BIOLOGIC SUPPORT FOR CLINICAL SELF-DISCLOSURE

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The clinical social worker and the therapeutic alliance that is forged are considered the primary indicator of successful therapeutic outcomes; therefore a strong therapeutic alliance needs to be the first goal of any social worker's and service user's collaborative endeavor (Bliss & Rasmussen, 2013; Drisko, 2012; Cameron & Keenan, 2010; Gitterman & Heller; 2011; Duncan, et al. 2010; Farmer, 2013). Central to the helping relationship since the origins of social work, the depiction of the therapeutic alliance has varied according to the practice model being employed. Richmond (1917), Hamilton (1940), and Hollis (1939) believed in a social worker/service user relationship based on acceptance, comfort, trust, safety, empathy and honesty. Although clearly understanding the need for relationship, the building of that relationship was not considered strongly enhanced through social worker self-disclosure. Their vision of relationship was more hierarchical than reciprocal; social workers were to be sensitive and kind, but their voice was privileged above the service users'. The Functionalists (Robinson, 1930) and Perlman (1957) fought against the rising predominance of the medical model that propelled many social workers into a casework model that supported a professional hierarchical therapeutic relationship. Eventually, though, the therapeutic relationship became a detached and unemotional connection in the task-centered approach (Reid & Epstein, 1972) that supported no clinical social worker self-disclosure of any kind. Through the proliferation of practice models during the 20th century, the depiction of the therapeutic alliance has undergone many variations. In most current practice models of the 21st century, the hierarchical nature of the relationship has been abandoned in favor of a client-centered, collaborative alliance in which the detached and unemotional stance of the clinician is

discarded in favor of honest and genuine communication. However, although clinician self-disclosure is no longer completely frowned upon by many social workers, the parameters of the use of clinical self-disclosure as a therapeutic technique continues to be debated (Henretty & Levitt, 2010, Peterson, 2002).

The Therapeutic Alliance

The relationship between the social worker and the service user will determine the direction, extent, and ease with which the service user accomplishes goals in therapy. It is the most common of the Common Factors that occur across disciplines and models of successful therapeutic practice (Duncan, et al., 2010). In order to build a strong alliance, certain social worker qualities and skills are needed.

Clinician Qualities

Sidney Wolf outlined 10 traits of effective counselors (referenced in Small, 1981). Some of those traits can best be renamed as personal qualities, while others fall more understandably within the category of skills and techniques. Those unteachable qualities that are innate to the person include: empathy, respect, warmth, potency and self-actualization. Empathy involves the accurate perception of another person's experience. Respect relates to the esteem one affords another. A counselor's warmth flows from her in a display of affection. Potency is the descriptor used by Wolf for charisma or that certain magnetic quality that some people exude. Deriving from Maslow's (1970) description of levels of need, self-actualization can be compared to the biopsychosocial competence one has as a person. Maslow described human motivation, or focus, in terms of meeting basic physiological, safety, belonging, and esteem needs. He came to regard the need for self-actualization and then self-transcendence as his highest

motivational levels (Koltko-Rivera, 2006). The self-actualized person has achieved a balance and awareness of neurochemical and social engagement that permits an expertise and ease of cognitive, social and moral reasoning, leading to the capacity for self-fulfillment and self-transcendence. Reaching one's personal potential imparts the mix of confidence and humility that permeates a quality social worker's ability to fully engage with the person seeking assistance in an open, honest relationship that benefits the service user. As will be discussed later in this paper, these qualities are directly connected to the social worker's biosocial construct – the connection between the neuroscience of the body and the social impacts upon it.

Skills and Techniques

The skills/techniques that according to Wolf must be mastered in order to be effective as a counselor include: genuineness, concreteness, confrontation, immediacy and self-disclosure (referenced in Small, 1981). Genuineness is the ability of a social worker to be freely and totally oneself, without pretense of any kind. It involves the skill of <u>not</u> putting on a "professional face". The ability of a social worker to obtain and retain focus, direction and clarity for the service user is the skill of concreteness. The technique of confrontation involves the social worker's ability to point out discrepancies between what a service user is saying and doing. Being actively present with the service user and that person's here and now feelings is the skill of immediacy. Immediacy is often handled through the technique of social worker self-disclosure.

Clinician self-disclosure is the opening up of oneself to the service user, for the benefit of the service user. It is a technique that requires skill for its appropriate and effective use.

