Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Occupational Therapy and the Multidisciplinary Team

To the Editor: It was with much enthusiasm that I sat down to read the article by Liberman and colleagues (1), "Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation," in the October 2001 issue. Unfortunately, my enthusiasm did not last through the whole article. I was encouraged by the thorough review of the literature and the clear depiction of the elements that may contribute to an effective multidisciplinary team. The authors cited recent, evidence-based, and practical information for the reader to consider in practice, and I found Tables 1 and 2 to be informative. I also support the broad-based team approach espoused in the article and the prudent use of the skills and expertise of the various professionals who typically constitute the multidisciplinary team.

I was less enthusiastic about the representation of my discipline, occupational therapy, as has often been the case in reading articles by Dr. Liberman and his colleagues (2,3), and I have written a previous letter to the editor on this topic (4). My excitement about seeing a doctoral-level occupational therapist, Dr. Tsang, listed among the authors was significantly dampened when I read the limited and dated description of the role and expertise of the occupational therapist. Dr. Tsang's contribution to the article appears to have been to cite references that are 11 or 12 years old! Even more dismaying was that references used are not evidence-based or drawn from any current theoretical textbook. Surely, given the plethora of evidence-based research being conducted and published internationally by occupational therapists, including Dr. Tsang (5), the article could have provided a better description of the discipline and of the variety of evidence-based strategies used by occupational therapists who work with persons who have serious mental illness.

I recognize that it is difficult for the journal editor to ascertain the accuracy of the content of the articles published in *Psychiatric Services.* This responsibility clearly rests with the authors. It is imperative that recent, accurate, and comprehensive information be disseminated through peer-reviewed journals so that multidisciplinary teams can continue to provide good-quality, comprehensive community care for persons with serious mental illness.

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To the Editor: I am writing in response to the article in the October 2001 issue by Liberman and colleagues, entitled "Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation." I was surprised to see that occupational therapy practitioners were apparently categorized as "paraprofessionals," with the term "professional" reserved for psychiatrists, psychologists, social workers, and nurses. Dr. Liberman himself has edited two texts on psychiatric rehabilitation (1,2) in which occupational therapists are consistently referred to as professionals. Dr. Tsang also describes occupational therapists as professionals in his publications (3).

The role of the occupational therapist in providing mental health care is highly varied, but it is generally accepted that an occupational therapist's training and practice are specifically focused on functional performance (4). The occupational therapy literature—notably in journals such as *American Journal of Occupational Therapy* and *Occupational Therapy in Mental Health* as well as in major textbooks in the field—provides rich descriptions of the role of occupational therapists in helping persons with severe mental illness learn the skills necessary for living independently in the community.

Liberman and colleagues refer narrowly to the field of occupational therapy as "[growing] up with a conceptual framework and a hospital-based practice for diversional activities that were successful in engaging patients but that rarely had carry-over effects in job finding and job tenure." Without citing any references that describe current practice, the authors admonish occupational therapists who work in locked facilities and hospitals and who may provide patients with expressive arts activities and leisure skills training to include training in community living skills in their repertoire. The authors thus imply that the practice of occupational therapy is lacking in balance and relevance. A significant benefit of nonverbal, manual activities is symptom

stabilization for patients hospitalized for this purpose. Comparing the goal of stabilizing patients with acute or chronic conditions in a hospital-based facility to the goal of finding and maintaining employment for higher-functioning, more stable clients seems misguided. Because the authors did not mention the role of occupational therapy in areas of treatment other than diversional activities, such as evaluating the functioning and independent living skills of inpatients to prepare them for discharge and providing occupational therapy units in which employment-related skills are practiced, it can be assumed that the authors made no real effort to accurately or more comprehensively report on the current state of occupational therapy practice in hospital-based settings.

However, in considering occupational therapy practice as a whole, it would be more accurate, current, and comprehensive to also cite the work done by occupational therapists in community support programs, such as day treatment and ambulatory care programs, supported housing programs, clubhouse programs, and assertive and regular case management programs. In these community-based settings, practitioners can enter the client's environment and train the individual in vivo, a locus of treatment that is generally acknowledged to be more productive in working with a person who has severe and persistent mental illness. Descriptions of these approaches to the provision of services for people with serious mental illness can be found throughout the recent occupational therapy literature.

Occupational therapists who work in community mental health settings should and do regard themselves as psychiatric rehabilitation practitioners who provide a broad range of services on rehabilitation teams. In fact, Dr. Tsang, an occupational therapist and one of Dr. Liberman's coauthors, has documented the positive outcomes of psychiatric rehabilitation services provided by occupational therapists and has published reports in journals with a wide multidisciplinary readership (5).

