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## Defining the Therapeutic Relationship

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**T**his chapter contrasts the role of the casual helper—who informally provides help or guidance to friends and family—with the role of the professional helper.

### Therapeutic Figures

Our conception of a proper therapeutic relationship may come from a variety of sources: We may have been involved in therapy as a client and seek to emulate various aspects of the therapist that we utilized. Readings of various therapeutic orientations can also influence our ideas as to the kind of therapist we aspire to be. Undeniably, another influential source of our conception of therapy is the media. There is no shortage of fictional therapists and television/radio “shrinks” providing some sense of entertainment. In some cases, such intervention efforts may be facilitative; however, for the sake of theatrical performance or literary license, much of what is depicted as therapy in movies or other popular media cannot be thought of as appropriate models for more traditional therapeutic practice.

Each of us has, on occasion, provided guidance, advice, and help to family, friends, and acquaintances in an informal manner. Typically, good intentions,

## 2 Therapeutic Communication

common sense, personal experience, and the wish to be helpful provide a good compass for these facilitative efforts. The purpose of this chapter is to delineate the therapeutic role by contrasting social relationships with the client-therapist relationship in four domains: (1) the therapeutic process, (2) social and emotional aspects, (3) professionalism, and (4) self-disclosure.

## The Therapeutic Process

### Selection

Typically, we think of ourselves as free to select our friends at will based on personal preferences. A variety of things can attract us to an individual: similar interests, physicality (overall appearance, fashion, grooming, stature, etc.), talents, common backgrounds, ethnicity, attitudes, demeanor, and common friends. In a professional setting, there is usually no such privilege. Your role as a therapist involves the commitment to provide quality care to clients without bias with respect to age, ethnicity, culture, race, disability, gender, religion, sexual orientation, or socioeconomic status (*Ethical Standards of Human Service Professionals*, Statement 17; Council for Standards, 1996).

It is common that managers will assign clients based on the expectation that you possess the skills necessary to competently provide services to the client. Skilled supervisors may choose to take into account such attributes as gender, age, ethnicity, specialized training, or expertise when considering making such assignments, such as by assigning an adolescent boy who is exhibiting conduct problems to a male therapist, whereas a female rape survivor would likely be paired with a female therapist. Generally, as a professional therapist, you do not get to select who your clients will be; in fact, it is likely that the individuals who present themselves as potential clients are not going to be the specific types of individuals that you would voluntarily select for friendship.

Unlike social relationships, the selection process involves some deliberate information exchanges: A potential client is usually required to schedule an appointment, complete forms, and be screened for eligibility for services and identification of the primary problems (Neukrug, 2002).

Additionally, an agency or organization may be set up to provide only a selected set of services to those who meet a particular set of needs criteria such as homeless, substance addicted, low income, young mothers, HIV positive, or over 65. Unlike in social settings, there may be any number of eligibility criteria that may contribute to client selection.

## Initial Contact

Social relationships can begin in a variety of ways, such as introductions through friends; incidental conversations at parties, with coworkers, with fellow students; or Internet contact. Additionally, there are no fixed ground rules that need to be articulated or followed in order to start a friendship or relationship; social and personal norms guide this process. In the professional realm, clients may be self-referred or they may seek out a facility based on a referral from another such as a family member, significant other, friend, physician, or a member of the clergy. The initial contact may also include a professional disclosure statement detailing the therapist's characteristics, which may contain information regarding qualifications, education, license status, treatment modalities, or specialties. The potential client is also given information regarding the agency's policies involving such things as appointment cancellations, fee structure, and services provided and not provided. The client signs an appropriate "consent for treatment" form, which typically spells out the information and legal parameters regarding confidentiality (Corey, Corey, & Callanan, 2006).

## Termination

Social relationships may end in a variety of ways for a variety of reasons, ranging from irreconcilable differences to geographical relocation. Such deliberate endings may be gradual or abrupt. Alternatively, people may drift apart or become more occupied with other people, projects, or interests. Unlike social relationships, which may last a lifetime, the professional therapeutic relationship is ultimately meant to be finite. The termination phase of the therapeutic process is handled in a purposive and deliberate manner; termination often involves a systematic review of the progress that the client has achieved in therapy and issues that will require continued work, along with strategies and resources for the client to continue this work after therapy ends. As the final session approaches, feelings regarding termination are discussed and processed by both the client and therapist. Occasionally, termination may happen abruptly. A client may quit therapy with little or no notice. Termination is discussed in more detail in "Overview of Appendixes A, B, and C."

## Time

When it comes to friends and family, we usually do not think about the duration of the relationship. Such relationships are typically considered as

## 4 Therapeutic Communication

enduring over time. Although we may set a time to meet with such acquaintances, less often is there a predetermined end time. Spontaneous or unannounced visits may also be characteristic of our social contacts. In a therapeutic setting, time is considered to be a more crucial factor. Your professional contact with a client may be limited by a fixed number of sessions, or termination may be indicated upon the accomplishment of the designated goal or goals. Unlike casual contacts, therapeutic appointments are scheduled with a specified beginning and ending time. Usually clients establish a standing weekly appointment, traditionally 50 minutes in duration and typically not extended with the exception of genuine crisis situations.

Despite wishes to methodically fit clients into consistent appointment time slots, it is important to be flexible when working with some Latino clients, who by tradition may place a higher priority on the task completion—such as tending to a friend—than adherence to a rigid appointment time (Martinez, 1986; Sue & Sue, 2003). Similarly, traditional American Indians may perceive time as a naturally occurring event, as opposed to a phenomenon that controls their lives (Barcus, 2003; Ho, 1992; Sue & Sue, 2003).

### Goal

Social contacts need not be goal-directed. Sometimes, we just choose to visit and casually “shoot the breeze” with friends. It is socially appropriate and common to desire friendly companionship with or without a particular task or project in mind. Conversely, effective psychotherapy largely depends on the identification of specific goals and consistent efforts directed toward advancing the accomplishment of such goals (*Ethical Standards of Human Service Professionals*, Statement 1; Council for Standards, 1996).

In social circumstances, there are no enforceable guidelines with respect to setting goals. Either individual may submit a goal. In professional settings, you will collaborate with the client to articulate appropriate goals that are acceptable to him or her (*Ethical Standards of Human Service Professionals*, Statement 1; Council for Standards, 1996). In your role as the therapist, you may provide recommendations with respect to setting goals, but despite your good intentions, it is essential to resist the temptation to unilaterally set goals for the client. The client’s self-determination must remain at the forefront at each step of the therapeutic process (*Ethical Standards of Human Service Professionals*, Statement 8; Council for Standards, 1996). Provisional goals can be established by engaging the client to thoughtfully discuss the problem. Consider asking the client what, if anything, he or she has tried in the past to address the problem, the outcome of these efforts, and what the

client's life might be like once the problem is reduced or resolved (Sperry, Carlson, & Kjos, 2003).

