

## Law and Ethics

A-2

### **CE – refresher of what you already know**

- Confidence builds competence and vice versa

### **Competence – Learning new skills and current updates**

- Hopefully this workshop has both
- My perspective...
- The “law of no surprises”
- Bibliography at end of each section
- Slide numbers won’t match yours
- You have some slides I MAY not be discussing due to time constraints but I wanted you to have the information
- Questions will be collected at the end of each section
- Relax and plug into our professionalism

**Dr. John Norcross**  
**“Belief in what we are doing is primary element of successful treatment”**

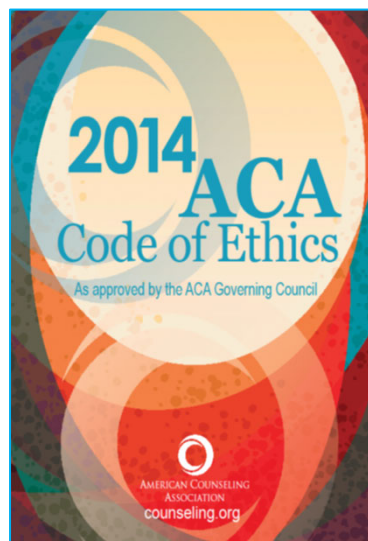


**Dalai Lama: “When in doubt, be kind”**

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## Mechanism #2 ~ Ethics Codes ~ LPCCs ACA.ORG

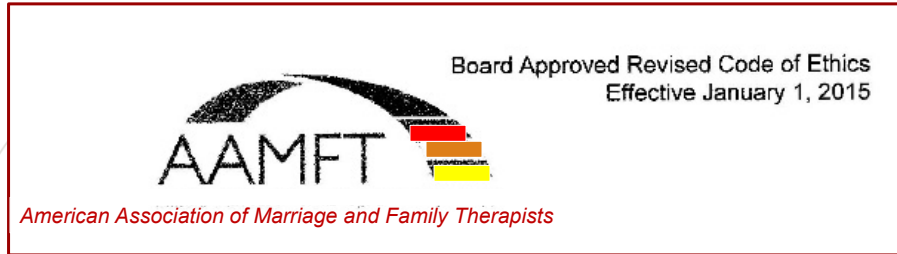
A-2



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A-3

## Mechanism #2 ~ AAMFT of Ethics, 2015



### AAMFT Ethics Committee

#### Commitment to Service, Advocacy and Public Participation

Marriage and family therapists are defined by an enduring dedication to professional and ethical excellence, as well as the commitment to service, advocacy, and public participation. The areas of service, advocacy, and public participation are recognized as responsibilities to the profession equal in importance to all other aspects. Marriage and family therapists embody these aspirations by participating in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return. Additionally, marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest. Marriage and family therapists also encourage public participation in the design and delivery of professional services and in the regulation of practitioners. Professional competence in these areas is essential to the

#### Ethical Decision-Making

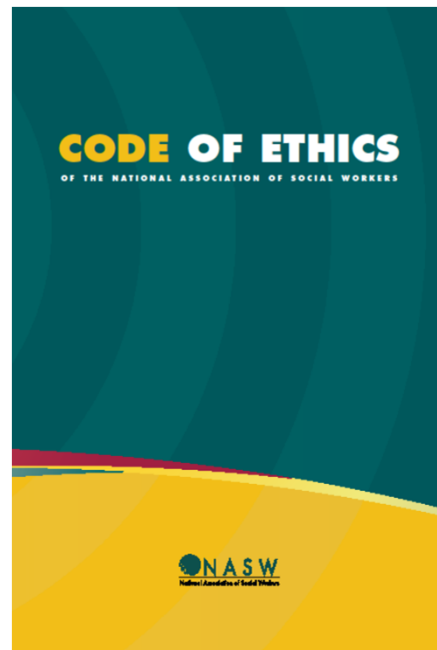
Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

Marriage and family therapists remain accountable to the AAMFT Code of Ethics when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the

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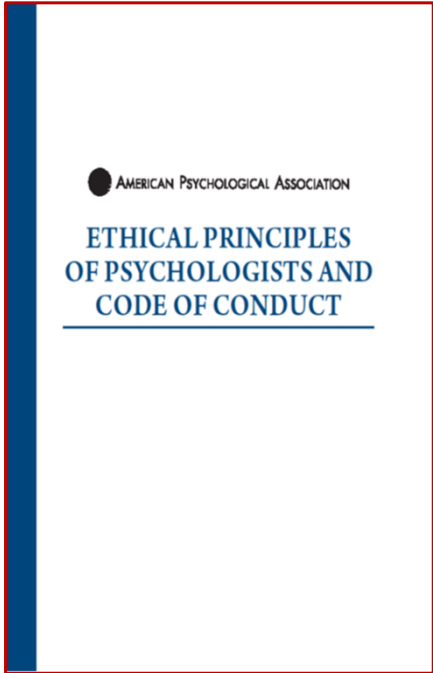
A-4

## Mechanism #2 ~ NASW [www.socialworkers.org](http://www.socialworkers.org) 2018



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A-5 Mechanism #2 ~ APA  
[www.apa.org](http://www.apa.org)  
2017



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6 Update to APA Code of Ethics

*The APA Ethics Code Task Force (ECTF) is engaged in the process of drafting a transformational new Ethics Code. That Code will retain those aspects of our Ethical Principles of Psychologists and Code of Conduct that serve the public and our discipline and profession well.*

*The goal is an Ethics Code that remains a leading practical resource regarding ethics for psychological science, education, and practice.*

SEE <https://www.apa.org/ethics/task-force>

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## Status of New APA Ethics Code

<https://www.apa.org/ethics/task-force/updates-ethics-code-revisions.pdf>

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A-8

Ethical Guidelines  
National Latina/o (AKA Latinx)  
Psychological Association  
January 1 2018

[Ethical Guidelines NLPA Adopted Jan 1st.pdf](#)

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A-9

Ethical Standards of Association of Black Psychologists  
<https://www.abpsi.org/LCPP.html>

