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2021

Therapist Self Disclosure, Countertransference and Self Care: Ethical Considerations

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Counter transference

Therapist Impairment

Therapist Self-Disclosure

Self Care

1

Therapist Feelings: Ethics Codes Counter transference Issues

2

AAMFT 3.3 *http://www.aamft.org/*
MFTs seek appropriate professional assistance for their personal problems or conflicts that impair work performance or clinical judgment

ACA A.1a *www.counseling.org*
The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

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3

Therapist Feelings: Ethics Codes
www.socialworkers.org

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

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Therapist Feelings:
APA 2.06(a) Personal Problems & Conflicts

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

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Ethical Standard of Black Psychologists
http://www.abpsi.org/pdf/EthicalStandards AssociationofBlackPsychologists.pdf

THE ETHICAL STANDARDS

I. Responsibility
II. Restraint
III. Respect
IV. Reciprocity
V. Commitment
VI. Cooperation
VII. Courage
VIII. Accountability

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https://www.nlpa.ws/assets/docs/ethical%20guidelines%20nlpa_adopted%20jan%201st.pdf

Ethical Guidelines National Latina/o Psychological Association - 2018

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Distinguishing the Difference When Dealing with Ethical/Legal Dilemmas

Beliefs and Behaviors

Beliefs

Are personal values
Can be different from client's Constitutional rights

Behaviors

Must abide by the Ethics Codes related to discrimination

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Unrecognized Counter-transference

Making the Unconscious Conscious

- *Unrecognized CT can interfere with successful treatment*
- *It can be a tool and a hindrance*
- *A sensitive interpersonal barometer*

Countertransference is, in fact, "a most powerful force, and if it remains an unrecognized element, it can be also be very dangerous" (Kraemer, 1958, p.30).

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Unrecognized Counter-transference
Reidbord, 2010

Mental Check List

1. *Is this feeling characteristic of how I feel in a session*
   - *How often do I have this feeling*
2. *Why do I have this feeling with this particular patient*
3. *Is the feeling triggered by something unrelated to the patient*
   - *Feelings caused by hunger, one's personal life, bureaucracy in the agency and profession*
4. *Is the feeling related to the patient in an obvious way*
   - *Is the patient "acting out" or saying negative things about me or the treatment*

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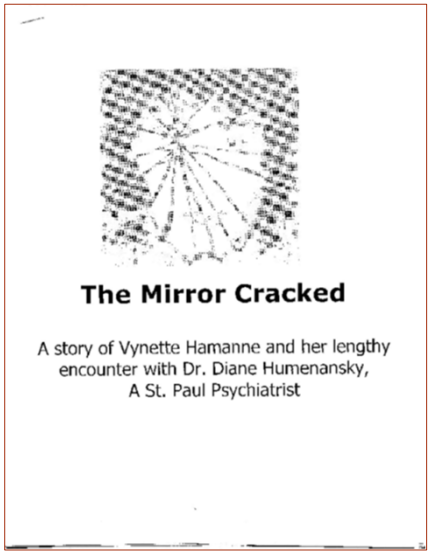
The Mirror Cracked



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Counter-transference (Captioned)

Psychoanalytic term

Considered important in all orientations

Various uses and definitions

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Transference
LaPlanche & Pontalis, 1973; Greenson, 1967

A pattern of expectations the patient brings into the therapy relationship based upon relationships with significant others

- *Repetition of past conflicts*
  - *Positive and negative*
- *Events rooted in childhood experience*
  - *Directed toward therapist*

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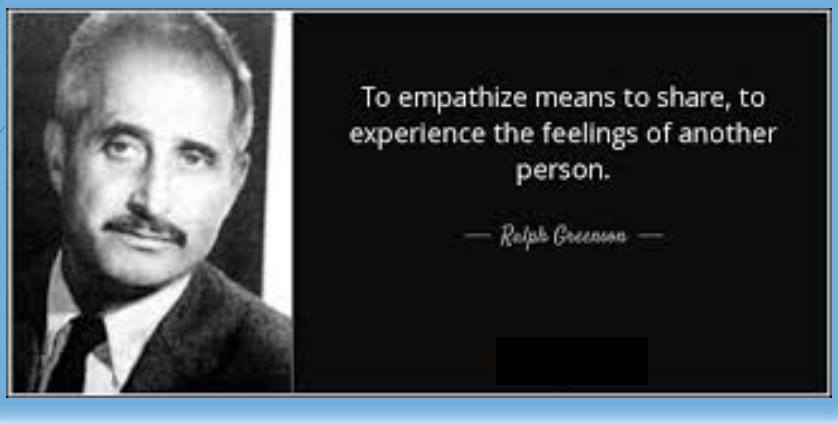
Ralph Greenson, 1967



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Transference
Laplanche & Pontalis, 1973

POSITIVE TRANSFERENCE

Therapist seen as:

- *Ideal*
- *Can do no wrong*
- *Nurturer and savior*
- *Wise and all-knowing*
- *May lead to "good patient" syndrome*

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Transference
Laplanche & Pontalis, 1973

NEGATIVE TRANSFERENCE

Relationship with therapist based upon:

- *Hostility and frustration*
- *Anger and rage at therapist*
- *Overt or covert fury*
- *Therapist can do no right*
- *Therapist seen as withholding and cold*

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Transference

NEGATIVE TRANSFERENCE

Examples

- *"Its cold in here"*
- *"Have you gained weight?"*
- *Constantly rejecting interpretations*
- *Insults*
  - *Colleague with scalp infection*

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Counter-transference

Much Debate About Definition

Primarily theoretical literature

Few empirical studies

Therapists rather speak about patients than themselves

- Difficulty admitting own feelings

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Counter-transference
Laplanche & Pontalis, 1973

Classical Definition

The whole of the analyst's (therapist's) unconscious reactions to the individual analysand (patient) – especially to the analysand's own transference.

