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Forensic Association
Section C
2012
NOT ALL SLIDES INCLUDED

Therapist Self-Disclosure and Counter-transference
Self-Care and Resilience

C-1

Self-Disclosure
Henretty & Levitt, 2010

"When therapists self-disclose, it is crucial that they do so with a clear rationale." (p. 72)

C-2

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.

C-3

Self-Disclosure
Bridges, 2001, p. 22

Self-disclosure is not only inevitable, but also an essential aspect of the psychotherapeutic process.

C-4

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*

C-5

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.*

C-6

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…"*

C-7

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*

C-8

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…*

C-9

Self-Disclosure

Psychiatric Service, 2001; Zur, 2009

Three Types of SD

3. Deliberate Disclosures – TWO TYPES

A. Type One: Self-Revealing

- *Care giver reveals information about self*
- *Example: age, children, marital status*

B. Type Two: Self-Involving

- *Care givers' personal reactions about clients and occurrences in sessions*
- *Example: sweater comment*
- *Example: scalp issue*

C-10

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)

C-11

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*

C-12

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."

C-13

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).

C-14

Self-Disclosure

Henretty & Levitt, 2010; Bridges, 2001

Five Primary Guidelines for Self-Disclosing

5. RETURN FOCUS TO CLIENT IMMEDITELY 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*

C-15

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?*

C-16

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

C-17

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*

C-18

Self-Disclosure

Barrett & Berman, 2001, p. 602

Results

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

C-19

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

****Self Report*

C-20

Self-Disclosure

Barrett & Berman, 2001

Results Related to THERAPIST SDs

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

C-21

Self-Disclosure

Barrett & Berman, 2001

Results Related to CLIENT SDs

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

C-22

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*

SD = Self-Disclosure
CTD = Counter-transference Disclosure

C-23

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

C-24

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*

SD = Self-Disclosure
CTD = Counter-transference Disclosure

C-25

Self-Disclosure & Counter-transference
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

C-26

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

SD = Self-Disclosure
CTD = Counter-transference Disclosure

C-27

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

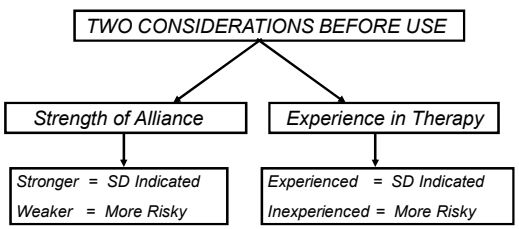
General Findings

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

SD = Self-Disclosure
CTD = Counter-transference Disclosure

C-28

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



C-29

Self-Disclosure
Henretty & Levitt, 2010, p. 65

Ethnicity Considerations

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

RESULTS OF QUANTATIVE RESEARCH:

"If a relationship exists, clients of Mexican cultures may prefer nondisclosure, whereas African-American/Black clients may prefer SD."

C-30

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

C-31

Self-Disclosure & Counter-transference

Risky Client Traits

- *Borderline or narcissistic clients*
- *Victimized or abused clients*
- *Similar background, over identification*
- *Abused clients*
- *Substance abusing clients*

C-32

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

C-33

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)*

E-34

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)

E-35

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"*

E-36

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*

E-37

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*

E-38

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*

E-39

Therapist Self-Care
O'Connor, 2001

Varied Roles Changing Rapidly Causes Stress

1. *Very little time to process*
2. *Limited time to transition*
3. *No time to recover between clients*

E-40

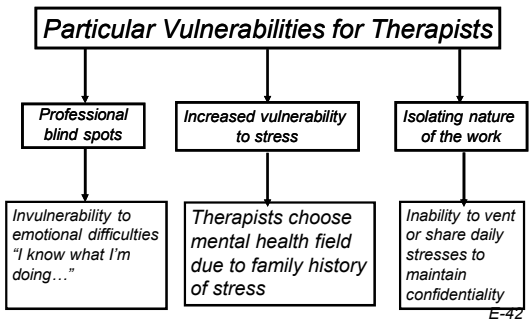
Therapist Self-Care
O'Connor, 2001

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*

E-41

Therapist Self-Care
Smith & Moss, 2009



E-42

"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*

E-43

"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)

E-44

"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)

E-45

"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)

E-46

"Impairment" – Terminology
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)

E-47

"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*

E-48

"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*

E-49

"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*

E-50

"Impairment" – Effective Management
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*

E-51

"Impairment" – Effective Management
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*

E-52

"Impairment" – Effective Management
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*

E-53

"Impairment" – Effective Management
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*

E-54

"Impairment" – Effective Management

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*

E-55

"Impairment" – Effective Management

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!"*

E-56

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.

E-57

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.

E-58

Countertransference:

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.

INTERPRETATION:

Research
Consultation
Time off
Seek personal therapy

AAMFT 3.3
CAMFT 3.4
NASW 4.05
CSWA 4.b

E-59

"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."

E-60

"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.' "

E-61

"Impairment" – Protected Term
Falender & Collins, 2006

Potential Language

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

E-62

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)

C-63

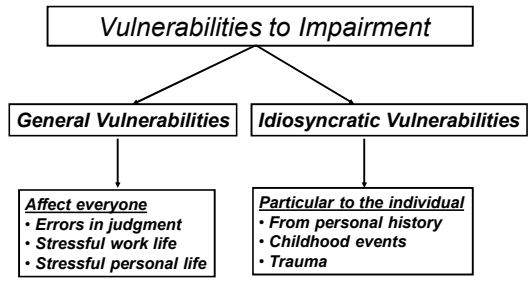
Developing Resilience
Tjeltvett & Gottlieb, 2010

Four Elements of Resilience

1. *Specific skills for dealing with difficulties*
   - *Especially with temptation to transgress*
2. *Stable personal characteristics helping to cope*
   - *Values, morals, dignity, spirituality*
3. *Emanating from social and support networks*
   - *Family, friends, community*
4. *Multidimentional concept*
   - *Integrating many coping mechanisms*

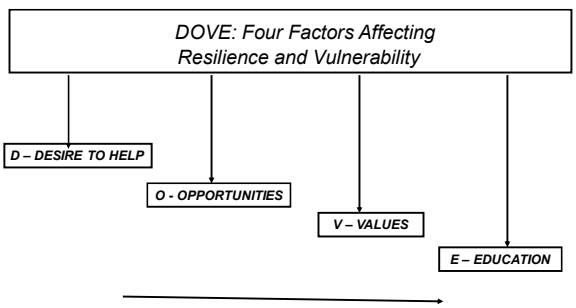
C-64

Developing Resilience
Tjeltvett & Gottlieb, 2010



C-65

Developing Resilience
Tjeltvett & Gottlieb, 2010



C-66

Developing Resilience
Tjeltvett & 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*

C-67

Developing Resilience
Tjeltvett & 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*

C-68

Developing Resilience
Tjeltvett & 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*

C-69

Developing Resilience
Tjeltvett & Gottlieb, 2010

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

E - 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*

C-70

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