Clinician self-disclosure may be symbolic or spontaneous, professional or personal. Diagram 1, adapted from Buck (2014, p.149), represents the constant presence of spontaneous communication and its overshadowing by symbolic communication. Also portrayed is the spectrum of self-disclosure from personal experiences that occur outside of the therapy session to professional responses to the service user in the context of the session. Spontaneous and symbolic communication will be discussed in more detail in a later section of this paper.

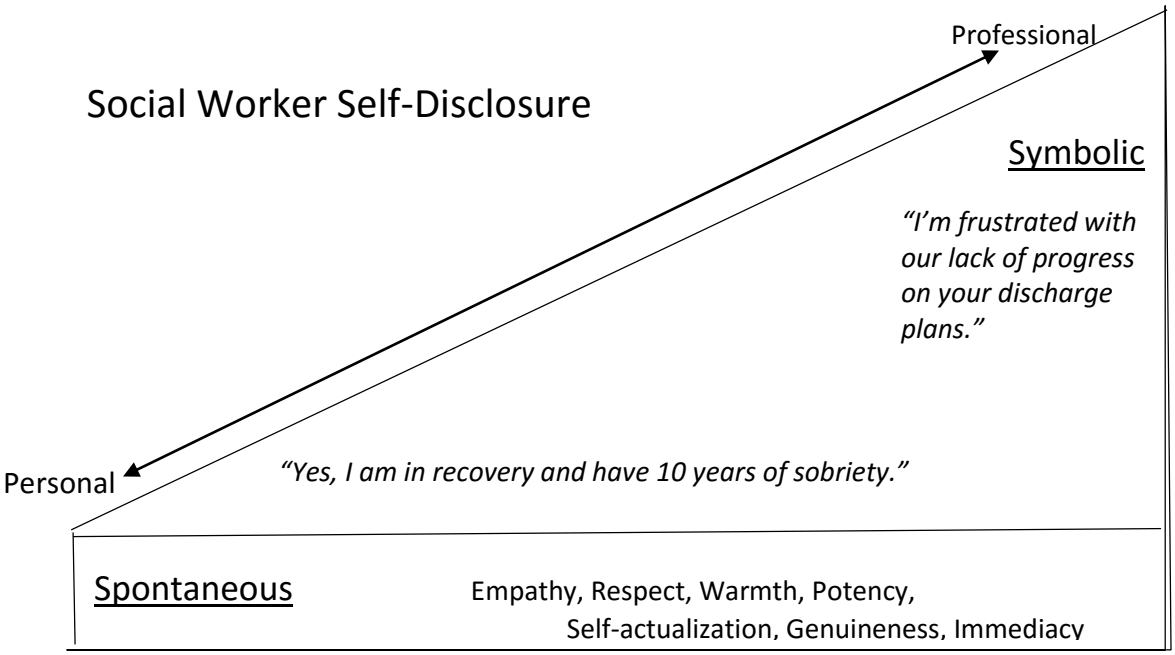

Diagram 1

Utilizing Social Worker Self-Disclosure

Social Worker self-disclosure is a skill that requires experience and excellence in reading the needs of the service user, timing, choice of words, tone of voice, and all the other attributes that relegate the quality social worker to the status of artist. Self-disclosure will have great

impact upon the service user. When done well, there will be noticeable positive progress in both the therapeutic alliance and the resolution of the service user's needs. When misapplied, the results can irreparably damage the therapeutic alliance. Clinical self-disclosure opens the social worker to some degree of vulnerability. Some social workers believe in limited self-disclosure that centers on the feelings engendered within them by the service user (Quillman, 2011). Other social workers expand the parameters of self-disclosure to include anything about themselves that meets the service user's needs (Marcus, 2009). The bottom line for these social workers is that the needs of the service user are primary; self-disclosure is not used for personal enrichment. The closer the social worker is to self-actualization, the more comfortable she will be in exposing herself as collaborator with the service user, as opposed to an authority figure.

Enhanced Therapeutic Alliance

The enhancement of the therapeutic alliance will, by default, also enhance the service user's chances of successful outcomes from therapy. The enhancement of the alliance will "facilitate important processes of neural integration and lead to an increase in the client's capacity to regulate affect and understand the mental states of self and other" (Farmer, cited in Shapiro, 2010). Therefore, any action that can strengthen this alliance will be beneficial to the service user. "Self-disclosure can be used to further intimacy or to fill up the space with the analyst's material and block intimacy" (Marcus, 2009 p.576). How then can social workers utilize self-disclosure to further intimacy?

