Recognizing and Responding to Ethical Blind-Spots in Self, Peers, and Supervisees

This workshop was originally presented for three CEU hours on February 12, 2015 by David Jensen, LSCSW, LCMFT, RPT, at Valeo BHC Lower Level Conference Room 330 Oakley, Topeka, KS.

Presenter
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Learning Objectives:
1. Participants will determine their own current functioning level of impairment utilizing the assessment measure presented in the workshop.
2. Participants will be familiar with legal and professional expectations of ethical functioning.
3. Participants will be aware of their own risks for impairment from possible physical health issues, medications, mental illnesses, addictive and compulsive patterns, and life stressors such as complicated bereavement.
4. Participants will establish their “red flag” warning signs for reaching “too impaired” to practice, and will have considered their ethical responsibilities for seeking help and for informing their employer of higher risk struggles in order to be supported and monitored.

Introduction
As helping professionals working with people we are people first. People who frequently are in the trenches day in and day out dealing with the most extremes of life experiencing compassion fatigue or secondary trauma, typically working long days with limited resources. Because we are people with all of our own vulnerabilities and humanness combined with the intense stressors of our work, practitioner impairment impact is a serious issue that impacts our ethical practice.

In Gabbard and Lester’s book on sexual boundary crossings, I found their description of the typical high risk work practices of psychoanalysts and psychotherapists to be similar to many of the helping professionals I have known:

“Psychoanalysis takes place in isolation. Unfortunately, the very isolation that makes the process viable also severely limits the analyst’s opportunity for feedback from colleagues...The
need for regular consultation cannot be stressed strongly enough...By monitoring the early signs of nonsexual boundary violations that suggest countertransference enactments that deviate from their usual practice, analysts can recognize the need for consultation with a colleague.”

The final preventative measure is one that cannot be regulated quite so easily as some of the others. It has to do with the way analysts choose to construct their lives. From early in their training, they become geared to a procedure in which they carefully put their needs aside in the service of trying to tune into the needs of their patients. A certain cost is incurred in this demanding and arduous procedure. The practice of analysis can subtly become a masochistic exercise in self-neglect and self-sacrifice.

Many analysts see their first patient at 6:00 or 7:00 a.m. and do not finish their office hours until well into the evening. They may have little interaction or fulfillment of their own needs for love and succor. Their primary contact with others involves seeing patients in the privacy of the consulting room. Their need for human contact gradually may become directed toward their patients as they grow increasingly distant from the loved ones that ought to constitute their support system. Many analysts spend more time thinking about their patients than about their marriages. Although it should be obvious, most analysts neglect to see the connection between having an emotionally gratifying personal life and their effectiveness as analysts.”

(Gabbard and Lester, 1995)

Over the years as I have attended ethics workshops, and taught ethics in my classes and in workshops, it has seemed the assumption is that by educating and training clinicians about what is ethical and what is not that clinicians could and would make the correct choices. What I have experienced in practice is that clinicians are primarily alone in doing our work with our clients’ hour after hour-commonly quite intense long hours. For us to recognize high risk ethical situations or boundary crossings, we have to be cognitively open and effectively self-monitoring.

In practical reality I believe that all of us at times struggle in our personal life’s with relationships, grief and loss, parenting challenges, substance use, PTSD, and our own chemical imbalances of depression, bipolar, ADHD, and even psychotic episodes. We also are at high risk with our stress levels and work habits of experiencing severe physical health issues both chronic and situational that may cloud our cognitive and emotional functioning.

I believe that our defenses block us from seeing clearly what we don’t want to see out of our fear, denial, and rationalizations that we are impaired, have distorted thinking and a blurred inaccurate view of ourselves and our clients. None of us want to accept being impaired and unable to effectively do our jobs. Most of us live pay check to pay check and would be terrified
of losing our jobs—our incomes. Many of us are overly dependent on our work identity for our self-esteem and purpose.

My motivation to research and present this workshop on ethical blind-spots is captured in the following quotation from the introduction of the *Impaired Social Worker Resource Book* published by NASW in 1987: “Social workers, like other professionals, have within their ranks those who, because of substance abuse, chemical dependency, mental illness or stress, are unable to function effectively in their jobs. These are impaired social workers.... The problem of impairment is compounded by the fact that the professionals who suffer from the effect of mental illness, stress or substance abuse are like anyone else; they are often the worst judges of their behavior, the last to recognize their problems and the least motivated to seek help, not only are they able to hide or avoid confronting their behavior, they are often abetted by colleagues who find it difficult to accept that a professional could let his or her problems get out of hand.”

Researching and writing this workshop has been emotionally difficult as it touches me personally with my mental, substance, and health issues over the years. It also impacts as a close friend crashed in her social work job and has been struggling to regain her balance for the last two and a half years. Some of my work on this workshop was while in the hospital with pneumonia. In following up after discharge my pulmonologist re-tested my oxygen level and urged me to return to using oxygen 24/7 as I was below the level necessary to keep my body healthy. I found myself wondering how impaired am I in my teaching and providing psychotherapy without it—where on the continuum of functionally impaired/disfunctionally impaired I would score. I know that the last hour of my six hour suicide workshop presentation I was seriously oxygen deprived and could not think effectively. Consequently, I made myself start back using oxygen. One of my blind spots became too hard to ignore.

In re-reading this last paragraph, I found myself wondering, does it make a difference as to what type of job a professional helping person is performing as to what level of impairment is tolerable? For me, my answer is yes. I am less at risk of causing harm in my teaching and training role than when I am providing psychotherapy. Impaired professionals could do paperwork tasks or co-lead groups getting ready to return to work or when “over-the-top” with stress, grief, or just not feeling good. What are your thoughts on this? For me, my answer is yes, I am less at risk of causing harm in my teaching and training role than when I am providing psychotherapy. Impaired professionals could do paperwork tasks or co-lead groups getting ready to return to work or when “over-the-top” with stress, grief, or just not feeling good.

- This workshop will take the stance that all helping professionals have some degree of impairment at different points in their careers.
• Impairment will be presented as being on a continuum—not as black and white.

• The challenge with different forms of impairment including physical health issues, medications, mental illnesses, addictive and compulsive patterns, and life stressors such as complicated bereavement; is being able to recognize and self-monitor developing impairments or crisis created impairments.

• A method for self-assessing functioning level will be presented as well as a “peer” monitoring system when individuals fear they may be or are becoming too impaired.

• Together we will explore where the ethical line of “too impaired” to practice needs to be and how to clearly convey this in personnel expectations.

• The state legal mandate and professional ethical standards of impairment will be reviewed. We will explore the ethics of requiring clearances to return to work from health, mental health, and addictions professionals.

• Additionally, we will examine agency’s ethical responsibility to have work output expectations that do not force workers to complete excessive hours and/or function in a “hostile” work environment that may trigger or accelerate impairments. A self-monitoring process will be suggested for agencies to monitor their level of providing a healthy environment vs. a hostile unhealthy environment.

**Helping Professionals’ Impairment**

For me impairment is used similarly to how the word dysfunctional is used as in “This family is dysfunctional”. Families are not totally dysfunctional nor do they function perfectly all of the time as in “This as is a functional family”. None of are functioning perfectly. Most of us practice at times with some degree of physical and/or emotional impairments. The challenge is to both define when the degree crosses the line and recognize when the degree of impairment puts clients and/or staff at risk of unethical practices.