There are no practical limitations on setting socially defined goals. As such, one may encourage or coordinate with a friend to carry out a vengeful or illegal goal, such as formulating a retaliatory plan against a disliked person or organization, whereas in your professional role as a therapist, you are constrained by legal and ethical considerations and cannot suggest, condone, or facilitate the setting, planning, or execution of any such illegal, unethical, or (self-)destructive goals. In such cases, your familiarity with and commitment to the professional code of ethics pertaining to your particular field of practice should provide a useful framework for making responsible clinical judgments (Brammer, 1993). Case in point: Suppose a client presents that the ex-spouse persistently fails to provide child support as specified in their divorce agreement. In your role as a therapist, you are ethically and legally obliged to discourage illegal actions. As an alternative to participating in or encouraging any possibly illegal actions that the client may be considering or fantasizing about, you may provide an environment for venting and processing such feelings along with appropriate referrals for legal or arbitration services that could be used to address this problem within legal and ethical boundaries.

For some cultures and individuals, it is customary to engage in some initial "small talk" as a warm-up prior to embarking on clinically goal-related discussion; in the interest of facilitating rapport, you may find it useful to engage the client in such dialogue and then appropriately guide the discussion to address the therapeutic issues at hand. In order to enhance your effectiveness as an evolving therapist, it can be useful to orient yourself to the multicultural characteristics of your community and the social norms of such groups (Pendersen, Draguns, Lonner, & Trimble, 1996; Sue, 1992). Specifically, Latino clients may prefer to engage in some brief nontherapeutic chatting (*la plática*) as a customary warm-up prior to embarking on therapeutic issues (Martinez, 1986). Conversely, this practice would be inappropriate for Asian clients who, per cultural practice, may perceive such social conversation as an unnecessary delay to discussing tangible immediate goals (Root, Ho, & Sue, 1986; Sue & Sue, 2003).

Occasionally, the client may enter the session with a crisis issue that may be unique from the predominate goal for therapy. In such cases, a temporary departure from the primary goal may be appropriate in order to help the client manage such acute circumstances.

Goals must also be consistent with the client's belief system. For example, suppose a client expresses that he or she has a problem with alcohol addiction and that it is mutually agreed that the client will attend AA meetings

## 6 Therapeutic Communication

daily for the next 90 days; however, the client's spiritual beliefs require ceremonial attendance at some point during that period, which interrupts the 90-day commitment. Although you are welcome to address concerns regarding the impact that this may have on the client's sobriety, you are not in a position to insist on the client's strict compliance with the 90-day plan. Again, the client is recognized as the chief decision maker in his or her life. One way to conceptualize your role might be to think of yourself as the client's "mental health consultant." In this case, you would work with the client to arrive at alternative ways of coping with the recovery issue. This might involve the client calling to check in with his or her sponsor on missed meeting days, thus respecting the client's spiritual beliefs.

### Topic of Conversation

Social conversations have no particular limitations in terms of subject matter; participants may raise any topic at will. In a therapeutic setting, topics of conversation are not necessarily limited, but they are typically more focused. Topics of conversation are guided in order to address those issues specifically related to the therapeutic goals. Unlike casual conversations, wherein the participants typically discuss things that they mutually want to discuss, therapeutic discussions may involve emotionally challenging issues that the client may be hesitant to discuss but which are essential to addressing and resolving the problems at hand (Kadushin, 1990). Whereas casual conversations are free to drift seamlessly or abruptly from one topic to the next, therapy is typically more focused. When a client drifts off topic, part of your role is to recognize this departure and assess the value of such conversation. Valuable ancillary information may be revealed in the content of such discussion. Conversely, you may feel that it is beneficial to discuss the nature of this shift by asking the client some questions about it: Did the client feel anxious and feel the need to switch to a more comfortable line of discussion? Did some critical piece of information suddenly come to mind? As the therapist, it is your responsibility to keep the discussion on track. This may involve deliberately directing the discussion back to the (most) relevant therapeutic issues. Specific techniques for *redirecting* and *refocusing* are discussed further in Chapter 4.

Social conversations are usually balanced between the members in terms of who the subject of the conversation will be. For instance, sometimes Jane will tell Mike about what is going on in her life, and sometimes Mike will tell Jane about his life issues. This reciprocity is not characteristic of the therapeutic process. The client consistently remains the focal point of the discussions; typically you would not indulge in confiding in the client. Exceptions to this rule may include profession-related inquiries, such as the

client seeking information regarding the therapist's education, qualifications, clinical experience, special training, or certifications. Guidelines for the use of therapeutic self-disclosure are discussed later in this chapter.

## Advice

Social conversation is often laced with casual advice, suggestions, recommendations, and sometimes even firm demands. Such guidance can be based on anything including empirical research, personal opinions, anecdotes, impulsive ideas, or belief systems. Though well intended, there are no formal guidelines with respect to the quality or appropriateness of recommendations given in the role of the casual helper. As a therapist, advice giving is typically not the first order of business. Prior to submitting recommendations, you would typically take the time to assemble a comprehensive profile of the client to better ensure that the advice will be suitable to the unique attributes and circumstances of the client. Factors that should be taken into account include the client's perception of the problem and internal factors, which might include the client's personality, prior coping, motivation, belief systems, personal ethics, spiritual base, physical health, and external factors such as social system, family, friends, community resources, and culture. Advice that is given prematurely is less likely to fit within the boundaries of the client's life. Haphazardly given advice is likely to be a mismatch to the client's characteristics and is seldom followed. The better the fit, the better the likelihood that the client will actually follow through.

In social settings, one has the privilege to, with good intention, unilaterally insist that a particular action be taken. In concordance with the ethical standards of health and human services professionals, it is essential to genuinely respect the client's right to self-determination and facilitate empowerment at each phase of the therapeutic process. Consider the client as an expert on his or her own life and work collaboratively with the client to flesh out a facilitative course of action suitable to the unique needs and attributes of the client. This can involve prompting the client to discuss the (problematic) circumstances, identify functional and dysfunctional components, and select which part(s) of the problem that the client is motivated to resolve. This is not to say that as the therapist you withhold potentially useful advice waiting for the client to stumble upon it. Quite the contrary. Through your education and experience, you may possess and propose specialized clinical knowledge or experience that may be suitable to addressing the problem at hand. Additionally, you may have knowledge of, or access to, reputable resources. Providing meaningful referrals is an essential supplement to the therapeutic process.

## 8 Therapeutic Communication

There are no constraints on what sort of advice can be given in social settings. Socially, one might offhandedly recommend that a friend try hypnosis to help control an eating disorder, discuss an herbal remedy for severe headaches, or refer a friend to a promising Web site for health information, products, or services that may be helpful. Such benevolent recommendations may indeed turn out to be beneficial. In your role as a mental health professional, you are obliged to provide reputable referrals that have been adequately researched.

In casual settings, there are no binding rules as to who the beneficiary of such advice may be: John may attempt to persuade Kate to take actions that are not necessarily exclusively beneficial to Kate; John may be motivated for others to be the primary, or perhaps secondary, beneficiary of Kate's modified behavior. This is contraindicated in therapy. Per ethical and legal rules, as the therapist, you cannot be the beneficiary—primary or otherwise—of professional interventions (Ivey, 1983). The client must consistently remain the focal point of therapeutic planning and interventions. Specific techniques for *informing* and *advising* are presented in Chapter 5.

