing up for appointments early. These actions also demonstrated the value of disclosure and how it contributed to a strong therapeutic alliance which produced a sense of a deep understanding, connection, and trust for military clients. Therefore, therapeutic alliances with military clients were enhanced from counselor self-disclosure of information in session, which is congruent with the established roles of self-disclosure (Hanson, 2005).

Dr. Tom's self-disclosure in his therapeutic alliances with military clients assisted him in making human connections. His disclosure was successful in establishing and maintaining therapeutic relationships as well. He placed significant value on the acceptance of his military clients as human beings with the intent of moving them towards their potential. In addition, it helped him gain an understanding of his military clients' internal frames of reference or the way individuals experience and feel about the world from their own unique perspective (Corsini & Wedding, 2008). Therefore Dr. Tom's, *unconditional positive regard,* or the acceptance of a client's thoughts, feelings, and beliefs, assisted him in empathizing with his military clients and helped him gain an understanding of the experiences of his military clients (Rogers, 1951). As indicated in literature, these qualities assist in forming therapeutic alliances and typically takes place when the counselor is genuine or trustworthy (Rogers, 1967). In this regard Dr. Tom's

experiences are similar to what is established historically and contemporarily in the literature about self-disclosure.

In addition to making human connections in the therapeutic alliance, trust was a key ingredient in forming therapeutic relationships with military clients. Barriers such as stigmatization, feelings of being misunderstood, or lack of trust based on past experiences with other counselors (Blais & Renshaw, 2013; Erbes, Curry, & Leskela, 2009; Kim, Britt, Klocko, Riviere, & Adler, 2011; Leong & Kalibatseva, 2011; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Visco, 2009; Vogt, 2011) motivated Dr. Tom to devote his energies toward gaining the confidence of his military clients. His self-disclosure created opportunities for clients to gain different perspectives and views about counseling, symptoms-related distress, and military life in general. This was due in part to the trust level he developed from his ability to understand the clients' emotional experiences. If Dr. Tom could not establish this cultural congruency with the military clients, he would have not been able to continue being in a therapeutic relationship with his clients.

Thus, in summary, I conducted a study that contributes to the literature by supporting the use of self-disclosure as a therapeutic intervention. The participants used self-disclosure when working with military clients. However, the key contribution to the literature is that had the participants not used self-disclosure to establish cultural congruency, it is possible that there may have not been a shift in the therapeutic relationships between the counselors and their military clients that lead to the military clients not receiving the counseling they needed.

Safe Space: A Judgement Free Zone

Providing a non-judgmental safe space where sensitive issues can be discussed is vital in therapeutic alliances with military clients. In this study, a safe space symbolized a therapeutic

alliance where both a counselor and a military client are free to be open and vulnerable. In this safe space, military clients sense a feeling of security about disclosing intimate details of their lives without feeling judged, humiliated, or embarrassed about it in session. Established literature indicated that culturally diverse clients are reluctant to speak about important cultural issues or may feel anxious after introducing these topics in session (Audet & Everall, 2010; Burkard, et al., 2006; Constantine & Kwong-Leimn, 2003). However, Drs. Stacey and Tom created safe spaces in their alliances with military clients to discuss intimate topics focused on cultural issues that were typically taboo or uncomfortable to reveal. Self-disclosure literature indicates that clients disclose more when they trust that their counselors can handle their disclosure in an affirming and caring way (Audet, 2011; Hanson, 2005; Farber, Berano, & Capobianco, 2004). Likewise, Quillman (2012) describes how self-disclosure increases intimacy in a therapeutic space and encourages clients to take risks in disclosing more sensitive issues (Audet & Everall, 2010). Similarly, counselors who engage in disclosure assists their clients in feeling free to expose issues that are sensitive and/or difficult (Farber, Berano, & Capobianco, 2004). Moreover, strong therapeutic alliances enable clients to discuss otherwise embarrassing topics in sessions (Corsini & Wedding, 2008).

Recall the participants in this study used self-disclosure to help their military clients feel secure in their therapeutic alliances to share information about difficult topics or sensitive issues. Both Drs. Stacey and Tom demonstrated how their disclosure about similar topics helped their military clients feel comfortable talking about sensitive or difficult topics. Additionally, their military clients felt that they could trust them more with their sensitive disclosure and their vulnerability. In this way, they felt they were given permission to speak openly.

Counselor self-disclosures model vulnerability to their clients (Quillman, 2012). I would argue that Dr. Stacey's self-disclosure conveyed an open acceptance of her military clients (Kronner, 2013). This open acceptance helped one military client feel safe enough to disclose the sexual harassment she experienced in the military (Farber, Berano, & Capobianco, 2004; Constantine & Kwong-Leimn, 2003). Such use of self-disclosure is closely aligned with the literature were self-disclosure is seen to be generative, especially when dealing with sensitive and complicated topics (Barrett & Berman, 2001; Cardemil & Battle, 2003, Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003). Moreover, after Dr. Stacey disclosed information regarding her Christian spirituality with one client, he felt encouraged enough to relate the difficulties he experienced within himself from the contradictions between his religious beliefs and his sexual orientation. Dr. Stacey's decision to be vulnerable and her judgment-free stance eased her client's apprehension, thus allowing him to disclose his own discomfort with regard to his sexual orientation and the difficulties he experienced in the military. Dr. Stacey's disclosure supports the findings from Audet and Everall (2010) study where 9 of their clients reported that their therapist that disclosed helped to eased any feelings they may have had of intimidation. Additionally, those clients reported that their therapists' disclosure helped to remove barriers in the relationship and "encouraged them to take risks by sharing vulnerable information they would not have otherwise shared" (Audet & Everall, 2010, p. 336).

Dr. Tom's disclosure with military clients also illustrated a safe space that was free of judgment. His disclosure about similar topics helped him to gain his clients' trust and demonstrate vulnerability (Quillman, 2012). Dr. Tom's disclosure to his veteran military client about experiencing pain eased his client's feelings of distrust and encouraged him openly discuss the sensitive topic of losing his wife after returning from deployment with a disability. The

disclosure here was of a sensitive nature because Dr. Tom's client was mandated to counseling after a social worker and teachers reported him for child neglect. Thus, he did not trust those in authoritative positions in the community where he resided. This helped to fuel a mistrust of others who he felt had similar titles of authority. Therefore, Dr. Tom's client was not forthcoming with information he felt might prevent him from continuing to take care of his children. Consequently, there was a need for Dr. Tom to gain the trust of this client. However, Dr. Tom's perspective is that his disclosure may have been the reason his client trusted him which was similar to the four participants in Audet's (2011) study who reported that their therapist's disclosure was a symbol of trust. One client from the study shared that their therapist "must not be so bad" after their therapist disclosed. Additionally, clients in the Audet study felt respected, cared for, and confident from their therapist's disclosure in the therapeutic alliance. And he did so by sharing the importance of educating and modeling behavior in sessions with his clients. In discussing intimate details about his life, he was able to motivate his military client to disclose similar information in sessions (Audet & Everall, 2011).

