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Emotional Engagement and Mutual Influence

Basic Issues as Therapy Begins

> The most important source of resistance in the treatment process is the therapist's resistance to what the patient feels.
> — Paul Russell (1998, p. 19)

As much as we want to be present and to feel our clients' pain, we also naturally fear that same experience. Part of our resistance to receiving our clients' disturbing feelings is that psychotherapy training has not traditionally included a discussion of the therapist's feelings and how to use them constructively in the therapeutic interaction. In the last two decades, much emphasis has been placed on therapy as a relationship. A successful treatment arguably has more to do with the therapist–client relationship than with anything else. Navigating *any* relationship that entails the expression of deep emotion is naturally challenging. The premise of this book is that therapists need more insight and more effective strategies for actively responding to their clients. They need to better understand how and why clients express strong emotions as the therapy unfolds, and how and why their own feelings emerge in tandem. They also need teachable *interactive* skills they can implement on a daily basis.

The literature on affect confirms that, in a relationship, the more intensely one person expresses emotion, the more likely the other person is to share that experience, both consciously and unconsciously (Sullins, 1991). Also, the more we like and identify with the person we

are treating, the more intensely empathic we will be (Hess & Kirouac, 2000). Nothing quite prepares any therapist for the reality of sitting quietly in a room with another human being who is in intense emotional pain. The therapist's emotional and visceral reactions to his client's feelings can be moving, but also disturbing. The client's emotional impact on the therapist is arguably the most neglected area in therapist training.

Trauma counselors were perhaps the first group of therapists to openly discuss the "emotional contagion factor" for therapists. While treating clients who had suffered severe abuse, these therapists soon found themselves experiencing physical and emotional symptoms similar to those of their clients, and often needed to resist the client's emotions to avoid what has been labeled "vicarious traumatization" (Pearlman & Saakvitne, 1995). Although the experience of shared affect in nontraumatized clients is not so obviously difficult to manage, it nonetheless exists.

For decades most psychoanalysts viewed the client's need to influence the therapist as pathological resistance. But others, like Levenson (1972) and Searles (1979), understood that it was natural for clients to recognize that both their feelings and their intentions are received and processed by the therapist. Their intuitive understanding has only recently been confirmed by affect research, demonstrating that emotions are *meant to be received and responded to* (Kemper, 2000). One of the many functions of affects is to influence others and stimulate a response in them. This volume is devoted to understanding what the client is soliciting and needing at a given point in time.

Reconceptualizing Freud's notion of repetition compulsion, Greenberg and Mitchell (1983) and Mitchell (1988) emphasized that all people acquire certain relational patterns as they attach to their caretakers, which they subsequently repeat in all relationships, including the therapeutic one. These patterns include feelings, thoughts, and expectations learned in early childhood that are repeated unconsciously in adult relationships simply because they are familiar. Neuroscience confirms that these patterns are, indeed, laid down in the brain at an early age and do not change easily. So now we perceive our clients' need to evoke an emotional response from us as an inevitable function of their early attachments, laid down as easily triggered affect programs in the brain (Griffiths, 1997). What we do *not acknowledge* is that therapists bring the same established ways of being to every relationship. Just as our clients seek an emotional response from us, so we, as we enter into a relationship with them, seek their affective response. The patterns of

relating that are established within the therapist determine with whom she is likely to work well and in what ways she is likely to influence and be influenced.

THE IMPORTANCE OF A GOOD MATCH

Understanding that both therapist and client have relational patterns anchored in attachment makes it easier to comprehend the necessity of a good match, as well as the naturally occurring mutual desire to influence each other. If I attempt to treat someone who is too different from me, and whom I do not readily relate to, the likelihood of success diminishes. However, if I identify too much with a prospective client I can easily make the mistake of attempting to influence him based on my needs rather than his own. Ideally, a good match includes compatible styles of relating—just enough shared early emotional experience to make for a connection, but not so much as to blur the distinctions between therapist and client.

Intellectual discussions of a good match (Kantrowitz, 1995) essentially make these points, but predictably cannot offer much advice to therapists regarding whom they should treat and whom they should not treat. Matching on the basis of diagnosis has not proven to be consistently productive. Even if you have had success working with clients with bipolar disorder, for example, you cannot assume you would make a good match for most clients with bipolar disorder. Any judgments about matching patients to therapists based on diagnosis require a feel for nuances, which comes only after years of experience. But new therapists need criteria they can use when they are just starting out.

Given that new therapists struggle with anxiety, how can they make good judgments about whether to work with a particular client presenting for treatment? How does a therapist make this assessment in the first session or two in any reasonable way? And, once the relationship has been established, how do therapists avoid resisting the client's deep emotional experiences that may be uncomfortable?