### Perspective

Social relationships and conversations can be driven as much by fact as by feeling. In such relationships, what is said from one member to another can be comprised of a combination of such things as intuition, knowledge of one's self and the other person, personal opinions, life circumstances, and experience. In the therapeutic relationship, the perspective is not that different from the casual relationship. In your evolving role as a therapist, you will be aware that you are not completely objective. You do have personal opinions about what you think a client should or should not do; however, in light of the ethical principles promoting each client's right to self-determination, a clinician's personal opinion has lower priority in a professional setting. Bearing in mind that although you have good intentions on behalf of your clients, it is the client who holds the privilege and responsibility for determining the shape of his or her life and ultimately carrying out those plans or not.

As in social contexts, you accumulate a level of understanding about the client, both in terms of the data provided and also from a sense of feeling and intuition that is a natural part of the communication process. Although the efforts of a trusted friend may indeed be helpful in providing support and solving problems, in your capacity as the therapist, you have the advantage of a social science education. This more objective perspective enables you to utilize the appropriate theoretical framework(s) to gather and process information and feelings in a systematic manner, identify source problems,

formulate diagnostics, and collaboratively assemble and implement appropriate therapeutic treatment.

## Social/Emotional Factors

### Emotional Involvement

It is appropriate and expected that we have close emotional relationships with the people in our lives. We do not exist in an isolated intellectual realm. We are social, feeling beings. In our contact with others, we have the privilege of experiencing a wide spectrum of emotions, ranging from the joy of a loving relationship to profound hurt and sense of loss. Much of our identity is characterized by our emotional characteristics. Often when describing a person, we may refer to his or her social or emotional hallmark. (*“He’s the kindest person I know.” “In the morning she’s a little rough around the edges.” “He’s good with kids.” “She can make anyone laugh without even trying.”*) The therapeutic relationship is by no means devoid of feelings; in fact, effective therapy largely depends on expressing, perceiving, and processing feelings as they pertain to the client’s life circumstances. Therapy largely consists of acknowledging such feelings and sensitively working with emotionally laden issues while maintaining a professional emotional distance. Issues related to effectively identifying and working with the emotional aspects of the therapeutic process are addressed in Chapter 4.

### Objectivity

It is difficult to achieve a sense of objectivity in close personal relationships. Personal involvement with friends and loved ones appropriately confounds our sense of objectivity. We are not indifferent or uninvolved in the lives of others. Quite the contrary. We do have opinions about the quality of our friends’ lives and the choices they make. Some of these choices may affect or involve us personally. In the professional setting, it is essential to identify and take into account the client’s feelings. It is equally important to keep an appropriate emotional distance in order to maintain a less obscured view of the client and his or her problems. That is to say, in your capacity as a therapist, you have the unique opportunity to provide an additional perspective to the problem: *What might this problem look like with the emotions subtracted?*

Consider a case in which the well-meaning client describes how each Sunday is dedicated to personally supervising an alcoholic friend so that the friend will be sober for work on Monday. As the therapist, your objectivity

## 10 Therapeutic Communication

affords you the opportunity to convey critical observations: (a) This activity is well-meaning. (b) This friend is failing to take responsibility for his or her own actions and inactions. (c) The client's rescuing efforts serve to cushion the friend from the reality of this situation, which in turn is unintentionally delaying the pathway to a meaningful recovery. (d) The client may be holding resentments against this friend for consuming half of each weekend. Hence, your objective perspective may enable the client the opportunity to view and present problems *with* and *without* the emotions in place, which may provide alternative routes to the problem-solving pathway.

### Rescind Your Ego

Although it may seem overly simplistic, it is worth stating that as thinking, feeling, social beings, we take our personal lives personally. You care about the people in your life and you want them to care about you as well. To varying degrees, it matters to you what family and friends think and feel about you, just as your thoughts and feelings matter to them. This sense of cognitive, emotional, and social reciprocity can be thought of as the basis for such relationships. Your close relationships are far from objective. You are not impartial to the people in your life. Appropriately, you have strong feelings about the people that you are close with; you care what happens to them; and presumably, you care about their opinions and interactions with you.

The therapeutic setting is somewhat different. Although the therapeutic process is a collaborative relationship, rich with feelings and a sense of connection, the therapist maintains a certain level of objectivity with respect to the client.

Objectivity enables you to embark on providing effective therapy, placing the appropriate ethical principles first. Though you are entitled to form and express your impressions and opinions in a professional manner, client self-determination must remain at the forefront of the therapeutic process. At times, your clients may thank you for your helpful efforts or blame you for failing to fix their problems; it is critical to remember that though your mission is to be helpful in improving the quality of client's lives, the client is the primary decision maker and actor in his or her life. As a therapist, you may think of yourself as a kind of emotional consultant (the client solicits your professional opinion and guidance with respect to some form of problem solving). Although it is your job to collaborate with the client using social science principles to process issues, it is the client who is responsible for his or her life. Although it may be tempting to assume an inordinate amount of credit for a client's successes or failures, ultimately, the client's decisions, actions, inactions, and outcomes are ultimately in the client's hands, not yours.

## Personal Contact

Personal relationships are comprised largely of personal contacts, which can take a variety of forms including spontaneous telephone calls, social lunches, leisure activities, or visits. A social relationship may consist of a single role, such as tennis partner, or multiple roles wherein one person may be your best friend, confidant, work-out partner, and travel companion. The therapeutic relationship differs in that out-of-the-office contacts are contraindicated; ethical and legal statutes regulate the extent of such contact. As a therapist, you are obliged to separate your social life from your professional life. Dual or multiple relationships wherein the therapist socializes with clients or has friends as clients are contraindicated, thereby facilitating the preservation of the professional contact. Dual relationships have the potential of harming the therapist's sense of professionalism and objectivity. Additionally, in a dual relationship, the client may continue to perceive the therapist as an authority figure, creating the risk of a potentially exploitive relationship (*Ethical Standards of Human Service Professionals*, Statement 6; Council for Standards, 1996). In short: Your friends cannot become your clients, and your clients cannot become your friends.

In some ways, the personal friend has advantages over the therapist: The personal friend has the opportunity to make first-hand observations of a person in a variety of natural settings (the breakfast table, the bowling alley, interacting with family at home, etc.), whereas in your role as therapist, you will typically see the client outside his or her "natural habitat," leaving you largely dependent on the client's report of circumstances and events occurring outside the office between sessions.

Lacking observations of the client in his or her natural settings, such as home or with friends, it is possible that social desirability can be a confounding factor wherein the client may distort or choose not to discuss selected events, thoughts, or feelings for fear of being negatively judged (Rubin & Babbie, 1993). Another possibility is that the client may not see a particular event occurring outside the session as relevant to the therapy; hence, the client may not feel that it is worthy of mention. Without presuming a suspicious stance, it is not unreasonable to consider the likelihood that the client may only be telling half a story or skewing a story. Such conveyance is not necessarily attributable to social desirability. Rather, the client only has a single point of view. At best, a story can only be told in the way that it is initially perceived and later remembered.