In our conflict with loyalty to friends and colleagues many of us “don’t see” what we don’t want to see. Although mandated by professional ethics to intervene and/or report our peers, research tells us that this is not happening. “Clients who are affected most by impaired performance generally do not know it. Unfortunately, many social workers avoid interfering in the lives of their troubled colleagues, despite the ethical mandate to intervene”. (NASW, 1999)

Rather than “snitch out” our peer, I think people would be more willing to get involved if a constructive supportive relationship structure is established. I wonder if some of the reluctance could be the thought that “I may be the next one losing it or not functioning well and I don’t
want to be reported” or possibly, “We are in this war together and no one else understands the demands of battle”.

**Definitions of Impairment**

1. A. An inability and/or unwillingness to acquire and integrate professional standards into one’s repertoire of professional behavior.
   B. An inability to acquire professional skills in order to reach an acceptable level of competency.
   C. An inability to control personal stress, psychological dysfunction, and/or excessive reactions that interfere with professional functioning. (Lamb, et al., 1987)

2. *The Social Work Dictionary* defines an impaired social worker as:
   “one who is unable to function as a professional social worker and provide competent care to clients as a result of a physical or mental disorder or personal problems, or the ability or desire to adhere to the code of ethics of the profession. These problems most commonly include alcoholism, substance abuse, mental illness, burn out, stress, and relational problems” (Barker, 2003).

Impairment is different than inexperienced. It is assumed that the professional has functioned effectively previously. Language that I value clarifying degree is, “one who is unable to function as a professional social worker and provide competent care to clients”. “Competent care” for me is more specific language. It indicates that there is a point on the spectrum of caring moving from incompetent to competent to higher levels of competency. Of course the next challenge is defining the point it goes from competent to less than competent.

In my research I came across the wording in *DSM-5* explaining dementias and thought it might be useful in exploring cognitive impairments. “Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual–motor, or social cognition)” (*DSM 5*, p. 602). All of these areas impact professionals functioning capacity. For me another primary area of possible impairment is in mood and emotional reactivity.

In my own life’s journey and in having many psychotherapy clients with severe health issues, I have seen how moderate to severe physical health issues cause forms of impairment. Physical health challenges will be explored as well as mental health challenges (substance issues will be included).

**Causes of Impairment**

Reamer’s review of research in 1992 found distress among clinicians to fall into two categories:

- environmental stress, which is a function of employment conditions (actual working conditions and the broader culture’s lack of support of the human services mission)
• professional training, and personal stress, caused by problems with one’s marriage, relationships, emotional and physical health, and finances. (Reamer, 1992)

With respect to psychotherapists in particular, Wood et al. (1985) noted that professionals encounter special problems from the extension of their therapeutic role into the non-work aspects of their lives (such as relationships with friends and family members), the absence of reciprocity in relationships with clients (therapists are `always giving’), the frequently slow and erratic nature of the therapeutic process, and personal issues that are raised in their work with clients.”

As Kilburg, Kaslow, and VandenBois (1998) concluded: “Stresses of daily life–family responsibilities, death of family members and friends, other severe losses, illnesses, financial difficulties, crises of all kinds–quite naturally place mental health professionals, like other people, under pressure. However, by virtue of their training and place in society, such professionals face unique stresses. And although they have been trained extensively in how to deal with the stresses they themselves will face...Mental health professionals are expected by everyone, including themselves, to be paragons. The fact that they may be unable to fill that role makes them a prime target for disillusionment, distress, and burnout. When this reaction occurs, the individual’s ability to function as a professional may become impaired.”

Social Work Profession’s Responses
• The social work profession first acknowledged the problem of impaired practitioners formally in 1979, when the National Association of Social Workers (NASW) issued a policy statement concerning alcoholism and alcohol-related problems.
• By 1980 a nationwide support group for chemically dependent practitioners, Social Workers Helping Social Workers ((SWHSW), formed when Le Claire Bissell invited 50 MSW’s to meet for mutual support. Almost all accepted her invitation to meet, because many had held the mistaken belief that they were the only social worker in the USA in recovery.
• In 1982, NASW established the Occupational Social Work Task Force to develop a consistent professional approach for distressed members.
• In 1984 the NASW Delegate Assembly issued a resolution on impairment.
• In 1987 NASW published the Impaired Social Work Program Resource Book to help NASW chapters and other groups develop programs for impaired practitioners.

Reamer in his 1992 classic article on impairments suggested the following:

Model Assessment and Action Plan
1. Identify and collect data on the professional’s impairment.
2. Speculate about the possible causes of impairment.
3. Constructively confront the professional with evidence of the impairment.
4. Urge the professional to seek help and review the available options.
5. Emphasize the consequences of the professional’s failure to address the problem or problems.
6. If necessary, notify a local regulatory body or an NASW committee on inquiry.
7. Formulate a rehabilitation plan or impose sanctions, as appropriate, following standard due process proceedings.
8. Monitor and evaluate the profession’s progress.
9. Review the practitioner’s standing in the profession (such as licensure and employment status) and modify it as appropriate. (Reamer, 1992)

In 1996 NASW added to its Code of Ethics, Ethical Responsibilities:

**Standard 4 Professional**

*Social workers should not allow their own personal problems, psycho-social distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interest of people for whom they have a professional responsibility.*

*Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and other social workers.*

*Social workers who have direct knowledge of a social work colleague’s impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with the colleagues when feasible and assist the colleague in taking remedial action. (standard 2.09 [a])*

*Social workers who believe that a social work colleague’s impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations. (standard 2.09 [b]).*

For me the language in these statements seems “absolute” meaning if a social worker allows any degree of personal problem to interfere s/he is practicing unethical social work. I certainly know that is not the intent, but believe the language needs to be changed to something more realistic like, “significantly interfere”. If you would change this language, how would you word it?
“In spite of these various efforts social workers (as well as all other groups of professionals) often find it difficult to acknowledge problems in their own and in colleagues’ lives. Impairment is a hard fact to face. Sometimes social workers find it difficult to seek help because of their denial about the seriousness of their problems, mythical belief in their ability to help themselves and in their vulnerability, skepticism about colleagues’ ability to help them, and concern about confidentiality and cost...

Clearly, social workers have a responsibility to be alert to possible impairment in their own and in colleague’s lives and to respond to the impairment constructively and assertively. We owe this openness not only to ourselves and those within the profession but also-and most importantly-to the clients we serve.” (Reamer, 2002)

**Kansas Regulations on Unprofessional Conduct**

All of us who are alcohol and drug counselors, psychologists, social workers, and marriage and family therapists fall under the Kansas Behavioral Sciences Regulatory Board and its rules and regulations. In my research I found the following regulations relevant to professional impairment:

**Social Workers**

*Kansas Regulation 102-2-7. Unprofessional conduct. Any of the following acts by a licensee or an applicant for a social work license shall constitute unprofessional conduct:*  
*(h) failing to recognize, seek intervention, and otherwise appropriately respond when one’s own personal problems, psychosocial distress, or mental health difficulties interfere with or negatively impact professional judgment, professional performance and functioning, or the ability to act in the clients best interests;*  
*(x) using alcohol or illegally using any controlled substance while performing the duties or services of a license;*

**Addictions Counselors**

*Kansas Regulation 102-7-11*  
*(g) failing to recognize, seek intervention; and otherwise appropriately respond when one’s own personal problems, psychological distress, mental health difficulties interfere with or negatively impact professional judgment, professional performance and functioning or the ability to act in the client’s best interests.*  
*(u) using alcohol or any illegal drug or misusing any substance that could cause impairment while performing the duties or services of an addictions counselor;*

**Professional Counselors**

*Kansas Regulation 102-3-12 (a) Unprofessional Conduct*
(8) failing to recognize, seek intervention; and otherwise appropriately respond when one’s own personal problems, psychological distress, mental health difficulties interfere with or negatively impact professional judgment, professional performance and functioning or the ability to act in the client’s best interests;

(24) using alcohol or illegally using controlled substance while performing the duties of a professional counselor or clinical professional counselor;

Psychologists
Kansas Regulation 102-1-10 Unprofessional Conduct
(b) practicing with impaired judgment or objectivity which shall include the following acts:
(1) using alcohol or other substances to the extent that it impairs the psychologists ability to competently engage in the practice of psychology; and
(2) failing to recognize, seek intervention and make arrangements for the care of clients if one’s own personal problems, emotional distress, or mental health difficulties interfere or negatively impact professional judgment, professional performance and functioning, or the ability to act in the client’s best interests.

