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Forensic Association
Section C
2012
NOT ALL SLIDES INCLUDED
Therapist Self-Disclosure and Counter-transference
Self-Care and Resilience

Self-Disclosure
Henretty & Levitt, 2010
“When therapists self-disclose, it is crucial that they do so with a clear rationale.” (p. 72)

Self-Disclosure
Zur, 2009
Definition
When therapist disclosure goes beyond the standard professional disclosure of name, credentials, office address, fees, office policies, etc., it becomes self-disclosure.

Self-Disclosure
Bridges. 2001, p. 22
Self-disclosure is not only inevitable, but also an essential aspect of the psychotherapeutic process.

Self-Disclosure
Barrett & Berman, 2001, p. 602
Primary Research Findings
“The results of this study demonstrate that therapist self-disclosure can influence the outcome of [treatment].”
• Decreased symptom distress
• Clients liked the care giver more
  – More on future slides

Self-Disclosure
Psychiatric Service, 2001; Zur, 2009
Three Types of SD
1. Inescapable Disclosures
   – Unavoidable events and situations
   – Generally out of therapist’s control
     • Therapist demographics
     • Personal style: clothing, hairstyle, etc.
Self-Disclosure
Psychiatric Service, 2001; Zur, 2009

Three Types of SD
2. Inadvertent or Accidental Disclosures
   – In client-therapist dyad
     • Impulsive and unplanned
     • Encounters outside the treatment setting
     • Spontaneous interventions
   – Parapraxes AKA “Freudian Slip”
     • Example: “Spur of the moment…”
     • Example: “My pleasure…”

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Self-Disclosure
Psychiatric Service, 2001; Zur, 2009

Three Types of SD
3. Deliberate Disclosures (1)
   – Planned and cautious
   – Not impulsive
   – Intentional to aid treatment process
     • Verbal and non-verbal

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Self-Disclosure
Psychiatric Service, 2001; Zur, 2009

Three Types of SD
3. Deliberate Disclosures (2)
   – Gestures and comments
     • Example: Gesture: Raising eyebrows
     • Example: Specific relevant interventions
       – “I am in recovery also.”
     • Example: Admitting to errors
       – Forgetting a client’s name
       – My error: Forgot client’s parents were divorced…

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Self-Disclosure
Henretty & Levitt, 2010

Five Primary Guidelines for Self-Disclosing
1. SELF-DISCLOSE INFREQUENTLY
   “Therapist SD were one of the few remarks clients could remember after termination.” (p. 73)

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Self-Disclosure
Henretty & Levitt, 2010; Bridges, 2001

Five Primary Guidelines for Self-Disclosing
2. DELIBERATE FIRST
   • 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

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Self-Disclosure
Henretty & Levitt, 2010; Bridges, 2001

Five Primary Guidelines for Self-Disclosing
3. CHOOSE WORDING CAREFULLY
   - Focus on observational feedback
   Examples:
   "I don't think that would be helpful to you..."
   "I worry that you may not be thinking of all your
   options here."
   "I am concerned you are not ready to go back to
   your duties."

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Self-Disclosure
Henretty & Levitt, 2010; Bridges, 2001

Five Primary Guidelines for Self-Disclosing
4. REMAIN RESPONSIVE TO CLIENT
   "Therapists should observe carefully how
   clients respond to their disclosures, ask
   about client reactions and use the
   information to conceptualize the client’s
   and decide how to intervene next." (p. 74).

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Self-Disclosure
Henretty & Levitt, 2010; Bridges, 2001

Five Primary Guidelines for Self-Disclosing
5. RETURN FOCUS TO CLIENT IMMEDIATELY
   AFTER SELF-DISCLOSURE
   - Maintain awareness of own needs
   - Do not burden or confuse client with SDs
   - Self-disclose ONLY in response to client’s
disclosure
   - Observe client’s response carefully

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Self-Disclosure
Barrett & Berman, 2001

Major Concerns
- Tx focus shifting 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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Self-Disclosure
Barrett & Berman, 2001, p. 602

Results
When therapists increased levels of 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 Checklist

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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

Results Related to THERAPIST SDs
- SDs were brief and infrequent
- Approximately 5 per session
- Averaged < 15 seconds each

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Self-Disclosure & Counter-transference
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

As Judged by Doctoral Student Subjects
When Alliance Was…

Positive
- Sessions were rated deeper
- Therapist viewed more expert rather than when none made

Negative
- Sessions were rated shallower
- Therapist rated less expert than when no disclosures made

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

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

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**Self-Disclosure & Counter-transference**  
*Myers & Hayes, 2006*

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

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**Self-Disclosure & Counter-transference**  
*Myers & Hayes, 2006*

**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

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**Self-Disclosure & Counter-transference**  
*Myers & Hayes, 2006*

**General Findings**
- CT is inevitable
  - Studies report CT in approx. 80% of sessions
  - Must be handled therapeutically

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**Self-Disclosure & Counter-transference**  
*Myers & Hayes, 2006*

**Ethnicity Considerations**
- Clients had preference for greater SD when therapist was of different ethnicity

**RESULTS OF QUANTATIVE RESEARCH:**
“The relationship exists, clients of Mexican cultures may prefer nondisclosure, whereas African-American/Black clients may prefer SD.”
Self-Disclosure
Henretty & Levitt, 2010, p. 66

Gender Considerations
RESULTS OF QUANTATIVE RESEARCH:
No clear findings between gender of client and
gender of therapist and SD

Self-Disclosure & Counter-transference

Risky Client Traits
• Borderline or narcissistic clients
• Victimized or abused clients
• Similar background, over identification
• Abused clients
• Substance abusing clients