Often strong emotions are woven into the memory of events, which may compromise the accuracy of otherwise objective information. With the client's written permission, it can be advantageous to the therapeutic process

## 12 Therapeutic Communication

to have access to collateral information. This may include relevant records, consults with other health care professionals—specifically physicians, psychiatrists, and prior therapists—or it may involve including other significant people in the therapy (McClam & Woodside, 1994). For example, a solo female client may describe her boyfriend as consistently late coming home, verbally cruel, and physically withdrawn. Our initial impression may lead us to conclude that this is an abusive or neglectful relationship. Upon including the boyfriend in the therapy, we may find out that he is a part-time college student working a night job and that he becomes verbally abrupt with his girlfriend when she forcefully awakens him for further attention. In short, supplemental information, appropriately gathered, can provide you with a more comprehensive understanding of the client's life circumstances, thereby better focusing the assessment, treatment planning, and interventions.

### Involvement

In personal relationships, when it comes to helping, there are no limitations with respect to involvement. As an illustration, suppose an individual has lost a job. As a friend, in addition to consoling, you may choose to step in and skillfully craft the résumé and cover letter, write a letter of recommendation, help shop for appropriate interview attire, perform the job searches, submit résumés, schedule interviews, and may even go so far as to transport the person to the interviews. Each of these is a valuable service. It is socially appropriate for friends to help each other per their talents and needs. Additionally, in this case, it is clear that the workload is unevenly distributed: About 90% of the work is being done by you and about 10% by your friend. In a social or friendship setting, there is nothing inherently wrong with this balance. In a professional helping relationship, this workload distribution would be inappropriate. The fundamental ethical principles of therapy involve empowerment, self-determination, self-efficacy, and the right to refuse services (*Ethical Standards of Human Service Professionals*, Statement 8; Council for Standards, 1996). Essentially, instead of doing this work for the client, as the therapist, your role would be more in the capacity of coaching the client to do as much for him- or herself as possible by collaboratively identifying meaningful goals and providing feedback and encouragement, thereby fostering personal growth and facilitating independence. In this case, it may be appropriate to utilize the sessions to help the client to cope with the emotional stresses related to unemployment such as self-esteem issues, depression, anxiety, frustration, or financial concerns. The therapy may also take the direction of identifying and resolving emotional roadblocks that may encumber the rigors of the job search.

In terms of the mechanics of achieving employment—which may include activities like refining the résumé, crafting a clear cover letter, and job hunting—as the therapist, you would take a more directive and less active stance. For instance, as opposed to your actually writing or editing the résumé, it would be more appropriate to recommend that the client confer with a résumé service or vocational guidance counselor. In terms of the job search itself, you may possess useful knowledge of some job search resources. Providing information regarding reputable Web sites, job boards, or reliable employment services would be appropriate, whereas performing the actual search for the client would likely be considered to be beyond the scope of your professional responsibility.

## Professionalism

### Legal

There are no special laws that govern the social conduct between friends. As such, there are no grounds for legal action with respect to such unfortunate happenstances as disappointment, rudeness, or hurt feelings, whereas there are clearly defined ethical and legal rules that govern the client-therapist relationship: Unlike casual friendships which typically have no supporting documentation, therapists are obliged to maintain thorough client records—including information detailing the consents for treatment, initial problem, diagnostic information, therapeutic goals, progress notes, and collateral information—in order to review clinical progress and as a professional service to other providers who may be involved with, or take over the care of, the client (Committee on Professional Practices and Standards, 1993).

As a health care practitioner, you must also adhere to laws and procedures governing mandated reporting, requiring you to breach the client's confidentiality under special circumstances. In instances when you believe that a client poses a plausible physical threat to him- or herself or others, as a therapist, you are legally mandated to notify the appropriate parties of the potential threat (Tarasoff warning; Kagle & Kopels, 1994). Additionally, as a therapist, you are required to understand potential compulsory breaches to confidentiality in terms of the laws regarding mandated reporting should you reasonably suspect that a client has perpetrated child abuse (Hepworth & Larsen, 1993). You must also be knowledgeable regarding your legally mandated responsibilities and protocol with respect to promptly reporting suspected abuse or neglect of a child, dependent adult, or elderly person. Those who submit such reports in good faith are protected from legal recourse from those named in the report (Lindsey, 1994). In your professional capacity,

## 14 Therapeutic Communication

you must also know where you stand in terms of responding properly to subpoenas, depositions, and court orders, which varies from state to state. These legally enforced limitations regarding confidentiality may be provided to the client in the form of intake documentation. Other times, they may be a point of discussion early in the initial session.

Although avoiding social contact with clients is typically considered to be an ethical issue, engaging in sexual contact with a client, even among consenting adults, is both unethical and illegal (*Ethical Standards of Human Service Professionals*, Statement 7; Council for Standards, 1996). Laws vary considerably from state to state with respect to the therapist having sex with ex-clients; as with confidentiality, you are responsible for knowing and adhering to the laws of the states in which you practice.

### Confidentiality

In casual relationships, individuals are free to exchange information and opinions with each other. For instance, John is free to tell Jane of his afternoon spent with Scott, which may include details regarding activities, conversations, or impressions. John may also choose to disclose one of Scott's secrets; although this may be perceived as a breach of trust among friends, such disclosures are not illegal, per se. In your role as a health care provider, confidentiality is legally and ethically paramount. As a therapist, you are committed to protecting an individual's confidentiality. The content of therapy is considered privileged information, which can only be disclosed to others with the client's written consent, except for special circumstances delineated by law (Kagle & Kopels, 1994; *Ethical Standards of Human Service Professionals*, Statements 3 & 5; Council for Standards, 1996).

You may partake in professional peer consultations with another therapist. Such consults should be conducted privately, as opposed to in open or public spaces where one could be overheard, and only the essential details should be provided. Take care to preserve the client's anonymity by omitting potentially identifying information. Make a consistent effort to protect the identity of clients by conducting therapy in a private sound-protected setting, properly storing client files and related data and, when indicated, properly destroying and disposing of identifying material. It is your responsibility to actively protect client identity, including confidential record management protocol as it pertains to current, ex-, and deceased clients. Additionally, as a professional, you are responsible for exercising appropriate protocol related to sharing client information with other practitioners, specifically signed consents when disclosures could suggest the identity of the client. This practice is also applicable to those requesting information via phone or other

media. Haphazard breaches in confidentiality will cost you and your colleagues the trust and support of clients and compromise public opinion of such services (Crenshaw, Bartell, & Lichtenberg, 1994).

Depending on the state laws governing therapists' privilege, your notes may be subject to subpoena or court order, and depending on the case, you may be called to testify in a court of law.

Concerns regarding confidentiality may be particularly critical to traditional Asian clients with whom the stigma of mental health issues reflects unfavorably, not only on the individual client but also the family as a whole (Gaw, 1993).

## Scope of Practice

Casual relationships afford the privilege to engage in a wide latitude of helpful efforts. Friends are free to mutually experiment with such practices as acupuncture, hypnosis, or herbal remedies. Additionally, there are no practical limitations with respect to social contacts offering recommendations or referrals. In the realm of professional therapy, you are only sanctioned to provide services for which you have received appropriate training, certification, or licensure (*Ethical Standards of Human Service Professionals*, Statement 26; Council for Standards, 1996). This constraint to limit therapists to practice within the realm of one's training and competency cannot be superseded with the client's consent, or even pleading. In such cases, you are obliged to refuse to provide the supplemental service; if appropriate, you do, however, have the privilege to provide reputable referrals to the client.