Through an understanding of spontaneous and symbolic communication we know that all social worker's self-disclose, whether that disclosure is acknowledged as such or not. At the

extreme end of the spectrum presented in Diagram 1, professional symbolic communication would be the least productive way of enhancing the therapeutic alliance as it is greatly overshadowing spontaneous communication. However, it is the way in which every social worker communicates. At the moment of the first encounter between social worker and service user, the symbolic communication begins through the choice of office furniture and how it is arranged, by the choice of wall decorations, by the display of licenses and certifications, by the display or not of family photos and memorabilia, by the manner in which the social worker is dressed, and does or does not shake hands. These symbols will all have meaning to the service user that may be quite disparate with the meanings attached to them by the social worker. Before the first word has spoken, symbolic communication has begun.

Occurring concurrently, self-disclosure through spontaneous communication has also begun. A social worker's warmth, genuineness, potency and immediacy can be "felt" by the user of her services before a single word is spoken, through the look in her eyes, the way she guides the timid person into the office chair, the way she attends to the guest's coat, and her "presence".

Trust of the social worker by the service user is not a given; remember that the social worker is not part of the service user's "in-group" when they first meet. Trust must be developed through the social worker's authentic displays of empathy and immediacy, which by spontaneous communication, the Mirror Neuron System (MNS) and Oxytocin (OXY), will become reciprocal communication experiences resulting in a stronger therapeutic alliance. This movement towards "in-group" status is the basis for using personal self-disclosure.

Personal self-disclosure has been used by "specialist" social workers for many years, "specialists" being those social workers who work with specialized populations such as survivors of domestic violence, people in recovery from substance use, recently incarcerated persons, and persons going through grief and loss. It has been deemed helpful for service user's to know that the social worker has had similar life experiences. Whereas the social worker's "in-group" status as a survivor, a person in recovery, an past offender or a person who has suffered the loss of someone close to them cannot be seen on the surface, it will often be verbally disclosed – sometimes right up-front, and other times when the moment seems right. Howe (2011) describes this as being "in the same minority group, but this fact is not known by the patient". The timing of the self-disclosure is part of the artistry inherent in being a social worker; there is no right or wrong time, as long as the primary reason is to benefit the service user. The experienced social worker will know the right time by being attuned to the spontaneous communication from the service user, while the inexperienced social worker will quickly learn if she trusts herself to be in synch with the service user.

The primary benefit of this group status self-disclosure is enhancement of the therapeutic alliance. As in-group members verbally share similar experiences, the MNS will activate and the service user will feel that the social worker "gets me". In-group members share specific pre-attunements that others cannot have, increasing the amount of spontaneous communication and OXY, which in turn, enhances empathy, potency, warmth, genuineness, respect and trust.

Besides this type of "Recovery" group disclosure, there are two other types of group disclosure that can be beneficial to the therapeutic alliance: Attribute groups and Endeavor

groups. Attribute groups would include those people who share an ethnicity, gender, sexual orientation, political stance or religion. Attributes may be visual or hidden until disclosed. As an example, a visual shared attribute of race may quickly add to some persons' comfort with their social worker. A social worker in a faith-based or church-based setting who self-discloses personal beliefs in line with the setting may be a draw to service users with shared religious beliefs. Endeavor groups would include those who share a common recreational activity (i.e., sports, music, reading), educational activity (i.e., night school, college), or developmental activity (i.e., parenting, employment, retirement). Often endeavor group affiliations present over the course of the relationship, and noting them can help to solidify the alliance between social worker and service user. Types of endeavor groups are almost unlimited, and therefore an easy way to make a connection. The concept is that bonding around an endeavor, an attribute, or recovery will enhance the therapeutic alliance, thereby increasing the chances for successful outcomes in treatment.

This triad of "In-Groups" falls along a spectrum of self-disclosure that ranges from private to social. Each type can be beneficial in its own way; however, the more personal the self-disclosure the more of a clinical impact it may have upon the receiver, as the more closely aligned it is with spontaneous, rather than symbolic, communication (Diagram 2).