From the time the client first walks in the room, I note my gut reaction to him. What do I feel when I look at him? Did he look at me when I shook his hand? What do I notice about his physicality? Do I feel attracted, neutral, removed, or put off? When he begins to speak, do I feel emotion? If so, what emotion? Do I imagine a rewarding relationship for both of us? I have discussed elsewhere (Maroda, 2005) that some degree of gratification for the therapist is necessary for the treat-

ment to be successful, especially if it is long term. Making the decision about whether to treat someone relies heavily on the therapist's access to her own emotional experience in the moment.

Does the fact that someone has presented himself for therapy mean you should treat him? I find that few therapists will admit to not wanting to take someone on. But it is not a good idea to engage in therapy, even short-term work, with someone you are either not interested in or dislike (Maroda, 1999). Given that the literature has shown that all people, places, and things evoke an immediate positive or negative response (Andersen, Reznik, & Glassman, 2005; also see Bargh, Chaiken, Govender, & Pratto, 1992; Fazio, 1986; and Russell, 2003), perhaps therapists need to be more self-aware of the potential for not working well with certain clients.

Therapists who believe they can transcend their immediate dislike of a client and provide needed empathy almost always prove themselves wrong. In order to establish a working alliance, both parties need to be sufficiently curious and interested in each other. The emotional connection that serves as a conduit for the client's experience of his own emotions will not be made if the match is a poor one.

When I presented these ideas in a workshop, one participant asked, "Who is going to treat all the unlikable people in the world if we start rejecting them?" I responded by saying that's like wondering how someone whom you are not interested in dating will ever find a partner. Just as in social relationships, if a client looks hard enough he will probably find a therapist who makes a good match. A client who is obnoxious to one therapist will be intriguing to another. Therapists who take on clients who do not elicit their curiosity and whom they do not like are doing an injustice to the clients as well as to themselves.

However, this does not mean that you should not take on a client who has negative traits or behaviors. Most of our clients do have issues that interfere with their relationships, even if only temporarily, and our job is to help them overcome their obstacles to relating well to others. When you have been practicing long enough, you may be tempted to reject a workable client who reminds you of someone who did not work well in treatment.

Once I received a call from a therapist out of town, asking me if I was willing to see a client of hers who was moving to the area. I asked a bit about this client, and the therapist reluctantly admitted that she had not made much progress. But she quickly added that this client, Debra, a student in her early 20s, was highly intelligent and could be endearing. The therapist tried to assure me that Debra had potential for

making progress in therapy. My gut reaction when I was talking to this therapist on the phone was that she was not being forthcoming. But I agreed to meet with Debra when she came to town to see if we were a match.

When I went into the waiting room to meet Debra for our first session, I extended my hand and introduced myself, as I normally do at a first meeting. She shyly looked down and offered me a very weak half-handshake. Her shyness was not a problem for me, but her exceptionally weak handshake triggered a negative response. As I inquired about her history of relationships, which is the only history I focus on early in treatment, she revealed almost no relationships outside her family. She had had three previous therapists and had been in therapy continuously since she was a teenager. I began to see a pattern of therapists serving as a lifeline for her. Because of her family's wealth, she could essentially pay therapists to keep her company. Always choosing someone psychoanalytic, she immediately set up multiple sessions per week, presumably to engage in the analytic process.

I was frank with Debra and told her I was concerned about therapy being a substitute for having relationships out in the world, rather than facilitating her ability to navigate successfully on her own. She assured me this was not the case. She just needed more time. Given her poor relationship history and my lack of genuine interest in her, I should have referred her elsewhere. I was influenced by Debra's reluctance to meet with other therapists, by the referral from a colleague anxious to get her situated with a new therapist, and by the fact that I had open hours. Since I did not have any strong negative feelings toward her, I agreed to treat her.

The first year of therapy with Debra went rather well. Since she presented as excessively fragile, she enjoyed the fact that I did not treat her that way. Her previous therapists had hesitated to confront her for fear of triggering her all-too-frequent suicidal obsessions. When she told me she felt like committing suicide, I asked her who she was angry with. Slowly, she began to get better. She made better eye contact with me, began to talk more herself rather than relying on me to question her, and she experienced a significant decrease in her depressive symptoms. Debra began to talk more with people at work, but still had no social relationships of any kind. She also started exercising, which made her feel better emotionally and physically.