In addition to your clinical efforts, clients may, of their own accord, choose to supplement their treatment plans by including care providers that are considered traditionally acceptable within their realm. Some African Americans may utilize folk healers for treatments involving herbs, teas, and appropriate rituals to remedy medical or mental disorders (Baker & Lightfoot, 1993; Wilkinson & Spurlock, 1986). Similarly, Latinos may confer with religious leaders to aid in the resolution of mental health issues (Dana, 1993; Ho, 1992; Martinez, 1993). American Indians may include consultations with culturally relevant figures such as tribal leaders or elders when dealing with family social issues (Paniagua, 2005).

## Boundaries

Personal relationships are typically characterized by implicit boundaries, defined by social and personal norms and values. These boundaries can vary from one relationship to another. Topics discussed in one relationship may

## 16 Therapeutic Communication

include subject matters such as politics, career issues, and media, whereas the subject matter with another person might include topics such as family functioning, details of one's sex life, and discussion of dreams. Socially, either person has the privilege to specify topics that can and cannot be discussed. Such relationships are usually not one-way. Conversations consist of mutual open self-disclosure, exchange of opinions, and advice sharing. In a therapeutic relationship, the focal point of each session remains on the client; as a therapist, your self-disclosure is typically kept to a minimum. Keep in mind that every minute spent talking about the therapist's life is a minute taken away from focusing on the client's life. As a therapist, you need not remain a complete enigma to the client. Appropriate self-disclosure typically consists of openly answering questions related to professional qualification, such as education, training, clinical experience, or experience working with a particular clinical issue. A more detailed discussion regarding the appropriate uses of therapeutic self-disclosure is presented later in this chapter.

Personal relationships can be characterized by flexibility. Over time, the contact can evolve into a variety of forms, including such venues as telephone chat friends, lunch friends, sexual partners, or business associates. The therapeutic relationship does not afford such opportunities. Your professional contact and conduct with the client should be confined to competently providing goal-directed therapeutic services at the agreed-upon time and location only and should not involve casual contact outside the therapeutic setting (*Ethical Standards of Human Service Professionals*, Statement 6; Council for Standards, 1996).

Predictability, stability and robust boundaries have been shown to be key factors, in terms of clinical effectiveness, in building and maintaining the therapeutic relationship, carefully balancing the separateness and independence of each individual within the context of a collaborative setting (Epstine, 1994).

As important as it is to set and maintain appropriate professional boundaries, flexibility is essential in order to accommodate cultural factors, particularly when working with Latino clients. The development of the therapeutic relationship may evolve from the initial formalism (*formalismo*) wherein it is appropriate to address clients in a formal manner (e.g., Mr. Garcia) to a more personal (*personalismo*) form wherein first names would be used (Bernal & Gutierrez, 1988; Ho, 1992; Martinez, 1993). Additionally, some traditional Latino clients may offer a token gift to the therapist as a sign of gratitude. Persistent refusal of such gifts could be perceived as an insulting violation of the *personalismo* practice and thereby unintentionally damage rapport (Paniagua, 2005).

## Time Commitment/Responsibility

Social relationships have the advantage of time flexibility. There are no set limits on the number of contacts, frequency of contacts, type of contacts (in-person, telephone, Internet, etc.), or ultimate duration of the social relationship. Friends may be together for months, years, or a lifetime. In a psychotherapeutic setting, sessions are typically held at a fixed appointment time and duration, usually 50 minutes, and it is expected that sessions will begin and end on time (Kadushin, 1990). The number of sessions may be limited. Six to twelve sessions is not uncommon. This limitation may be a matter of financial constraints as designated by the client's managed care company or insurance provider, agency policy, or adequate resolution of the problem. Additionally, there is typically an agreement established in the initial session regarding missed or cancelled appointments. Traditionally, clients are asked to provide 24-hour notice in order to cancel an appointment. There may also be limitations regarding the total number of missed appointments.

## Respect

Respect can be thought of as holding another person's feelings, beliefs, and thoughts in as high a regard as you hold your own. Although mutual respect could be considered a natural part of casual relationships, it is not necessarily mandatory. Social communication may include derogatory language such as insults, teasing, sarcasm, taunting, or mocking, which may range from playful to severe. Additionally, in casual relationships, we may not always take the other person seriously. A particular topic may be of little interest or considered trivial by one member, therefore eliciting anything from superficial listening to an abrupt change of subject. In a therapeutic relationship, it is essential to consistently convey respect for the client's dignity in order to foster a facilitative helping relationship (*Ethical Standards of Human Service Professionals*, Statement 2; Council for Standards, 1996). This is not to say that as a therapist, you are resigned to playing the role of the yes-man. The quality of the therapy largely depends on the therapist's ability to offer an honest reflection of the client's life circumstances and alternatives, but this must be delivered with respect and tact. For example, a client may choose to partake in activities that you find distasteful or do not agree with; certainly the client has the right to make his or her own decisions. Although it is your role to honor the client's right to self-determination, you need not pretend to agree nor sit silently. You would be entitled to engage

## 18 Therapeutic Communication

the client to discuss relevant concerns or potential consequences regarding the client's decisions and actions in a purposeful manner, taking care not to degrade or shame. One of the greatest challenges that health and human service professionals face is that of honoring the client's right to self-determination, even when you do not agree with the client's decisions, actions, inactions, (potential) outcomes, or belief systems.

### Nonjudgmental Attitude

As humans, it is natural that we form opinions about people, which influence our decisions about our associations, how we treat others, and our expectations of them. Socially, one has the privilege to select who will be in one's life and the nature of the relationship that we will have with another. Part of the responsibility of being a therapist is keeping one's personal biases in check. Ideally, your professional relationships need to be free of judgmental attitudes/feelings and opinions and to provide an inherently accepting stance with respect to an individual client's unique attributes (race, age, gender, sexual orientation, ideology, social class, intellect, political affiliation, religious beliefs).

Some cultures may practice rituals that are unfamiliar to you, or they may adhere to belief systems that seem foreign or implausible to you. For instance, some Latinos attribute mental or emotional disorders to evil spirits or witchcraft and may, in addition to therapy, seek help from a folk healer. In order to best serve such clients, be prepared to suspend your own judgment and work within the framework that is culturally relevant to the client (Martinez, 1986).

The value of holding a nonjudgmental attitude is twofold: By setting aside your preconceptions of the client, you are better able to comprehend who he or she genuinely is and what the actual nature of his or her problem is, as opposed to your uninformed presumptions. Also, clients are often dealing with difficult feelings that may include stress, guilt, fear, shame, or general hurt related to their problems; the last thing they need is for the therapist to put more weight on those feelings by imposing negative judgments (Ivey, 1983).

Depending on the openness or narrowness of one's perspective outside of the therapeutic environment, maintaining a nonjudgmental attitude may pose more of a challenge to some than others. There may be circumstances that may not be conducive to conducting therapy due to profound differences between you and a particular client, for instance, a minority therapist working with a client whose hallmark characteristic concurs with the principles

of a hate group. In such circumstances, it is appropriate to evaluate, as honestly as possible, the extent to which you feel you can provide quality, unbiased service to this client. If after thorough consideration—which may involve conferring with peers or one’s supervisor—the mismatch is not resolvable, then it may be necessary to inform the client, as blamelessly as possible, of this insurmountable roadblock and to tactfully provide the client with appropriate referrals. Alternatively, a client may express his or her own biases. For instance, a client may wish to have a therapist of the same gender or ethnic background. Certainly, you have the privilege to articulate your capacity to provide quality care; however, if after you have submitted such a proposal, the client still wishes to terminate or switch to a different therapist, the client’s preference must ultimately be honored, with the exception of certain in-patient or compulsory treatment venues. The notion of a nonjudgmental attitude as a means for promoting a trusting therapeutic contact will be covered in further detail in Chapter 2.

