

Practice Makes Progress:

Navigating trauma, empathy, and self-disclosure in clinical social work practice.

for

The Elizabeth N. Brehler Scholars Program

by

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I believe that my social work education calls me to be introspective, to wrestle with my fears, biases, and resistance, to truly discern my values in order to be a clinician who practices competently, and with integrity. I believe that when I encounter strong resistance within myself, I must examine it and push through it, to try to figure out what lesson I am resisting learning—because very likely, that is the lesson I most need to learn. I believe that empathy is the core of our work as social workers: feeling ourselves into another person’s emotional experience in order to feel with them and collaborate with them to work through painful challenges. It is this empathy that gives us the ability to work effectively with clients who are facing challenges we have never faced ourselves. I believe that life is a journey and although I don’t believe it is a circular journey, I speculate that there are certain motifs, as my mentor says, that come up again and again throughout our lives, themes that we revisit over and over, hopefully learning something new as we encounter it again.

The part of my journey that this paper describes started six years ago, when I graduated from a BSW program in another part of the state and began my first post-baccalaureate social work job: a counselor at a substance abuse detox clinic. I had little personal experience with substance abuse beyond being acquainted with a few individuals in recovery, and no professional experience in the field either. However, I wanted a job, especially one that related to my social work education, and when this entry-level position opened up at a reputable agency near my undergraduate university, I jumped at the opportunity.

When I think of myself at this time, I think of myself as a “baby social worker,” unsure of how to apply the practice skills I had learned in the classroom, insecure in my abilities, and possessing very little understanding of addiction. On my first day at the detox center, when I asked my supervisor how I should respond to clients who asked if I was in recovery, she replied,

“It’s up to you!” Although this may be empowering for even a slightly more experienced clinician, I felt completely adrift, especially when clients had strong negative reactions to my disclosure that I was not a recovering addict. I began to feel that I had to refuse to disclose or somehow misrepresent my experience to make it sound like I had more firsthand knowledge of addiction than I really did.

I only lasted six months in this position, overwhelmed not only by feeling professionally inadequate, but also by a serious personal crisis going on at the same time. I left my job at the detox center thinking that in order to be a successful substance abuse counselor, I needed to experience and overcome an addiction; in time, I came to realize that what I really needed, to be successful in any area of social work, was to deepen my capacity for empathy.

What is empathy? How does it develop? These are questions much explored in the literature. Empathy is, colloquially, “putting yourself in someone else’s shoes,” trying to understand their emotional experience by imagining oneself into their place. Empathy involves identifying with another’s experience, finding points of commonality between his or her experience and one’s own, and drawing on that commonality while maintaining awareness of the differences in the other’s subjective experience (Freedberg, 2007; Aragno, 2008; Clark, 2010). Empathy involves responding to the way other people’s emotions and experiences resonate within oneself (Aragno, 2008; Freedberg 2007). Clinically, many consider empathy to be the basis of the therapeutic alliance (Aragno, 2008; Freedberg 2007; Mallow, 1998; Kohut, 2011; Jordan, 2000). Clinical empathy requires not only compassion, authenticity, and attunement with the client, but also the therapist consciously monitoring her feelings, thoughts, and affects aroused by the empathy, in order to use the empathy for the client’s benefit (Aragno, 2008; Freedberg 2007; Jordan 2010). Heinz Kohut considered empathy not to be a magic cure for

whatever ails the client, but rather, a source of information for appropriate action (2011). Recent studies suggest that social workers who practice empathically work more effectively with their clients. By practicing empathically, the social worker is more likely to be able to understand the client and intervene in a way that is most helpful for the client at that moment (Gerdes & Segal, 2011). Rather than a static character trait, empathy, clinical or otherwise, is a dynamic process, a mode of interacting, a way of knowing.