*PREAMBLE*

*We hold to be true that persons certified in **African Centered/Black Psychology** are completely committed to no less than the absolute liberation of the Black mind shall be recognized as proficient or competent in African Centered/Black Psychology. We also hold to be true that the commitment process simultaneously recognizes:*

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

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A-10

<https://gaylesta.org/code-of-ethics>



**GAYLESTA**

*GAYLESTA, The Psychotherapist Association for Gender and Sexual Diversity, is an organization of mental health professionals who come from a variety of professional backgrounds and with a wide range of clinical specializations.*

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## Ethics Codes that Apply

*AAMFT 3.3 Seek Assistance*

*ACA A.1 Client Welfare*

*NASW 4.05 Impairment*

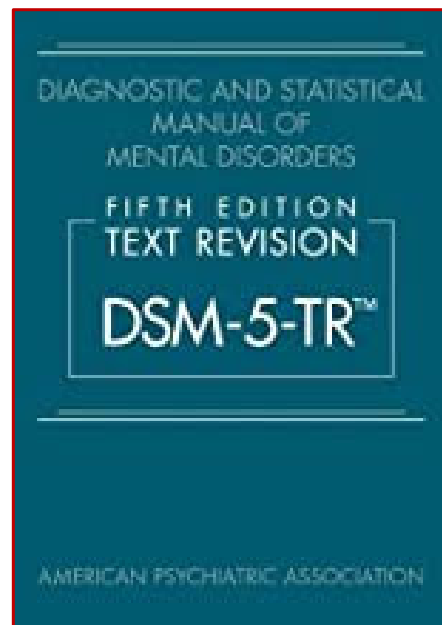
*APA 2.06 Personal Problems and Conflicts*

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C-12

## DSM-5-TR

[https://dsm-psychiatryonline-org.lib.pepperdine.edu/doi/full/10.1176/appi.books.9780890425787.x00a\\_preface\\_to\\_TR](https://dsm-psychiatryonline-org.lib.pepperdine.edu/doi/full/10.1176/appi.books.9780890425787.x00a_preface_to_TR)



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B-13

## Counter transference

*In a systematic review of 25 counter-transference studies, researchers found an association with positive counter-transference, such as feeling close to the client, and positive outcomes, including improvement of symptoms and a good therapeutic relationship.*

**RESOURCE:**

de Bitencourt Machado D, da Cunha Coelho FM, Giacomelli AD, et al. [Systematic review of studies about countertransference in adult psychotherapy](#). Trends Psychiatry Psychother. 2014;36(4):173-185. doi:10.1590/2237-6089-2014-1004

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B-14

## Counter transference As A Jointly Created Phenomenon Gabbard, 2017

### **A Jointly Created Phenomenon**

- *Clinicians accept countertransference can be a useful source of information about the patient*
  - *Therapist feels a certain way in the session*
  - *This may be how others feel when they are with the patient*
- *At the same time, the therapist's own subjectivity is involved in the way the patient's behavior is experienced by the therapist*

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B-15

Counter transference As A Jointly Created Phenomenon  
Gabbard, 2017

Therapist responds in a way that reflects influence by patient's projection into the therapist

Therapist is enacting something that originated in the internal world of the patient

Known as the "Counter transference Enactment"

Has valuable aspects that can be discussed between patient and therapist

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B-16

Projective Identification (PI)  
Klein, 1949; Gabbard, 2017

**A Mode Of Projection**

- ▶ *PI is a defense mechanism in which the individual projects qualities that are unacceptable to the self onto another individual*
- ▶ *That person internalizes the projected qualities and believes himself or herself to be characterized by them (to split off the bad aspects)*
- ▶ ***Projective identification and countertransference reflect the patient's attempt to evoke feelings in the therapist that the patient cannot tolerate***
- ▶ *Melanie Klein: a defense mechanism in which a person fantasizes that part of his or her ego is split off and projected into the object*
- ▶ *The patient may project some aspects of his/her internal world into the therapist, and the therapist may react as though he/she has been "taken over" by the patient.*

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Projective Identification (PI)  
Klein, 1949; LaPlanche and Pontalis, 1973

**A Mode Of Projection**

- ▶ *Projective Identification can be understood in three steps:*
  - ▶ *a) an aspect of the patient's self (or an internal representation of others) is projectively disavowed (split off) by the patient and unconsciously placed in the therapist;*
  - ▶ *b) the patient exerts interpersonal pressure that coerces the therapist to experience or unconsciously identify with what has been projected; and*
  - ▶ *c) the recipient of the projection processes and contains the projected contents and helps the patient take back, in modified form, what has been projected*

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B-18

Managing Counter transference  
Allen, 2020

*Traditional self-care activities, which are usually focused on relaxing, reducing stress, and increasing our joy, may be inadequate in and of themselves for managing countertransference and projective identification reactions*

- ▶ *More in self care discussion later*

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B-19

## Managing Counter transference Hayes et al, 2018

### **Results of Research on Counter transference**

*Meta-analytic evidence points to the likely conclusions that the acting out of CT is typically harmful, though not necessarily irreparably so, and that CT management typically proves helpful to patient outcomes*

*Developing CT awareness:*

1. *Professional consultation*
2. *Return to therapy*
3. *Peer consultation*
4. *Self care*
5. *Reflection*
6. *Literature review*

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## Counter-transference Definitions Westerling et al, 2019

### **Counter-transference**

**General:** *The therapists' feelings and reactions to their patients*

**Historically:** *Seen as a hindrance and obstacle*

**Currently:** *Seen as an integral and useful element of psychotherapy*

**Research:** *Countertransference is a robust construct in predicting therapy outcomes*

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Counter-transference Definitions  
Allen, 2020; Westerling et al, 2019

B-21

**CT is an inevitable aspect of psychotherapy**

*Positive and negative effects*

*Depending on how the therapist deals with it*

*It generally comes on gradually*

*Thus it is harder to acknowledge*

**Therapist self-insight:** *The extent to which the therapist is aware of his or her own feelings*

**Therapist self-integration:** *Therapist's possession of an intact, basically healthy character structure*

**Anxiety management** *refers to therapist's ability to experience and handle anxiety*

*The internal skill to control and understand anxiety*

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Counter-transference Considerations  
Hayes et al, 2018