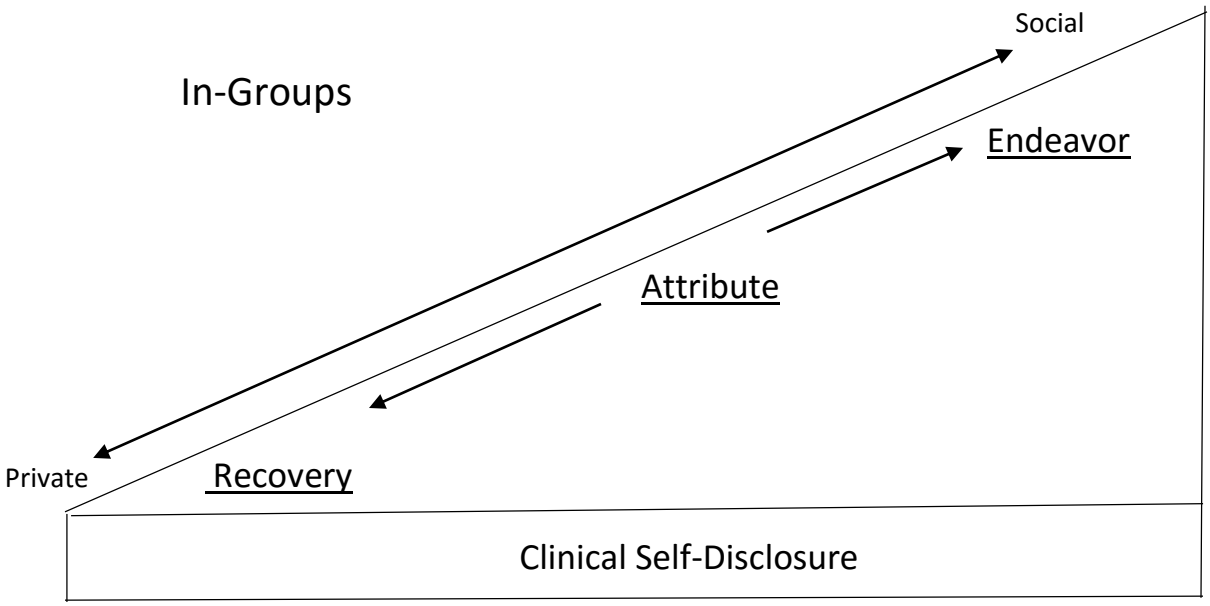

Diagram 2

To return to the previously stated maxim, clinician self-disclosure is for the benefit of the service user. The service user's need for social worker self-disclosure, the right timing, the right context may never occur. If and when the need is there and the timing is right, another factor may still stop the social worker from utilizing this skill – willingness. As previously implied, social workers who are insecure within themselves, that are not progressing toward self-actualization, do not have the capacity to become vulnerable to and collaborative with their service users. Rather, these social workers stay hidden high up in the tower entitled expert, while their service user is on the ground below. The medical model of treatment has supported this paradigm for many decades. Although relational models have achieved much popularity, the power differential they hoped to change through client-centered care is only as amenable to change as those social workers who employ it. Frank (1997) reflected upon the

attitude of willingness needed by social workers to be known by their service users. He encouraged social workers to "loosen up" and "to respond [to service users] with personal as well as professional resources—common sense, personal experience, wisdom—rather than through strict adherence to a clinical methodology (Frank, p.309).

Neuroscience Underpinnings

A working knowledge of the biologic foundation that informs our understanding of clinical self-disclosure and the therapeutic alliance is necessary before discussing further clinical implications.

Mirror Neuron System

Rosemary Farmer (2013, p.) condenses much complexity into one sentence when she states: "The mirror neuron system links visual and motor experiences; makes possible implicit learning via imitations of what is seen, heard, and felt; and is believed to be involved in the development of empathy and understanding the intentions of others". Clearly the MNS has a direct impact upon the capacity of the service user and the social worker to build a strong therapeutic alliance. To better understand the MNS and other neuroscience factors as they relate to the therapeutic alliance and clinical self-disclosure, a basic understanding of emotion as a biosocial synthesis (Buck, 2014) is helpful.

Every person continually experiences emotions as the readouts of neurochemical systems, but do not always bring these feelings to the forefront of their conscious thoughts. One's body is always responding to the whisper of this genetically based presence, even if the cognitive mind is not. At life's earliest stages, these neurochemical processes bring the ability to acquire knowledge by acquaintance (KA) - direct, self-evident and immediate. An alternative

acquisition is knowledge by description (KD), a result of "information processing and inference" (Buck, 2014, p.17). Knowledge by description tends to increase in utilization as people traverse the life course. The more a person esteems KD, they more they tend to fail to acknowledge the impact of KA. Associating KD with reason, and KA with emotions/affect, one may also say that those who place a priority on KD are, in American idiomatic expression, left-brained, and those who still sense and are attuned to KA are right-brained.