- *Why analyst requires own analysis*
- *Prior to the "relationship or collaboration" belief system*
  - *LePlanche & Pontalis, 1973, p. 64*

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Counter-transference

Totalistic Definition

The analyst's conscious and unconscious reactions to the patient in the treatment situation which are reactions to the patient's reality as well as to his transference; and also to the analyst's own reality needs as well as to his neurotic needs

- *Kernberg, 1965, p. 38*

All feelings and attitudes of the therapist toward the patient

- *Epstein and Finer, 1965*

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Counter-transference

Unconscious CT

- *Neurotic reactions*
- *A hindrance*

Conscious CT

- *Awareness of patient's experience*
- *A tool*

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Counter-transference
Schoeberl, 2014

1. CT to Patient's Transference

- AKA "Objective" CT
- Direct reaction to patient's transference
- Taking on characteristics of patient's significant other
  - Deeper understanding of patient's experience
  - Tells you how patient felt as child
  - Gives information about parental relationship

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Counter-transference
Schoeberl, 2014

2. CT Based upon Activation of Therapist's Archaic Conflicts

- AKA "Subjective" CT
- Activation of unresolved issues
- Re-stimulation of issues with significant others
- Used as a tool for self-understanding
- Examine why specific patient elicits reaction
- Example
  - Patient's perfume

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Counter-transference
Schoeberl, 2014

3. CT Based Upon Reality

- *AKA "Objective" CT*
- *Actual patient behaviors, attitudes naturally elicit normal reactions from therapist*
- *Therapist NORMAL, NATURAL reactions*
- *Examples*
  - *Swastica*
  - *Forgetting checkbook*
  - *Kleenex guy…*

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Counter-transference

Dealing with your own reactions

- *Off hours calls*
- *Late cancellations*
- *Examples:*
  - *Tiger 'Woods bulging disk*
  - *"Dr. Harmell Speaking…"*
  - *When did they start "dating…"*
  - *"My Pleasure!"*
  - *"President Elect…"*

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Counter-transference
Schoeberl, 2014

Recognizing your own CT reactions

GOAL: to make CT conscious

- *Takes vigilance*
- *Introspection*
- *Continuing education*
- *Own psychotherapy*
- *Awareness of visceral responses*
- *Handling your CT: SELF CARE*
  - *Hobbies, time off, lit review, consult, possibly refer client*
  - *Personal therapy, workshops, continuing education*

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Counter-transference
Schoeberl, 2014

AS AN INVALUABLE TOOL

- *Major source of data for understanding*
- *Pay attention to non-verbal communication*
- *Visceral responses – clue to inner dynamics*
- *How others feel about patient*

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Counter-transference
Schoeberl, 2014

AWARENESS OF CT REACTIONS

- *Visceral reactions*
- *Over-reactions*
- *Re-capitulation of own issues*
- *Seek personal therapy*
- *Seek professional consultation*
- *Seek continuing education*

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Counter-transference

RESULTING PROBLEMS

- *Over-solicitousness*
- *"Withholding" or avoiding patient*
- *Need for patient's approval*
- *Identifying with patient*
- *Compulsive advice giving*

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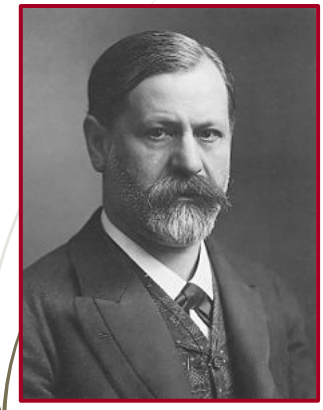
BURNOUT: Abandonment of Seduction Theory



Freud initially thought that his patients were relating more or less factual stories of sexual mistreatment, and that the sexual abuse was responsible for many of his patients' neuroses and other mental health problems. Within a few years Freud abandoned his theory, concluding that the memories of sexual abuse were in fact ***imaginary fantasies.***

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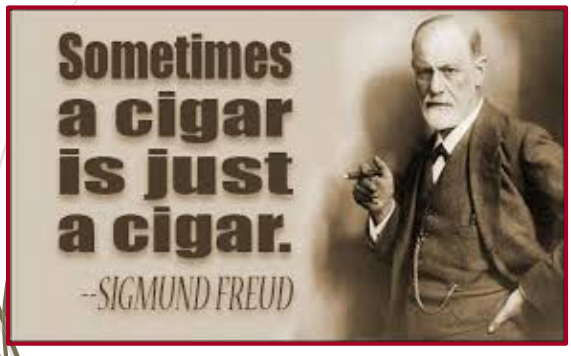
Abandonment of Seduction Theory

When I'm smoking it, Its just a cigar. When you're smoking it, It's a phallic symbol.



The Freudian Cover-up *is a theory first popularized by social worker Florence Rush in the 1970s, which asserts Freud intentionally ignored evidence that his patients were victims of sexual abuse.*

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Bibliography for CT – Iconic Sources

ORIGINAL SOURCES

Epstein, L., & Finer, A. (1979). Counter-transference: The therapist's contribution to treatment. Contemporary Psychoanalysis, 15, 489-513.

Freud, S. (1910). The future prospects of psychoanalytic therapy.

Greenson, R. (1987). The technique and practice of psychoanalysis. NY: International Universities Press.

Greenson, R. (1978). Explorations in psychoanalysis. NY: International Universities Press.

Heiman, P. (1950). On counter-transference. International Journal of Psychoanalysis, 31, 81-84.

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ORIGINAL SOURCES

Kernberg, O. (1965). Notes on counter-transference. Journal of the American Psychoanalytic Association, 13, 38-56.

Langs, R. (1982). Counter-transference and the process of cure. In: S. Slipp (Ed.), Currative factors in dynamic psychotherapy. (pp. 127-152). NY: McGraw-Hill.

Laplanche, J. & Pontalis, J. (1973). The Language of Psychoanalysis. NY: Norton.

Racker, H. (1957). The meaning and uses of counter-transference. Psychoanalytic Quarterly, 26, 303-357.

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The "Impaired" Professional
www.encyclopedia.com/

An impaired member of any profession creates legal and ethical difficulties for himself or herself, and can cause harm to others as well. For these reasons, the impaired professional merits serious attention.