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**Empathy:**

*Permits the therapist to focus on the patient's needs*

*despite difficulties he or she may be experiencing*

*Empathy is part of a larger sensitivity to feelings*

*Awareness prevents acting out of CT*

**Conceptualizing Ability:**

*Therapist's ability to draw on theory and personal*

*awareness in the work*

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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

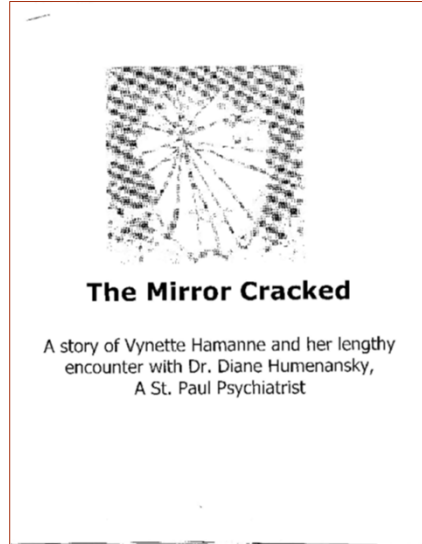
### *Mental Check List*

- *Is this feeling characteristic of how I feel in a session*
  - *How often do I have this feeling*
- *Why do I have this feeling with this particular patient*
- *Is the feeling triggered by something unrelated to the patient*
  - *Feelings caused by hunger, one's personal life, bureaucracy in the agency and profession*
- *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 3 min)

### **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



To empathize means to share, to  
experience the feelings of another  
person.

— Ralph Greenson —

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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*

2/12  
8:30

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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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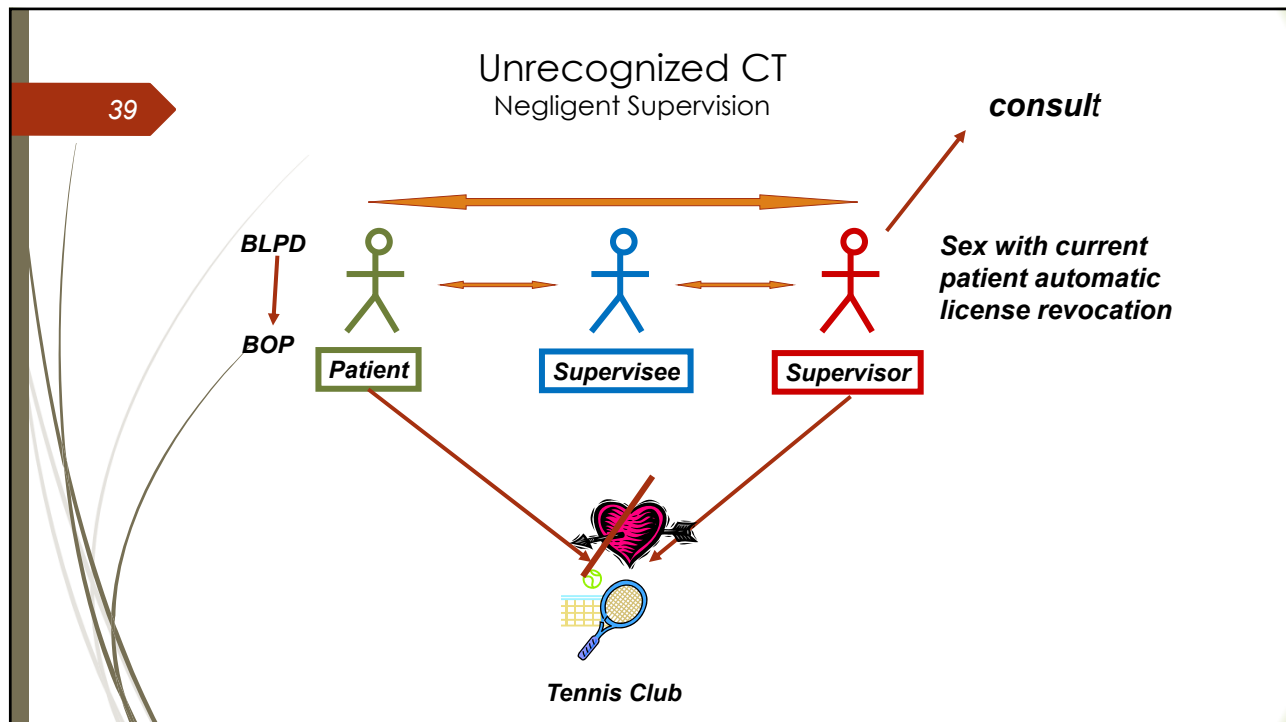
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Counter-transference  
Schoeberl, 2014

## **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  
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

**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



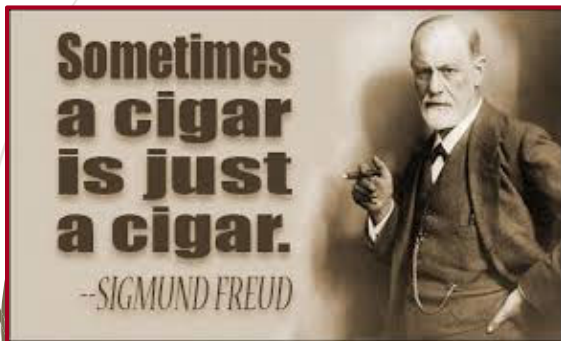
*Freud initially thought that his patients were relating more or less factual stories of sexual mistreatment, and that the sexual abuse was responsible for many of his patients' neuroses and other mental health problems. Within a few years Freud abandoned his theory, concluding that the memories of sexual 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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## Bibliography on CT – Iconic Sources

### **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.), *Curative 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/](http://www.encyclopedia.com/)

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

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## 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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## 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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## 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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## 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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## 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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## 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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## 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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## 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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## 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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## 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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## 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, 2021