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In Reply: We are delighted that our article on multidisciplinary teamwork in psychiatric rehabilitation engendered responses from its readers, because our emphasis on the competencies of clinicians rather than on the importance of traditional disciplines is both controversial and limited in its penetration in practice settings. Even though we predict that competency-based training in empirically validated interventions will dominate the future preparation of mental health practitioners, we most assuredly include occupational therapists as professionals, not paraprofessionals.

Both Ms. Rebeiro and Ms. Auerbach suggest that a great deal of evidence-based research has been conducted and published internationally by occupational therapists. We do not intend to diminish the vital role of occupational therapists in their increasingly frequent delivery of rehabilitation services that are evidence based. However, we are dismayed that the long-standing focus of occupational therapists on functional performance has not been paralleled by empirical studies on psychiatric rehabilitation by members of this profession. A literature search of research reports published since 1998 in the *American Journal of Occupational Therapy, Occupational Therapy in Mental Health,* and *Occupational Therapy Journal of Research* found only three controlled studies of rehabilitation interventions by occupational therapists, and two of these were by Dr. Tsang, a doctoral-level occupational therapist and a coauthor of our article (1–3).

We are well aware of the outstanding clinical work being carried out by occupational therapists in teaching mentally disabled persons the skills needed for reintegration in the community. For example, at Northwestern University School of Medicine, occupational therapists have a key role in conducting skills training as a major component of the services delivered by that facility's multidisciplinary team, which offers dialectical behavior therapy for individuals with borderline personality disorder. At the Neuropsychiatric Behavioral Health Services at the University of California, Los Angeles, Tracey Martin, M.S., O.T.R., leads skills training modules in workplace fundamentals, social problem solving, and personal effectiveness. Training programs for occupational therapists, such as the one at the University of Southern California, are increasingly providing students with an understanding of psychiatric rehabilitation practice, including community-based teamwork.

We hoped that our article would challenge practitioners from all of the mental health professions to acquire the competencies required to deliver evidence-based rehabilitation interventions. We are enlivened by the confidence and progress in the professional development of occupational therapists reflected in the letters of Ms. Auerbach and Ms. Rebeiro, but we are disappointed in the apparent lack of response by members of other mental health disciplines. Our active involvement in the international dissemination of evidence-based treatments for persons with serious mental

illness has encouraged us and made us optimistic about the progress being made (4). However, these positive feelings are accompanied by the sober realization that efforts to change the mental health professions will encounter many barriers at many levels—system, professional, organizational, institutional, team, and practitioner levels (5).

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Robert Paul Liberman, M.D.
Donald M. Hilty, M.D.
Robert E. Drake, M.D., Ph.D.

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Reexamining Therapist Self-Disclosure

To the Editor: I was surprised to see the article "Reexamination of Therapist Self-Disclosure," published in the November 2001 issue of *Psychiatric Services* (1). I had thought that interest in this topic had long ago disappeared.

I would like to remind the authors that objective studies of self-disclosure began with Sidney Jourard in the 1950s and culminated in two books, published in 1964 and 1971 (2,3). I followed Jourard's work with several articles and a book, *Therapist Disclosure: The Use of Self in Psychotherapy,* which was published in 1978 and reissued in 1983 (4,5).

Then, as now, there were few objective data from the practice of psychotherapy. In my experience, therapists need to gratify a patient's needs for real relationships sufficiently to maintain the treatment relationship but not to the extent that they undermine the patient's relationships with other important persons in his or her life. A therapeutic relationship is not a substitute for a family or a social life.

On the basis of my review of the literature, I suggested four absolute indications for self-disclosure by a therapist: when it is necessary to preserve the life of the patient or the therapist, when some real event in the life of the therapist significantly alters the therapeutic relationship, when some aspect of the therapist as a person severely disrupts the therapeutic relationship, and when a direct interpersonal experience between the therapist and the patient as individual human beings is the only means by which a specific patient can learn an important lesson in life.

Contraindications are much more difficult to enumerate. However, they include situations in which a therapist's feelings about a patient, if expressed, would make it difficult for the patient to maintain his or her self-esteem and when a therapist wants to guarantee a patient that he or she can save the patient's psyche or life. The latter instance involves disclosure of omnipotent fantasies.

The power of self-disclosure is determined by some of the factors that determine the potency of any therapeutic activity: dosage, timing, context, and content. Expressing concerns or caring for a patient as a person should not be confused with psychotherapy.

I welcome the reintroduction of this discussion and look forward to learning more about therapist self-disclosure.

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