The need to provide safe and non-judgmental spaces for clients that could induce further disclosure is established in the literature as stated above. In that regard, this study supports the existing literature in terms of the arguments forwarded about the role of self-disclosure as it relates to creating safe, non-judgmental experiences. Particularly this study then contributes to the literature by demonstrating some of the ways in which such safe environments could be created with clients with a military background, which is scant in the literature when considering clients with diverse backgrounds.

Counselor Self-Disclosure as a Common Practice

This study is designed to contribute to the understanding of why some counselors endorse the use of self-disclosure and how the role of counselor self-disclosure can effectively assist in establishing and maintaining therapeutic alliances with their military clients. Both participants in this study discussed several reasons for using counselor self- disclosure. However, one reason which is significant to this study with respect to how it contributes to the literature, is the modeling of disclosure specifically with military clients in session.

Dr. Tom placed emphasis on his use of disclosure and the value of modeling it for his military clients. Furthermore, he shared how self-disclosure aided him in determining whether his clients' verbal language matched their body language (non-verbal) and symptoms (Quillman, 2012). What is of importance here is that military clients' disclosure could be beneficial for those who are experiencing symptoms of distress. As stated previously in the study, symptoms of distress are common among the military population, specifically those who have returned from multiple deployments (Sayers, Farrow, Ross, & Oslin, 2009; Vogt, 2011). According to a longitudinal study by Hoge et al. (2004) examining the effects of combat on soldiers returning to the U. S. from deployments in Iraq and Afghanistan, 11 to 17 percent of military personnel may be at-risk for suffering mental disorders three to four months after returning from combat. These include major depression, generalized anxiety, the presence or absence of Post-Traumatic Stress Disorder (PTSD), alcohol abuse, and emotional and/or family problems.

Research indicates that counselor self-disclosure elicited reciprocal self-disclosure from clients (Audet & Everall, 2010; Farber et al., 2004; Quillman, 2012). It is clear that Dr. Tom's disclosure assisted his military clients in recognizing and understanding how to manage their mental health symptoms. It is also noted that self-disclosure enabled his clients to establish an

enhanced awareness of their own body dynamics (the physical self) by decreasing anxiety concerning negative emotions brought on by past trauma. This is vital because some military clients are unable to verbalize what they are feeling or experiencing because it may be difficult to do so. This may be due to their prolonged suppression of emotions, or their belief to fight through emotional distress from learned military cultural behavior. Therefore, Dr. Tom disclosed about his familiarity with working with military clients who have experience physical symptoms from various mental health issues. His disclosure was used to inform and educate his military clients about the symptoms they were experiencing in session. Dr. Tom used disclosure in his therapeutic alliances with military client when he sensed difficulties in their ability to disclose about or understand the symptoms they were experiencing which supports Quillman's (2012) report that he used psychoeducational component in his therapy with clients. Likewise, he shared how clients find relief in understanding how symptoms affected them.

Researcher Reflections on Counselor Self-Disclosure with Military Population

As a private-practice license professional clinical counselor, I have worked with the military population for more than 10 years across all branches. I have extensive knowledge about the culture from work with active duty services members, their spouses, and their children. I have provided counseling for individuals, couples, and groups to this population. Therefore, I consider myself an insider in the population from my experience. At the same time, as stated previously, I am the spouse of a soon-to-be retiring active duty service member of over 20 years, which positions me as an insider by belonging to the culture. For that reason, I believe I can provide reflections on counselor self-disclosure with the military population from my own

counselor's perspective. I use counselor self-disclosure as a way to build trust through the establishment of safe therapeutic alliances that promote change.

I understand how important it is for clients to know that they are working with someone who is culturally competent and can relate to the many stressors that active duty service members and their families face on a daily basis. Therefore, I can attest that knowing the cultural background of the military population will help in understanding the importance of that military client or family member attempting to seek help. If counselors working with military clients use self-disclosure in a therapeutic alliance, I would recommend they use it carefully to show their *street cred*, borrowing Dr. Stacey's term, which includes knowledge of the family structure and the frequent moves, separations, and deployments these military families often endure. Further, I recommend counselors working with military clients gain an understanding of the causes of trauma, suicide, symptoms of distress, and the stigma and shame associated with seeking mental health within the military. In addition, I suggest counselors learn what military clients do in their specific careers and memorize the ranking system to help with identifying one's rank. Of equal importance, is an understanding of military jargon, so that clients are not sitting in session educating their counselor and using valuable therapy time without getting therapy. I also advise counselors working with military clients to know the culture before attempting to disclose or establish connections through human experiences that are authentic, because in my experience, it is not at all difficult for a military client to identify a "fake" or someone who is unfamiliar with the military culture. Likewise, counselors could ask questions to help gain a better understanding of the military clients' experiences and explain up front that they are outsiders to the culture, if in fact they are. This is the example of honesty and trustworthiness that a military client is typically seeking, and it depends on how the military client makes meaning of the disclosure and the

interaction that takes place in the therapeutic alliance. Consequently, counselors need to ask themselves the question of how they are situated as insiders and outsiders in relation to their clients experiences and cultural background.

Through this study and in my everyday work with the military population, I believe there needs to be more training of counselors who specialize in working with the military. I also believe that relationally-orientated practices that are culturally sensitive are required for counselors to be ethically sound. It is therefore imperative that counselors are trained during their graduate programs to become culturally sensitive about the military and recognize the population as a culturally diverse group in the United States. Similarly, it is crucial that teachings of a variety of relational practices that focus on understanding suicide rates due to the increased influx of suicides among those in the military. Moreover, the treatment of PTSD, TBI, and other mental health disorders should be required in counseling programs.

As I stated in the literature review, the culture of the military is a mirror of the culture in the United States. Thus, I understand that clients from the military culture may possibly be experiencing the same stressors as the culturally diverse populations of the country they serve. For example, people with culturally diverse backgrounds are suffering without receiving assistance when returning from deployments. Hence, when some military members return to civilian life as veterans, they have not received treatment and are not prepared to make the necessary adjustments to regular civilian life. Thus, many veterans fall through the cracks and struggle with mental health issues while attempting to manage their own stress levels and cope with the systems of inequity that exist both within and outside of the military.