Marriage and Family Therapists
Kansas Regulation 102-2-12 Unprofessional Conduct
(8) failing or refusing to recognize, seek intervention and otherwise appropriately respond when one’s own personal problems, psychological distress, or mental health difficulties interfere with or negatively impact professional judgment, professional performance and functioning, or the ability to act in the client’s best interests;

(24) using alcohol or illegally using controlled substance while performing the duties or services of a marriage and family therapist;

The wording in the regulations of unprofessional conduct for all of these professions include the wording, “interfere with or negatively impact professional judgment, professional performance and functioning, or the ability to act in the clients best interests”. In my opinion there are daily factors that people in all of these professions experience that interferes and negatively impacts to some degree. The question really is how and when this impact is significant enough to be harmful. Where does the line needs to be drawn? Where would you draw it?

The language varies for the use of alcohol and/or illegal drugs. For some it specifically states it is unprofessional to use any amount of alcohol and/or drugs while performing one’s work. Others are worded more openly that it is unprofessional to use alcohol and/or other drugs to the extent that it impairs the professional’s ability to competently engage in practice. I certainly support all helping professionals not drinking or using drugs while on duty, but believe the other language is also needed. Again, I personally like the use of the word “competently”.

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Renewal for all licenses includes question #5, “In the past 24 months have you suffered from any impairment, which might affect your ability to safely practice?”

I am not sure what is meant by “safely” yet I have signed my renewals answering no. I assume this means for our clients’ safety or wellbeing and likely for the practitioner to not be impaired to the degree that she or he will cause harm. For me safely needs to be replaced with “competently” practice. Competently would then need to be defined and for that matter impaired. I should have said yes to that question after I had been in a comma for two months. There were periods of time that I was impaired after a family member committed suicide and another made serious attempts. For me the language needs to at least be, “significantly impaired”. What language would you recommend be considered?

Physical Disorders Impacting Impairment
I move outside of my competency here, but want to identify health issues that for me pose risks and to elicit your feedback as to what you agree and/or disagree with.

Insomnia
How many of us as new parents were sleep deprived which has great impact. Chronic sleep deprivation poses great concentration and cognitive processing risks. I found myself asking is it less an ethical concern if impairment is for “good vs. bad” reasons such as new parents vs. partying too late? My answer is that it should not, but suspect in practice it does. What do you think?

Causes of acute insomnia can include:
• Significant life stress (job loss or change, death of a loved one, divorce, moving)
• Illness
• Emotional or physical discomfort
• Environmental factors like noise, light, or extreme temperatures (hot or cold) that interfere with sleep
• Some medications (for example those used to treat colds, allergies, depression, high blood pressure, and asthma) may interfere with sleep
• Interferences in normal sleep schedule (jet lag or switching from a day to night shift, for example)

Causes of chronic insomnia include:
• Depression and/or anxiety
• Chronic stress
• Pain or discomfort at night

Symptoms of Insomnia include:
• Sleepiness during the day
• General tiredness
• Irritability
• Problems with concentration or memory
http://www.webmd.com/sleep-disorders/guide/insomnia-symptoms-and-causes#4

Diabetes
Cognitive impairment occurs when blood sugars are significantly out of balance.

Infections with High Fevers
Some cognitive impairment can occur as well as impacting level of fatigue. It is critical that employers encourage staff who are seriously sick to take time off to get better. I have known of agencies that required staff to not miss work both formally and more often informally even though staff have a high fever with threat of disciplinary actions and/or consequences for falling behind.

Treatment and/or Prescription Medication Side-Effects
Twelve years ago in July, I went to Lawrence to run a 10k. Instead I ended up in the ER with the worse constipation pain I ever experience. Wrong. I had surgery to remove my appendix which was completed but was not the problem. I had severe diverticulitis and infection and spent a week in the hospital with my incision open on high level antibiotics. I reported to Washburn starting a new job on Monday after being released on Friday. My brain was in a fog. It was the next February that it cleared. I thought I was incompetent as a teacher. I couldn’t think. During this time I was “toughing it out” doing my private practice. I was impaired, but don’t know to what degree. I was told that the medications utilized to “knock us out” when we have surgeries can have lasting effects.

Debra Gordon wrote the article, Chemo Brain: Cognitive Problems after Cancer Are Not Imaginary, in NeurologyNow. In it she shared that data from the National Health and Nutrition Examination Survey found that 14% of those with a history of cancer had memory problems compared to 8% of those without a history of cancer-a 40% increased risk. Studies in breast cancer patients found rates of chemo brain between 17 and 75%.

Chemo brain can cause people to:
• Lose track of what is being said in the middle of a conversation
• Go into another room forgetting the reason for being there
• Get distracted in the middle of one chore or task resulting in not completing the original task
• Experiencing thinking that feels sluggish, like starting a car on a cold day

Differentiating between depression and cognitive impairment, neuro-oncologist Lynne Taylor, M.D., FAAN, explains that with memory impairment, “you put something into your memory and
can demonstrate that it’s there, but when you can’t demonstrate that it ever went into your memory because your concentration is so poor and scattered”. (Gordon, April/May 2014)

**Severe Pain**
Acute pain can interfere with focus and concentration, and can impact mood.

**Chronic Obstructive Pulmonary Disease (COPD)**
Lack of oxygen certainly interferes with our brain functions and our capacities as clinicians.

Nine years ago I thought I had the flu, but couldn’t breathe. My oxygen level upon arrival at the ER was 61. Two months later after being in Intensive care, on dialysis and life support, I came out of a comma with a feeding tube and a tracheotomy to learn I had double pneumonia with MRSA (methicillin-resistant-staphylococcus-aureus) when I arrived at the hospital. I went to my daughter’s MSW graduation the weekend after release but did not teach that summer. With oxygen I gradually returned to private practice.

When I first wrote this last paragraph, I originally stated that I returned to work when released by my physician. After sitting with that, I realized that I never asked a doctor when I could return to work—likely because I did not want to hear his or her answer. I returned to work as quickly as I thought I could to be productive, to show that I was ok, and to make money. My readiness was not my main concern. I pushed myself as I had always done. Ethically, I should have sought a doctor’s opinion as to my readiness and returned when cleared. I suspect that I am not the only helping professional who does what s/he wants not necessarily what the doctor may say.