However, as we moved into the second year, I noticed that she was no longer improving and, if anything, was becoming more depressed again. I attempted to understand this backward slide and engaged Debra

in conversation about it. Nothing had changed, yet she was inexorably sinking back into the passive-dependent, severely depressed mind-set that she presented with at the beginning. Her psychiatrist upped her antidepressants, but this had little positive effect. Debra regularly came to her Monday sessions and announced with an odd smirk that she had not exercised or had any social contact over the weekend. In fact, she had not left the house at all. I naturally tried every intervention I could think of to turn this situation around. But nothing worked. I finally asked her if her previous therapies had followed this pattern. She said they did. She also noted that she made much more progress in this therapy than she had in her other treatments.

"So the progress inevitably falls away and you return to the state in which you started?" I said.

"Yes," she answered. "I thought maybe this time would be different, but it isn't."

What struck me as particularly odd was that Debra said this without any emotion or any concern at all. She routinely displayed a slight smirk when she reported her self-defeating behaviors. Having been severely controlled as a child, she didn't let anyone get too close, and when someone was having a positive effect on her that was undeniable, she needed to negate that influence. After a great expenditure of energy on both our parts, I realized Debra was not really getting any better. I regretted having taken her on. I finally told her it was time for her to find a new therapist because I felt it was not ethical to continue treating someone who was not responding to treatment. She was upset, but resolved this situation by moving back to the city where her family lived.

I vowed never again to take on anyone who was so unengaged and unable to take responsibility for her own life. About 15 years later, a client I will call Rebecca, whom I discuss throughout this book, came to me for therapy. She had recently moved to the area and had done Internet research to find a good therapist. Having had a recent bad experience with a therapist, she wanted to choose her next one carefully. Rebecca found my name, Googled it, and discovered my writing and speaking engagements. She read some of what I had written and decided I was the best choice for her. She called and made an appointment. When I walked into the waiting room to meet her for the first time, I was taken aback by the sight of a 20-something woman who looked very much like Debra. They had the same withdrawn, passive demeanor, similar coloring and body shape—and the same difficulty making eye contact. They also shared a slow, almost shuffling depressive gait. My immedi-

ate reaction was: I do not want to treat this person. She is too much like Debra and I have no intention of repeating that experience.

As we settled in to talk about why she had come to see me, it became evident that she shared even more with Debra. They both had had numerous previous therapists, and both had been hospitalized for severe depression and suicidal ideation. Rebecca additionally had a history of cutting herself. I told her that I wasn't taking on clients who required after-hours phone calls and possible hospitalizations. I said I was leaving that to my younger colleagues, and would be happy to refer her to one of them. But she was persistent.

"But I like you, and having read some of your stuff, I think you would be the best therapist for me. I will not be too much trouble. I can manage and not make phone calls, and I definitely do not want to be hospitalized again."

I explained to her that it was not in her best interest to have to hide her untoward emotional events, and that it was unfair to her to expect that she could control whether she needed hospitalization in the future. She was better off seeing someone else. At first I thought she was fighting to get me to take her on simply because she didn't want to be rejected. But I gradually realized that she was not just like Debra. In spite of all they shared, they were also very different.

Moved by Rebecca's determination, I began asking other diagnostic questions, and discovered that she was able to maintain relationships, and had several long-time friends. She was also close to her family, especially a younger brother whom she felt protective toward. The way in which she differed most from Debra was that she did not hesitate to engage with me and to work to convince me that she was treatable. Her passivity disappeared when she needed something. Rebecca also displayed a witty, playful side, and even went so far as to humorously mock me for being so reluctant to treat her. I liked that. Moments later, I realized I liked her, and that underneath her passive, weak façade was a fighter. I agreed to treat her and, unlike my experience with Debra, this treatment has been one of the most successful in my career.

Clearly, past experiences and personal biases can color initial reactions to clients. But I believe therapists are much more prone to taking on people they do not feel good about than to prematurely referring those people out. Probably the biggest obstacle to referring someone elsewhere is how to broach the subject with the client without causing hurt feelings or discouraging that person from going into therapy. Keep in mind that if you know this person is not a good match with you, at some level the client knows it too.

The primary responsibility for assessing the match is the therapist's. If the therapist is not sure, she will naturally make another appointment and give the possible match some time. But if you know right away—and I think most people do—you can simply tell the client that you think he would work better with a colleague of yours. If you are working in a group practice, you probably have a coworker who might work better with the client in question. If you are in private practice, you have a myriad of choices. This process is made easier by telling the client up front that part of the purpose of the first interview is to see whether you are a match. If I think I am the wrong person to be treating a client, I may say something like, "Having heard about your symptoms and problems, I think my colleague Dr. A. is more experienced in this area and would be a better person for you to see."