Furthermore, I assert that practicing counselor self-disclosure is more than good counseling skills in regards to being attentive in a session. I argue that counselors need to be

culturally aware along with having strong counseling skills before choosing to disclose in their sessions with clients. An awareness of the culture may provide those moments when disclosure should be used. Likewise, being culturally sensitive can provide value to counselors in gauging whether the timing of self-disclosure is appropriate. When counselors are in session and they show a lack of awareness of cultural sensitivity, they might make the mistake of disclosing an idea or a past occurrence that may inadvertently lead to a negative outcome for both the client and counselor. This could potentially cause a rupture in the therapeutic relationship. However, I understand and value counselor self-disclosure. I believe it *is* needed in multicultural therapeutic alliances with military clients because it benefits both the counselor and military client (in this case) to recognize that the counselors they choose to work with *are* culturally competent.

Conclusion

In this exploratory case study, I sought to gain an understanding of how two counselors made meaning of the role counselor self-disclosure plays in establishing and maintaining a therapeutic alliance with military clients. Dr. Stacey and Dr. Tom's experiences supported existing literature about how the use of counselor self-disclosure assists with establishing and maintaining therapeutic alliances with military clients. They discussed how their military clients enter counseling with preconceived notions about them as counselors, as well as what will take place in the counseling process. Additionally, the participants discussed barriers that existed for military clients, especially as it pertains to the stigma associated with mental health care that seems considerable among those within the military culture. Additionally, there are some military clients who, at some point, might have developed a mistrust of counselors and other mental health providers from past experiences, and this may have threatened to prevent the participants from developing connections with their military clients.

Counselor self-disclosure was used as a relationally-oriented intervention to assist participants with establishing and maintaining connections with their military clients. While self-disclosure is not a new practice and has been used by several counselors with a variety of clients, what became evident in this study is that self-disclosure was key to establishing and maintaining a therapeutic relationship with military clients. In Dr. Stacey's case, self-disclosure allowed her to gain what she called, "street cred" and in Dr. Tom's case self-disclosure allowed him to be seen as vulnerable, down-to-earth, and sincere instead of hierarchical, authoritative, and flawless. Due to the stigma associated with seeking mental health services, military clients are apprehensive about seeking help from military counselors, as these counselors might be in a position to report incidences of sexual assault, rape, and other issues. Additionally, even if military clients did not see a military counselor for sensitive issues, but still sought mental health services, if these clients want to advance in their career, these visits to the counselor would be in their files, and could be used against their advancement goals.

Due to this stigma, specifically with military clients, there has to be a strong effort made by the counselor to ensure emotional safety of the clients, especially when the clients are in a culture where expressing emotional distress is frowned upon and seen as weakness. Thus, military clients often dismiss their own emotional distress, learn to ignore symptoms, or develop negative coping mechanisms leading to other health issues. It is important that counselors working with these clients understand the emotional states of these clients as soon as they walk in to their offices to establish trust and safety immediately so that the client would be inspired to continue therapeutic treatment. For the military clients to even seek mental health services outside of the military culture may be an indication that they recognized their inability to cope with their emotional distress, and in their own way, they are acknowledging the issues by taking

the risk to seek help with a counselor. This is critical, since that acknowledgment within the military puts a label on the military client seeking help, and the military client could be classified as unfit for duty. For all these reasons, military clients may need a counselor outside of the military who understands the military culture, ranks, and jargon to immediately put the client at ease and continue to cultivate a safe and non-judgmental therapeutic environment.

The ways in which the participants established therapeutic environment with their clients through using self-disclosure allowed for their military clients gain awareness. The participants interpreted that their clients were better able to recognize symptoms of their mental health issues that they may have suppressed or did not recognize as being present due to the repressive norms of the military culture. These awareness of symptoms, then created conditions for the client to speak more openly about their previously unrecognized symptoms. Thus, the participants offered more accurate diagnosis, provided appropriate psycho-education for the diagnosis, and offered better treatment which was aligned with the military client's mental health needs. Given that a counselor often has to rely on clients' self-report, if the client is not aware of his or her symptoms, then the counselor may not have enough information to make an accurate diagnosis, which would be harmful for the client. Therefore, using self-disclosure to bring awareness to the client's expression of emotional distress opens up a dialogue that otherwise might not have been possible.

While both participants used self-disclosure with their military clients, it is important to remember that the clients' cultural training in the military and within broader social discourses do not disappear just because they are seeking help with their mental health issues. In other words, while self-disclosure could bring awareness for some clients, and establish trust and credibility, for other clients' self-disclosure could bring cognitive dissonance with their

internalized cultural programming, leading them to resist therapy altogether and prematurely terminate the relationship, especially when seeking the help was already embedded with apprehension. Therefore, timing, counselor experience, and gauging the capacity of the client to receive self-disclosure is key to establishing and maintaining strong therapeutic relationship.

Implications for Therapeutic Practitioners and Other Stakeholders

This study produced valuable information that should be used to gain an increased understanding how counselors make meaning of their use of self-disclosure when establishing and/or maintaining a therapeutic alliance with military clients. This study provides valuable insights about the use of self-disclosure in therapeutic alliances with military clients, and as it relates to the retention or loss of those clients in counseling. Therefore, several stakeholders would be interested in this study. I discuss the implications for practice below.

Practitioners, counselor educators, professional organizations, and governmental agencies, such as the military branches and veteran affairs organizations, can gain a deep understanding of the role of counselor self-disclosure use with military clients. This study adds clinical value in that it can act as a guide for understanding the importance of establishing strong therapeutic alliances with clients from the military population. A trusting therapeutic alliance with military clients is clinically important because of its positive effects on treatment outcomes, regardless of the intervention used or cultural background of an individual (Blais, Jacobo, & Smith, 2010). Therefore, a deep understanding of counselor self-disclosure can help practitioners to gain the trust of their military clients, which is vital due to many military clients' skepticism and lack of trust in their mental health providers' ability to understand and meet their mental health needs.

Additionally, this study adds value by helping practitioners identify ways to establish strong connections with military clients through the use of counselor disclosure. This study stresses using disclosure for positionality as an insider or outsider in the culture, modeling vulnerability, modeling disclosure, and knowing the importance of timing acquired by counselors. Moreover, this study demonstrates clinical implications for understanding ways to help military clients feel safe within the relationship to disclose about sensitive topics they experienced while serving. These sensitive topics may consist of anything pertaining to their mental health, family, and military culture.

Furthermore, multicultural counseling courses for counselor education programs that teach about understanding and awareness of military clients' culture can prevent ruptures in the therapeutic alliance with military clients. This educational incentive may help to reduce or prevent premature terminations with the military population and helps to increase retention of mental health services that are desperately needed within this population. In addition, this study serves as motivation for practitioners to begin using more relationally oriented interventions that are culturally sensitive and challenge mainstream traditional counseling practices that are incongruent with culturally diverse military clients' lifestyles. Furthermore, practitioners and counselor educators gain an awareness of the different barriers and stigma that exist with military clients in need of services. Moreover, counselor educators can teach cultural competence and ways to provide relationally-oriented practice competencies to their students.