### *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

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, 2021

### **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, 2021

### **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, 2021

### Potential Language

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

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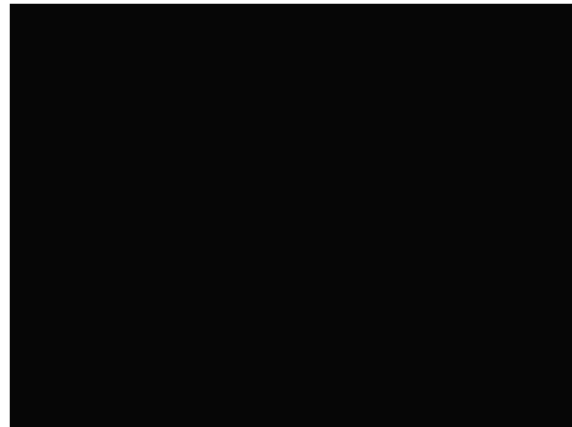
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### “Impaired Therapist” to the Extreme (captioned 3.5 min)



claims the killing was self-defense. jurors must hear about the couple's bizarre relationship, which began nearly 30 years ago, Horowitz said.

Susan Bolling, then 15, was sent to Felix Polk, then 40, first for an evaluation, and subsequently for therapy. She wasn't going to school regularly and her family and school counselors were concerned. Within a year, however, the doctor-patient relationship changed, and Susan began having a sexual relationship with the married father of two, according to the defense.



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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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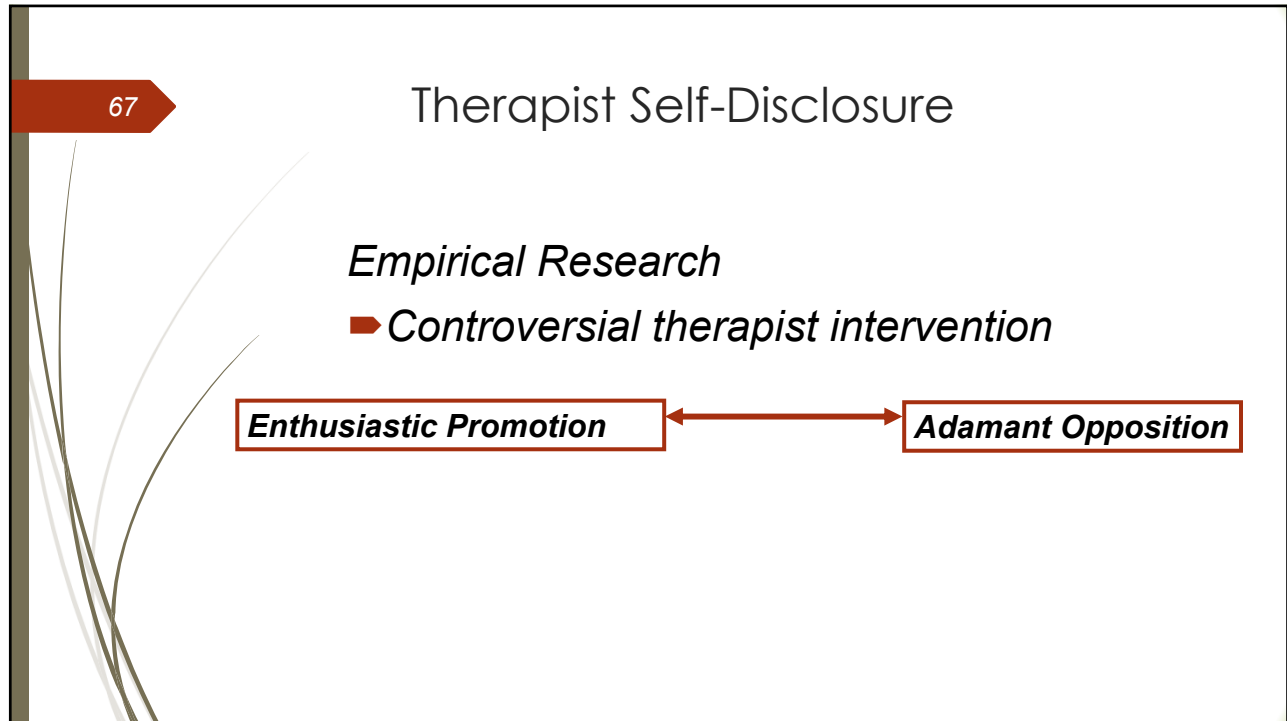
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## Therapist Self-Disclosure

*Empirical Research*

- ▀ *Controversial therapist intervention*

**Enthusiastic Promotion** ↔ **Adamant Opposition**



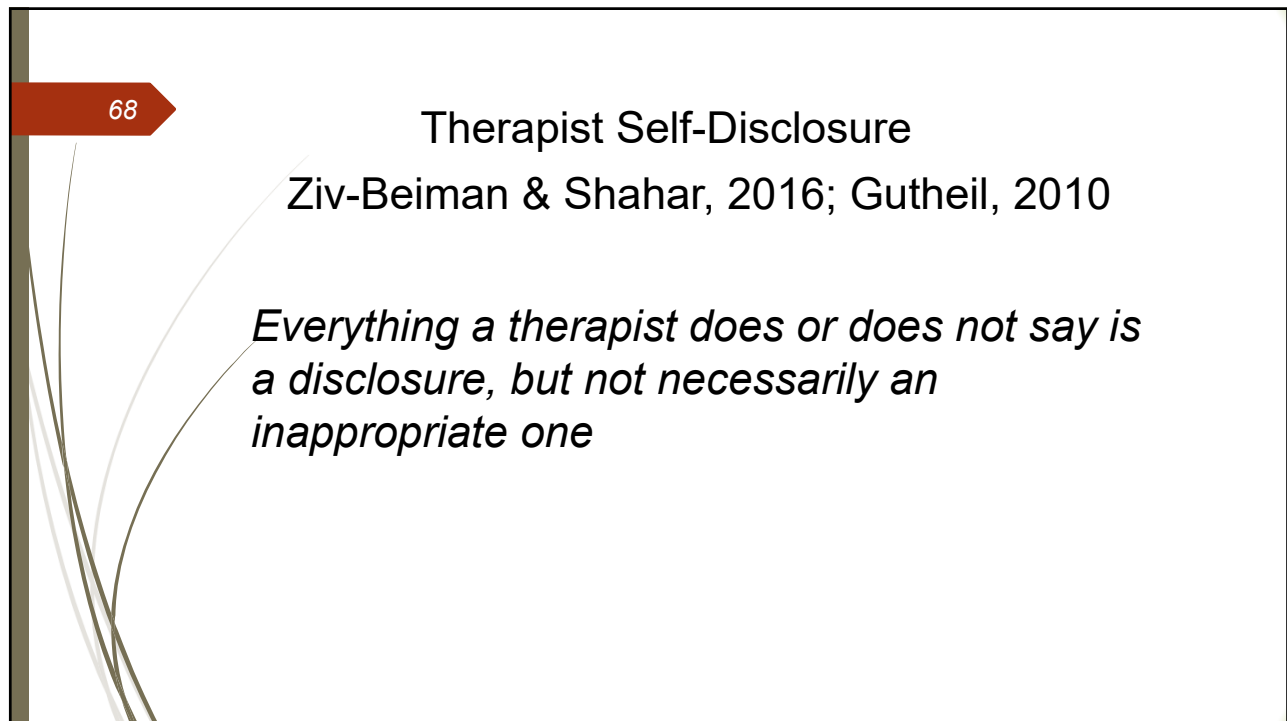
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## Therapist Self-Disclosure