The MNS allows the acquisition of KA through the direct visual or auditory experience of actions and emotional displays of self or others. However, the MNS also reacts to hearing someone else tell about the experience or imagining the experience (Gallese & Cuccio, 2015). Hundreds of thousands of mirror neurons have been found in several brain areas including frontal premotor cortices, the parietal region, the amygdala, Broca's Area, and the frontal lobe (Gallese & Cuccio, 2015; Farmer, 2009; Cozolino, 2006). The MNS links different areas of the brain creating a bridging network between motor, emotional, and cognitive functions that generates social knowledge and social interactions. Mirror neurons not only remember and replicate the input they receive, they create pre-attunements to the understanding of the experiences of others. In this way, they "not only link networks within us but link us to each other" (Cozolino, p.198). The pre-attunements strengthen individual and group survival skills, as people learn to recognize and anticipate safe situations or dangerous ones. When the experiences have been positively reinforcing and responsive to one's needs, these pre-attunements become the basis of empathy.

Spontaneous and Symbolic Communication

Pre-attunements are an example of spontaneous communication – communication that is nonintentional, nonpropositional, and nonvoluntary that is delivered through signs rather than symbols (Buck, 2014). While people may learn to mediate their spontaneous communication, the "real" message may still go through to the receiver. As an example, there are good liars and bad liars. The good liars are able to effectively mediate their spontaneous communication, and the bad liars are not. Spontaneous communication, as with KA, is an undercurrent within our bodies that is continuously turned on. However, again as with KA, spontaneous communication is not always perceived by either the sender or the receiver. Dependent upon factors such as developmental stage, experiential context, and relational context the spontaneous message may be overshadowed by concurrent symbolic communication.

Symbolic communication utilizes a socially determined signal system composed of arbitrary symbols that is understood by both the sender and the receiver, is intentional, propositional, and voluntary (Buck, 2014). The symbolic communication can be through words, gestures, pictures or any system that communicates by using an intentional representational means. Symbolic communication tends to become the preferred means of social engagement through the human lifespan, blocking out the awareness of some spontaneous communication. Exceptions to this tendency include the heightened spontaneous communication between close friends or colleagues, intimate partners, and parents and children (Buck, 2014; Feldman, 2012; Atzil, Hendler, & Feldman, 2013).

Replicating the reduction of KA to the right brain and KD to the left brain, spontaneous communication could be said to be more right brained, while symbolic communication is left

brained. Montgomery (2002) believes that it is the right brain that is more responsive to therapeutic influence. While this may or may not be as simple as she states, the implication is that the spontaneous communication between the social worker and the service user is more important than the "intellectual" connection they make utilizing a symbolic communication based treatment curriculum - an indicator that the therapeutic alliance is of primary importance in therapy.

Oxytocin and Vasopressin

The peptide hormones Oxytocin (OXY) and Vasopressin (AVP) play a role in bonding, attachment, and other social behaviors (Cozolino, 2006; Buck, 2014). In connection with the amygdala, it is surmised that they also play a role in the creation of trust. OXY in particular has been found to increase trust, empathic concern, and interactive synchrony (Buck, 2014). Buck (2014, p.190) hypothesizes that "an implication may be that OXY functions to increase accurate emotional communication". OXY has many binding sites and its release "can become conditioned to all kinds of social interactions, psychological states, and mental imagery" (Cozolino, p.119). Perhaps a strong therapeutic alliance will engender additional OXY to be released, enhancing trust, increasing empathy and developing advanced spontaneous communication.

A lesser known effect of OXY is the creation of "in-groups" and "out-groups" (Buck, 2014; Decety, 2015). As some people bond together, reciprocally reinforcing their connection through spontaneous communication, those outside their attachment group become "others". For example, "empathy is not equally aroused by the emotional signals of any individual, but rather is … biased toward parties close to the observer" (Romero, Castellanos, & de Waal,

2010). The other in-group members are then favored over the out-group others. Again, understanding some of what OXY can do has implications for the therapeutic alliance – when the social worker is perceived as "other" the alliance will not be as strong as if they were perceived as a member of the "in-group".

The Working Alliance

Once therapy begins, there is even more occasion by which to strengthen the therapeutic alliance through self-disclosure of empathy and respect by both spontaneous and symbolic communication. In both social worker and service user, the MNS will be participating in this endeavor, as will OXY. Stimulation of the MNS will result in therapeutic opportunities to develop the social worker/service user relationship, to expand the service user's repertoire of socially beneficial pre-attunements, to reciprocally benefit from a right-brain to right-brain connection that may be increasing OXY at the same time as it is increased by OXY, while concurrently new analytical information is being symbolically presented from left-brain to left-brain. Quillman (2011, p.3) states that "what is important is not how accurate the patient's left brain thinks the interpretation is, but how the right brain somatically receives the experience of the interpretation".