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"Impairment" – Categories
Johnson, 2017; Smith & Moss, 2009

Three Categories of "Impairment"

1. *The Incompetent Professional*
   - *Poorly trained*
   - *Not abreast of current standard of care*

2. *The Unethical Professional*
   - *Dishonest*
   - *Uncaring*
   - *Predator*

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"Impairment" – Categories

Johnson, 2017; Smith & Moss, 2009

Three Categories of "Impairment"

Our Primary Discussion Point

3. The Impaired Professional

- *Not malicious, dishonest, or ignorant*
- *One who is ill*

"Interference in professional functioning due to chemical dependence, mental illness, or personal conflict." (p. 2)

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"Impairment" – Terminology

Johnson, 2017; Smith & Moss, 2009

Difference between "Distress" & "Impairment"

Warning Signal

Similar but distinctive

- *Distress does not necessarily lead to impairment*

Distress is "an experience of intense stress that is not readily resolved, affecting well-being, and functioning, or disruption of thinking, mood and other health problems that intrude on professional functioning." (p. 2)

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"Impairment" – Terminology
Johnson, 2017; Smith & Moss, 2009

Difference between "Distress" & "Impairment"

- *The line between the two remains blurred*

Impairment is "a condition that compromises the psychologist's professional functioning to a degree that may harm the client or make services ineffective." (p. 2)

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"Impairment" – Terminology
Johnson, 2017; Smith & Moss, 2009

Authors suggest the term
"NEGLIGENT PRACTICE"

- *Rather than the term "impairment"*

"If one's source of distress results in deficits of practice (e.g., a psychologist's depressive symptoms lead to premature termination of clients without appropriate preparation or referral), then these markers may also be considered to be impairment. Sexual intimacies with clients, a clear ethical violation (APA, 2002) that can be considered negligent practice, may also be a sign of impairment." (p. 3)

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Additional Resource

Morse, G. et al. (2012). Burnout in MH services: A review of the problem and its remediation. Admin Policy Mental Health, 39(5), 341-352.

Reith, T. (2018). Burnout in U.S. healthcare professionals: A narrative review. Cureus, 10(12), e3681

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"Impairment" – Statistics

Reith, 2018: Smith & Moss, 2009, p. 3

Rates of Distress/Impairment

Lack of consensus on definition

- *Depression*
  - *Self report survey = 42%*
    - *Experienced suicidal ideation*
    - *Or suicidal behavior*

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"Impairment" – Statistics

Morse et al, 2012; Smith & Moss, 2009, p. 3

Rates of Distress/Impairment

Lack of consensus on definition

- *Alcohol & Substance Abuse*
  - *Self Report Survey*
    - ***9%** experienced a drinking problem at sometime in professional life*
    - ***6%** conducted sessions while under the influence of alcohol*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

1. Difficulty Confronting Colleagues

- *Visibly alcohol impaired therapists*
  - ***43%** - worked with male colleague abusing a substance*
  - ***28%** - worked with female colleague abusing a substance*
  - ***ONLY 19%** confronted the abusing colleague*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

2. Failure to Identify Symptoms of Distress (1)

- *Reduced energy*
- *Decreased patience, irritability*
- *Decreased confidence*
- *Emotional exhaustion and isolation*
- *Grief, anger, and sorrow*
- *Hyper-vigilance and numbing*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

2. Failure to Identify Symptoms of Distress (2)

- *Quantity and quality of work fails*
  - *Falling behind in paperwork*
  - *Failure to maintain records*
  - *Tardy to work*
- *Working overtime or odd hours*
  - *Attempting to catch up*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

2. Failure to Identify Symptoms of Distress (3)

- *Intoxication and withdrawal symptoms*
  - *Hangover at work*
  - *Complaints from co-workers about work*
  - *Decrease in self-care, hygiene*
  - *Frequent, unexplained absences*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

3. Colleagues Who Fail to Act (1)

- *What prevents confrontation?*
  - ***43%** did not think behavior was affecting offender's professional functioning*
  - ***26%** believed intervention would result in adverse outcome*
    - *Fearful offender will deny problem*
    - *Fearful offender will reject help*
    - *Many hope someone else will handle it*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

3. Colleagues Who Fail to Act (2)

- *What prevents confrontation?*
  - ***22%*** *did not know what to do*
    - *Do not know what information is required*
    - *Unfamiliar with how to report*
  - ***19%*** *worried about risk to themselves*
    - *Reduced referrals*
  - ***13%*** *were preventing risk to the colleague*
    - *Fearful colleague will be disciplined*

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"Impairment" – Effective Management

Reith, 2018; Smith & Moss, 2009

Barriers to Intervention

4. Failure to Identify Distress in Oneself

- *Lack of education*
- *Fear expressing personal weaknesses*
- *Maintain appearance of complete competence*
- *Rationalization for unethical behavior*
  - *"Everyone does it!"*

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"Impairment" – Protected Term
Falender & Shafranske, 2018

Why the term should NOT be used

"It is no longer an option for psychologists to use "impairment" as a general term to refer to trainees who are functioning below expected performance levels... use of the term creates legal jeopardy."

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"Impairment" – Protected Term
Falender & Shafranske, 2018

Not meeting performance requirements

Why the term should NOT be used

- *Formerly described problematic behavior*
- *Current legal risk when using term*
- *Specific legal meaning akin to disabled*
  - *Prohibits discrimination*
  - *Requires employers to make accommodations*

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"Impairment" – Protected Term

Wikipedia, 2009

Americans with Disabilities Act, 1990, 2009

- *Signed into law July 26, 1990*
- *Amended January 1, 2009*

"It affords similar protections against discrimination to Americans with disabilities as the Civil Rights Act of 1964 which made discrimination based on race, religion, sex, national origin, and other characteristics illegal. Disability is defined as a physical or mental impairment that substantially limits a major life activity….a covered entity shall not discriminate against a qualified individual with a disability."

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"Impairment" – Protected Term

Falender & Shafranske, 2018

CAUTION:

"Use of the term 'impairment' or 'impaired' in the context of providing adverse or negative feedback or performance evaluation suggests that the evaluation was based on the physical or mental impairment (a potentially discriminatory act under the ADA), rather than on objective evaluation of performance tasks."