**Neurocognitive Disorders**

**Delirium**
My wife, who is a social worker, was hosting an office gathering at our home. Before it started she slipped in a private practice appointment. As she arrived home shortly before people were to arrive, she called me asking why our home was set up for a party—if I had moved things. I reminded her of what she was doing becoming quite concerned she did not remember. Immediately after we hung up she called back asking the same question and remembered nothing of our previous conversation. I went home immediately and took her to the ER fearing a possible stroke, aneurism, blood clot, brain tumor, or toxic reaction to the mixing of cleaners getting ready for the gathering. Her physical appearance ruled out the stroke. Much later in the evening, she finally began to retain information. She mentioned having started over the counter holistic medications while increasing a prescription medication. It turned out she experienced a delirium from medication reactions. She knew she had a session with a client, but had no memory of its content. Her impairment was immediate and responded to quickly because of its severity.
As I reflect on this last paragraph, I found myself wondering if my wife even considered mentioning this incident when she applied to renew her license-I doubt it as it was so brief.

Symptoms of a delirium include:
“A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment)...An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).”

(DSM 5, p. 596)

**Major Neurocognitive Disorders (Dementias)**
After a couple months of returning to work following my lung issues, I feared I had medically induced dementia as I was forgetting things and again could not think on my feet. I requested a neuropsychological exam that was most troubling as I believed that if I had “failed” the exam that I needed to stop practicing. In my anxious state it felt like I had failed. Instead the doctor said it was from the trauma effects of my illness and would get better which gradually happened.

Symptoms of dementias include:
A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual –motor, or social cognition) based on:
1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive functioning; and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

(DSM 5, p. 602)

Sadly, I am hearing of more and more early onsets of dementias. Helping professionals experiencing a dementia like Alzheimer’s disease would be gradually impacted with impairment making it difficult to notice in the disease’s early stages. The helping professional, his/her peers, and supervisor would need to notice signs and be willing to share concerns and to be evaluated.

If we should be experiencing symptoms of dementia most of us, in my opinion, would be in a state of denial out of absolute terror of it being true. Feedback from others would be crucial along with sensitively required by Human Resources.

I suggest that following major illnesses, surgeries, and/or accidents that human resources require helping professionals to bring a clearance to return to work that includes cognitive functioning and emotional stability. This would include results from neuropsychological evaluations. What are your thoughts and reactions?

**Valeo BHC Human Resources Practices Manual**
**702 Return to Work:** Valeo is committed to providing a safe workplace for our employees. Preventing work related illness and injury is our primary goal. The Return to Work Policy is to
return workers to employment at the earliest possible date following an injury or illness. The policy applies to all eligible workers and will be followed whenever appropriate. Valeo defines transitional work as temporary, modified work assignments within the worker’s physical abilities, knowledge and skills. Where possible, transitional positions will be made available to injured workers to minimize or eliminate time lost. For any business reason, at any time, we may elect to change the position such as working shift, location, etc. based on the needs of the company. Valeo cannot guarantee a transitional position and is under no obligation to offer, create or encumber any specific position for purposes of offering placement. HR will provide more detailed information upon request or in the event of work-related injury. [8/29/13]

I assume that Valeo’s HR policy would also apply following leave for mental health and substance abuse treatments.

**Mental Health Disorders Impacting Impairment (includes substances)**

**Bereavement**

Personally, I have found that most “normal” people don’t experience the loss of a loved one consistent with the DSM 5’s Uncomplicated Bereavement, “As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode—for example, feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss…” (DSM 5, pp. 716-717).

Instead I have found most of “us” to grieve more consistently with the symptoms of Persistent Complex Bereavement Disorder—which is still under study—that include, “Persistent yearning/longing for the deceased...Intense sorrow and emotional pain in response to the death...Preoccupation with the deceased... and preoccupation with the circumstances of the death...” (DSM 5, p. 789). Reactive distress to the death include the following possible symptoms; Marked difficulty accepting disbelief or emotional numbness over the loss...Excessive avoidance of reminders of the loss...” (DSM 5, p. 790). Social or identity disruption include the following possible symptoms; A desire to die to be with the loved one...Difficulty trusting other individuals since the death...Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased...Confusion about one’s role in life, or a diminished sense of one’s identity...” (DSM 5, p. 790)

The majority of people I have known are greatly impacted by the death of a family member and are impaired to some degree during the grieving process. Regrettfully, the DSM only focuses on the death of a person rather than the other many meaningful losses like the death of a favorite pet; divorce; loss of a home or family farm/business to fire or bankruptcy, the ability to breathe, walk, see, hear; experiencing chronic pain; inability to conceive; etc.
For me it is normal to be impacted by serious loss or multiple losses. The challenge is knowing for how long, to what degree—which commonly is a roller coaster, or what may trigger intensification of the symptoms (a client asking if you are married the day you receive your final divorce degree). I have had “normal” clients experiencing psychotic symptoms from lack of sleep and the trauma of loss.

Obviously, I believe that grief and loss impact clinicians’ functioning and they are at times to some degree impaired. I could see myself tearing up as a client talked about a recent death when I had just experienced the death of someone special. I could see myself acknowledge this commonality with my client and effectively use the shared experience. On the other hand I could also imagine my being preoccupied with memories and feelings leaving no room for my client’s story or feelings. Reality is that there are a limited number of days off for bereavement.

Valeo’s *Code of Ethics* addresses issues like this by stating: “Staff is expected to recognize that personal problems and conflicts may interfere with professional competence. They will refrain from undertaking activities in which a personal problem may lead to inadequate professional service or harm to a client or customer. Staff experiencing such problems is expected to seek competent professional assistance. The Agency makes available an Employee Assistance Service for all staff.”

**Obsessive-Compulsive and Related Disorders, Feeding and Eating Disorders, and Substance-Related and Addictive Disorders**

A high risk for professionals, like non-professionals, is abuse of alcohol and drugs. Studies have found it to be at “...troubling levels” among social workers. In one NASW study 12% of the social work sample population was at serious risk of alcohol and/or drug abuse. Of those considered high risk, 53% reported some type of impairment and 20% reported three or more impairment incidents (Siebert, 2003). Denial of impairment among professionals has been found especially with alcohol and other drug abuse (Siebert, 2003). Effects of impairment reported included providing inadequate or substandard client care, missing appointments, being late, engaging in inappropriate relationships, missing work, being disciplined by employer, and being fired (Siebert, 2003).

Findings from an NASW member study found that social workers do not frequently seek help, even when they are at high risk for alcohol and other drug use (Siebert, 2005). Their reasons for not seeking help included concern about confidentiality, professional consequences, and treatment options were unacceptable, feeling uncomfortable because they knew the providers personally or professionally, believing that they could not take time from work to obtain assistance, and believing that counseling would be ineffective (Siebert, 2005). I have been confused for years about agency policies on substance use. For me alcohol problems are not given sufficient attention while illegal drug use is inconsistently handled. Our inconsistent approach with alcohol being legal despite it being one of the most damaging and
dangerous drug while not accepting that many individuals can use illegal substances recreationally impacts how staff are treated. When I sought treatment for my alcohol abuse my employer (which was, in my opinion, a very unhealthy agency) had no idea I had a problem. My wife at the time and best friend, also a social worker, did not think I had one. Their views were biased with how alcoholism is accepted in our families. My friend later realized his own dependency and is in recovery. All three of our families have extensive patterns of substance abuse.

I have never been drug tested while employed despite it being presented as a potential requirement. Word gets around when testing is not done and encourages use in my opinion. If we say we may test then we must have required random tests for all for our policies to be effective.

In assessing impairment there is the question of whether someone is impaired only while under the influence at a certain level. Substances’ half-life affect them showing up on testing. If staff have a low amount of marijuana in their system they likely are not impaired. While in my opinion while not impaired, staff testing positive are still breaking a rule and need to be held accountable differently than if they were working while using their substance of choice.