This complex relationship will be benefitted or hindered by the social worker and service user's capacity for acknowledging the KA undercurrent, and any discrepancies between it and the emotional displays of the participants. While the social worker may need to start this process and pull the service user along, using the skills of confrontation and concreteness in conjunction with self-disclosure, bonding will begin. When a discrepancy between a spontaneous communication of fear and the symbolic communication of "Yes, I can try that" is

felt and heard by the social worker, a self-disclosing confrontation of “It worries me that when you said ‘Yes, I can try that’ your whole body tensed up. What about the plan is bothering you?” When a service user is loudly proclaiming a litany of complaints, the social worker can respond with “You know, I really can’t think straight when someone is yelling. If you could lower your voice, we can work on these issues one by one. Which one would you like to start with?”

This level of self-disclosure is on the professional side of the spectrum portrayed in Diagram 1. It is a response to the in-session communication of the service user and discloses the social worker’s feelings about what the person has said or done. However, if the social worker is not genuine or authentic, and is not good at what Buck (2014) labels pseudospontaneous communication (substituting a voluntary expression for an involuntary one), this form of self-disclosure may have negative repercussions. In the first example above, if the social worker was not truly worried or concerned, and the service user could “feel” the spontaneous communication which was at odds with what the social worker was saying, the confrontation would be diverted into a debate about whether or not the social worker really cared. If the verbal expression was congruent with the spontaneous communication, the therapy session would continue on course and the therapeutic alliance would be strengthened. In the same way, if in the second example the overriding spontaneous communication from the social worker to the service user was anger and her words did not convey that anger, the attuned service user would no longer trust the social worker to engage in honest, authentic communication. Frank (2012) emphasized the need for social workers to engage in emotional honesty, to be genuine and truthful in responses. “Emotional honesty is as central to the

analytic relationship (and therapeutic action) as to any of our mutually trusting, meaningful personal relationships" (Frank, p.346).

Criticisms of Social worker Self-Disclosure

Contemporary critics of social worker self-disclosure appear to either not be aware of or not fully understand the potential benefits to the therapeutic alliance that neuroscience demonstrates can be engendered through its use. Their arguments include the need for social worker objectivity in order to encourage transference, not wanting to remove the focus from the client, not wanting to blur professional boundaries, or that it is simply unnecessary (Duncan, et al., 2010; Raines, 1996). These arguments are either irrelevant given the information we now have regarding neuroscience, or questioning the ability of social workers to ethically employ the technique. As for the "simply unnecessary stance", Raines (1996) warns that the difficulty in this is the element of trust between the service user and the social worker. If a social worker consistently refuses to reveal anything about herself, the service user could easily begin to detach and not trust – showing that harm was done to the therapeutic alliance.

Ginot (2007), however, has a clear understanding of the MNS and its relationship to attachment and empathy, and yet firmly advocates against using this knowledge simply to enhance the therapeutic alliance. "Disclosure of general personal information is not encouraged, nor is it regarded as an acceptable way to promote a sense of intimacy. Rather, self-disclosure is seen here as an integral element in the resolution of enactments…" (Ginot, 2007, p.329). The alliance will be enhanced by the increase in empathy and attunement, but that is not the goal of the social worker/service user interaction. Ginot (2009, p.305) recognizes that any clinician self-disclosure "involves the blurring of self-other boundaries", but when

utilized within the stated parameters, “it is ultimately about helping the patient become more aware of and integrate what previously could only be enacted”. I do not believe that quality care can be as prescriptive as Ginot wishes to make it. I believe that as we practice within the parameters of the profession’s ethics, we can and should use whatever techniques will enhance the therapeutic alliance and the chances for successful therapeutic outcomes for the users of our services.

Conclusions

Clinical self-disclosure of experiences, feelings and ideas can be the direct catalyst for a service user’s progress in therapy, as well as provide for an enhanced therapeutic alliance. Rather than differentiating between personal information or professional information, the social worker should consider the appropriateness of any information that may be self-disclosed so that it will be of useful benefit to the service user, it is pertinent to the topic at hand, and it will enhance the therapeutic relationship. It requires an excellent sense of timing, discretion, understanding of the spontaneous communication of the moment, and the careful choice of language. It is not a time for the social worker to be conducting her own therapy. “Therapeutic self-disclosure is an art, one that can be developed. It is the ability to use our self and our experiences as instruments of healing” (Small, 1990, p.61). It can exemplify a collaborative recovery process.