This study lends relevance to professional organizations such as American Counseling Association, National Board of Certified Counselors and government agencies such as the Veterans Affairs and Substance Abuse and Mental Health Services Administration that provide continued educational training for professionals in the field of mental health. These professional

organizations and agencies can use this study gain an understanding of how civilian counselor are retaining military clients. Moreover, this study can provide training to teach in areas of cultural competencies, clinical practice, and more for civilian or military counselors who work with clients from the military population. I intend to present these findings from the study at professional counseling conferences, web-based trainings to bring awareness and provide a deep understanding of the military population. This understanding is essential for decreasing underutilization of mental health services among the military.

Given that proper diagnosis is critical in helping clients, it is most important that military clients are open and genuine with counselors so that counselor can make an accurate diagnosis. In this study, self-disclosure was the catalytic vehicle for such conversations and for continuous therapeutic alliance where the client revealed more symptoms that they had not disclosed earlier in the therapeutic relationship. Therefore, this study highlights the need for ongoing training and support for counselors when they use self-disclosure so that they can continue to improve their own clinical practice skills and learn from the times that they were able to use self-disclosure correctly and incorrectly. And once members of the military community know of the counselor's cultural competence in working with military clients, they will refer other military clients for mental health services, therefore utilizing mental health services, which is a critical need for the military population.

Future Directions of Research

There are several possibilities for future research emerging for this study. In this section I will first, considering that there are so few studies in literature that support counselor self-disclosure with the military population, more research is needed. I would assert that a similar study could be conducted using active duty military members, military spouses, military

children, or veterans as participants. These various participant perspectives could potentially help deepen and expand the findings of this study from the voice of the military clients. Likewise, gaining the military clients' perspectives could provide a different understanding of the meaning counselor self-disclosure has for such clients in a therapeutic alliance. I have provided additional areas that can be expanded and deepen the study below:

- Barriers in therapeutic alliance with the military population
- Counselor self-disclosure and managing symptoms distress
- Counselor self-disclosure use for positionality in race and the military culture

These topics could deepen the understanding of self-disclosure from both the military clients' and counselors' perspectives and expand the nuanced understanding of self-disclosure and how it unfolds for all stakeholders in therapeutic alliance.

A military client's perspective also assists in identifying barriers, that may be unknown and has the potential to provide an understanding of barriers from each military client/participant perspective (i.e., a child, spouse, veteran), which I assume would be different. An explorative case study could be conducted to identify barriers that could aid in understanding how to engage with various clients from the military to establish therapeutic alliances. Moreover, understanding barriers may help to preventing ruptures resulting from an unknown barrier within the therapeutic relationship. Awareness of potential barriers will provide ways of thinking about the importance of establishing trustworthy connections with various clients from the population, which could assist with decreasing premature termination among those in the military.

Additionally, a study that explores counselor self-disclosure and how to manage symptoms distress could be useful for understanding how counselors could use disclosure to model and teach clients to disclose and regulate their symptoms. The use of a quantitative study

using Likert scales or surveys could be used to understand participants' symptom outcomes before and after self-disclosure. This study could add to existing literature by providing an understanding of the benefits of self-disclosure in modeling and teaching emotional regulation in therapeutic alliances. Likewise, a study that addresses modeling disclosure to clients can also assist counselors with making proper diagnoses from military client's self-reporting of their symptoms to counselors after learning about disclosure.

Finally, findings from the study suggest that counselor self-disclosure was helpful for working with military clients across different cultures. Therefore, it would be helpful to understand if positionality in the military culture and racial similarity or differences between the counselor and the client would have an influence in the therapeutic relationship. These types of studies could be helpful to determine how culturally diverse military clients and counselors establish and maintain therapeutic alliances.

Chapter Summary

In this chapter, I presented my view of this study and reiterated the purpose of the study for the readers. I connected the three tenets of symbolic interactionism theory to the findings to assist in answering the research questions in this study. In addition, I discussed how the findings contributed to the existing literature. Next, I recommended implications from this study and future directions for research in the field of counselor education and multicultural counseling. Through the chapter, I continued to place significant emphasis on how the participants described the role of their use of self-disclosure in establishing and maintaining therapeutic alliances with their military clients.

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Appendix A - Email Solicitation of Participants

Subject: Request for Participation in Study

Hello

My name is Ophelia Blackwell and I am a PhD student at Kansas State University. Currently, I am working to complete a study as a part of my PhD program in Counseling Education and Supervision.

I am writing to ask that you consider participating in a research study that I am conducting. This qualitative case study is designed to explore how counselors describe their role with the use of self-disclosure in a multicultural therapeutic alliance with military clients. By gathering information about the experiences of counselors, the goal is to better inform mental health professionals about the benefits of therapist self-disclosure when working with the military population. This study has received Institutional Review Board (IRB) approval, Approval (#) for the use of human subjects.

Participation in this study is completely voluntary. Participants in the study are to meet the following requirements: (a) participants must be licensed to practice by the state, (b) must practice self-disclosure with military clients (c) believe that positive outcomes resulted from their practice of self-disclosure and, (d) military clients terminated successful as a result of their practice of self-disclosure. (e)Potential participants must practice independently with a background in one of the following disciplines: license professional counselor, marriage and family therapy or social work. Participants will be selected for their ability to provide detailed information about their experience in using self-disclosure with military clients.

Participants selected for the study will receive an e-mail arranging a 10 to 15 minute orientation to the study. During the orientation participants will be asked to complete an informed consent form. To protect and keep your identity confidential, you will be asked to select a pseudonym to be used throughout the research process.

Participants will also be asked to complete three separate interviews with the researcher. The length of the interviews will be 60 minutes. During this time you will be asked questions about your experiences using self-disclosure with the military population. Data collected will be used in research contexts (e.g., analysis for presentations) where the names of participants will never be used, unless permission is obtained. Interviews will be conducted in person. The interview will be audio recorded. The interviews may happen at a time convenient for you (e.g., weeknights and weekends are available for interviews).

After the data are collected, I would like to send you the findings of my analysis and interpretations and have you review and provide any additional insight. Participants will have the opportunity to remove themselves or information provided from the study at any time without penalty.

At this time, I would like to ask you to be a participant for my study. If you are interested in participating in this research study, please contact me via email by (date). After hearing from you I will arrange a time to set up a 10 to 15 minute orientation to the study. If you have additional questions about this study, please also feel free to contact me (omb9999@ksu.edu, 704-315-0897) or major professor Dr. Kakali Bhattacharya-(kakalibh@k-state.edu, 785-532-1164).

Thank you!

Sincerely,

Ophelia M. Blackwell, LCPC, Doctoral Candidate
College of Education, SECSA
407 Bluemont Hall
Manhattan, KS 66506

Appendix B - IRB Approval

KANSAS STATE UNIVERSITY | University Research Compliance Office

TO: Kakali Bhattacharya
EDLEA
321 Bluemont

Proposal Number: 7727

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: 05/12/2015

RE: Approval of Proposal Entitled, "Case Study of Counselors who use therapist self-disclosure (TSD) with military clients."