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 and Immediacy  
Current Research  
Hill et al, 2018

**Therapist Self Disclosure Definitions**

- ▶ **TSD Definition:** **Verbal** revelation about the therapist's life outside of therapy
- ▶ Excluding nonverbal self-disclosures (e.g., a family photo on the desk)
- ▶ **Immediacy (Ims) Definition:** "a discussion of the therapeutic relationship by both the therapist and client in the here-and-now, involving more than social chitchat (e.g., 'It's nice to see you')" or "any discussion within the therapy session about the relationship between therapist and patient that occurs in the here-and-now, as well as any processing of what occurs in the here-and-now patient-therapist interaction"

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Therapist Self-Disclosure and Immediacy  
Current Research  
Hill et al, 2018

**Therapist Self Disclosure (TSD)**

- ▶ TSDs can be about:
  - ▶ Feelings (e.g., "I get angry when someone pushes in front of me")
  - ▶ Similarities (e.g., "I also had an anxiety disorder")
  - ▶ Insight (e.g., "When I was a student, I realized that I had difficulty studying because I was distracted because of my parents' divorce")
  - ▶ Strategies (e.g., "I try to eat fruits and vegetables and walk every day")
  - ▶ Therapists presumably use TSD to establish a bond, to help clients feel normal or understood, and to encourage more client disclosure

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Therapist Self-Disclosure and Immediacy  
Current Research  
Hill et al, 2018

**Therapist Im (immediacy responses)**

- ▶ *Present moment: “How are you feeling talking about this with me?”*
- ▶ *Expressing immediate feelings: “I’m feeling annoyed that you are frequently late for sessions”*
- ▶ *Drawing parallels with other relationships: “You said no one seems to care about you. . . . I wonder if you feel that I don’t care about you?”*
- ▶ *Making the covert overt: “You seem so quiet. . . . I wonder how you feel about being here?”*

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Therapist Self-Disclosure and Immediacy  
Current Research  
Hill et al, 2018

**Therapist Im (immediacy responses)**

- ▶ *Acknowledging a breach in the relationship: “We seem to have reached an impasse”*
- ▶ *Trying to repair ruptures: “I apologize for saying something offensive to you”*
- ▶ *Intentions for Im include...*
  - ▶ *Encouraging clients to express unstated feelings*
  - ▶ *Attempting to negotiate, enhance, or repair the therapy relationship*
  - ▶ *Modeling appropriate ways to interact with others during conflict*

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Therapist Self-Disclosure and Immediacy  
Current Research  
Hill et al, 2018

**Outcome**

- ▶ *When considered together, the subsequent processes associated with TSD and Im were largely positive*
- ▶ *When directly compared, some differences appeared*
  - ▶ *TSDs were more likely to be associated with improved mental health functioning, overall helpful for client, and enhanced therapy relationship, suggesting that these are helpful, supportive interventions*
  - ▶ *In contrast, Ims were more likely to be associated with clients opening up, suggesting that these are useful interventions for dealing with problems in the therapeutic relationship*

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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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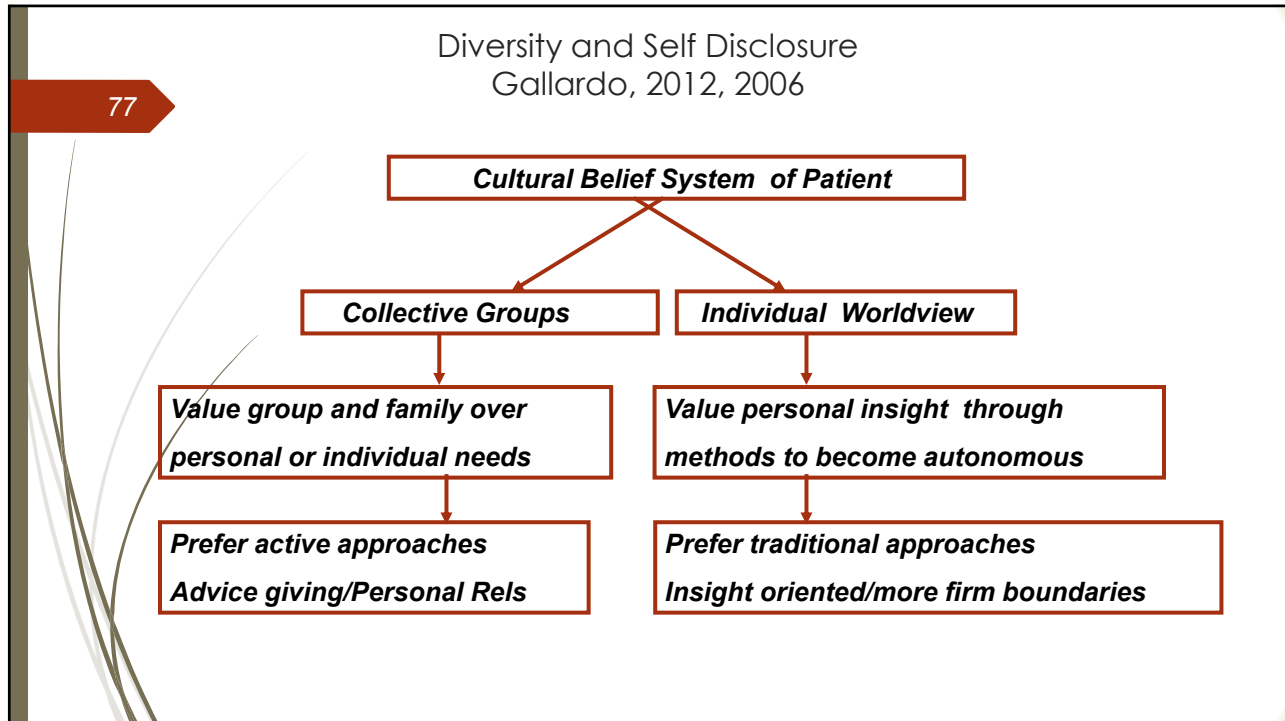
76