### Positive Regard

Social relationships afford substantial latitude in terms of accepting or rejecting others. Friends may express feelings toward each other ranging from pride to disappointment; heated accusations, chastising language, sarcastic retorts, and stabbing insults, though hurtful, may all have their place in such contexts. In a provocative social setting, one may proclaim the other to be a no-good failure who will never amount to anything. In your role as a therapist, you are essentially committed to fostering a perspective of positive regard, wherein the value and worth of the person remain foremost (Rogers, 1957). Although the therapeutic process inherently challenges clients to grow and change, ethical standards and research support the use of a positive, as opposed to punitive, framework. Consider a case wherein a client fails to achieve a specified goal or reverts to a dysfunctional behavior. Positive regard does not mean that you ignore it. Instead of accusing the client of laziness or failure, it would be more appropriate to engage the client in a facilitative dialogue, accentuating the client’s past accomplishments, strengths, goals, and work to identify and resolve some of the factors that may have confounded or encumbered his or her progress, thereby empowering the client to lay the groundwork to try again or identify alternatives. Persistent conveyance of an attitude of positive regard toward the client promotes the therapeutic relationship (Nugent, 1992). Conveying a genuine “I’m on your side” attitude carries the positive implication that the client possesses the capacity to achieve the objectives set forth in therapy.

## Self-Disclosure

Within the context of personal relationships, mutual self-disclosure is a natural part of the communication stream. In social situations, individuals typically exchange personal information about themselves in a free and spontaneous manner. Such dialogues can foster a sense of intimacy and trust between the individuals. The therapeutic relationship is different in that the focus is primarily dedicated to the story and needs of the client and not you.

In the therapeutic milieu, your self-disclosure can be thought of in two realms: professional and personal.

Suppose a client admits to a history of substance abuse and is requesting help toward achieving and maintaining recovery. In terms of making a *professional* self-disclosure, you may choose to briefly tell the client that you interned for a year as a substance abuse counselor at a chemical dependency recovery center. Such a disclosure can facilitate the therapeutic process by calling attention to the fact that you possess specialized professional experience to address such a problem. Few would argue the appropriateness of such a brief, focused, professional self-disclosure; however, opinions vary with respect to making *personal* self-disclosures. Using this example, there is an array of advantages and disadvantages to disclosing extensive details regarding your own substance abuse history and recovery to a client within a therapeutic setting.

Traditionally, as the therapist, you would presume the role of the unbiased helper; in order to accomplish this, self-disclosure, on your behalf, is typically kept to a minimum. Regardless of how little you verbally disclose about yourself, clients are privy to a multitude of other clues when it comes to formulating an impression of you. Your readily observable personal attributes, such as your gender, race, ethnicity, grooming, attire, wedding ring, mannerisms, demeanor, physicality (stride, posture, gestures), approximate age, and language characteristics (vocabulary, expressions, accent) are undeniably evident. Your working environment may provide further hints as to your tastes, personality, and education: Clients may assemble an impression of you from such common things as photos on your desk, artwork, furnishings, diplomas, licenses, certificates, and books; so even without providing extensive, detailed disclosure, the client has some basis for forming an impression as to who you are. Essentially, the principle is not necessarily for you to present as an enigma but rather to provide a neutral canvas, ready to accept the client's verbal rendering in an unbiased fashion.

There is no single right answer regarding the use of self-disclosure in the therapeutic realm; one factor that mediates the appropriateness of the therapist's use of self-disclosure is the therapist's theoretical orientation. For

instance, a psychodynamically oriented therapist would consider self-disclosure inappropriate, as it could corrupt the transference potential; a humanistic therapist, however, may readily utilize self-disclosure as means to facilitate authenticity (Goldfried, Burckell, & Eubanks-Carter, 2003).

### Advantages of Self-Disclosure

Self-disclosure, wherein you share with the client that you have dealt with issues similar to the client's, may facilitate a therapeutic alliance by demonstrating commonality. The client may feel that you are uniquely qualified to understand the problem from personal experience. Using your matching experience can help normalize the client's feelings by letting the client know that he or she is not the only one, that his or her experience is not one in a million. Research indicates that the therapist's use of moderate—as opposed to high or low—levels of self-disclosure in the initial interview results in higher rates of return to future appointments by clients (Simon, 1988; Simonson, 1976).

Studies also indicate that the therapist's sharing of personal thoughts and feelings provides the client the opportunity to know the therapist, thereby developing the professional relationship (Shulman, 1977). The use of focused self-disclosure may help the client perceive you as a facilitative role model, someone who has faced a relevant challenge and successfully overcome the obstacle, thereby instilling the client with a sense of hope. Successfully modeling a process or adaptation to a problem may serve as an instructive template for the client to follow (Bandura, 1986). Research suggests that the therapist's self-disclosure can result in a reciprocity effect, wherein the client, in return, engages more readily in his or her own self-disclosure, thereby advancing the therapeutic process (Doster & Nesbitt, 1979).

According to a study of clinicians, therapists tend to use self-disclosure most frequently to increase the client's awareness of options, enhance the client's self-disclosure via modeling, lower anxiety, and convey authenticity. Among the therapists studied, the most disclosed topics include the therapist's personal history and current relationship; least disclosed topics include sexuality and money (Anderson & Mandell, 1989).

### Disadvantages of Self-Disclosure

When choosing to self-disclose in the therapeutic setting, you are inherently faced with the running question of to what extent do you tell your story. You must then select which personal facts to disclose, as well as the depth of detail suitable for each story.

## 22 Therapeutic Communication

Excessive self-disclosure may lead to the gradual development of an inappropriate bond between you and your client. Specifically, there is a risk of role reversal. In a setting wherein you regularly reveal vulnerable attributes of your life, the client may naturally develop a sense of sympathy toward you. As the client takes your personal feelings and life experiences into consideration, the client may resist burdening you with his or her own (genuine) problems. The client may feel that perhaps you are already dealing with a full load and should be spared the burden of the client's potentially critical problems. The client may resort to such strategies as withholding difficult topics, omitting details, even distorting or editing truths so as not to overtax or offend you. The client's evolving sense of compassion toward you may cause the client to feel uncomfortable discussing therapeutic roadblocks or complications in the treatment plan implementation for fear of making you feel as though you somehow failed. In such circumstances, the client is short-changed: If you are being misled into believing that the therapeutic process is working idyllically, then critical opportunities for tuning the therapy may be lost at the expense of the client.

