Best Practices for Physician Self-Disclosure

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Introduction

- Background: Ph.D. in clinical psychology
- Psychotherapy process research
- Post-doc in Clinical Health Psychology
- Current position:
  - Research Assistant Professor
  - Ohio University College of Osteopathic Medicine
  - Research on telephone-administered psychotherapies for older adults with HIV/AIDS

Objectives

- 1. Understand what self-disclosure is (and is not) and distinguish among various subtypes of disclosure.
- 2. Learn research-based guidelines for using self-disclosure in clinical settings (what, when, how, where, and why)
- 3. Discuss professional comfort with using self-disclosure in clinical settings (attitudes toward, beliefs about, professional “policy” vis-à-vis disclosure)

Snapshot

1. Preliminary discussion: thoughts on SD
2. Review Therapist Self-Disclosure literature
3. Review Physician Self-Disclosure literature
4. Identify potential Best Practices for using SD

Perceptions of Self-Disclosure

- What comes to mind when you hear “clinician self-disclosure?”
- Attitudes toward/beliefs about
- Experiences with disclosure
  - Professional: your use of SD as a physician or behavioral scientist
  - Personal: experiences of providers disclosing to you

Why Talk about Physician Self-Disclosure?

- Medicine is an *art* and a science; all too often the former is neglected
- Research on PSD helps establish a scientific basis for the "art" of bedside manners and physician communication
- Helps codify a subjective, idiosyncratic, and poorly understood practice
  - Identify what we should and should not do

PSD and Patient-Centered Care

- Medical Home principle of the Personal Physician (Rosenthal,2008)
  - ability to “accurately perceive the essence of the patient’s story” -and-
  - Demonstrate empathy within a “doctor-patient relationship, which, like any relationship, develops incrementally.”

PART 1: A Brief Tour of Therapist Self-Disclosure

Evolution of theory and research from Freud to the present

Freud and Psychoanalysis

- Classical psychoanalysts: blank screen approach
  - *"The analyst should remain opaque to his patients, and, like a mirror, and show them nothing but what is shown to him." Freud 1912*
- "Wild" Analysts:
  - Ferenczi's mutual analysis:
  - Khan: *"My brother's death changed my whole outlook on life."* and *""You don't look like one of the upper classes to me"*
- Relational psychoanalysts: relationship and attachment is primary. Analyst is an active participant in the treatment. Disclosure as intervention.

Therapist Self-Disclosure: Humanistic Psychologists

- Carl Rogers, Sidney Jourard
- Emphasis shifted from therapist as interpretive expert to cultivator of a healing relationship
- “patient-centered” approach:
  - Genuineness, unconditional regard,
  - Focus on the “real” relationship, rather than the blank screen
- Feminist psychologists: level the playing field

Therapist Self-Disclosure: Research Summary

- Sidney Jourard; Clara Hill; Barry Farber
- 40 years of research
- Methodologies:
  - Analogue studies (vignettes)
  - Surveys to access attitudes and beliefs
  - Experiments (systematic manipulation of disclosure conditions)
  - Qualitative studies: explore phenomenology of disclosure

Therapist Self-Disclosure: How to Classify?

- * need a clear operational definition to compare studies
- Autobiographical disclosures vs. process (i.e., feeling) disclosures
- Immediate vs. distal
- Reciprocal vs. non-reciprocal
- Knox and Hill (2003)
  - Disclosures of : facts, feelings, insights, strategies, reassurance/support, challenge; immediacy.

Therapist Disclosure: Key Findings

- Low impact, high yield intervention
  - Occurs <1% of the time, yet rated most helpful by clients (Hill et al 1987)
- Clients rate therapists more favorably when disclosures are reciprocal . Linked to less symptom distress post-therapy (Barrett & Berman,2001)
- Low intimacy disclosures are helpful and effective, more intimate disclosures can be seen as harmful

PART 2: Overview of Physician Self-Disclosure

A critique of the current literature

PSD: Empirical Findings

- Lester & Smith(1993):
  - Compared patient responses to video vignettes depicting a physician diagnosing a suspicious growth
  - Physicians demonstrated positive communication behaviors (including empathic self-disclosure) vs. negative communication behaviors
  - Participants told 1 of 4 outcomes to vignette:
    - Positive; negative but not MD's fault; negative for uncertain reasons; and negative due to MD error
  - Participants endorsed significantly less litigious feelings toward positive communicating MD, regardless of outcome/perceived fault

PSD: Empirical Findings

- Breyan & Elon (2000)
  - Video vignettes of a health education video in which a physician:
    - Discloses own health behaviors in one vignette (1 ½ min disclosure + apple/bike helmet visible)
    - Does not disclose health behaviors
  - Viewers rated the disclosing physician:
    - Healthier
    - More believable
    - More inspiring/motivating

PSD: Empirical Findings

- Beach et al. (2004): PSD & Patient Satisfaction
  - Routine appointments of 59 PCPs and 65 surgeons recorded and coded for PSD
  - Frequency of PSD:
    - 17% in PCPs vs. 14% surgeons
  - Patient responses to PSDs:
    - Greater feelings of warmth, friendliness, reassurance, comfort, and satisfaction with surgeons.
    - Significantly less with PCPs who disclosed
  - Explanations?

