

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 5 • CORE READING 5 OF 6

05

Boundaries and Self-Disclosure

The ordinary, everyday questions every practitioner eventually has to navigate

What This Document Covers

This document turns to practical territory that every practitioner working with trauma eventually encounters: how much personal information to share, how to respond when a client asks something personal, and how to hold boundaries in a way that feels genuinely trauma-informed rather than simply rigid or cold.

Why This Is Harder Than It Sounds

Generic professional training often teaches boundaries as a fairly simple rule — minimal self-disclosure, clear limits, consistent structure. In trauma work specifically, this generic guidance runs directly into the material covered across this entire unit. As Document 2 covered, a client with a history of relational trauma may transfer expectations of coldness, unreliability, or danger onto a practitioner who holds boundaries too rigidly, in a way that inadvertently confirms exactly the pattern the relationship is meant to help repair. Equally, a practitioner overcorrecting toward excessive warmth or self-disclosure, sometimes driven by the rescuer countertransference covered in Document 3, risks a different, equally real problem.

Thinking Through Self-Disclosure

Rather than a fixed rule, self-disclosure is best approached through a genuine clinical question, asked in the moment: who does this actually serve? Self-disclosure offered because it genuinely serves the client's therapeutic process — normalising an experience, modelling something useful, responding honestly to a direct, reasonable question — is different from self-disclosure offered because it serves the practitioner's own need to be seen, liked, or to manage their own discomfort with a boundary.

A few practical questions can help distinguish between these: Is this disclosure brief, and does it return focus promptly to the client? Does it serve a clear therapeutic purpose the practitioner could articulate if asked? Would sharing this make the practitioner feel more comfortable, at the client's potential expense? Honest answers to these questions, in the moment, tend to be more useful than any single fixed rule about disclosure applied uniformly across every situation.

Pause and Consider

Can you think of a moment, in a professional or personal context, where sharing something personal genuinely helped the other person, versus a moment where it may have served your own comfort more than theirs? What was actually different between the two?

Boundaries That Feel Trauma-Informed, Not Just Rigid

As Unit 1 established, trauma-informed care involves genuine collaboration and restored choice, not the removal of structure. Applied to boundaries specifically, this means the goal is not the absence of limits, but limits held with transparency and explanation, rather than imposed as unexplained, arbitrary rules. A practitioner who explains why a particular boundary exists — session length, contact between sessions, the limits of what can reasonably be offered — is doing something genuinely different from a practitioner who simply enforces the same boundary without context, even where the actual boundary itself is identical in both cases.

This connects directly to the rupture and repair material in Document 4: a boundary held with warmth and explanation is considerably less likely to produce an unnecessary rupture than the same boundary enforced coldly or without context, and where a boundary does produce a difficult reaction, that reaction becomes genuinely useful clinical material rather than simply an inconvenience to be managed.

Common Boundary Situations Worth Thinking Through in Advance

- A client asks a direct personal question (“Do you have children?”, “Have you been through something like this yourself?”)
- A client requests contact outside of scheduled sessions during a difficult period
- A session runs over time because a client is in genuine distress as the hour ends
- A client offers a gift, or asks the practitioner to attend something significant in their life

None of these situations has a single universally correct response — context, the specific client's history and presentation, and the practitioner's own clinical judgement all matter. What matters is having genuinely thought through one's own general approach in advance, rather than improvising a response for the first time in the moment, under the pressure of an actual, live situation.

What's Next

This unit closes with a document addressing common myths about transference and countertransference — several of which connect directly to the practical territory covered in this document.

A Few Things to Take With You

- Generic boundary guidance often runs into real complications specific to trauma work, given the transference and countertransference dynamics covered earlier in this unit
- Self-disclosure is best evaluated through the question of who it actually serves, rather than a single fixed rule
- Trauma-informed boundaries involve genuine transparency and explanation, not simply rigid, unexplained enforcement
- Thinking through common boundary situations in advance produces better clinical decisions than improvising under pressure in the moment

Before You Move On

- Of the four common boundary situations listed in this document, which do you imagine you would find most difficult to navigate well?
- Why might a boundary held with transparency and explanation produce a different relational outcome than the identical boundary enforced without context?
- How does this document's approach to self-disclosure connect back to the countertransference patterns covered in Document 3?