The Committee on Research Involving Human Subjects has reviewed your proposal and has granted full approval. This proposal is **approved for one year from the date of this correspondence, pending "continuing review."**

APPROVAL DATE: 05/12/2015

EXPIRATION DATE: 05/12/2016

Several months prior to the expiration date listed, the IRB will solicit information from you for federally mandated **"continuing review" of the research**. Based on the review, the IRB may approve the activity for another year. **If continuing IRB approval is not granted, or the IRB fails to perform the continuing review before the expiration date noted above, the project will expire and the activity involving human subjects must be terminated on that date. Consequently, it is critical that you are responsive to the IRB request for information for continuing review if you want your project to continue.**

In giving its approval, the Committee has determined that:

☒ There is no more than minimal risk to the subjects.
☐ There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file as written. Any change or modification affecting human subjects must be approved by the IRB prior to implementation. All approved proposals are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced post-approval monitoring may be performed during the course of this approval period by URCO staff. Injuries, unanticipated problems or adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB and / or the URCO.

203 Fairchild Hall, Lower Mezzanine, Manhattan, KS 66506-1103 | 785-532-3224 | fax: 785-532-3278 | k-state.edu/research/comply | comply@ksu.edu

Appendix C - Sample Transcript

Participant 1: Okay.
Interviewer: All right. Dr. Stacy, I want to thank you for taking the time out of your busy schedule to do the interview with me this morning.
Participant 1: No problem.
Interviewer: Do you have any questions for me pertaining to the consent form and the things that we talked about on the other day?
Participant 1: No, I'm good.
Interviewer: Okay, all right. The first question that I would like to ask is can you give me a little background information about yourself and how you got into the field?
Participant 1: Yeah, I knew I always wanted to be a therapist, and when I was in undergrad, I majored in psychology. I wanted to be a child psychologist, but I didn't want to go to school for that long before I could practice. I learned about marriage and family therapy in the program, and I jumped right in, finished that up, and then decided that I wanted to do a PhD, so that I could have both the teaching as well as the therapeutic experiences.
That's what it is. I like to help people sort through problems and find solutions to different issues that they experience and help them live more happy and healthy lives.
Interviewer: Okay, all right. Thank you. How many years have you been in your field?
Participant 1: I've been practicing, gosh... Are you wanting to count internships and all that?
Interviewer: You can count from... Let's count your professional years. Participant 1: Okay. Since 2009, I've been practicing. What is that, six years? About seven years. Interviewer: All right. What made you want to go into private practice?
Participant 1: I like the idea of not really having to report to someone. It is a little... With one thing, you lose another. You lose the person who takes care of your taxes. You've got to be really careful with that, but I've never liked the idea of working for an agency. It gets so messy. I like making the choice between who I want to pick, who I want to practice with and who I want to work with, as opposed to being told who I have to work with.
Interviewer: Okay. Good. Tell me about a specific experience that stands out to you in regards to counseling a military client in as much detail as you can.
Participant 1: Okay. I had one client who was in the military, but he was struggling with some sexuality issues. He was really wanting to have a place for him to come and talk about that, as well as the struggle with him was also spiritual, because he was definitely identifying himself as a Christian. Those backgrounds pretty much say that you can't have homosexuality as a practice. He was working through those things, and we were talking through things, and when he made mistakes, meaning he gave into temptation and had sexual relations with men, he struggled mightily with that within himself. Very intelligent and West Point graduate, decorated to hill, but really struggling with his identity and not wanting to reveal that in his military setting. He worked to a point where he was able to come to a place of understanding what it was he was dealing with, and then we were able to move forward in therapy at that point. That's one of the good ones.
Interviewer: Okay, good. Think about a time when you used therapeutic self-disclosure with a military client, and tell me about it in as much detail as you can remember.
Participant 1: Okay. Let's see. I have a client who currently who is client with self-image issues and really trying to come into her own as a member of the military and has dealt with some