It is believed that empathy develops through experience and practice. Jordan emphasizes the importance of experiencing mutual empathy, that is, receiving empathy from others, and having the opportunity to give it in return (2000). Additionally, she emphasizes the importance of developing self-empathy, the ability to look at one's self, past, present, and future, with an empathic attitude, one that is nonjudgmental, understanding, and compassionate. In order to extend empathy to others, one must first extend it to oneself (2000). Salmon (2003) also emphasizes the importance of observing empathy in action and experiencing empathy from others, as well as practicing empathy in an environment that is supportive, acknowledging and encouraging of one's efforts. Like other therapeutic skills and traits, empathy also develops through life experience: experience with family, marriage, and parenting, experience with the arts and the literature, as well as learning from professional successes and failures (Johnson, 1956).

My capacity for personal and clinical empathy matured and expanded through a series of important life experiences in my early twenties, as well as through introspection. Around the time period that I was working at the detox center, I was raped on three separate occasions. As might be expected, these acts of violence created chaos in my life, and triggered the onset of Post-Traumatic Stress Disorder. In the first months following the last of these attacks, I struggled

to reach out and seek help, and instead turned to self-destructive behaviors like self-harming and bingeing and purging. As my self-destructive behavior escalated to contemplating suicide, my mother intervened and helped me connect with much-needed sources of social and therapeutic help. Through family support, dialectical behavior therapy, and peer support groups, I began the long process of recovering from rape and managing PTSD. In this process, I began to recognize that although many people helping me had not had the same experiences as I, they were still able to support and facilitate my healing and recovery, because their support was enriched by genuine empathy and care.

An aside: in this exercise of contemplating empathy, it strikes me as especially poignant that my mother was the person to intervene; according to several theories of early development, the mother-child bond is the original template for empathy (Surrey 1991; Freedberg 2007). Her empathic ability to perceive my profound distress even when we were geographically distant not only saved my life, it created an opportunity for me to develop and deepen my own capacity for empathy, the seeds for which were planted in early childhood.

Joyful events also helped me deepen my capacity for empathy. Beginning a relationship with my now-husband, a few years into my recovery, and becoming a parent with him, have created opportunities to practice empathy every day, in times when it is easy, and in times when it is exceptionally challenging. My husband is a deeply connected, loving person; following his example, I strive to reciprocate his care and attentiveness. As a parent, I have made an effort since my daughter's birth to understand her experiences as a new, tiny person with her own feelings and perceptions, and to respond to her with respect, genuineness, and compassion. Becoming a doula, a professional who provides emotional support to pregnant, birthing, and postpartum women, was a somewhat ironic highlight of my development. Though I began

working in this capacity before personally experiencing pregnancy and childbirth, I felt confident in my ability to relate to my doula clients; oddly, this confidence coexisted with my lingering conviction that I couldn't work in addiction treatment because I hadn't experienced addiction. Simply growing up has enhanced my capacity for empathic attunement as well. Developing a stronger sense of self, of my values and priorities, as well as getting a deeper understanding of my experiences, and my conscious and unconscious motivations has been profoundly helpful for being able to understand and relate to others as separate individuals. Knowing where I stop and other people begin has moved me from simple identification and merging with other's experiences and emotions, to a deeper, more nuanced experience of understanding and compassion for others.

When I began the field placement process for the MSW program at Wayne, I was initially resistant to any placement in the substance abuse field. I still felt certain that my future career could not possibly include work as a substance abuse therapist. However, the process ultimately led me to a placement at a substance abuse treatment center. True to my belief that the universe steers me toward things I am resistant to because there is some sort of lesson I need to learn, I accepted this placement and spent the summer prior to starting the placement vacillating between excitement and anxiety. I was excited by the opportunities the placement offered for good supervision, as well as direct experiences working with clients individually and in groups. I was anxious about revisiting the questions: "Are you in recovery? If not, how can you help me?"