As I understand the criteria for Obsessive-Compulsive and Related Disorders, Feeding and Eating Disorders, and Substance-Related and Addictive Disorders; all basically have the same dynamics with a different focus. All include obsessive thinking and compulsive behaviors. The effect on thinking and behavior certainly varies between the need to count repeatedly before taking action vs. preoccupation with getting a drink of alcohol, getting the next “fix”, being able to binge or purge, worrying about how fat you look, being able to get back to on-line to place a bet or two, to watch porn, vs. the chemical brain changes from binging, placing a bet, being under the influence of alcohol and/or other chemical substance.

In the addictions field it is common to hear relapse starts way before the first drink or use of substance. Being a “dry drunk” recognizes that the impact of addictions are not just the using behaviors and their effects but include the “stinking thinking”- the preoccupation with the substance or behavior. They are in withdrawal or preoccupied finding their next high or drink. The obsessive thinking component of the obsessive-compulsive pattern impacts impairment. Over the years I have known several helping professions who are “functional” substance abusers. They are able to avoid going to work directly under the influence. However, some of these individuals may be in the same room with their clients but their thoughts and focus are trapped in their addiction.

The DSM-5 presents evidence that I have seen for years. Certain behaviors trigger chemicals being released to the brain that mirror substance dependence effects. Only gambling was included in this version, but I expect sexual addiction and compulsive self-harm to follow soon.
workaholism may take a while. For me individuals with moderate to severe levels of these patterns pose impairment risks as their thought are preoccupied with their compulsive thinking. Additionally gambling, self-harm, and inappropriate use of pornography or sexual behaviors may occur during work hours.

When professional helpers experience depressive feelings, there often is a need for treatment in inpatient and/or outpatient therapy and these individuals are welcomed back to work when they are able to return. I have known mental health clinicians who have a chemical dependency problem and are allowed to return to work when the addiction is not directly interfering with their jobs. In my experiences chemical dependency counselors seem to be held to a different standard. Commonly they have not been allowed to return to their position until a certain period of recovery is maintained. Is this a practice that should be modeled with clinicians recovering from depression, bipolar, PSTD or other mental disorders?

**Valeo’s HR Policy**

**821 Drug and Alcohol Use:** We operate under the provisions of the Drug-Free Workplace Act. You may not report to work or be on duty under the influence of alcohol or illegal drugs. You must: (a) notify us of your criminal conviction for drug-related activity occurring within the workplace within five days after conviction; (b) not use, possess, distribute, sell, or be under the influence of illegal drugs or alcohol at work; (c) report any employee or consumer in violation; (d) take prescribed medications safely and without impairment or leave work; (e) accept help from the Employee Assistance Program and/or get help in the community if you have a substance problem. Upon probable cause of being on duty under the influence of alcohol or illegal drugs, you will be placed on leave and transported by a supervisor for testing as allowed by law. Contact Human Resources for the testing location. Upon probable cause, post-accident (following a work-related injury requiring medical attention) or at random, we may require a sample of your blood, urine or hair for testing as allowed by law. If you refuse to be tested, or your positive preliminary test is confirmed, we will place you on immediate suspension and consider the options of remedial action or discharge. [7/11/13]

Agencies, professions, and licensing boards focus only on the chemical dependency disorders and actively being under the influence. Ethically, in my opinion, impairment is occurring with active eating disorders, gambling and sexual addictions, and other obsessive-compulsive disorders; and with extreme obsessive preoccupied thinking of active chemical dependent disorders. What are your reactions and thoughts to my view? How do you think of recovery and relapse in terms of impairment and competent practice? Your thoughts?

**Major Depression episode**

“Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)”.

(DSM-5 p. 161)
One study of depression among social workers found that 19% of a sample of NASW members reported current symptoms of depression. Sixteen percent had seriously considered suicide. Sixty percent self-evaluated as either currently depressed or had been in the past (Siebert, 2004). Surprising to me, it was found that those with more years of experience, professional designations, and higher degrees were less likely to report depressive symptoms. The most concerning finding from the study was that the percentage of respondents self-assessed as depressed was three times the lifetime rate in the general population.

With Depression and Bipolar Disorders I am concerned about the cognitive impact during depressive episodes, “8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)”\(^a\); the lack of energy, “4. Insomnia or hypersomnia nearly every day…6. Fatigue or loss of energy nearly every day.” and the impact of emotions, “1. Depressed mood most of the day, nearly every day…7. Feelings of worthlessness or excessive guilt…9. Recurrent thoughts of death…” (DSM 5, pp. 160-161)

Clinicians’ capacity to focus, process, assess, and retain information is impacted to some degree during depressive episodes. There is the risk of clients perceiving the clinician’s sad affect as a reflection of how hopeless the client is. There is also a risk that a clinician’s assessment and intervention with a suicidal client may be impacted by the clinician’s own suicidal feelings.

**Bipolar Disorder**

**Manic episode**

With an active manic episode clinician’s functioning is impacted by, “A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy...B. During the period of mood disturbance and increased energy and activity...inflated self-esteem or grandiosity, more talkative than usual or pressure to keep talking...Flight of ideas or subjective experience that thoughts are racing...Distractibility...Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). ” (DSM 5, p. 124)

Manic episodes with Bipolar Disorder have occasionally been involved with sexual boundary crossings (Gabbard and Lester, 1995).

At moderate to high levels of severity I have found individuals to over rate their abilities and experience distortions in their perceptions of reality. A clinician with an active high level of mania may think he or she can treat schizophrenia without medication, or inaccurately perceive a client’s presentation and needed response. Boundaries are more at risk of being blurred.

**Attention-Deficit/Hyperactive Disorder**

For me the risks with impairment primarily are with inattention symptoms including:
“a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate)...
c. Often does not seem to listen when spoken to directly (e.g., mind seems else-where, even in the absence of any obvious distraction).
d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)...
h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i. Is often forgetful in daily activities (e.g., keeping appointments).”

With hyperactive and impulsivity symptoms, I am concerned about the impact of:
“f. Often talks excessively.
g. Often blurts out an answer before a question has been completed...
i. Often interrupts or intrudes on others...”

Trauma-and Stress-Related Disorders
Acute Stress Disorder
Post-Traumatic Stress Disorder (PTSD)
With Acute Stress Disorder and PTSD symptoms that could create impairment include:
Intrusion symptoms; Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)...Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring...Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) (DSM 5, pp. 280-281)

Sadly, I have known of many professional helpers who have experienced one or both of these disorders. Those who have done the personal work needed are able to use their experiences in helping others. Others who have not—or get triggered—are unable to work for periods of time, or have to accept going on disability.

Dissociative Disorders
I have worked with many clients who dissociate from trauma experiences usually tied to PTSD and am very aware of my sense of betrayal to them by including these experiences. They have suffered much too much. They commonly have a hard time trusting which is sadly what life has taught them. I have a hard time imagining a person with DID trusting HR to share his or her reason for being off work.
It is common for me to hear about clients dissociating at work. One, who is a helping professional, reported losing 75% of her time yet was getting her job done. Later as work stress increased she found herself staring off in space not getting her job done. Included in her diagnosis is Dissociative Amnesia Disorder although I strongly suspect she experiences DID but does not feel safe enough to face it or allow me into this private world. Even though obviously
impacted I did not consider her impaired losing time as her work appeared to be getting done. I strongly suspect her employer would think differently and she would lose her job if I shared this information in a progress report. Another helping professional, a teacher with DID, switched personalities, left her classroom going into the bathroom, cut herself by writing “die bitch” on her leg, took a picture which this alter sent me by text, switched back, and returned to teaching her class.