Examples:

Patient chart updates

Counter-transference issues

Attendance

Other requirements

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"Impairment" – Protected Term
Falender & Shafranske, 2018

Why the term should NOT be used

- *Creates legal jeopardy*
- *Must provide reasonable accommodations*

CAUTION:

"The law recognizes it is generally incumbent on the impaired individual to request an accommodation, the ADA requires employers to provide reasonable accommodation to the 'known physical or mental limitations of an otherwise qualified individual with a disability.' "

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"Impairment" – Protected Term
Falender & Shafranske, 2018

Potential Language

- *Problematic student / intern*
- *Troubled therapist*
- *Underperforming*
- *Weakness*
- *Deficiency*
- *Diminished*
- *Temporarily incompetent*
- *Inadequate functioning*

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Ethics and Critical Thinking
Pope & Vasquez, 2011, p. 16

The club of ethically perfect therapists – those with flawless ethical judgment and fallacy-free ethical reasoning – is snobbishly exclusive. So far, no one has qualified for membership.

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SELF-DISCLOSURE

DIVERSITY & SELF DISCLOSURE

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Therapist Self-Disclosure

Empirical Research

- *Controversial therapist intervention*

Enthusiastic Promotion ⟷ ***Adamant Opposition***

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Therapist Self-Disclosure

Ziv-Beiman & Shahar, 2016; Gutheil, 2010

Everything a therapist does or does not say is a disclosure, but not necessarily an inappropriate one

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Therapist Self-Disclosure

Sadighim, 2014; Gutheil, 2010

Definition

Statements that reveal something personal about the therapist

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Accidental Self-Disclosure

Dealing with your own reactions

- *Off hours calls*
- *Late cancellations*
- *Examples:*
  - *Tiger 'Woods bulging disk*
  - *"Dr. Harmell Speaking…"*
  - *"My Pleasure!"*
  - *"President Elect…"*
  - *"Go A-head…"*
  - *Patient's sister joined her to go out unexpectedly…*

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Diversity and Self Disclosure
Gallardo, 2012, 2006

Unwillingness for Patient to Self Disclose

- *Blank slate technique fails*
- *Specific interpretations may offend*
- *Understanding of "Collective" experience*
  - ***Any intervention effects entire system***
  - *Inquire regularly* →

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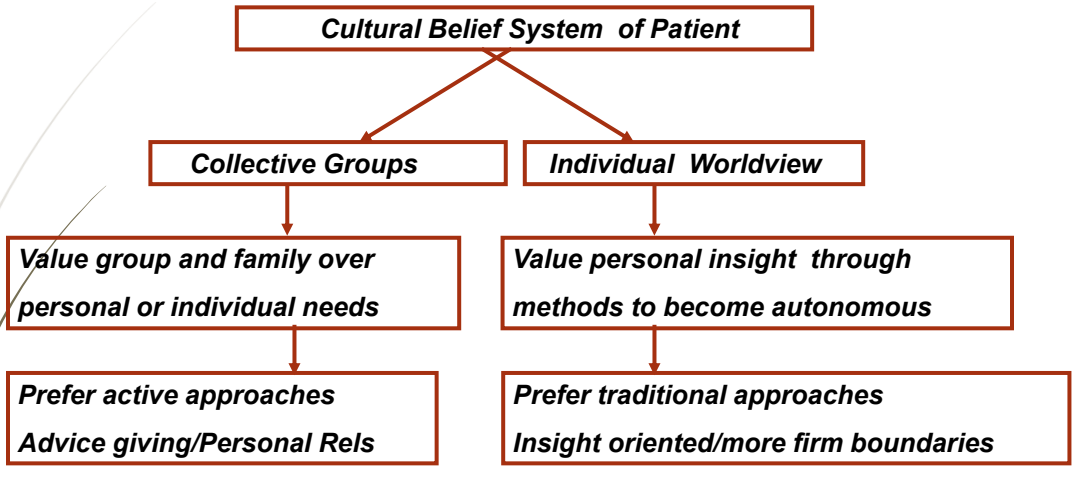
Diversity and Self Disclosure
Gallardo, 2012, 2006



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Self-Disclosure

Gutheil, 2010; Hill & Knox, 2001, p. 413

*Clients who have experienced a responsible informed consent process seem to view **self-disclosure** more positively and have more optimistic expectations for counseling outcome (Goodyear, Coleman, & Brunson, 1986).*

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Self-Disclosure

Pinto-Coelho et al, 2018; Gutheil, 2010

Positive Aspects

- *Elicits greater disclosure by client*
  - *In response to therapist's SD*
- *Enhances client self-exploration*
  - *Relationship issues*
- *Encourages atmosphere of honesty*
- *Strengthens therapeutic alliance*
  - *More on future slides*

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Self-Disclosure
Szezygiel, 2020; Gutheil, 2010

Why Not Disclose?

- *Interferes with projections and transference*
- *Disputes concept of anonymity*
- *Prevents abstinence and neutrality*
- *May blur boundaries*

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Self-Disclosure
D'Aniello & Nguyen, 2017; Pinto-Coelho et al, 2018

Three Types of SD

1. *Inescapable Disclosures*
   - *Real events such as pregnancy*
2. *Inadvertent Disclosures aka Immediate SD*
   - *In transference-CT dyad*
     - *Impulsive & unplanned*
   - *Tone of voice, clothing, personal attributes, office*

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Self-Disclosure
D'Aniello & Nguyen, 2017; Pinto-Coelho et al, 2018

Three Types of SD

3. *Deliberate Disclosures aka Intentional SD*
   - *Planned , more cautious*
   - *Not impulsive*

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Self-Disclosure

Major Concerns

- *Focus shifts from client to therapist*
- *Studies focus upon intentional therapist SD*
  - *Not uncontrolled SD*
- *Conclusions*
  - *Therapist SD can influence the outcome of Tx*
  - ***How?***

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Gold Standard, Foundational Research on
Self Disclosure
Mentioned in all Current Research on SD

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Self-Disclosure
Barrett & Berman, 2001, p. 602