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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Self-Disclosure  
Gutheil, 2010; Hill & Knox, 2001, p. 413

**Self Disclosure is Related to Informed Consent**

*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*

\* Hopkins Symptom Check List


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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

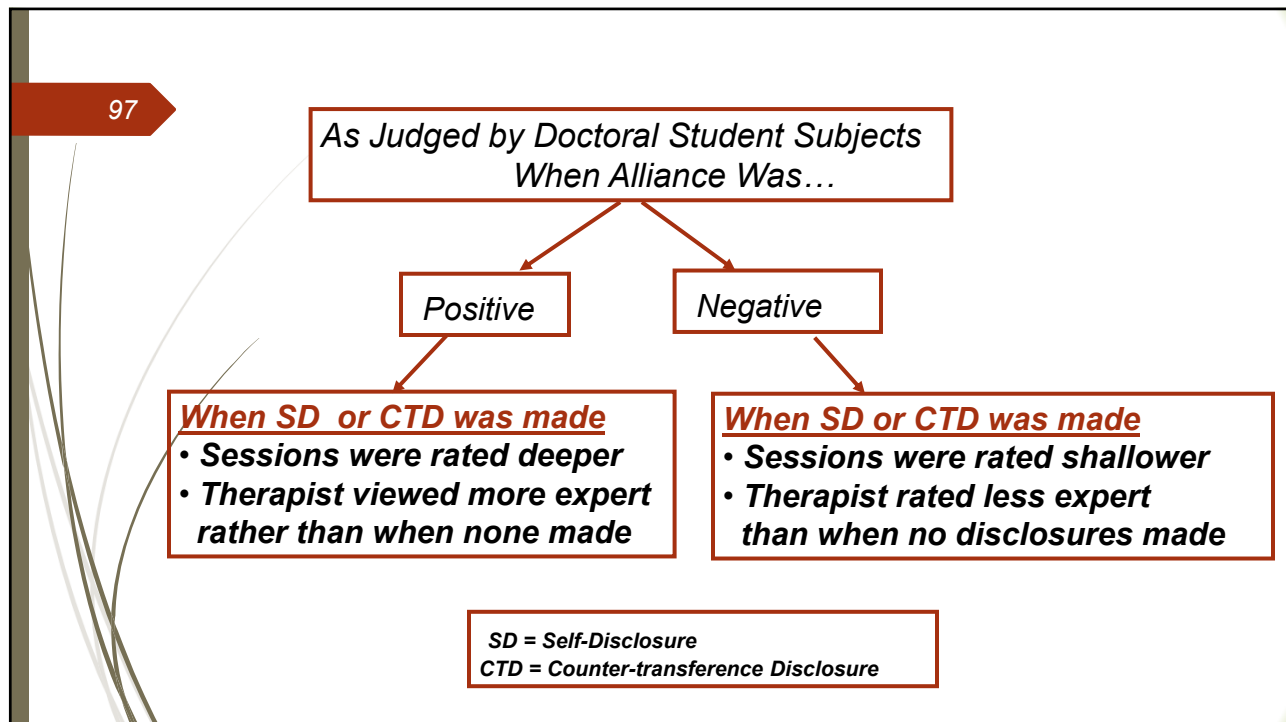
### **Findings**

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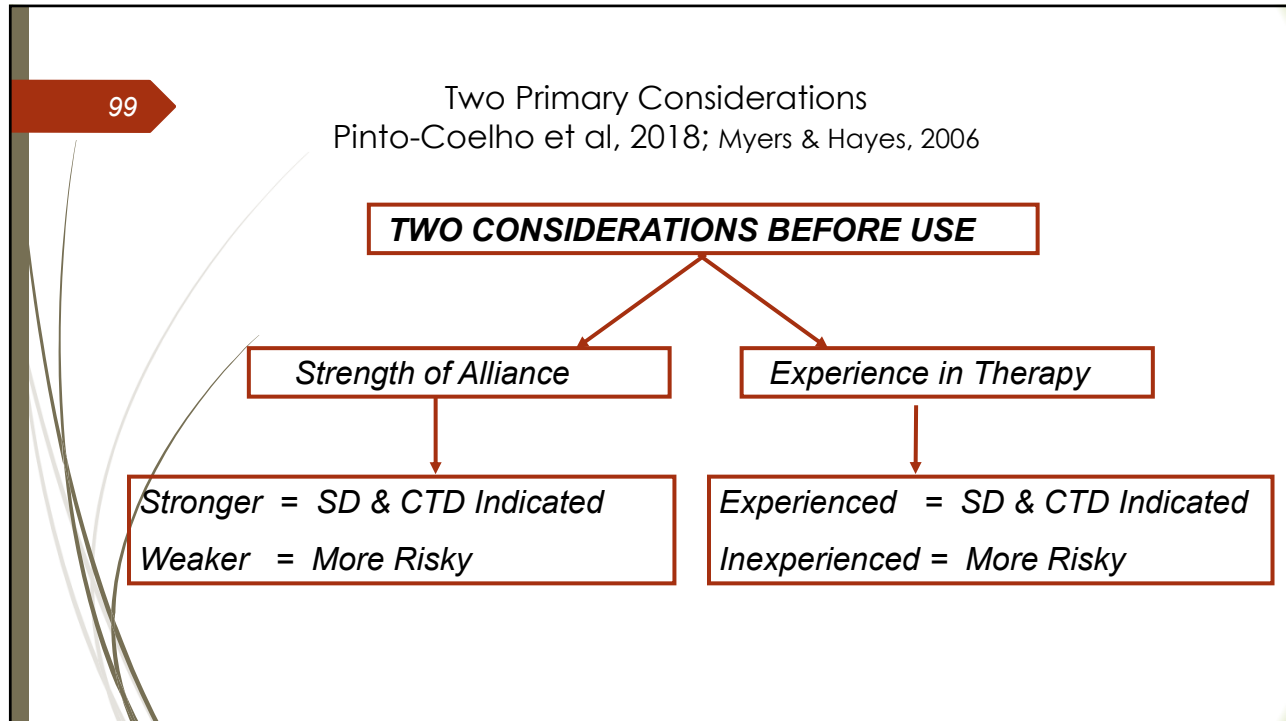
Self-Disclosure & Counter-transference  
Yeh & Hayes, 2011; Myers & Hayes, 2006, p. 181