She obviously is very impaired, yet I believe able to stay focused and present with her students. If she had been a social worker, do you think I should have reported her breaking confidentiality? Should psychotherapists who are mandated reporters have to turn their clients into BSRB if we consider the professional helping client to be significantly impaired?

Because I questioned if I knew the answer to this question, I called the Kansas BSRB and was made aware that confidentiality overrides reporting as earlier in this regulation it states, Social Work 102-2-7 Unprofessional Conduct

(b) Except when the information has been obtained in the context of a confidential relationship, failing to notify the board, within a reasonable time, that any of the following conditions apply to any person regulated by the board or applying for a license or registration, including oneself.

Over the years I have worked with people in the helping professions with DID-and always a number of co-occurring disorders like depression, panic attacks, agoraphobia, substance and eating disorders, and PTSD. I have known them to have chronic thoughts of suicide and of switching frequently while on their jobs. Most of the time I have trusted that they are able to do their work competently though impaired. I have also worked with others in the helping profession with DID who have had to stop working and go on disability as they could not contain their symptoms while at work.

Anxiety Disorders
Panic Attacks and Agoraphobia are two of the anxiety disorders that I have known to cause significant impairment in helping professionals, including my close friend who was so overwhelmed by work stresses and life’s challenges and was unable to continue working.

Personality Disorders
Gabbard and Lester found that many of the analysts and other psychotherapists who had sex with patients fall into Predatory psychopathy and paraphilias; these include antisocial personality disorders and narcissistic personality disorders with antisocial features. Analysts or psychotherapists in this category regard patients as objects to be used for their own gratification. They have no empathy or concern for the victim. In many cases of the narcissistic
personality extreme, the analyst appears charming and capable of functioning professionally. Some of these clinicians have a childhood history of profound neglect and/or abuse. 

(Gabbard and Lester, 1995)

“Education is clearly a cornerstone of preventative efforts, but analytic candidates with severe narcissistic or antisocial character pathology will be relatively impervious to education interventions and will probably exploit the analytic situation to gratify various sadistic wishes. More careful screening of applicants to analytic institutes is needed to keep such individuals out of the analytic profession, but history has taught us that no form of assessing applicants is foolproof.”

(Gabbard and Lester, 1995)

**Borderline Personality Disorder**

Over the years I have had to supervise staff with BPD, work with colleagues with BPD, and had professional helpers with BPD as clients. Some did a good job of managing their symptoms through hard work, others caused significant disruption, drama, and harm. Some were repeatedly fired. Some had to go onto disability. Other than having staff with antisocial/narcissistic qualities, this impairment can have the most damaging ripple effect within an agency-and with clients.

**Degree of Impairment/Recovery of Mental Health Issues for Competent Practice**

I would offer the model that Valeo staff created in 2011 called *Journey to Recovery: A Model of Recovery and Treatment for People with Severe and Persistent Mental Disorders* as a potential tool for defining the degree of impairment to be considered “significantly” impairment. By utilizing the Third Phase of recovery as a boundary line of recovery functioning between significant impairment triggering interventions and/or stopping practice and impaired but not significantly. I am proposing that professionals with mental health issues be required to at least be functioning at the Community Focused Living level. If professionals are at Phase Three or below, their practice would be considered significantly impaired and unable to work. **As you read through Phase Three, for those of you who, like me, suffer from forms of mental health issues, assess where you currently stand in recovery. I appreciate Valeo being willing to allow me to share their most impressive work.**

**Phase Three-Reaching Beyond**

(Professionals at this level would be considered significantly impaired)

**Core Features**

**Symptoms**

- Symptom Status has far less impact on daily functioning & structure
- Motivation & energy levels are more consistent, with occasional lows
- Physical symptoms, medical conditions, & sleep disturbances more regulated thoughts
• Impaired thought process (usually) managed effectively with meds & coping skills
• Sustained organized/focused activity, despite some impaired thought processes
• Can be challenged about distorted thinking; content of thoughts frequently positive
• Abled to make connections between thoughts, feelings, & actions
• Has better insight; makes better decisions; remembers past consequences
• Thoughts of self/other harm may remain chronic for some time; but rarely acted on emotions
• More directly expressed; shows greater range, includes capacity for joy & pleasure
• Feelings may be intense at times, but more able to tolerate than before
• Moods are more stable; highs aren’t as high & lows aren’t as low
• Emotions shown are appropriate to situations most of the time

Management of Illness

Daily Living
• Maintains daily structure with use of coping & problem-solving skills
• Has good hygiene, usually dresses appropriate to the situation
• Isolates less in response to stress
• Increasingly able to sustain work/productive activities
• Finding balance between taking & giving back to community

Symptoms Management
• Uses treatment processes actively and with purpose to manage symptoms
• Seldom uses self-destructive coping strategies; has identified healthier alternatives
• Able to describe connections between symptoms, feelings, & behaviors
• Describes understanding of mood patterns and triggers
• Able to self-soothe, regulate emotions, manage impulsivity, think before acting
• Has “clean” time & sustains sobriety
• Self-directed management of health care needs & getting to appointments
• More able to adapt to new circumstances & deal with change
• Infrequent to rare need for crisis services
• Acceptance of relapse as part of recovery; may anticipate relapses

Treatment Related Behaviors
• Decreased dependence on treaters; self-directed with community focus
• Med compliant most of the time
• Accomplishes treatment goals; starts transition to community focused supports

Relationship to Self

Self-Esteem
• Self-esteem more consistently positive
• Experiences minimal & fleeting self-hatred
• Good ability to identify strengths
• Able to challenge inner critic on their own
• More consistent self-confidence in various life arenas
**Self-Definitions**
- Can describe and act on value system, boundaries, and needs
- Infrequently sees self as victim; aware of personal power and how to build on
- Defines self as more than an illness or diagnosis-focusing on life; less internal stigma
- Ability to express hope, faith, & life purpose; has personal spiritual base

**Self-Responsibility**
- Assumes & follows through with responsibilities in various life arenas
- Increased ability to identify & achieve self-directed goals
- Owning responsibility for past mistakes
- More able to accept & forgive personal limitations

**Progress Indicators: Signs A Consumer is Moving from Phase III to Community Focused Living**
(I suggest this is when Professional Helpers can return to work)

**Core Features**
- Relapses occur with less frequency, intensity & duration
- Able to function effectively despite some disruption or psychotic thought processes
- Has positive thoughts more frequently than negative
- Feelings are more accepted (vs. judged) & used to inform choices
- Using emotional regulation; distress tolerance; interpersonal effectiveness & mindfulness
tools to cope on daily basis

**Management of Illness**
- Day is centered on work, school, friends, & family vs. treatment
- Is actively aware of importance of balancing activities & down time symptoms are effectively
managed & relapse plans are used
- Effectively uses internal and external resources; focus shifts to “giving back”
- Is more responsible in all decision-making processes

**Relationship to Self**
- Accepts personal strengths & limitations, forgiving of past errors
- Accepts illness & actively demonstrates “recovery” in everyday life
- Exhibits attitude: “I have created a life worth living”

**Relationship to Others**
- Accepts strengths & limitations of others’ forgiving of past grievances
- Sustains strong community-based support system
- Expresses increased sense of “belonging” in multiple life arenas

**Transition to Community Focused Living**
- Actively identifies personal achievements & gains; willing to “celebrate” successes
- Has fears about discontinuing some services, but does; minimal services are needed
- Looks to new activities to take the place of treatment activities
- Transitions to decreased services with minimal disruption in gains previously attained
- Can describe phases of their personal recovery process & factors that “made a difference” to their progress
• Understands need to stay on meds & alert treaters if effectiveness changes
• Recognizes “red flags” that indicate need for new episodes of treatment
• Asks for help when needed
• Has hope for the future & confidence in having a meaningful life

Daily Mental Health Self-Monitoring Tools
For a self-monitoring tool which would be shared with the support person, I would suggest something similar to the “Tools” developed by Valeo’s staff for Journey to Recovery Teaching Tools #1 and #5. This would be done as a daily “inventory” to keep blind spots out in the open.