Results

When therapists increased levels of "appropriate" SD, clients reported greater reductions in symptom distress than did clients whose therapists limited their level of SD

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Self-Disclosure
Barrett & Berman, 2001, p. 602

When Therapist Increases Level of Self-Disclosure…

↓

*Clients Report Greater Reduction in *Symptom Distress…*

↓

Than Did Clients Whose Therapists Limited SD

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Self-Disclosure
Barrett & Berman, 2001, p. 602

Results

Clients liked their therapists more when amount of therapist disclosure was increased

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Self-Disclosure
Barrett & Berman, 2001, p. 602

When Therapist Increases Level of Self-Disclosure…

↓

Clients Report Liking Their Therapists More…

↓

Than Did Clients Whose Therapists Limited SD

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Self-Disclosure
Pinto-Coelho et al, 2018; Myers & Hayes, 2006

Results Related to THERAPIST SDs

- *SDs were brief and infrequent*
- *Approximately 5 per session*
- *Averaged < 15 seconds each*

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Self-Disclosure
Barrett & Berman, 2001

Results Related to CLIENT SDs

- *Far more frequent*
- *Mean of 60 per session*
- *Client disclosures dominated sessions*

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Self-Disclosure
Pinto-Coelho et al, 2018; Gutheil, 2010

Safeguards

- *Monitor and assess continually*
- *Guard against excessive SD*
- *Continue self-scrutiny*
- *Prepare to work through full range of client's feelings and reactions*
- *Unintentional SD must be considered carefully for counter-transference reactions*

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Self-Disclosure
Pinto-Coelho et al, 2018; Gutheil, 2010

Guidelines

- *Focus on timing and sensitivity*
- *Remain patient-focused*
- *Awareness of patient's resources and strengths in handling SDs*
- *Model emotional honesty*
- *Explore meaning of SD in Tx process*

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Self-Disclosure
Pinto-Coelho et al, 2018; Gutheil, 2010

Guidelines

- *Monitor client's self-distortions*
- *Exploration of transference schemas*
- *Focus on observational feedback*

Examples:

"I don't think that would be helpful to you…"

"I worry that you do not fully understand the effect your words have upon others…"

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Self-Disclosure
Pinto-Coelho et al. 2018

Spontaneous Disclosure of Counter-transference

- *Caution with spontaneous SDs when therapist is tested emotionally*
  - *Anger*
  - *Exhaustion*
  - *Pressure*
  - *Work overload*
- *Frustrated SD versus "formulated"*

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Self-Disclosure
Gutheil, 2010; Bridges, 2001

Repair of Injuries in Therapeutic Relationship

- *When therapist inadvertently crosses boundaries, or…*
- *If client is injured*
- *Understanding internal and relational issues*
- *Attempt to repair the connection*
- *My example: Steve and Bill*

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Self-Disclosure & Counter-transference
Yeh & Hayes, 2011; Myers & Hayes, 2006

Findings

- *Judicious use of SD and counter-transference disclosures (CTD) can be therapeutic*
- *Little empirical data about effects of SD of therapist counter-transference to clients*
- *Authors looked at concept*

SD = Self-Disclosure
CTD = Counter-transference Disclosure

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As Judged by Doctoral Student Subjects When Alliance Was…

Positive

When SD or CTD was made
- ***Sessions were rated deeper***
- ***Therapist viewed more expert rather than when none made***

Negative

When SD or CTD was made
- ***Sessions were rated shallower***
- ***Therapist rated less expert than when no disclosures made***

SD = Self-Disclosure
CTD = Counter-transference Disclosure

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Self-Disclosure & Counter-transference
Yeh & Hayes, 2011; Myers & Hayes, 2006, p. 181

From Previous Findings

- *Self disclosing therapists judged more generally attractive and trustworthy*
- *Reports were more favorable when SD was more personal in nature*

SD = Self-Disclosure
CTD = Counter-transference Disclosure

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Self-Disclosure & Counter-transference
Pinto-Coelho et al, 2018; Myers & Hayes, 2006

General Findings

- *SD problematic when therapeutic alliances are weak*
- *SD beneficial when therapeutic alliances are strong*

SD = Self-Disclosure
CTD = Counter-transference Disclosure

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Self-Disclosure & Counter-transference
Pinto-Coelho et al, 2018

Client Reactions

- *"Experienced" clients preferred CTD over general SD*
- *"Inexperienced" clients preferred general SD over CTD*
- ***Authors' Explanation:***

  -- Perhaps experienced clients were more familiar with therapist CTD than inexperienced clients

  -- THUS, do not make self revealing disclosures until after solid alliance is established

SD = Self-Disclosure
CTD = Counter-transference Disclosure

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Self-Disclosure & Counter-transference
Pinto-Coelho et al, 2018; Myers & Hayes, 2006

General Findings

- *"Blank Slate" is not fully possible*
  - *Research shows as contra-indicated*
  - *Valuable information can be lost*
- *CT is inevitable*
  - *Studies report CT in approx. 80% of sessions*
  - *Must be handled therapeutically*

SD = Self-Disclosure
CTD = Counter-transference Disclosure

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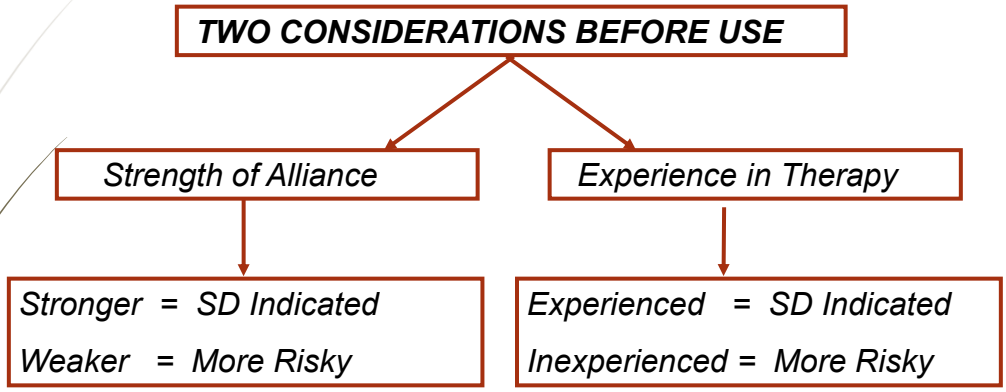
Two Primary Considerations
Pinto-Coelho et al, 2018; Myers & Hayes, 2006