**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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- 100
- 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*

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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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Self-Disclosure  
Hill et al., 2018; Welfel, 2016

**Results Related to THERAPIST SDs**

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

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Self-Disclosure  
Hill et al., 2018; Welfel, 2016

**Results Related to CLIENT SDs**

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

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

**PROS**

*Decrease in PT isolation*  
*Decrease in PT shame*  
*Instill hope in PT*

**CONS**

*Therapist seen as impaired*  
*Therapist seen as self-focused*

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Therapist Self-Disclosure  
Sunderani, 2016; Gutheil, 2010

**Positive Aspects of Therapist SD**

- ▶ *Elicits greater disclosure by client*
  - ▶ *ESPECIALLY from clients with **Collective** perspective*
- ▶ *Enhances client self-exploration*
  - ▶ *Experience relationship issues with therapist*
- ▶ *Encourages honesty*
- ▶ *Strengthens therapeutic alliance*
  - ▶ *More on future slides*

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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

<b>W</b>	<b>Why</b>
<b>A</b>	<b>Am</b>
<b>I</b>	<b>I</b>
<b>T</b>	<b>Talking</b>

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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.*

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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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*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*

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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

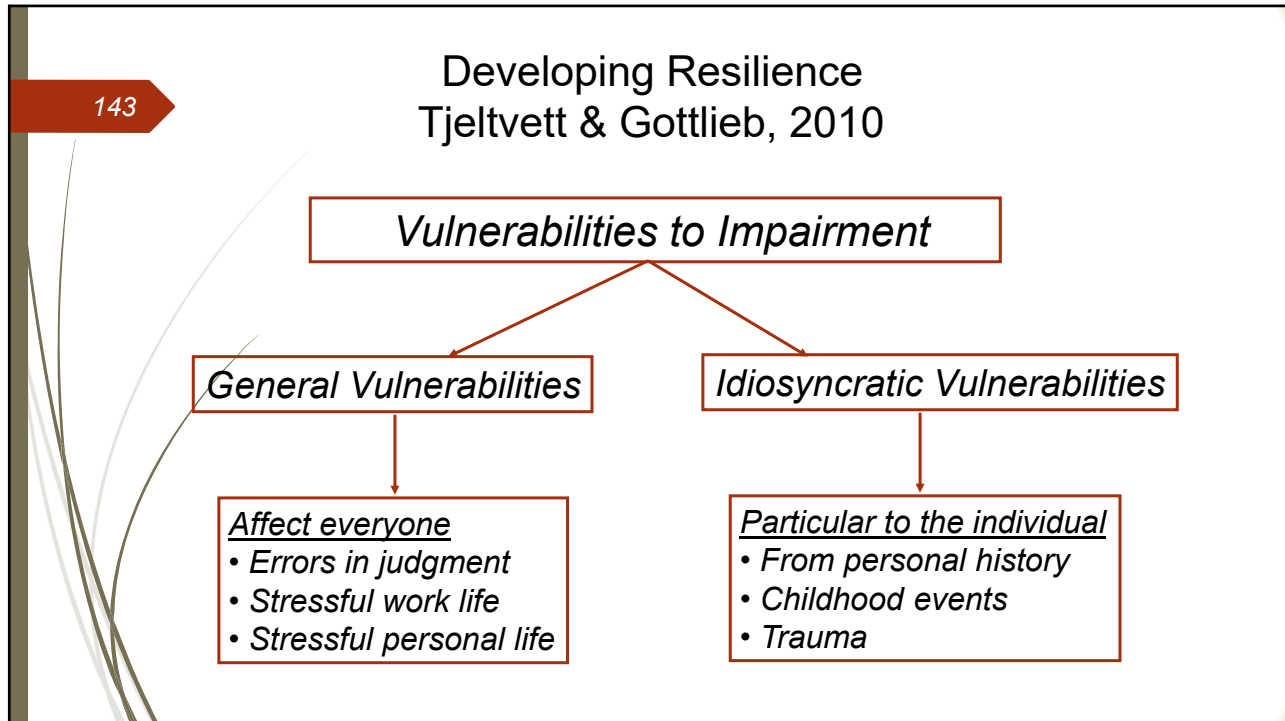
**Resilience**

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

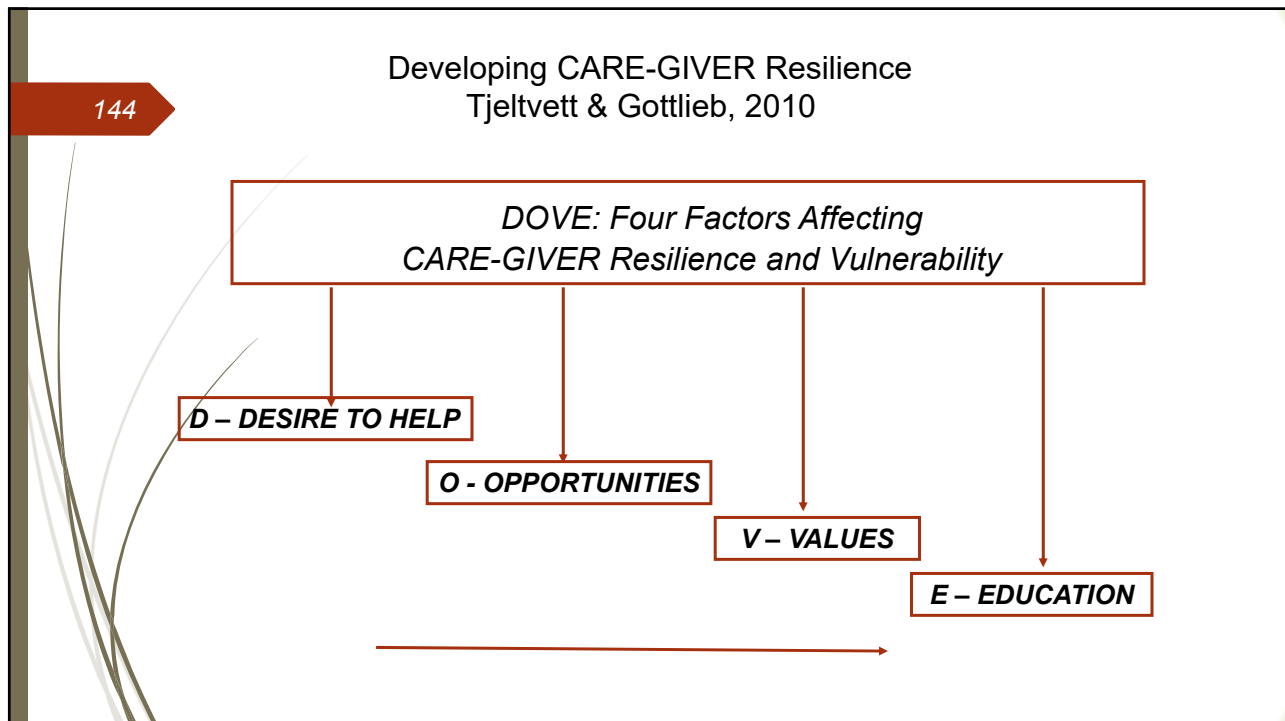
**Vulnerability**

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

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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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## Example of Burnout (captioned)

After a short vacation  
in 1909:

“Today I resumed my  
practice and saw my  
first batch of nuts  
again...”

*Freud*



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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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## 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?*