Traditionally, self-disclosure has played a major role in substance abuse treatment. Contemporary substance abuse treatment has customarily incorporated the principles and practices of Alcoholics Anonymous (Martino, Ball, Nich, Frankforter & Carrol, 2009). Self-disclosure is the fundamental tenet of Alcoholics Anonymous and all similar, mutual aid, 12-step

based programs: members help each other recover from addiction by “sharing their experience, strength, and hope.” (Martino et al., 2009; Mallow, 1998). Coming from this perspective, it is not uncommon for clients in substance abuse treatment to demand that the therapist disclose his or her personal history with addiction and recovery—or lack thereof. However, even when working in programs that utilize or incorporate 12 Step tenets, social workers, whether in recovery or not, must recognize and help their clients recognize that the goals of substance abuse treatment are different from the goals of 12 step fellowships: in Alcoholics Anonymous, the goal is for members to provide mutual support and help each other stay clean. In treatment, the goal is for the therapist and client to collaborate to help the client examine their challenges, develop more adaptive ways of coping, and to achieve a higher level of understanding and functioning (Mallow 1998).

The clinical literature identifies the ways therapeutic self-disclosure can be beneficial to the client, but also cautions about the ways it can be detrimental. By modeling openness and vulnerability through her own self-disclosure, the therapist contributes to the establishment of the therapeutic alliance, encouraging the client to do so as well (Henretty & Levitt, 2010; Goldfried, Burckell, & Eubanks-Carter, 2003). Additionally, it may enhance the clinician’s credibility in the eyes of the client: the therapist is not only formally educated, but has also learned through similar life experiences (Martino et al., 2009). However, though some clients may be encouraged by learning that their therapist has overcome struggles similar to their own, other clients may feel competitive toward the therapist, or might become overly concerned with trying to take care of the therapist. This speaks to the need to be discerning about what types of self-disclosures to make and to which clients (Henretty & Levitt, 2010; Mallow, 1998; Goldstein, 1994). I contend that the use of self-disclosure in substance abuse treatment needs to follow the same guidelines

as the use of self-disclosure in other types of therapy. Therapists need to be clear about why they are choosing to share this personal information with this specific client at this specific time; ultimately that reason must be because they see it as having a clear benefit to the client. The disclosure must serve the client's needs, not those of the therapist. Direct self-disclosures such as these are best made with a thorough understanding of the client's personality and relational patterns, as well as with thoughtful consideration of the overall nature of the therapeutic alliance (Henretty & Levitt, 2010; Goldfried et al., 2003; Goldstein 1994).

Toward the end of my employment at the detox center, I was standing outside in the winter cold, smoking cigarettes with a few clients. (Smoking was, in fact, a habit I had picked up early in my employment, in large part to feel like I had more in common with the detox clients). The clients were lamenting the fact that detox rules prohibited them from having coffee, except while out in the community attending 12 step meetings. I should have expressed sympathy about how difficult it can be to go without coffee and left it at that. Instead, from a desire to get them to like me, and to validate me with their camaraderie, I shared that when I was "in treatment" (referring to a brief stay in a hospital psychiatric unit for suicidal intentions), coffee was prohibited, but that I skirted the regulations by faking a migraine and obtaining Excedrin, a non-prescription analgesic containing caffeine. Telling this story was completely inappropriate, not only because of the content and the intentional misrepresentation of my treatment experience, but also because I only shared it out of a desire for their approval. I was not motivated to disclose this story because I thought it would be helpful for them, but rather to fulfill my own needs for validation and acceptance.

Therapeutic self-disclosure requires authenticity, an understanding of the therapist's position, as well as attunement with the client's needs. It requires introspection, both in the

moment with the client, as well as on the part of therapist outside the session. Henretty and Levitt (2010) note that although opportunities for therapeutic self-disclosure arise spontaneously during work with a client, it is important for the social worker to anticipate and reflect on the issue outside of work: by considering how she would respond in hypothetical situations, how she has responded —effectively or ineffectively— to opportunities for self-disclosure in the past, and what she might do differently in the future. In an effort to prepare for the questions that had unnerved me so deeply as a brand new social worker and detox counselor, I contemplated how I might respond to new clients who would ask, “Are you in recovery? Are you an addict?”