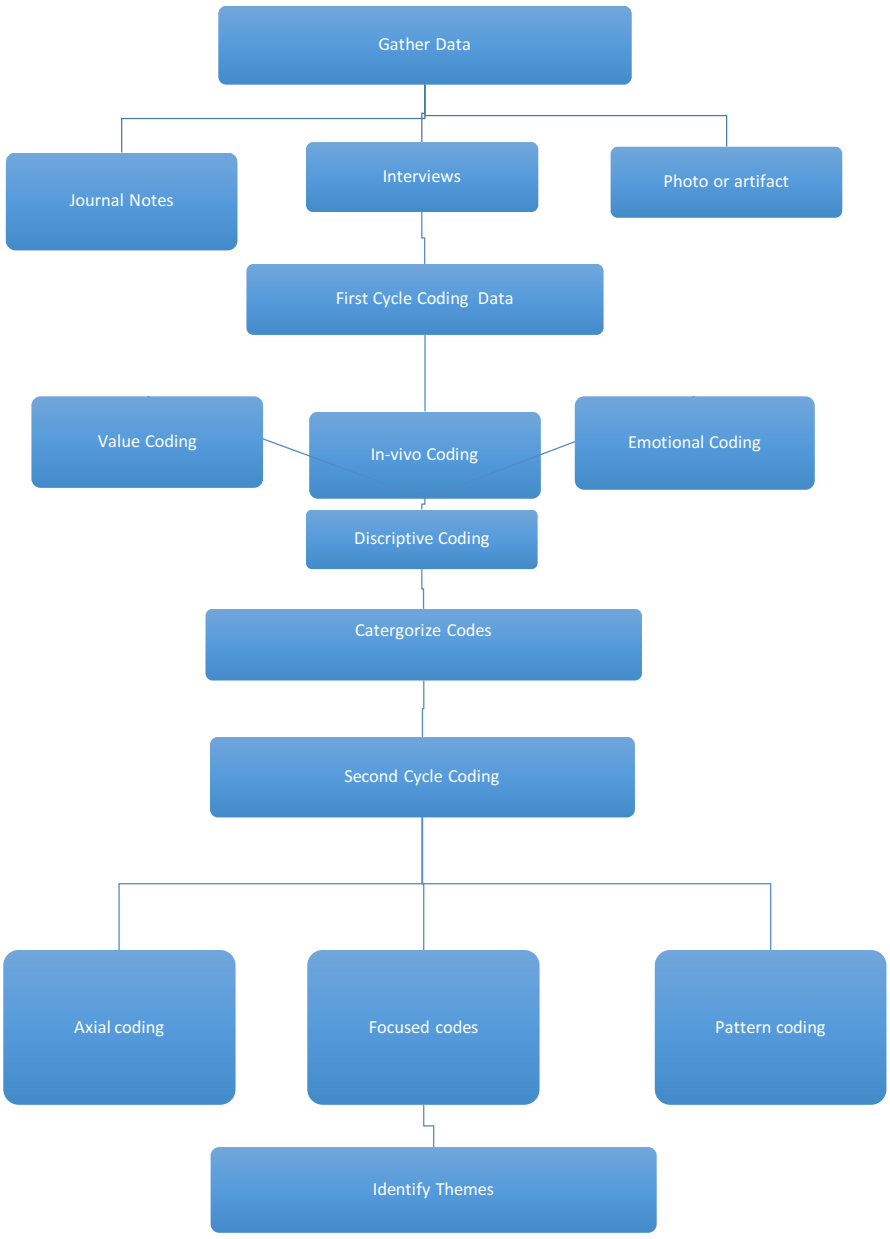
sexual harassment, that type of thing, but also has that insecurities. Very beautiful woman, but still has those insecurities, which cause her to act out in certain ways.
What I've talked with her about is some of the similar struggles that I've had, and not going into detail, but saying hey, I understand. I understand the struggle is real, and I've been there myself, and she talked about having some issues of depression and I said I've been there too. I remember her saying that, wow, that makes me feel much better that I know that it's not just me, and I know that you can be trusted with this information, and you can understand from your own personal standpoint.
That really helped in the process of joining with her. We've been able to do some great work together, because of that.
Interviewer: Good. Do you feel that because you disclosed that opened up the door for her to trust? Is that what I'm hearing you say?
Participant 1: Absolutely. That is absolutely correct. She came in, she was very... You can tell when they're nervous, kind of standoff-ish, not sure what to expect, and once I was able to reach in with her and say, hey, I've experienced that too, and here are some things that I've tried and let's work through this, let's try this, what works for you, that type of thing. For her to actually verbalize that and say I feel so much better now, that's huge. Yes, I don't think I would've gotten that response without my self-disclosure.
Interviewer: Okay. All right. On the same note, maybe this client or any client in the past, could you walk me through a typical initial intake session with the military client, and when you use self-disclosure and found it helpful. Kind of what you were just talking about how you do that in the intake?
Participant 1: Okay. First thing that I ask is what brings you in. We sign the necessary paperwork, the informed consent, those types of things, and then we dive right in. What brings you in? What's going on with you? What made you feel like you needed to come in and receive help? Then we talk through that. Then I look through their intake forms and we walk through that as well, on the different things that they wrote down, about the different types of issues that they've been having, and we talk specifically about those. Then, if they have a certain thing that they may feel... I've had some that had things that they feel ashamed of on their intake form, they've written it down, but they don't want to talk about it, and I obviously point to everything. I don't leave anything out. When they seem skittish about that, I explain that I've had many other people or I myself have experienced those types of things, so I understand the embarrassment, and I understand the reluctance that you may have to discuss it, but this is a judgment free zone, and if you need to talk about it, we can talk about it, and I can understand it from my perspective from things that I've experienced, but I want to understand it from your perspective as well.
Interviewer: Okay. When you use self-disclosure, do you find it to be helpful? What's it doing in the midst of the initial intake?
Participant 1: I think it relaxes them. I think it makes them see me, as a therapist, as a human being, and not somebody perfect trying to help other people do stuff, because I'm perfect. I think it also gives me "street cred." I've been through some stuff, so it gives me credit to be in the position that I'm in. I can actually help some people with stuff, as opposed to someone who's been maybe sheltered or not really experienced a whole lot of things in life. I think it relaxes them and it builds trust.
Interviewer: Okay. All right. Walk me through a typical session, once you have established the rapport with the military client, and where you use self-disclosure and found that helpful as well.

Participant 1: Okay. There's one woman that I'm working with , and she's dealing with some infidelity issues. She's the one that's dipping out in the relationship, and she wants to stop, and a part of that is her image of herself, and some of it also, we believe, is due to watching her father do the same thing to her mother. She's very close to her father.
As we talk through that, you've got to be gentle as you bring family into the issue. Family of origin can be very significant in identifying different issues and problems that people are experiencing. She told me about her father and the things that he had done and how important her relationship was with him.
I asked her questions about her specific behaviors, and compared those to what was going on with her father.
Interviewer: Right.
Participant 1: I said do you think... I guess I'm wondering about a genetic pattern or you taking on the family's tradition and she was looking like, I've never thought about it like that. I was like, well, sometimes we pick up things from our family that we don't even realize. It's this intergenerational transmission of action and inaction or certain things that we do, and it's almost automatic. Your relationship with your father is very significant, and that could be definitely a way for you to go, if you think it would please him.
I said also, I've had things in my own life that have been passed down to me, and I've had to work through with my own therapy, to be able to get to a place of peace with it, and feel comfortable with myself, and as I move forward in my relationships. I understand that. We've got to figure out how to not let that be the issue, and you figure out how to be you in the midst of whatever circumstances you're experiencing.
Interviewer: Okay. All right. Thank you.
Can you tell me a time that you might have interpreted self-disclosure to enhance the session with someone from the military population and share it in more detail. What I'm saying is, when you had a time that you know that your self-disclosure enhanced that session with a military client, or someone from the population.
Participant 1: Okay. Yeah, I had a family come in and their struggle was communication. He's getting ready to deploy, he's not really communicating the way he needs to. It's one of those things where I'm getting ready to leave, so I don't want any emotional issue to come up, while I'm getting ready to leave. I think we focus on that, and sometimes he would pick fights with her. I talked about when I left my family, and moved to Kansas. I had an aunt who was the same way. When I would go visit, she would pick a fight with me, and we'd leave angry and all that type of thing. She really just wanted to tell me that she missed me, but she didn't know how to do that. What she did was project onto me the anger and frustration that she was feeling about me not living there anymore, instead of giving me the passionate and the compassionate emotion that was necessary in order for me to get the message that she missed me.
Interviewer: Right.
Participant 1: He was like, oh. She was like, mmm. Okay. That helped them to open up the lines of communication and really be able to talk about the deployment and talk about how long he was going to be gone and how they were going to be able to cope with it emotionally and those types of things. I really feel like it opened the door for him, in particular, because he was the one that was shut down, and she was wanting to facilitate change.
Interviewer: Okay, good. Thank you. Describe your relationship with one of your military clients prior to your use of self-disclosure.