Presenting with a genuinely friendly demeanor can be an asset in facilitating rapport; however, regularly disclosing personal information to the client may cause the client to begin to see the relationship as less a professional and more a social relationship. The risk is that the client may be misled or confused by such ambiguous boundaries. Under such circumstances, the client may desire or request that you join him or her for some social engagement. Such dual relationships are professionally contraindicated. That is to say, ethically it is inappropriate for you to serve both as a therapist and a social friend. In short, your objectivity as a therapist is compromised when a client is a friend. Additionally, expanding your professional relationships to a social realm wields an unsuitable air of authority. A client is likely to experience a sense of rejection should you fail to promote the relationship to the next level. (*"We get along so well in the sessions, I wonder why I haven't been asked to get together outside the session."*) Similarly, the client may feel as though he or she has been spurned should you decline an invitation to a social engagement.

Self-disclosure may also set off any number of unintended adverse reactions. Though well intended, your self-disclosure may not transfer to the client in the manner expected. Consider a case wherein the client raises the topic of substance abuse and you disclose that you are a recovering addict with a long history of sobriety. Depending on the drugs involved, the client may perceive you as either over- or underqualified to comprehend his or her circumstances. For instance, it is possible that a client who is a heroin addict may deem an ex-marijuana user a lightweight who cannot begin to

comprehend the client's problem. Conversely, a client who is addicted to prescription pain medication may form an unfavorable opinion of you should you proclaim that you used to use illegal street drugs.

When a client presents with a problem with which you have personally dealt, it can be tempting to play the "*Oh, I've been there. . . Here's how you handle this . . .*" card with the intention of normalizing the client's situation, instilling hope and delivering a facilitative treatment plan. Though this may initially seem the only reasonable approach, there is the potential for considerable drawbacks: Imparting the message, "*I've dealt with this, and you will too,*" naively denies the uniqueness of the client. Each individual is endowed with a unique set of talents, capabilities, and challenges. Additionally, social systems, which can include such things as family, friends, living conditions, and socioeconomic status, can vary considerably from person to person. In reality, the client and his or her circumstances are not like you and yours; hence, the solution pathway that worked for you may not transfer seamlessly to the client. Additionally, imparting your success story as it pertains to the client's problem may have an unintended negative paradoxical effect, whereby disclosing, "*I accomplished this, so you can too,*" may be received by the client with, "*Yeah, but you're a success and I'm not,*" potentially leading to a negative outcome (Mann & Murphy, 1975).

Instead of issuing fix-it directives, the derivation of which may appear elusive in nature and therefore difficult for the client to reproduce independently, consider engaging the client in a collaborative problem-solving process, thereby fostering the client's sense of skill building, empowerment, and independence. The client's participation in the solution process facilitates customized strategies that are concurrent with the client's resources and distinctive personality style, which may be different from yours. In terms of implementation, clients tend to be more likely to follow through on solution pathways that fit them, and clients more robustly embrace treatment plans that they have had a hand in assembling.

In some cases, your use of self-disclosure can potentially give the client the impression that the therapy is being guided by something less than clinically sound principles. Consider a client who discloses he or she is experiencing distress related to same-sex attraction, and the client wants to know what can be done to redirect his or her attraction toward the opposite sex. Suppose you respond by disclosing that you are lesbian, gay, or bisexual and then go on to explain to the client that attempting to alter one's sexual orientation is clinically contraindicated, and instead, the therapeutic approach involves helping the client to emotionally accept and embrace his or her orientation, not as pathological, but as a normal sexual variant. Although the clinical information given is, in fact, concurrent with the practice principles

## 24 Therapeutic Communication

of contemporary psychotherapy, having couched this information in the context of your own sexual orientation, the client may perceive the information as personally biased, or even coercive. The client may react by seeking a more objective opinion or perhaps abandon the therapeutic process entirely.

Some forms of therapy depend on the use of *transference*. Effective transference is facilitated by you, as the therapist, persistently withholding self-disclosure, presenting as a virtually unbiased blank slate (*tabula rasa*), wherein the client is free to superimpose (transfer) his or her feelings for a significant person in his or her own life (a parent, spouse, sibling, peer, etc.) onto you, the neutral therapist (Breuer & Freud, 1955). From there, you and the client gain access to the client's feelings and thoughts in a controlled and facilitative manner. Excessive self-disclosure on your behalf may pollute this (unbiased) transference potential. In other words, if the client comes to know you as a unique person via your extensive self-disclosure, then it may confound the client's ability to readily transfer the emotional cloak of another onto your distinct frame (Basch, 1980).

Time is also a factor when considering self-disclosure. Simply stated, each minute that you spend talking about yourself is a minute taken away from talking about the client. The client may resent that you are consuming the client's time and money talking about yourself. Additionally, the client may not necessarily agree that your self-disclosure is relevant or even interesting; hence, self-disclosure should be done sparingly, and each self-disclosure needs to be as concise as possible.

Therapeutic work can be emotionally rigorous. As you embark on tales of self-disclosure, the client may receive this as a welcome detour from having to deal with his or her own difficult issues. In such circumstances, you may not be doing the client any favors by diverting him or her away from the challenging therapeutic work that the client is there to accomplish (Hill, Helms, Spiegel, & Tichener, 1988).

It can be difficult to anticipate the effect that spontaneous self-disclosure may have on you in your capacity as a therapist. Self-disclosure can be fraught with a multitude of emotions, which may induce feelings of vulnerability, confusion, or disorganization, thereby risking destabilizing yourself, the client, and potentially the therapeutic frame(work) (Ulman, 2001).

### Self-Disclosures Should Be Honest

Though at times it may be tempting to fabricate or borrow someone else's storyline and present it as your own self-disclosure, doing so has the potential for creating more complications than benefits. Fundamentally, lying

breaches the ethical basis of any professional relationship. Lying also creates multiple confounds that can compromise the quality of the attention and care that you are able to provide. Even small deceptions can snowball over time (Peck, 1998). In order for a lie to present as plausible, the lie can seldom stand alone in a vacuum. To exist, it requires a contextual environment typically comprised of supplemental fabrications. For instance, suppose a client discusses stresses related to working at a radio station, and with no such background, you decide to falsely disclose that having once worked in radio, you understand how stressful that can be. Now your well-meaning statement is subject to appropriate inquiry wherein you will need supplemental false information in order to support your evolving lie. You are committed to inventing an entire fictional setting, including things such as the call letters of the station, the frequency, your job title, coworkers' names, personal characteristics and job titles, rating statistics, licensing or certifications that you held, terminology unique to that business, FCC regulations, and multidimensional characteristics of the city where you lived. Being unfamiliar with the business, you may have difficulty articulating this volume of detail on the fly. Not only must you work to conjure up this "B" storyline in real-time, it must also be accurately recalled on a consistent basis. This can be quite a volume of information to memorize and reliably recall. Composing and maintaining this false paradigm is a poor use of your cognitive capacity, as this sort of processing depletes your ability to concentrate on the client. Even if you are able to construct and sustain this fictional storyline, it cannot stand up to simple research and scrutiny. There are multiple ways in which a reasonably skeptical or curious client may discover, through outside means, that none of what you have proposed is true. Ultimately, lying risks the trust that is the very basis of the professional relationship.