PSD: Empirical Findings

- Beach et al. (2006): Types of PSD
  - Analyzed 242 disclosing statements from 195 visits
  - Reassurance PSD: sharing of similar experiences ("I've used quite a bit of that medicine myself.")
  - Counseling: Guide pt to action ("I just got my flu shot")
  - Casual: non-sequiturs ("I wish I could sleep sitting up")
  - Intimate: private revelations ("I cried a lot with my divorce too")
  - Extended Narratives: babbling

Beach et al (2006) Continued

- Conclusions:
  - Reassurance, counseling, and rapport-building disclosures most prevalent
  - Reassurance disclosures are a mainstay, but their impact is not clear
  - Intimate or extended disclosures are rare
  - Fear of a “slippery slope” of boundary violations is unsubstantiated in the study

McDaniel et al. (2008): "Physician Self-Disclosure in Primary Care Visits: Enough about You, What About Me?"

- Sequence analysis of the frequency, length, antecedents, and effects of PSD in during primary care appointments

- Analyzed transcripts from 113 initial appointments
  - 45 physicians
  - Sim. Patients: 1 male and 1 female patient each
  - Trained to represent either GERD or MUS

McDaniels et al. (2008) cont.

- Frequency: PSD occurred in 34% of visits
- Context and Characteristics of PSDs:
- 14% were elicited by patients
- 60% occurred after patient symptoms, family, or feelings
- 40% unrelated to patient
- No attempts to transition back to patient
- Effect: 85% not considered useful by research team (some were disruptive)

PSDs in McDaniels et al (2008) study

- Useful: (4%)
  - "I suffer from it myself." (then describes the condition in general)
- Disruptive: (11%)
  - PT: I'm 6' and she just told me I was 204
  - MD: Is that up a little bit for you, weight-wise?..... See, 'cause I'm weighing more like 172, 173, and I'm 6'….and I'm still running…I'm still Doing the half-marathons and…

  PT: So I'm 30 lbs heavier than you?

McDaniels et al (2008) conclusions

- "our data support the findings of Beach et al that use of disclosure to strengthen the patient-physician relationship is rarely successful in primary care"
- PSDs were "often non-sequiturs…..and focused on the physician's….needs"
- Expressed concern about the "I've got it too" category of PSD
  - Premature reassurance or advice
  - Increase chance of misdiagnosis
- Recommend using support groups rather than pts

Limitations:

- generalizability:
  - Use of trained, standardized patients
  - *All physicians were in Rochester, NY*
  - Physicians mostly white
- 40% of standardized visits could not be used because physicians detected them
- Small sample size
  - 11% ineffective disclosures = 8 visits
- All visits were *initial* appointments
- Evaluated all disclosures as though they were intended to be helpful (even “chatter”)

PART 3: Best Practices

Science-based recommendations for the art of physician self-disclosure

General Guidelines and Caveats:

1. Disclosure should occur only for the purpose of improving patient care.
2. Providers should consider self-disclosure *only to the extent that it is authentic for them*. Physicians averse to disclosure should never use it.
3. Disclosure for the sake of rapport-building cannot be "scripted" in advance. Polite refusals to disclose something, however, should be rehearsed.

Best Practices: *What* types of disclosures can physicians use?

1. Brief reassurances may be somewhat useful to patients ("I have GERD as well.")
2. Disclosures of strategy ("I use a weekly pill organizer to keep track of my medicines ") and health behaviors
3. Empathic disclosures that build rapport:

   --disclosures that legitimize the patient's experience

   -- "An MRI would make me nervous too. Don't worry, though, they'll give you something to help you relax."

Best Practices: Disclosures to Avoid

- Inadvertant disclosures, “chatter,” extended stories, non sequiturs
- Highly intimate or emotional disclosures (TMI)
- Excessive reassurances (especially regarding chronic illness)
- Disclosures that exceed your comfort level in revealing

Best Practice: *How* to Disclose

- Thoughtfully: register the impulse to disclose and assess motivation and potential utility
- Reciprocally: disclosures should be anchored in the patient's statements and should mirror them in content and tone. *All disclosures should be context-driven, not random.*
- Briefly: short statements directed back to the patient
- Infrequently: less is more

Best Practices: *When* to disclose

- In primary care: when patients are *established* and physicians have a sense of their expectations, needs, and personalities(not during initial visits)
- When the appointment concerns an acute, rather than chronic, condition. This is not set in stone, but research indicates SD in the context of chronic illnesses may not be perceived as helpful
- Immediately: disclosures should be reciprocal and experience-near.
- When there is a greater likelihood of building rapport, gaining trust, humanizing the medical encounter
- When patients appear vulnerable, judicious and appropriate self disclosure may set them at ease and reduce anxiety

Recommendations:

- Self-reflection:
  - Create a policy for disclosure based on :
    1. Comfort level
    2. Communication style/preferences
    3. What feels safe/appropriate to disclose
    4. The type of patient you feel may benefit
    5. The type of patient you feel comfortable/uncomfortable disclosing to
- Preparation:
  - Know in advance what you'll say and how you'll say it if a patient solicits a disclosure
  - Create scripted refusals and transitions following disclosures

Thank you!

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