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Self-Disclosure
D'Aniello & Nguyen, 2017

Other Considerations

Details on next slides

- *Client's diagnosis*
- *Presenting concerns*
- *Phase of therapy*
- *Skill level of therapist*
- *Personality of therapist*
- *Personality of client*

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Self-Disclosure
McCormic & Segrist, 2018

Risky Client Traits

- ***Borderline Personality Disorder***
  - *Risky if done impulsively*
    - *Litigious and unpredictable*
  - *Overlapping boundaries with therapist*
- ***Victimized or Abused Clients***
  - *Atmosphere of sympathy*
  - *Desire to rescue*
  - *Caution with over-identification*

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Self-Disclosure
McCormic & Segrist, 2018

Risky Client Traits

- *Similar Background or Situation as Therapist*
  - *Over identification with client*
  - *Tend to offer disclosures to aid recovery*
  - ***End***

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Client-Therapist Discussion
Racial and Ethnic Differences
Zhang & Burkard, 2008

"Perhaps the most significant factor in determining whether a client engages in counseling is the counseling relationship, particularly when the client and the counselor are racially and ethnically different." (p. 77)

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Diversity and Self Disclosure
Gallardo, 2012

Assume Less-Traditional Stance

- *To gain trust*
- *To promote credibility*
- *To provide foundation for connecting*
- *Demonstrate therapist is not part of "untrustworthy" establishment*

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Diversity and Self Disclosure
Sunderani, 2016; Gallardo, 2012

Less-traditional techniques

- *May be advantageous with diverse clients*
- *Self disclosure of personal experiences*
- *Advice giving*
- *Consultant*
- *Advocate*
- *Community activist*

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Clinical Implications from Research
Henretty & Levitt, 2010

Research Findings

- *Therapist self-disclosures were one of the few remarks clients remembered after termination*
- *It is one of the rarest therapeutic techniques*
- *May dilute the therapeutic potency*
- *Choose disclosures wisely*

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Therapist Self-Disclosure
Hill et al., 2018; Gutheil, 2010

Clients who have experienced a responsible informed consent process seem to view self-disclosure more positively and have more optimistic expectations for counseling outcome

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Pros and Cons of Therapist SD
Sadighim, 2014; Howe, 2011

PROS	CONS
Decrease in PT isolation	*Therapist seen as impaired*
Decrease in PT shame	*Therapist seen as self-focused*
Instill hope in PT	

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Therapist Self-Disclosure
Gutheil, 2010

Negative Aspects of Self-Disclosure

- *NEVER disclose from a position of ANXIETY*
- *Interferes with client perceptions*
- *Prevents neutrality*
- *May become more about therapist than client*
- *May blur boundaries*
- *Influences client disclosures*
- *AA slogan: WAIT*

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When it comes to putting something questionable online, take a lesson from AA…WAIT

W	***Why***
A	***Am***
I	***I***
T	***Talking***

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Online Inadvertent Self Disclosure
Hill et al., 2018; Zur, 2009

Online Inadvertent Self Disclosure

- *Client conducts online search of therapist*
- *Client paying for online search of therapist*
- *Client "curiosity" versus "stalking"*
  - *Finding out where therapist spends time*
  - *Club memberships*
  - *Religious affiliations*
  - *Political contributions*

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Online Inadvertent Self Disclosure
Hill, et al., 2018; Zur, 2009

Online Inadvertent Self Disclosure

- *Assume anything you post is available to public*
- *Do not discuss cases online*
- *Avoid online consultations*

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Diversity and Self Disclosure
Hill et al., 2018; Welfel, 2016

Sample Vignette – Lunchtime Session

Therapist fits a client in during his lunch hour. Knowing it is his lunch hour, she brings food to the session for the therapist in order to show her understanding of his commitment to her.

Self disclosure: may be verbal or non-verbal

- *A smile; a thank you*

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Clinical Implications from Research
Sunderani, 2016; Henretty & Levitt, 2010

Therapist Self-Disclosure Considerations

1. *Whom*
2. *What*
3. *When*
4. *How*
5. *Therapist responsiveness to client reaction*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline One: To WHOM Should Therapist SD? (1)

- *Clients with strong alliance and / or positive relationship*
- *Clients with ego-strength*
- *Sophisticated clients*
  - *More familiarity with treatment methods*
- *If therapist and client are members of the same small community*
  - *To avoid client learning about their therapist outside of therapy*
  - *Example: Sexual orientation; religion; values*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline One: To WHOM Should Therapist SD? (2)

- *Choose carefully*
- *Consider in advance*
  - *Clients who want to feel connected to their therapists*
    - *May perceive therapist SD as rewarding*
  - *Clients who value separateness and traditional therapy roles*
    - *May perceive therapist SD as intrusive*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Two: WHAT Should Therapist SD? (1)

- *Demographic information*
- *Values that may conflict with client values*
- *Professional information*
  - *Education, theoretical orientation, experience*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Two: WHAT Should Therapist SD? (2)

- *Practice caution when considering disclosures*
  - *Example: therapist struggles with addictions*
  - *May interfere with client's sobriety*
  - *Clients censoring themselves out of fear they might negatively affect their therapist*
  - *May illicit competition between client and therapist*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Three: WHEN Should Therapist SD?

- *Inconsistent results from research*
  - *Some therapists believe disclosing personal values is part of ethical informed consent*
  - *Presents therapist honesty*
- *Evaluate if therapist SD disturbs the therapeutic alliance*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Four: HOW Should Therapist SD?

- *Unspoken rule:*
  - *If client asks therapist personal information…*
    - *Before answering question evaluate the meaning to the patient*
  - *Disclose after consideration*
  - *Do not disclose impulsively*
    - *WAIT!!*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Four: HOW Should Therapist SD?