### Self-Disclosure Guidelines

As a general rule, selective self-disclosure is not inherently forbidden within the therapeutic setting, but it should be administered in a thoughtful and purposive manner. The following guidelines may help you regulate your use of therapeutic self-disclosure:

1. Assess how comfortable you feel disclosing this particular piece of information.

Regardless of how helpful you feel a particular piece of personal information might be to your client, if you do not feel comfortable sharing that information, then you should not. You are entitled to your feelings and sense of privacy. No matter how helpful you think a particular self-disclosure

## 26 Therapeutic Communication

might be in serving your client, you are in no way obliged to compromise your own sense of boundaries. Above all, in a professional setting, you reserve the privilege to keep your personal life personal.

2. Reflect on how beneficial this self-disclosure would be to the client.

Your self-disclosure should only be used as a means for client growth, not to satisfy your own needs (Evans, Hearn, Uhlemann, & Ivey, 1993). Ask yourself why you are considering telling the client this information about yourself. Is your hope that the client will genuinely benefit from what you are considering disclosing, or might you be motivated by other factors (the quest for admiration, validation, the desire to get something off your chest, etc.)?

3. Keep self-disclosures genuine.

Do not borrow, embellish, or fabricate stories.

4. Consider using self-disclosure sparingly.

Should you choose to embark on therapeutic self-disclosure, identify the specific personal information that you feel is therapeutically appropriate and convey it in a succinct and purposeful manner. Avoid indulging in lengthy or tangential storytelling. Remember: The subject of the therapy is the client, not you.

As a caveat to this discussion about self-disclosure and the guidelines put forth, it is worth noting that there is no consensus among practitioners regarding the clinical use of therapist's self-disclosure. These principles are merely provided for your consideration. As an evolving practitioner, it will be up to you to determine your own parameters for embarking on self-disclosure with respect to content, depth, and frequency. Some factors that may influence your thinking may include your theoretical orientation, clinical setting, agency policies, modality (individual, couple, family, group, helpline, etc.), cultural norms, your comfort with the client, your sense of commonality with the client, your comfort with the subject matter, your comfort in your role as a therapist, your sense of privacy, and your gut feelings in the moment. As with any aspect of the therapeutic process, trust yourself to make good decisions.

**Role-Play Exercise 1.1****Don't Mention It**

This is Adrian's first session; Adrian reports no prior involvement in therapy. The company provides for mental health as part of the benefits package, and as such, Adrian fears what might happen if the company found out the reason for therapy.

**Client**

- Present as moderately guarded, as if you genuinely do not know the rules regarding confidentiality, regardless of who is paying for the therapy.
- Discuss the potential consequences should your employer find out the content of the therapy.
- When you feel the therapist has adequately addressed your concerns, reveal the reason that you are seeking therapy (possible drinking problem, anxiety related to another job offer).

**Therapist**

- **Respect** (p. 17)  
Acknowledge Adrian's concerns and hesitation as valid. Do not press for immediate disclosure.
- **Legal** (p. 13)  
Explain that the insurance company will be billed, but the content of the session is considered privileged information that can only be disclosed with the client's written authorization.
- **Confidentiality** (p. 14)  
Provide examples of confidentiality and mandated reporting: what can and cannot be disclosed.

**Role-Play Exercise 1.2****Unpleasant Dreams**

Evan is an adult who is sporadically employed and occasionally resorts to prostitution for extra income. Recently Evan has been crying and is plagued by poor sleep (nightmares, insomnia).

**Client**

- Speak of the prostitution in a forthright manner, as if this is old news to you.
- Discuss the crying, sleep problems, and the content of the distressing dreams.
- Tell the therapist that you would like him or her to also provide acupressure or hypnotherapy. If the therapist refuses, then offer to demonstrate how easy it is to do.

**Therapist**

- **Scope of practice** (p. 15)  
Tactfully refuse to provide a service that is beyond your training and competency, even if Evan authorizes it.
- **Nonjudgmental attitude** (p. 18)  
Work with the client, not on the client. It is okay to make an effort to comprehend the prostitution component of the story, but to Evan this is not the central problem.
- **Positive regard** (p. 19)  
Identify the things that you find commendable about Evan (honesty, motivation to self-improve, sense of independence).

**Role-Play Exercise 1.3****My Therapist, My Friend?**

Ryan has been a client for about 3 months. The therapy has primarily focused on coping with an alcoholic parent. Ryan has made good progress in therapy but today begins asking questions about the therapist and proposes that they go to lunch today after the session.

**Client**

- Begin by asking professionally related questions (school, specialized training, etc.).
- Ask the therapist some personal questions (where he or she grew up, family, favorite food, etc.).
- Invite the therapist to lunch; if the therapist cites scheduling conflicts, then propose rescheduling.

**Therapist**

- **Personal contact** (p. 11)  
Discuss the ethical principles related to dual or multiple relationships.
- **Boundaries** (p. 15)  
Tactfully reject the offer for outside contact.  
*“It’s flattering that you’d like to spend time with me, but that really wouldn’t be appropriate.”*
- **Self-disclosure** (p. 20)  
Respectfully redirect the client’s nonprofessional questions about you.  
*“This therapy is about you, not me. Let’s get back to . . .”*

**Role-Play Exercise 1.4****Digital Dilemma**

Kyle and Toby have been involved in a close relationship for several years. Recently Kyle discovered some curious messages and pictures on Toby's computer that suggest that Toby may be interested in someone else. It is unclear if this is merely an online contact or if things have gone beyond that.

**Client**

- Ask for advice on to how to proceed: You want to confront Toby but that would reveal your invasion of Toby's privacy.
- Indicate that you have resisted talking to anyone else about this, fearing that news of your unauthorized computer access may leak back to Toby.
- Attempt to engage the therapist to take the lead in determining the meaning of the computer's contents. Offer to bring in evidence (the computer, printouts, photos) for the therapist's examination.

**Therapist**

- **Advice** (p. 7)  
Resist the client's requests regarding advice on how to proceed. Explain that at this point, the client knows the players and circumstances better than you do. Engage the client in discussing the nature of the relationship.
- **Confidentiality** (p. 14)  
If Kyle expresses concerns related to Toby finding out the content of the sessions, review the confidentiality rules.
- **Involvement** (p. 12)  
If Kyle asks you to investigate the content of Toby's materials, explain that this is not an appropriate activity for the therapist. Explain that, alternatively, you can help Kyle process feelings, thoughts, concerns, and alternatives.

**Role-Play Exercise 1.5****A Lot of Class**

Daryl is enrolled in 15 units at the university and is doing well with the exception of one class that is very challenging. Daryl is considering dropping this course in order to dedicate more time to the other courses but, having never dropped a course before, feels conflicted.

**Client**

- Present as confused about your goal: Should you put extra effort into this class or drop it to provide more time for the other classes. Are there other alternatives?
- Raise multiple topics (detailed information regarding the campus, classes, instructors, students, living conditions, friends, social organizations, entertainment).
- Express how lucky you feel that you were able to find a therapist who is so extraordinarily qualified (compassionate, attentive, well educated, dedicated, insightful).

**Therapist**

- **Goal** (p. 4)  
Work with Daryl to identify the primary problem. Help Daryl select appropriate therapeutic goals.
- **Topic of conversation** (p. 6)  
If numerous topics are raised, recap the topics and work with Daryl to understand how they may be related. Are all of the topics therapeutically relevant?
- **Rescind your ego** (p. 10)  
If Daryl expresses inordinate praise, graciously accept the compliment and then explain that any of your peers would essentially provide equivalent service.