Before I say something like this I have thought it over in my mind and tried to come up with someone who would work well with this client. Once I have given a name, or several if I can, I tell the client to feel free to call me if these people do not work out, and I will come up with other names. Sometimes this process occurs on the phone when the prospective client first calls, either because I have an immediate negative feeling about the person, or because she has a problem requiring expertise or experience that I do not possess. Although turning someone down for therapy is inherently anxiety-producing, it is better to refer out than to engage in a process that has little chance of being successful. Doing good therapy is challenging, even when the therapist and client hit it off and feel optimistic about the relationship. Both people deserve a reasonable opportunity to succeed rather than to fail.

FAILURE TO ENGAGE?

Barrett, Wee-Jhong, Crits-Cristoph, and Gibbons (2008) report that there has been no real change in the number of times a client sees a therapist. After a review, they found that 50% of clients drop out by the third session, and 35% end after a single session. Most clients do not attend more than six to eight sessions, which falls short of the recommended 11–13 sessions for a basic behavioral intervention. These figures apply to both institutional and private practice settings, and fee is not an issue: the same statistics apply when treatment is free. It appears that many clients are deciding after a single session (or the first few) that they do not wish to return. Given how difficult it can be to admit to needing help, taking the step of calling a therapist, and

then showing up anxiously for a first session, why do so few people remain in therapy?

Do clients determine on their own when they're poorly matched with a prospective therapist, and then decide to seek treatment elsewhere? Some may, but most do not, I suspect. To me, these statistics suggest that therapists need to do a better job of emotionally engaging new clients during the first session or two.

Though I urge therapists not to treat anyone they don't like and can't relate to, it is also true that those clients are not the majority. What about the clients who *are* likable enough and interested in therapy? Why aren't they staying in treatment longer? What happens, or fails to happen, during the first meeting that discourages them from returning?

Therapists experience anxiety at meeting a new person, just as anyone does. New therapists naturally feel more anxiety than experienced ones do. The question is, How do therapists manage their own anxiety at the prospect of meeting a new client and making the decision to work, or not work, with him? And are the affect-regulation methods for therapists adaptive—that is, do they work? Given the attrition rate of clients, it is safe to question whether they do.

Barrett et al. (2008) suggest that early termination is likely to be caused by either a failure to engage or a failure to address some deterioration or rupture in the therapeutic alliance. They acknowledge the difficulty, however, in pursuing negative feelings. They say:

> The process of recognizing and addressing weak alliances is difficult. For example, Regan and Hill (1992) found that both therapists and clients tended to leave negative things unsaid, particularly negative feelings. Leaving negative things unsaid is especially troubling because, in one study, therapists were aware of only 17% of what clients withheld. Even long-term experienced therapists were able to identify hidden negative feelings less than 50% of the time. (p. 256)

Clearly, therapist problems with managing affect, being uncomfortable with negative feelings, and even gentle confrontations with new clients make it more difficult to build the therapeutic relationship.

Another possible obstacle to building a strong therapeutic alliance from the beginning can be some of the traditional therapist behaviors that actually interfere with relationship building. Taking a history can be one of them. Hirsch (2008) prefers to allow the client's history to be revealed naturally during the dialogue with him or her. I agree, and suggest that note taking, turning to lists of prescribed questions, and spending large amounts of time on insurance forms and other paper-

work are obstacles to emotional engagement with clients. When someone comes to therapy he is usually in distress and nervous. Shaking hands when meeting new clients typically reveals sweaty, warm palms. Helping the client to become comfortable talking about himself is our first objective. The best thing we can offer is an opportunity for them to speak of their concerns as early as possible, and a demonstration of our ability to listen and be empathic. Unless we decide we cannot work well with a certain client, we need to help him overcome his fears of being vulnerable, weak, embarrassed, or ashamed.

First sessions are difficult for therapists too because they are often intensely emotional events, and we are unprepared for the impact an unknown person will have on us. Just as our clients fear that we will reject or not understand them, I think we unconsciously fear being overwhelmed by their anxiety, pain, or hopelessness. Over time we learn to adjust to our clients' displays of emotion. We develop a context for hearing and regulating our internal responses. But first sessions inevitably bring the fear of the unknown. Being aware of this fear before the first meeting can help therapists deal with the possibility of having strong visceral reactions and internally feeling slightly out of control in the presence of an emotional client. Anticipating countertransference emotions, and accepting them as natural, can aid therapists in keeping their attention focused on the affect-laden material the client is presenting, rather than distracting away from it with issues like getting a family history.