I decided that I would be forthright: I would own the fact that I am not in recovery from an addiction. However, I believed that based on my life experience, what I was learning as a student social worker, and my willingness to listen to their stories and learn from them, we could work together and that our work together could be beneficial to them. So far, seven months into my field placement at an inpatient substance abuse treatment facility for men mandated by the correctional system, my commitment to this decision has proven tremendously helpful. Many of the clients with whom I work express appreciation for my willingness to be honest with them about my personal experience; they also affirm feeling that I genuinely care about them and want to understand them. Through observing my supervisors’ skillful use of self-disclosure, I have been able to recognize that it’s not necessarily the content of what they share that makes their disclosures resonate with our clients, but rather the element of empathy and thoughtfulness in their messages.

Toward the end of my first semester at field placement, I was leading a group didactic session about mindfulness. We reviewed material about the specific ways that mindfulness technique can be an important tool for coping with recovery from addiction, and also discussed

different ways to practice mindfulness. Although a growing body of research indicates that mindfulness meditation can help people recovering from addiction cope with cravings and manage impulses to use substances (Carlson & Larkin, 2009), many of my clients were skeptical about how techniques like distraction or the use of little mind games like naming an animal for every letter of the alphabet could actually help them stop using drugs. Looking at my clients' uncertain faces, I quickly recalled how my personal mindfulness practice had recently helped me cope with a craving of my own. I shared with the group that I was one week away from the three year anniversary of my very last cigarette. My clients expressed first astonishment, then excitement that I had achieved this milestone. After the clapping died down, I related that the week before, while walking to class, the smell of the first snowfall had triggered in me an intense craving for a cigarette. I had wanted one so badly: I could taste it, feel it in my hand, and I desperately wanted to walk into a store and buy a pack of Marlboro Menthol Light 100s. However, I knew, despite my physical longing, that I really wanted to maintain abstinence from cigarettes. I told them that I had utilized mindfulness techniques like identifying my sensory experiences as well as the previously mentioned alphabet animal game to distract myself from my craving and the impulse to buy or bum a cigarette until I got myself safely and smoke-free to my class. The clients that had previously been skeptical of the mindfulness techniques' usefulness were now willing to consider that they might be worth trying. They were also open to hearing more of what I had to say, both in that group session and in others. Although I did enjoy their praise of my so-far successful avoidance of tobacco products, I was most excited that my self-disclosure had offered encouragement to my clients to consider learning some practical tools for addiction recovery. Moreover, it increased my credibility with them, and had enabled me to model strategies for coping with impulses to use substances.

Through developing my capacity for empathy and clarifying the purposes and methods of therapeutic self-disclosure, I have been able to enhance my ability to practice social work. In doing so, I am now better able to serve my current and future clients with integrity and competence. Where once I felt pressure to distort my experience to myself or others, or even ignore it or conceal it completely, I now own my experience and strive to share facets of it honestly and to use it to inform my practice in a genuine way. By doing this, I am now also better able to use self-disclosure in an effective, therapeutic manner. I have a better understanding of the ways self-disclosure can be beneficial, or not. Analogously, I am learning to discern when self-disclosure is appropriate, and when it is not, even when clients demand it. I am learning how to work more skillfully with clients to understand their motivations for requesting I disclose my experiences, rather than being coy or flat out refusing to do so.

It would be tempting to say that through this field placement experience, my story has come full circle: from an inexperienced, insecure social worker unsure of how to empathize with clients or effectively self disclose to a more confident, more experienced social worker with a better understanding of responding professionally yet genuinely to clients. However, I believe that this is not a destination, but rather the current stop on my professional journey. I do believe that this will be a lesson I keep learning, professionally and personally, whether I continue to work in substance abuse treatment, like I think I might, or go on to explore other kinds of clinical practice. As long as I am practicing social work with integrity and competence, I will always have room to grow and develop my skills, whether it is through the use of specific techniques, the expansion of my ability to practice clinical empathy, or to utilize therapeutic self-disclosure in a way that is consistently authentic and effective. I am proud of and grateful for the progress I have made so far, and excited for the progress to come.

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