Teaching Tool #1
My symptoms:
1. Seem out of control and have a big impact on how I do each day
2. Are up and down, but are more stable and manageable overall
3. Are pretty stable and I have some strategies for managing them that work most of the time

Medications:
1. I can’t seem to get them every day for one reason or another
2. I’m on the right meds now, but still inconsistent in taking them, or sometimes go off of them
3. I’m on the right meds and also take them daily as prescribed

Structure:
1. I have very little structure in my life; my illness interferes a lot with what I do
2. I am beginning to have some structure in my life, though it drops out at times
3. I have a consistent daily structure that helps me manage the day

Physical Self-Care:
1. I have a lot of trouble taking care of myself (examples: bathing, getting dressed every day)
2. I am taking better care of myself and some people have noticed the improvement
3. Taking good care of myself-bathing, hair, clothing-has become a regular habit

Motivation:
1. My motivation is often low and it’s hard for me to get things done because of this
2. My motivation has improved and I can get myself going most days
3. My motivation has become pretty consistent, with only occasional drops

Energy:
1. My energy is really low and I can’t count on being able to do what I want to do because of this
2. My energy fluctuates, but I am doing more activities despite that
3. My energy is fairly consistent and I am able to get done the things I most want to do

Sleep:
1. I have a lot of problems with sleep and it seems out of my control
2. I have problems with my sleep now and then, but meds have helped and I have some coping strategies that work sometimes
3. I am generally able to get the sleep I need by taking my meds and using my coping strategies

Attitude toward treatment:
1. I don’t trust anybody, especially my treaters
2. I have some trust in my treaters, but not all the time—still working on this
3. I have developed a good working relationship with my treaters and generally trust them

Attitude towards self:
1. I have a lot of self-hate and/or criticize myself a lot
2. I am beginning to like myself a little more often
3. I like myself and can see my strengths most of the time

Attitude toward others:
1. I don’t like to be around people and I isolate quite a bit
2. I am beginning to connect to some people and get out of the house more
3. I value my connections and have developed good circle of friends, treaters, and family members

Thoughts:
1. I have a lot of negative or distressing thoughts that interfere a lot with my day
2. I have some negative/distressing thoughts, but they cause me less trouble than they used to
3. Usually, my thoughts are more positive than negative, and I have learned how to manage or improve them when they cause me trouble

Self-destructive thoughts:
1. I frequently want to self-harm and don’t know how to manage these urges
2. I am aware of my urges to self-harm, but usually don’t act on them—I have some coping strategies I know how to use
3. I don’t usually have urges, but if I do, I know I can use my skills to manage them and stay safe

Life goals:
1. I don’t really have a good idea about goals
2. I have some idea about what I want to accomplish in my life
3. I have a good idea about my life goals and how to go about making these happen

Hope:
1. I frequently feel hopeless
2. My hope goes up and down a lot, but it’s a little better than it used to be
3. Even when things are bad, I am generally able to hold onto my hope

Recovery:
1. I don’t really know what “recovery” means
2. I have some idea about what “recovery” means and what that might look like and for me personally
3. I have a good understanding about what is meant by the idea of "recovery" and I know what I need to work on to do my recovery program

**Totals:** How many? ---- 1's ---- 2's ---- 3's

**Scoring:** Add up the number of 1's you have; then 2's; then 3's. Whatever category you have the most of may be the phase you are in. We suggest that you look at that phase more closely to see if it fits you.

**# 5 Progress Quick Check as of (date) ____**

Circle the % of time you are doing each of the following. The goal is to increase the % over time.

- Taking care of myself
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Asking for help when I need it
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Structuring my day with activities
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Taking my meds as prescribed
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Being honest with my treaters about my problems
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Using my coping skills and resources (friends, family, activities)
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Following my crisis coping plan
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

- Keeping up my hope for myself and my future
  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%

**Monitoring**

In thinking about the blind spots I have identified, the monitoring that seems necessary infringes on individual freedoms and privacy rights. It would require trust, respect, and loyalty between the staff and employer. I would propose that personnel policies require new employees to report any serious health, mental health, and addictions histories including if they are currently in treatment. If in treatment, staff would be required to sign a release for regular reports of their functioning level-no clinical or medical details. The staff would also be required to inform HR, if healthy with no history of problems, if problems develop and to also sign
releases allowing reports of functioning level. Sadly in my experiences staff who seek mental health and addictions treatments are mistrusted rather than praised encouraging others to keep their issues a secret, and pose a great risk to clients. For mental and physical health challenges, I would propose a voluntary peer support relationship in order to have someone readily available that is trusted for support and feedback on blind spots. The employee would pick someone s/he knows and trusts in the agency. This individual picked would have to be willing. The picked peer would monitor the employees functioning level using the Journey to Recovery levels. I would suggest modeling the 12 step daily inventory approach. The staff person would check out their level of recovery with an expectation that it be at least at the 60% level.

What are your thoughts and reactions to my proposals?

Agencies Ethical Role in Work Environment
In the 41 years that I have been employed in the helping professions, I have known of many agencies that provide healthy work environments and have known of many that contribute to employee’s impairment risks by having hostile environments and officially or unofficially have staff work excessive hours to complete their work. Some hold being fired as a constant threat over people’s heads. Too often staff only hear feedback when they are in trouble. Personally, I believe privatization has pushed agencies to under bid the necessary resources to adequately complete the required tasks and employees and clients have suffered. Employees putting in excessive hours and not being able to catch up or feel effective. Clients suffer with staff turnover as people quit or are fired.

Agencies’ Challenges
As a proponent of Murray Bowen’s Multigenerational Family Systems Theory, I believe that staff bring their family of origin patterns with them to the work place. Consequently, if staff have unresolved patterns of conflict, these could be replicated in the “family” work place. This is equivalent to counter transference at an individual level at an organizational systems level. Even if staff have their “act” together, it is expected that in human services agencies that clients’ unhealthy conflicts will be projected and reenacted with staff individually and as a family system. This system includes all members including the CEO, receptionist, attendant care employee, maintenance worker, and clinical staff. All have roles, responsibilities, and impact boundaries. These less healthy patterns of interaction are brought out or intensified when agencies and staff become overloaded and more stressed.

Over the years, I have used Schaef and Fassel’s The Addictive Organization to highlight the risk of agencies, systems, and organizations replicating the alcoholic/addicted family system. This text is an application of Bowen Multi-generational Family Systems Theory to organizations. The
authors define addiction as any substance or process that takes over our lives; that has control over us in such a way that we will be dishonest with ourselves and others about it.

Addictions by this definition lead us into increasing compulsiveness in our behavior like workaholism, sexual addictions, and gambling addictions. The organization becomes the addictive substance when the employees become hooked on the promise of the mission and stop looking at how the organization is actually operating. The organizations actions are excused or justified because of its helping mission. Schaef and Fassel found an inverse correlation between the loftiness of the mission statement and the congruence between stated and unstated goals. With this lack of congruence, the organization is at higher risk of developing a rigid denial system of defense. Loyalty and the benefits of loyalty are paths for the organization becoming an addictive agent or “fix”. When loyalty to the organization becomes a substitute for living one’s life, then the company has become the addictive substance. Personally, I think of this as compulsive instead of addictive.