- *Therapist self-disclosures should contain only information necessary for therapeutic goals*
- *No need to share personal information*
- *Avoid self-gratification*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Five: RESPONSIVENESS to Client's Reaction (1)

- *Before, during, and after a self-disclosure…*
- *Check in with clients to see how they feel about the SD*
  - *"I too am a single parent"*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Five: RESPONSIVENESS to Client's Reaction (2)

- *Ask clients' permission prior to SD*
  - *"I also struggle with public speaking. May I tell you some techniques that have been useful to me?"*
- *Some clients may need therapist's reasons for disclosing*
  - *"I have found it is helpful for our working relationship if I tell you a little about myself"*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Five: RESPONSIVENESS to Client's Reaction (3)

- *Observe carefully how client responds*
- *Look for…*
  - *Decreased eye contact*
  - *Cancelled appointments*
  - *Overly worrying about therapist welfare*

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Clinical Implications from Research
Henretty & Levitt, 2010

Guideline Five: RESPONSIVENESS to Client's Reaction (4)

- *Ask about client reactions*
  - *"I noticed when I spoke about my own sobriety you had a reaction… can we talk about that?"*
- *Use the information for treatment planning*
  - *Did SD aid or disturb the alliance?*

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Conclusions from Research
Pinto-Coelho et al, 2018; Barnett, 2011

Conclusions

- *A thoughtful approach rather than simple avoidance*
- *Contextual factors*
- *Therapist's motivation*
- *Consider cultural aspects*
- *Consider boundaries and ground rules*
  - *Therapeutic frame*
- *Awareness of client reactions to therapist SD*

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Conclusions from Research
Sadighim, 2014

Prior to Using SD Consider:

- *Is SD intended to help client or to a gratify my own personal need*
- *Does the client need to know this information to make informed consent about treatment*
- *Might this disclosure negatively impact the client's perception of my competence and professionalism*
- *How much and how often am I disclosing with this particular client*

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When it comes to client care and boundary violations,

take lesson from AA…HALT

Do not do anything impulsive when feeling…

H	***Hungry***
A	***Angry***
L	***Lonely***
T	***Tired***

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Sum Up Question

What are the three types of therapist self-disclosure?

ANSWER

1. *Inescapable*
2. *Inadvertent*
3. *Deliberate*

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Sum Up Question

What did the research find are the two primary considerations we should think about prior to using self-disclosure?

ANSWER

1. *Strength of alliance*
2. *Experience in therapy*

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Therapist Self Care

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Therapist Self-Care

Kleespies et al., 2011, p. 3

Statistics:

- *Rate of suicide for male psychologists*
  - *Same as general population*
- *Rate of suicide for female psychologists*
  - *Significantly elevated than females in general population*
  - *Nearly three times greater*
- *Under-reporting limits reliability*
  - *Stigma*

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Causes of Burnout
McCormack et al, 2018

Primary Causes of Burnout For Professionals

- *Professional responsibilities*
- *Intense nature of the work*
- *The work environment*
- *Job stress*
- *Vicarious traumatization*
- *Barriers to care*
- *Worry about patients during off hours*
- *Paperwork*

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Therapist Self-Care
Kleespies et al., 2011

Factors Contributing to Therapist Suicide

- *All same factors from general population*
- *Plus…*
  - *Professional responsibilities*
  - *Intense nature of the work*
  - *The work environment*
  - *Barriers to care*

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Therapist Self-Care
Posluns & Gall, 2019

Self-Care as Preventative Measure

- Regular self assessment
- Coping strategies
  - More on future slides
- Consultation
  - Decreases shame, embarrassment, feeling powerless

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Therapist Self-Care
Posluns & Gall, 2019

Barriers to Seeking Help

- Financial ramifications
  - Fear referrals will stop
- Lack of time
- Unaware there is a problem
- Not knowing personal indicators

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Therapist Self-Care
Posluns & Gall, 2019

Personal Indicators

- Note changes in behavior
- Changes to thinking
- Changes to professionalism
- Comments or reactions from others

10/12
10:45

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Career Sustaining and Self Care Techniques
Posluns & Gall, 2019; Dattilio, 2015

Career Sustaining and Self Care Techniques

- Hobbies
  - Music, reading, cooking, art, etc.
- Balance in work and professional life
- Regular consultation
- Exercise
- Reduce work hours where possible
- Other pleasurable activities
- Humor

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Self Care
Dattilio, 2015; Smith & Moss, 2009

Burnout Rates Higher Among:

- *Younger care givers*
  - *Less experience and resources*
- *Agency workers*
- *Vicarious traumatization workers*
  - *More likely with personal trauma history*
  - *More later*

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Therapist Self-Care
Posluns & Gall, 2019

Varied Roles Changing Rapidly Causes Stress

1. *Very little time to process*
2. *Limited time to transition*
3. *Not enough time to fully recover after difficult interactions with clients*

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Developing Resilience
Tjeltvett & Gottlieb, 2010

Resilience

"A class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development." (p. 100)

Vulnerability

"The areas in our lives that are not well protected from ethical lapses." (p. 101)

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Developing Resilience
Tjeltvett & Gottlieb, 2010

Vulnerabilities to Impairment

General Vulnerabilities

Idiosyncratic Vulnerabilities

Affect everyone
- *Errors in judgment*
- *Stressful work life*
- *Stressful personal life*

Particular to the individual
- *From personal history*
- *Childhood events*
- *Trauma*