Participant 1: Okay. Sometimes it's very difficult to work with people who don't know a little bit about you. With the one gentleman I talked about earlier, that was struggling with the sexuality issues, I didn't self-disclose right away. I listened a lot, and we talked through some of the issues that he was experiencing a lot, and because of the spiritual piece, I'm a Christian, and I'm not ashamed of that at all. He talked about it in terms of being sin, and him not wanting to continue to participate in that sin, but he wasn't sure that he had the capacity to not, to resist that temptation. I expressed to him, there are various sins that I have that I struggle with too, and I have a belief that God forgives, and he has grace and he shows us grace. That should cause us comfort and not necessarily cause us more angst and anxiety. He received that really well, and he was like, yeah, that's a good way of looking at it. I never thought about it that way before. He was saying that he only thought about it in terms of feeling guilty about his thoughts or his action on the sexual urges that he has, and those types of things.
Yeah, when I disclosed that I also have the same beliefs, and I have the same struggle with sin and what God would consider immoral behavior, he seemed to open up to that, and to be freer to talk about that a little bit more and to dive into that in depth.
Interviewer: Okay. All right. Tell me about your relationship with one of your military families... Oh, I just asked you that. No, okay, sorry. Tell me about your relationship with one of your military families after using the self-disclosure. Before it was prior, but then after you used the self-disclosure with the military client. Can you start it from start to finish for me?
Participant 1: Yeah. When I use self-disclosure, I try to be very simplistic with it, and not give very much detail. If they ask for detail, I would give it to them, but in a way that doesn't make it inappropriate. Do you know what I'm saying?
Interviewer: Yes.
Participant 1: Not too many personal details. Once I've done that and once I've shared that, having a relationship with a client in the military, who is struggling with some type of PTSD or some form of mental health issue that they feel ashamed about or aren't willing to confront right away, it allows a place of softening for them. They're able to feel more comfortable in the environment, because I have talked about some of my struggles and intermingled that with it every time. One of the things that I feel like is helpful after having done the self-disclosure, is to not keep doing it, saying, I did or I keep or what I'm saying, I had, when I did, because it's not about you, and at that point, you make it about you. If you can find that balance of I've experienced that, but let's talk about what your experience is, I feel like they've appreciated that so much more than me constantly telling them, remember I did. If you make it about them, and you keep it about them, it makes it a little bit easier for you to develop that deeper relationship.
Interviewer: Right. Is it a particular time that you can remember that that happened, that you chose to use the self-disclosure and then you noticed the difference afterwards?
Participant 1: Yeah. The client that I told you about that had the self-image issues, it was the same thing. That's exactly what I did with her. Sometimes she asked me questions about that, about how I feel about myself sometimes, and where I go for help with that type of thing, and she really feels like, at least from what she's expressed to me, she feels like that's been helpful for her, and her process of thinking about herself. Giving her homework and things to do that I've done for myself. I haven't told her that I've done them for myself, but she trusts me enough to do it. It's a little bit easier, once you've told people your own issue or your own struggle in the past or maybe current that you're working through. It's a lot easier for them to trust and continue with the process. She's been walking with me, and walking through it pretty much through the fire, and pretty much what she feels like she's going through. She's been walking with it and walking

through it, as I've walked with her through that. I believe it's directly related to the fact that I haven't judged her or made her feel like she's... What she felt was not accurate or not valid.
Interviewer: Okay. All right. Tell me about your process of successful termination with a military client after using self-disclosure.

Appendix D - Data Management and Analysis Process



Appendix E - Example of Categories

Dr. Stacey Categories

TYPES OF COUNSELOR DISCLOSURE

What I've talked with her about is some of the similar struggles that I've had, and not going into detail, but saying hey, I understand. I understand the struggle is real, and I've been there myself, and she talked about having some issues of depression and I said I've been there too. I remember her saying that, wow, that makes me feel much better that I know that it's not just me, and I know that you can be trusted with this information, and you can understand from your own personal standpoint.

She came in, she was very... You can tell when they're nervous, kind of standoff-ish, not sure what to expect and once I was able to reach in with her and say, hey, I've experienced that too, and here are some things that I've tried, and let's work through this, let's try this, what works for you, that type of thing.

When I use self-disclosure, I try to be very simplistic with it, and not give very much detail. If they ask for detail, I would give it to them, but in a way that doesn't make it inappropriate

give You've got to know how much to and how much not to, so you don't have this issue of transference or countertransference, as well

Once I've done that and once I've shared that, having a relationship with a client in the military, who is struggling with some type of PTSD or some form of mental health issue that they feel ashamed about or aren't wiling to confront right away, it allows a place of softening for them. They're able to feel more comfortable in the environment, because I have talked about some of my struggles and intermingled that with it every time

I had a family come in and their struggle was communication. He's getting ready to deploy, he's not really communicating the way he needs to. It's one of those things where I'm getting ready to leave, so I don't want any emotional issue to come up, while I'm getting ready to leave. I think we focus on that, and sometimes he would pick fights with her. I talked about when I left my family, and moved to Kansas. I had an aunt who was the same way. When I would go visit, she would pick a fight with me, and we'd leave angry and all that type of thing. She really just

wanted to tell me that she missed me, but she didn't know how to do that. What she did was project onto me the anger and frustration that she was feeling about me not living there anymore, instead of giving me the passionate and the compassionate emotion that was necessary in order for me to get the message that she missed me

I talked about not only the friend, that I had, who also struggled with the TBI. I also talked about being

TIMING OF CSD

Sometimes it's very difficult to work with people who don't know a little bit about you. With the one gentleman I talked about earlier, that was struggling with the sexuality issues, I didn't self-disclose right away. I listened a lot, and we talked through some of the issues that he was experiencing a lot

They may not be receptive to it. You got to know them, and sometimes it takes a little bit of time to figure it out, and sometimes it takes a little bit for you to be able to get to a place where they accept what you're saying

I feel like I have to time it right, because there's a time when you do it that it would be too soon or it would be too late. You got to time it, and you got to know your clients

It was too soon. She wasn't ready, but I was so concerned with her safety, because she was pregnant

When he first came in, he was very friendly, but you learn body language as a therapist. He was very apprehensive, and very uncomfortable. I could tell. As we went through the process, we talked about the different issues that he was struggling with, and like I told you before, I didn't self-disclose with him right away. I let him tell his story and what he was needing, and what he was needing help with,

Appendix F - Cross Case Analysis

Themes	Dr. Stacey	Dr. Tom
Knowledge and experience about the culture	X	X
Personal relationship being a part of the culture	X	
Experience with working with the culture	X	X
Disclosing about similar experiences or working with clients with similar experiences	X	X
Experience working with the culture helps with the human experience and connection		X
Nonjudgmental zone/ Safe Space	X	X
Establishing trust and understanding in a safe space through similar experiences	X	X
Developing a rapport and relationship based on timing	X	
CSD Common Practice & Advice before using CSD	X	
CSD to relax client	X	
CSD to appear human	X	
CSD to join with client	X	
CSD helps clients to disclose		X
CSD helps client to gain awareness		X
CSD helps clients reflect on feelings and behavior in session		X
Advice on timing	X	
Advice to know yourself	X	
Advice how much CSD is appropriate (purposeful)	X	X
Advice CSD appropriate when it benefits the situation (purposeful)		X
Advice CSD a good understanding and experience		X

with using basic counseling skills.		