Systems are internally consistent paradigms including boundaries, subsystems, and an internal culture containing formal and informal definitions and language. The paradigms rationalize or make sense of everything that happens. The paradigms explain our experiences and validate our actions. Risks of impairment and unethical behavior are much higher depending on the organization’s degree of opened or closed on the continuum.

Open systems welcome new information, flexibility, challenges, and planned change to evolve. In closed systems, different opinions and input are not allowed or even acknowledged. Closed systems are crisis driven and all or none oriented (parallel to borderline personality). Control tends to be maintained by coercion, threats, and intimidation. Closed systems foster secrets, denial, blaming, dishonesty, don’t talk, don’t feel, don’t trust, and triangles. In Closed systems employees are afraid to share their concerns about workloads and hours worked and tend to be blamed for not getting all of their work done despite it being impossible.

A triangle is an automatic, dynamic process in which a two person system draws in a third to stabilize itself under stress. Triangling is an attempt to bind anxiety in any system, but will escalate intensity in the system. Emotionality, gossip, and distancing are ways of perpetuating stress in an organization. People struggling with lack of self-differentiation often have poor boundaries and are more likely to create triangles as part of their internal defenses.

All organizations have triangles. But with the increased anxiety and stress of much of our current working environments, more interlocking triangles including more employees will develop. Trust between colleagues and with administration drops.

At Valeo the Code of Ethics attempts to address this risk with the following: “Criticism of a colleague’s services or procedures will be constructively addressed with the appropriate
individual in the organization, following proper Agency procedures. Criticism will not be given in a manner that is personally shaming or socially embarrassing”. This is very similar to the ethical mandate that I as a social worker am expected to follow.

In his 1992 article Reamer stated;
“As social workers intensify their focus on impairment in the profession, they must be careful to avoid reductionist explanations of the problems that colleagues experience. Although it is certainly appropriate to emphasize psychotherapeutic and other rehabilitative efforts in instances that call for them (including chemical dependence or mental illness), one must not lose sight of the environmental stresses that often lead to such disabilities. Distress experienced by social workers often is the result of unique challenges in the profession for which there are no adequate resources. Social workers who work day by day with clients who are subjected to poverty, hunger, homelessness, child abuse, crime, mental illness, and so forth are prime candidates for stress and burnout. Inadequate funding, thin political support, and public criticism of social workers’ efforts often produce low morale and high stress...In addition to responding to the private troubles of impaired colleagues, social workers must simultaneously confront the public issues and environmental flaws that can produce impairment. Those who confront impairment among colleagues must avoid blaming the victim in the same way they resist doing so with their clients.”

While I strongly agree with Reamer’s point, I disagree that the environmental challenges are more so with social workers. Sadly, I have seen the impact on all helping professions. As an example, I know that in treating chemical dependency issues there has continued to be an increase with clients being violent and/or suffering severe co-occurring illnesses while there is an ever increasing need for documentation.

In putting this material into practice to maintain or to obtain organizational health or openness, it requires “living” the principles of recovery. Valeo’s HR policy promotes this by stating, “Our experience has shown that when management and employees deal openly and work directly with supervision, communications will be clear, attitudes will be positive and the environment, constructive”.

It is crucial that we be able to build and maintain trust and safety with colleagues and administrative staff. Value conflicts as opportunities to practice safe and respectful resolutions. We must share responsibilities, appreciate flexibility; and avoid gossiping, triangulating, passive-aggression, aggression, keeping secrets, and avoidance. We need to talk directly and often. Don’t isolate and be a lone ranger/hero. Do be a team player. We are all on the same side and need to support each other in these very tough times.

Valeo took a strong position in supporting being an open system and avoiding triangulating in its Code of Ethics on employee responsibility which includes: “In providing services, they will
maintain the highest standards of their field (i.e. BEST PRACTICES). This means that staff will never work in isolation, but will seek peer and supervisory input... Staff will recognize the necessity of working together both as members of multi-disciplinary teams, as committee or work group members, or as partners with others in the Agency, in a climate of mutual trust, respect, dignity, edification, and impartiality... Staff are responsible to report, in a timely manner, all wrongdoings either directly observed or substantiated by reasonable facts.”

**Agencies Self-Monitoring**

In my concern for the impact of the work environment on staff’s health and impairment risks, I would suggest that helping organizations commit to self-monitoring by seeking input from all staff at least once but preferably twice a year with a simple anonymous survey. These are questions that I developed from the Solution-Focused approach and initially used in consulting with an agency concerned about its functioning including the effectiveness staff/management relationships.

**Your Input/Suggestions:** Attached is a questionnaire seeking your input/suggestions about what you currently believe is working well within your facility, and what you would like to see improved in staff’s working relationships. I will use your ideas as I meet with the administration and with a “focus” group of a cross selection of staff from different areas and shifts.

We want to build on your sense of pride and “ownership” of this facility.

**Defining Solution-Focused Change:** Focusing on the positive, the solution and the future. By emphasizing solutions-oriented talk rather than blaming, “finger pointing”, or gossiping, facilitates change in the right direction—as a united trusting team.

It is my intention to use the input/suggestions you provide me to help facilitate trust and positive growth in your facility.

**Staff Input/Suggestions**

1. What do you see as strengths of your facility/agency?
2. What do you see as your personal contribution to these strengths?
3. How do you receive positive feedback and appreciation for how you do a good job?
4. How could this be improved?
5. How do you give positive feedback to others when they have been helpful and/or have done a good job?
6. Are there any ways that you would like to do this differently?
7. If you could change the way staff works together, what would you do differently?
8. What would you be willing to contribute to help this desired change occur?
9. What do you like about the way performance evaluations have been done?
10. How could this process improve?

11. What might interfere in these changes being implemented and to continue to improve over time? Be hopeful and positive-and realistic.

12. On a scale of 1-100, with 100 being the best possible, how safe and healthy of an environment is there in your facility/agency which allows for staff to reasonably accomplish work in 40-45 hours per week? Circle percent as you experience it.

1...5...10...15...20...25...30...35...40...45...50...55...60...65...70...75...80...85...90...95...100%

My suggestion would be that if staff mark 50% or less that the facility/agency would then pursue seeking improvements to become more reasonably healthy of a work environment.

What level would you see as a trigger for improvements?

A risk could be for the agency/facility to go through the motions of eliciting input and then doing nothing to make itself better and morale would suffer even more with a sense of futility and hopelessness which feeds depression and stress, which increase risks for physical and mental impairments.

What are your reactions to the idea of agencies being held accountable for their role in employees’ health and impairments?

Closing

To bring our “secret” impairments out of our blind spots it needs to become safer to acknowledge or admit that we are having struggles in our lives. For me I hope it will help by “normalizing” our having some degree of impairment. Our regulatory board and human resource departments need to not be threatening and trying to catch and punish, but instead acknowledge the harmful environments of our professions and emphasize an openness to seek support for impairments hopefully to avoid impairments becoming more severe and harming clients and/or the professional. This support should include being able to reach out for a supportive mentor who understands the environment and is available for feedback and encouragement. We go into the helping fields because we care and want to make a difference. In our challenges to do more with less many of us, if not most of us, are over-functioning and are at higher risks of physical and mental health issues.

If in completing this workshop, you explored your definition of impairment as it applies to you and others and “tried on” how would I know and what would I do to take care of myself, then for me my efforts in researching and preparing this workshop were successful. Thank you for your attention and your participation.
References