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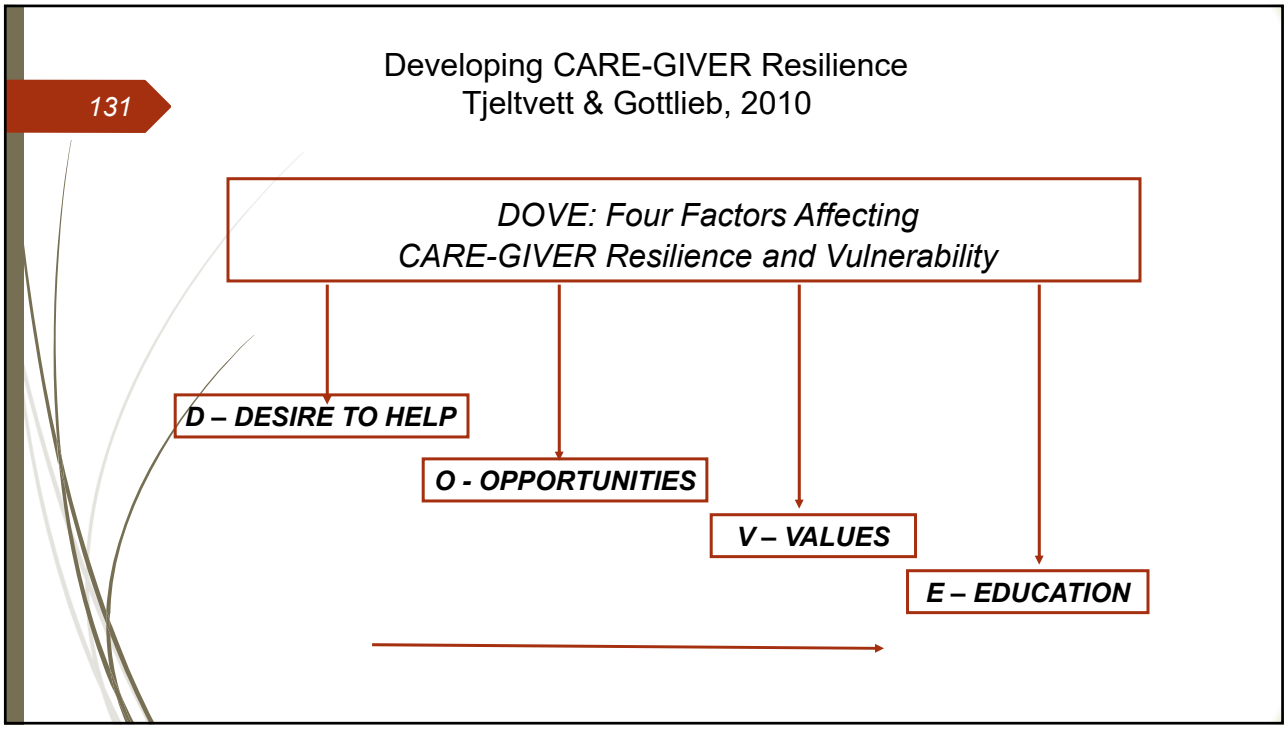
Developing CARE-GIVER Resilience
Tjeltvett & Gottlieb, 2010



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D.O.V.E. Model of Resilience & Vulnerability
Tjeltvett & Gottlieb, 2010

D - Desire to Help

- *Primary reason care givers enter profession*
- *Wish to benefit society*
- ***Resilience:***
  - *Effort to help despite adversity*
- ***Vulnerability:***
  - *"There is nothing that has gotten us into trouble more than the desire to be helpful!" (S. Behnke)*
  - *Requires skills in boundaries*
  - *We may want to help too much*
    - *Eg. Woman who gave a room in her home to her patient*

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D.O.V.E. Model of Resilience & Vulnerability
Tjeltvett & Gottlieb, 2010

O - Opportunity

- *To contribute to society through education*
- *To provide clinical care and help others*
- ***Resilience:***
  - *Kudos for work well done*
  - *Success in the care giver role*
- ***Vulnerability:***
  - *Exploitation and abuse of power*
  - *Abuse of client trust*
  - *Taking advantage of client*
    - *Ex: therapist who accepted tickets to Oscar party*

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D.O.V.E. Model of Resilience & Vulnerability
Tjeltvett & Gottlieb, 2010

V - Values

- *Professionals share certain core values*
  - *Important to contribute to society*
  - *Quest for knowledge*
- ***Resilience:***
  - *Aids in self care and self knowledge*
  - *Propels one forward*
- ***Vulnerability:***
  - *Self-serving behaviors*
    - *Ex. Falsifying data to get a study published*

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D.O.V.E. Model of Resilience & Vulnerability
Tjeltvett & Gottlieb, 2010

E - Education

- *Provision of knowledge and resources*
- *Continuing education to help others*
- *Prevents mediocrity*
- ***Resilience:***
  - *Lifelong rewarding process*
  - *Improves professional functioning*
- ***Vulnerability:***
  - *Assumption taking workshop is enough*

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Sum Up Questions

What is the primary prevention for therapist burnout?

***ANSWER**:*

Self care techniques

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Sum Up Questions

Name three stressors particular to psychotherapists:

Answer:

- *Professional responsibilities*
- *Intense nature of the work*
- *The work environment*
- *Barriers to care*
- *Paperwork*

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138

Sum Up Questions

Which gender is most likely to commit suicide in the population of psychotherapists according to the research?

Answer:

- *Rate of suicide for male psychologists*
  - *Same as general population*
- *Rate of suicide for female psychologists*
  - *Significantly elevated than females in general population*
  - *Nearly three times greater*

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Sum Up Questions

What is the DOVE method of building resilience for psychotherapists?

Answer:

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Developing CARE-GIVER Resilience
Tjeltvett & Gottlieb, 2010

DOVE: Four Factors Affecting CARE-GIVER Resilience and Vulnerability

- ***D – DESIRE TO HELP***
- ***O - OPPORTUNITIES***
- ***V – VALUES***
- ***E – EDUCATION***

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Sum Up Questions

The research suggests one of the three types of self-disclosure has better outcomes. Which one?

ANSWER:

1. *Inescapable Disclosures*
2. *Inadvertent Disclosures*
3. *Deliberate Disclosures*

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Sum Up Questions

All therapists are vulnerable to self disclosure that is not well thought out, especially when experiencing anxiety with a client.

ANSWER:

TRUE *FALSE*

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Sum Up Questions

Which of the two groups below might be more receptive to therapist self-disclosure?

ANSWER:

Collective Worldview

Individual Worldview

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Sum Up Questions

In the research findings, clients "liked" their therapists more when they gave appropriate and brief self disclosures.

ANSWER:

TRUE

FALSE

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