Cozolino (2006) also supports the use of the entire spectrum of information when employing clinician self-disclosure. With a firm grasp of the neuroscience underpinning social interactions and the therapeutic alliance, he states, “the transformative power of intimacy has its roots in the evolution and development of the brain through parenting, friendship, and love.

This same power is used in psychotherapy, education, and ministry" (p.20). Therefore, he challenges social workers by deducing that "far from detaching ourselves from felt experience, as is routinely accepted as the operative mode of science, our work requires the inclusion of our experience. Our personal experiences are no less important than the empirical evidence found in the laboratory" (Cozolino, p.19).

The technique of clinician self-disclosure utilizes the information learned through neuroscience regarding oxytocin, the mirror neuron system, spontaneous and symbolic communication, and the interconnections in which these and other attributes of our brain and mind create, develop and impact upon social interactions. When used with skill it will enhance the therapeutic alliance, a primary indicator of successful treatment outcomes.

Research Directions

Research into the effectiveness of self-disclosure in strengthening the therapeutic alliance could answer questions such as: What contexts/situations are best suited to strengthening the therapeutic alliance through self-disclosure? Is there a phase of treatment in which clinician self-disclosure is most effective in strengthening the therapeutic alliance? To what degree do service users feel an alliance with social workers who do not self-disclose? Which in-group social worker self-disclosures are most helpful to strengthening the therapeutic alliance: recovery, attribute, or endeavor? Is one or more types of in-group social worker self-disclosures not effective in strengthening the therapeutic alliance? Is there a type of service user who would prefer a medical model professional detachment, rather than social worker self-disclosure? Until such time as research guides us further down these paths, I suggest social workers trust their instincts, their KA, and the received spontaneous communication from their

service users to determine how to best utilize social worker self-disclosure in the building and enhancement of the therapeutic alliance.

Practice Implications

Using neuroscience to support the utilization of clinical self-disclosure denotes the relational model of treatment that I employ with those who use my services. I have utilized social worker self-disclosure throughout my practice career, oblivious to the neuroscience underpinnings, but knowing it "felt right". Other social workers could use this technique to elicit effective outcomes much more often than they do. I cringe when I hear superficial "professional" barriers being placed by social workers between themselves and their service users when they decline to answer questions or to accept comments that are common interactions within society. Berger (2008, p.77) reminds us that service users just want to be treated like they are the same as everybody else when she states that clinician self-disclosure makes "patients feel less interpersonally vulnerable and humanizes therapists". I believe that client-centered care that elevates the service user, while humbling the social worker is effective due to the enhanced therapeutic alliance, empathy, trust, respect and all the other pro-social emotions engendered through the reciprocity of MNS.

However, I also believe that inexperienced social workers need to rely upon the mentoring and supervision of a social worker skilled in this technique in order to learn the nuances and vagaries of appropriate timing and context. Also, the social worker needs to be continuously involved in self-reflection, with and without the use of supervision, in order to be more fully in tune with her own spontaneous communications, emotions, and displays.

As a final note, the use of social worker self-disclosure does not negate the abilities of social workers who are not part of an "in-group" to offer services to others. While they may not have the ability to enhance their therapeutic alliance in the same way as an in-group social worker that does not imply they cannot have a strong alliance. For example, a substance use treatment social worker who is not in recovery herself still has the capacity to do quality and effective treatment with service users. Whereas the social worker in recovery may have a step-up in the formation of a strong therapeutic alliance, the social worker not in recovery can still help those service users along their path by utilizing different forms of self-disclosure as well as the other qualities and techniques of effective counselors outlined by Wolf.

References

Atzil, S., Helndler, T., Feldman, R. (2013). The brain basis of social synchrony. *Social Cognitive and Affective Neuroscience,* September, doi:10.1093/scan/nst105.

Berger, B. (2008). Self-Disclosure in Psychotherapy. *Psychoanalytic Social Work,* 15(1), pp. 75-78.

Bliss, S., Rasmussen, B. (2013). Reflections on contemporary psychodynamic theory in clinical

social work. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community,* 27(3), pp. 211-215.

Cameron, M. & Keenan, E. K. (2010). The Common Factors Model: Implications for Transtheoretical Clinical Social Work Practice, *Social Work,* 55, pp. 63–73.

Cozolino, L. (2006). *The Neuroscience of Human Relationships.* New York: W.W. Norton & Company.