Appendix G - Sample Informed Consent Form

KANSAS STATE UNIVERSITY

INFORMED CONSENT FORM
You are invited to be a part of a research study. The researcher is a doctoral learner at Kansas State University in the College of Education. The information in this form is provided to help you decide if you want to participate. The form describes what you will have to do during the study and the risks and benefits of the study.

If you have any questions about or do not understand something in this from, you should ask the researcher. One important aspect of the research procedures is the interviews. The researcher wises to interview face-to-face or phone/audio interviews. Do no sign this form unless the researcher has answered your questions and you decide that you want to be part of the study.

PROJECT TITLE: CASE STUDY OF COUNSELORS USE OF SELF DISCLOSURE WITH MILITARY CLIENTS

APPROVAL DATE OF PROJECT: Spring 2015 EXPIRATION DATE OF PROJECT: Fall 2016

PRINCIPAL INVESTIGATOR: CO-INVESTIGATOR(S): Dr. Bhattacharya: Ms. Ophelia Blackwell

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS:Dr. Kakali Bhattacharya-785-532-1164
Ophelia Blackwell – 704-315-0897

IRB CHAIR CONTACT/PHONE INFORMATION: Dr. Rick Scheidt, Chair, Committee on Research Involving Human Subjects or Dr. Jerry Jaax, Vice President for Research Compliance and University Veterinarian, 785-532-3224, Room 203 Fairchild Hall, Kansas State University. Manhattan, KS 66506

SPONSOR OF PROJECT: N/A

PURPOSE OF THE RESEARCH: The purpose of the study is to explore how counselors describe their role with the use of therapist self-disclosure in a multicultural therapeutic alliance with military clients.

PROCEDURES OR METHODS TO BE USED: The qualitative case study guidelines will be as follows. Participants will be asked questions through three different 60 minute interviews. The participants will be asked to think about their experiences with military clients and the role that self-disclosure has had on the therapeutic process. The questions will be open-ended semi-structured questions. The interviews will be conducted face to face or via skype. A 10 to 15 minute orientation will be conducted to explain the research study, witness the signature of the

consent form, and answer any questions the participant may have about the research or the interview process.

ALTERNATIVE PROCEDURES OR TREATMENTS, IF ANY, THAT MIGHT BE ADVANTAGEOUS TO SUBJECT:

N/A

LENGTH OF STUDY: The estimated time that the participant is expected to participate is 60 minutes per interview. The participants' interviews will happen about 1 to 2 weeks apart. All data is anticipated to be collected within a 9-week period.

RISKS ANTICIPATED: None are anticipated. It is not likely that there will be any harm or discomfort from/associated with this research. Participants do not need to answer questions that they do not want to answer or that make them feel uncomfortable. Participants may withdraw from the interview or study at any time with no penalties or repercussions.

BENEFITS ANTICIPATED: There is no direct benefit for participation in the study. However, findings from this study may benefit the military population as well as other mental health professional working with this population. Participants will also assist in providing real life examples of implementation to guide their decision making about the tools ore activities they may have provided for this population's successful completion of the therapy.

EXTENT OF CONFIDENTIALITY: To protect and keep your identity and interview confidential, the researcher will use pseudonyms selected by the participant or assigned by the researcher. The data collected will be kept on an encrypted database system on a password protected laptop and iPad. All materials, documents, and artifacts will be scanned and also kept on the secured laptop. The researcher will not have originals of documents or artifacts during the research proceedings. Data collected will be used in research contexts where the source of the data or names of participants will never be used, unless permission is obtained. Information shared in the course of the study that has identifiable details the details will be removed or fictionalized to assure confidentiality. Three years after the conclusion of the research all materials (electronic and hard copy) will be destroyed as per IRB guidelines.

IS COMPENSATION OR MEDICAL TREATMENT AVAILABLE IF INJURY OCCURS:
N/A

PARENTAL APPROVAL FOR MINORS: N/A

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

(Remember that it is a requirement for the P.I. to maintain a signed and dated copy of the same consent form signed and kept by the participant)

Participant Name:_____
Participant Signature:_____
Date:_____
Witness to Signature: (project staff)_____
Date:_____

Appendix H - IRB

FOR OFFICE USE ONLY: IRB Protocol # _____ **Application Received:** _____
Routed: _____ **Training Complete:** _____

Committee for Research Involving Human Subjects (IRB)

Application for Approval Form
Last revised on January 2011

ADMINISTRATIVE INFORMATION:

- **Title of Project:** (if applicable, use the exact title listed in the grant/contract application)
  Case study of counselors who use therapist self-disclosure (TSD) with military clients

- **Type of Application:**
  ☐ **New/Renewal** ☐ **Revision (to a pending new application)**
  ☒ **Modification (to an existing #_____ approved application)**

- **Principal Investigator:** (must be a KSU faculty member)

Name:	**Dr. Kakali Bhattacharya**	**Degree/Title:**	**PhD/Associate professor and Co-Chair**
Department:	**EDLEA**	**Campus Phone:**	**785-532-1164**
Campus Address:	**321 Bluemont Hall**	**Fax #:**	**785-532-7304**
E-mail	**kakalibh@k-state.edu**		

- **Contact Name/Email/Phone for Questions/Problems with Form:** **Dr. Kakali Bhattacharya/kakalibh@k-state.edu/ 785-532-1164**
  Ms. Ophelia Blackwell/omb9999@k-state.edu/704-315-0897

- **Does this project involve any collaborators not part of the faculty/staff at KSU?** (projects with non-KSU collaborators may require additional coordination and approvals)**:**
  ☒ **No**
  ☐ **Yes**

- **Project Classification** (Is this project part of one of the following?)**:**
  ☐ **Thesis**
  ☒ **Dissertation**
  ☐ **Faculty Research**
  ☐ **Other:**
  Note: Class Projects should use the short form application for class projects.

- **Please attach a copy of the Consent Form:**
  ☒ **Copy attached**
  ☐ **Consent form not used**

- **Funding Source:** ☐ **Internal** ☐ **External (identify source and attach a copy of the sponsor's grant application or contract as submitted to the funding agency)**
  ☐ **Copy attached** ☒ **Not applicable**

- **Based upon criteria found in 45 CFR 46 – and the overview of projects that may qualify for exemption explained at** http://www.hhs.gov/ohrp/policy/checklists/decisioncharts.html **, I believe that my project using human subjects should be determined by the IRB to be exempt from IRB review:**
  ☒ **No**
  ☐ **Yes** **(If yes, please complete application including Section XII. C. 'Exempt Projects'; remember that only the IRB has the authority to determine that a project is exempt from IRB review)**

If you have questions, please call the University Research Compliance Office (URCO) at 532-3224, or comply@ksu.edu

Last revised on January 2011