Self-Disclosure Research
Henretty & Levitt, 2010; Hill & Knox, 2001

What type of therapists disclose?
• Most likely: Humanistic & Experiential
• Least likely: Psychoanalytic
• No gender, ethnic, cultural differences
Authors: Theoretical orientation is better
predictor of self-disclosure than demographic
variables

Therapist Self-Care
Barnett & Cooper, 2009

TERMINOLOGY
Self-Care is the application of a range of
activities with the goal being “well-
functioning,” which is described as the
enduring quality in one’s professional
functioning over time and in the face of
professional personal stressors.” (p. 17)

Therapist Self-Care
Smith & Moss, 2009

TERMINOLOGY
Burnout
“Chronic labor stress that is composed of
negative attitudes and feelings toward
coworkers and one’s job role, as well as
feelings of emotional exhaustion. It is
commonly conceptualized as a syndrome
composed of emotional exhaustion,
depersonalization, and a reduction of
personal accomplishment.” (p. 3)

Therapist Self-Care
Pearlman & McKay, 2009

TERMINOLOGY
“Vicarious traumatization can be thought
of as the changes that happen to
humanitarian workers, over time, as
they witness other people’s suffering
and need.”
• AKA “Compassion Fatigue”
• AKA “Secondary Trauma”
Therapist Self-Care
Smith & Moss, 2009

Burnout:
1. Emotional exhaustion
   • Most common of all three
   • Caused by high occupational demands
2. Depersonalization
   • Caused by low job resources
3. Reduction of personal accomplishment
   • Disillusionment with the profession

Statistics
O’Connor, 2001

Impairment prevalence = 5% to 15%
• 75% experienced distress in last 3 years
• 38% of these believed distress decreased effectiveness in work
• 62% reported working when too distressed to be effective
  • Even though 85% believed it was unethical to work when so distressed

Therapist Self-Care
O’Connor, 2001

Settings Promote ISOLATION
• Lack of reciprocity with patients
  – Ethical mandate to remain neutral
• Dual relationships are avoided
• Personal needs remain out of sight
  – Repression of basic human responses
  – Severe consequences for stepping over the line

Statistics
Smith & Moss, 2009

Psychologists Reported:
• 43% = Irritability & exhaustion
• 42% = Doubts regarding the profession
• 27% = Occupational disillusionment
• 60% = Working when too distressed to be effective
• 37% = Their distress decreased client care
• 4.6% = Providing inadequate care while distressed

Particular Vulnerabilities for Therapists

- Professional blind spots
- Increased vulnerability to stress
- Isolating nature of the work

- Involuntary to emotional difficulties
  “I know what I’m doing…”
- Therapists choose mental health field due to family history of stress
- Inability to vent or share daily stresses to maintain confidentiality
“Impairment” – Categories
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

“Impairment” – Categories
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)

“Impairment” – Terminology
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)

“Impairment” – Terminology
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)

“Impairment” – Terminology
Smith & Moss, 2009

Authors suggest the term
“NEGLIGENCE 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)

“Impairment” – Statistics
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
“Impairment” – Statistics
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

“Impairment” – Effective Management
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

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

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

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
“Impairment” – Effective Management
Smith & Moss, 2009

Barriers to Intervention

3. Colleagues Who Fail to Act (2)

- 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

Countertransference: Ethics Codes

CAMFT 3.4 http://www.camft.org/
MFTs seek appropriate professional assistance for their personal problems or conflicts that impair work performance or clinical judgment.

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.

Countertransference: Ethics Codes

www.socialworkers.org

NASW 2.09 Impairment of Colleague
Take action to help impaired colleagues

NASW 2.10 Incompetence of Colleague
Consult with colleagues who show signs of incompetence

NASW 2.11 Unethical Conduct of Colleagues
Social workers should seek resolution and take action when they receive knowledge of an unethical colleague.

“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."
“Impairment” – Protected Term
Falender & Collins, 2006

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.”

Potential Language
• Problematic student/ intern
• Troubled therapist
• Underperforming
• Weakness
• Deficiency
• Diminished
• Temporarily incompetent
• Inadequate functioning

Developing Resilience
Tjeltvet & 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)

DOVE: Four Factors Affecting
Resilience and Vulnerability

V – Values

E – Education

D – Desire to Help

O – Opportunities
Legal and Ethical Considerations

Developing Resilience
Tjeltvet & Gottlieb, 2010

D.O.V.E. Model of Resilience & Vulnerability

D - Desire to Help
- Care givers/Providers possess this factor
- Wish to benefit society
- Resilience:
  - Aids in sustaining 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 and limits
    - Not loaning money to a client in need
    - Not self-disclosing inappropriately

Developing Resilience
Tjeltvet & Gottlieb, 2010

D.O.V.E. Model of Resilience & Vulnerability

O - Opportunity
- To contribute to society through education
- To provide clinical care
- To lessen another’s burden
- Resilience:
  - Kudos for work well done
  - Success in the care giver role
- Vulnerability:
  - Exploitation and abuse of power when stressed
  - Abuse of client trust

Developing Resilience
Tjeltvet & Gottlieb, 2010

D.O.V.E. Model of Resilience & Vulnerability

V - Values
- Care givers/Providers share certain core values
  - Important to contribute to society
  - Quest for knowledge
- Resilience:
  - Aids in self care and self knowledge
  - Propels one forward
- Vulnerability:
  - When values are self-serving or rigid
    - Falsifying data to get a study published
    - Imposing own values upon another person

Developing Resilience
Tjeltvet & Gottlieb, 2010

D.O.V.E. Model of Resilience & Vulnerability

F - Education
- Provides care givers/providers with knowledge and resources
- Continuing education to help others
- Prevents mediocrity
- Resilience:
  - Lifelong rewarding process
  - Improves professional functioning
- Vulnerability:
  - Assumption taking workshop is enough

Bibliography


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