Drisko, J. W. (2004). Common Factors in Psychotherapy Outcome: Meta-Analytic Findings and Their Implications for Practice and Research, *Families in Society,* 85, pp. 81–91.

Duncan, B., Miller, S., Wampold, B., Hubble, M., eds. (2010). The Heart & Soul of Change. Washington, D.C.: American Psychological Association.

Farmer, R. (2011). *Neuroscience and Social Work Practice: The Missing Link*. Thousand Oaks, CA: Sage Publications.

Farmer, R. (2013). Mirror Neurons. In Matto, H., Stolin-goltzman, J. and Ballan, M. (Eds.). *Neuroscience for Social Work: Current Research and Practice.* New York: Springer Publishing Co.

Feldman, R. (2012). Parent-Infant Synchrony: A Biobehavioral Model of Mutual Influences in the Formation of Affiliative Bonds. *Monographs of the Society for Research in Child Development,* 77(2), pp. 42-51.

Frank, K. (1997). The role of the analyst's inadvertent self-revelations. *Psychoanalytic Dialogues: The International Journal of Relational Perspectives,* 7(3), pp.281-314.

Frank, K. (2012). Reply to Commentaries. *Psychoanalytic Dialogues,* 23, pp. 344-351.

Gallese, V., Cuccio, C. (2015). The Paradigmatic Body. In Metzinger, T., Windt, M. (Eds.). *Open*

MIND. Frankfurt: MIND group.

Ginot, E. (2007). Intersubjectivity and Neuroscience. *Psychoanalytic Psychology,* 24(2), pp. 317-332.

Ginot, E. (2009). The Empathic Power of Enactments. *Psychoanalytic Psychology,* 26(3), pp. 290-309.

Gitterman, A., Heller, N. (2011). Integrating Social Work Perspectives and Models with Concepts, Methods and Skills with Other Professions' Specialized Approaches. *Clinical Social Work Journal,* 39, pp. 204-211.

Hamilton, G. (1940). *Theory and practice of social case work*. New York: Columbia University Press, 1940.

Henretty J. R., Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review,* 30, pp. 63–77.

Hollis, F. (1939). *Social casework in practice: Six case studies*. New York: Family Service Association of America.

Howe, E. (2011). Should Psychiatrists Self Disclose? *Innovations in Clinical Neuroscience,* 8(12), pp. 14-17.

Koltko-Rivera, M. E. (2006). Rediscovering the Later Version of Maslow's Hierarchy of Needs: Self-Transcendence and Opportunities for Theory, Research, and Unification. *Review of General Psychology,* 10(4), pp. 302-317.

Marcus, D. (2009). Self-disclosure: The wrong issue. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 18(4), pp. 566-579.

Maslow, A. (1970). *Motivation and personality.* New York: Harper & Row.

Montgomery, A. (2002). Converging perspectives of dynamic theory and evolving neurobiological knowledge. *Smith College Studies in Social Work,* 72(2), pp. 177-196.

Perlman, H.H. (1957). *Social casework: A problem-solving process*. Chicago: University of Chicago Press.

Peterson, Z. D. (2002). More Than a Mirror: The Ethics of Therapist Self-Disclosure *Psychotherapy: Theory, Research, Practice, Training,* 39(1), pp. 21–31.

Quillman, T. (2011). Neuroscience and Therapist Self-Disclosure: Deepening Right Brain to Right Brain Communication Between Therapist and Patient. Clinical Social Work Journal, 40, pp. 1-9.

Raines, J. (1996). Self-disclosure in clinical social work. *Clinical Social Work Journal,* 24(4), pp. 357-375.

Reid, W.J. and Epstein, L. (1972). *Task-centered casework*. New York: Columbia University Press.

Richmond, M.E. (1917). *Social Diagnosis*. New York: Russell Sage.

Robinson, V. (1930, 1939). *A changing psychology in social casework*. Chapel Hill: University of North Carolina Press.

Romero, T., Castellanos, M., de Waal, F. (2010). Consolation as possible expression of sympathetic concern among chimpanzees. *PNAS,* 107(27), pp. 12110-12115.

Seabury, B., Seabury, B., Garvin, C. (2013). *Foundations of Interpersonal Practice in Social Work.* Thousand Oaks, CA: Sage Publications, Inc.

Shapiro, J. (2010). Neuroscience and Social Work Practice: The Missing Link, by Rosemary L. Farmer. *Social Work in Health Care,* 49(9), pp. 891-894.

Small, J. (1990). *Becoming Naturally Therapeutic: A Return to the True Essence of Helping.* New York: Bantam Books.