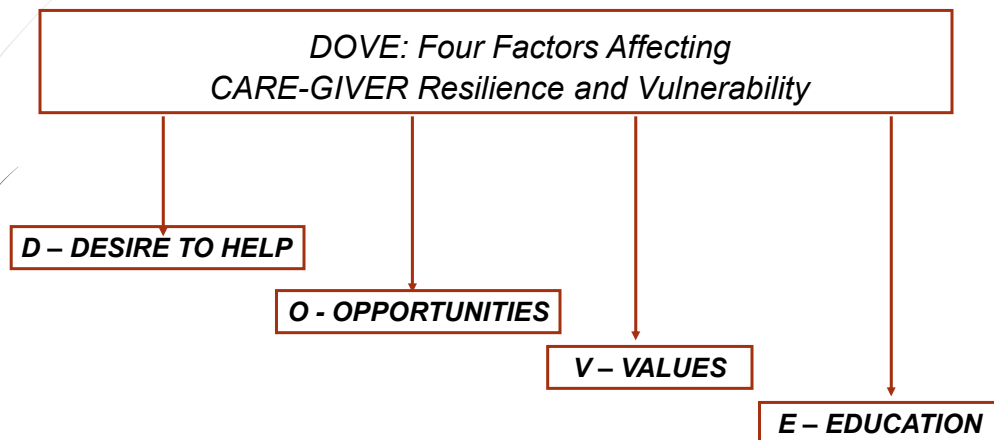
**Answer:**



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## Developing CARE-GIVER Resilience Tjeltvett & Gottlieb, 2010



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## Sum Up Questions

*Name the three types of therapist self-disclosure:*

**ANSWER:**

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

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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

157

158

## 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

159

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## Additional Exercise if Time

The Three Christs of Ypsalanti Michigan  
INFAMOUS Unethical Research

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## The Three Christs of Ypsilanti, Michigan

161

### **DELUSION: A firmly held false belief**

<https://www.thedailybeast.com/three-christs-the-curious-case-of-three-men-who-thought-they-were-jesus-christ>

- *Dr. Rokeach got the idea from an article describing two women who both believed they were the Virgin Mary. After being assigned as psychiatric hospital roommates, one of the women recovered from her delusion as a result of conversations with the roommate and was discharged*
- *As a similar study of **delusional** belief systems, Rokeach brought together three men who each claimed to be Jesus Christ and confronted them with one another's conflicting claims, while encouraging them to interact personally as a support group*
- *Rokeach also attempted to manipulate other aspects of their delusions by inventing messages from imaginary characters. He did not, as he had hoped, provoke any lessening of the patients' delusions, but did document a number of changes in their beliefs*

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## The Three Christs of Ypsilanti, Michigan

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### **DELUSION: A firmly held false belief**

<https://www.thedailybeast.com/three-christs-the-curious-case-of-three-men-who-thought-they-were-jesus-christ>

- *The graduate students who worked with Rokeach on the project have been strongly critical of the morality of the project because of the amount of dishonesty and manipulation by Rokeach and the amount of distress experienced by the patients*
- *Rokeach added a comment in the final revision of the book that, the experiment did not cure any of the three Christs*
- *Some people say they maintained their delusion by stating they were the "trinity"*
  - *"One was the father, one was the son, and one was the holy ghost"*

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