Note taking presents a significant hurdle because it disrupts the face-to-face contact and nonverbal affective communication that are vital to establishing a relationship. Therapists who take a lot of notes might want to pay attention to *when* they decide to write something down. I think they will find that rather than responding to the revelation of important facts in the client's life, they are responding to and trying to regulate their own internal emotional experiences.

PAYING ATTENTION TO WHAT THE CLIENT SAYS ABOUT HIMSELF

Clients usually tell you something essentially important about themselves in the first session, just as people do in all relationships. For example, one person jokingly says, "I told my girlfriend I'm a pathological liar, ha ha." In working with such a client, you will probably discover that he prevaricates a lot. Another client says, "I'm just no good at

relationships. They never work out for me." While I certainly wouldn't immediately write this person off, she is probably right and is telling her therapist that the therapy relationship will be troubled, at best. (I do determine prognosis on the basis of whether my client has been able to sustain any type of relationship over time. The inability to sustain a long-term relationship indicates a poor prognosis.)

Another client appears to be relatively healthy and high functioning. He may be well dressed, good looking, and articulate. Yet he casually mentions that he often thinks there is something seriously wrong with him mentally. He is probably right. Therapists want to see the best in clients and want to believe they can help them. But still, we ought to take what clients say about themselves seriously. Resist the impulse to write off what they tell you as simply an expression of low self-esteem or depression. It is more like a warning about what you are about to experience for yourself.

Clients' actions at the beginning of therapy are just as self-revelatory as their statements. The client who comes late, who sits as far away from the therapist as possible when offered the choice of seating, who is not just shy, but evasive—all of these behaviors tell you what to expect in the future.

In all fairness, the positive things clients say about themselves are also likely to be true. The person who says she mostly gets along well with others and is well liked is someone you will probably also like. The person who says he knows he has talent and will be successful—he just needs to work out a few things—is also likely to be right. All of us know far more about our present state and our likely future than we imagine.

THE THERAPIST'S IMMERSION IN THE CLIENT'S EXPERIENCE

One of the benefits of our profession is that it forces us to shake off our own everyday problems and small crises because the job demands it. Yet for beginning therapists, their self-consciousness and fear of failing may interfere with their ability to listen. Hill, Stahl, and Roffman (2007) report that new therapists "typically ask a lot of closed questions, give advice, disclose personal information, and talk a lot, as they would in informal helping situations with friends" (p. 365). Their research about novices, who reported their concerns through journaling, indicated that they were very anxious about being good therapists. They

reported problems with under- or overidentifying with clients; difficulties in directing the sessions, either pushing clients too hard or being too passive and letting clients ramble; and difficulty formulating good, brief interventions. This cumulative research on new therapists suggests they need more direction for handling clinical material, as well as increased self-awareness.

So how do you know when to intervene and when to be silent? I assume I should be as still and silent as possible once I have asked the opening question: "What brings you here today?" or "What can I help you with?" Most clients will talk the whole session without much intervention by the therapist. The occasional empathic remark or question may be needed to keep the narrative flowing, but not much more.

A very shy or frightened client may be more cautious and need more reassurance and prompting. But such clients make this known to us in short order. Although silence may have been overemphasized in the field years ago, I think it is underemphasized in many training programs today.

If a client asks you whether you understand what he is saying or feeling, be honest. If you don't understand, say so. Something like, "I'm not exactly sure what you mean when you say … " or "I can't tell for sure whether you are mostly sad or mostly angry about what happened" will clarify things for him. No client expects the therapist to be perfect. And being honest conveys a willingness to engage respectfully about his experience and admit when you are unsure about his meaning. If he speaks in half sentences or is so vague that you can not understand what he is trying to communicate, he needs to know this. Let him know you are giving him this feedback because it is important to you to understand him.

One of the most common errors new therapists make is assuming they need to speak more. A client seeking a response will pause and look at you or directly ask. Jumping in to show what you know, or asking too many questions too rapidly, is likely to result in keeping the client at the surface, rather than promoting an expression of emotion.

New therapists tend to believe they are supposed to solve the client's problem, and behave accordingly. Clients who directly ask their therapists for immediate direction or medications to soothe their distress naturally stimulate the therapist's feelings of responsibility. Nonetheless, working to calm the highly anxious client and help him talk about what is wrong is ultimately more therapeutic than attempting to quickly solve the problem.

I remain amazed at the relief clients experience simply by talk-

ing. Therapists may feel like they are doing nothing when they sit silently, allowing their natural emotional responses to surface and appear wordlessly on their faces. But if you think about how rarely this occurs in real life, you might appreciate how valuable it is to someone in distress. When telling problems to a friend or family member, most people quickly encounter the response of "Oh, yes, something similar happened to me." Then the listener proceeds to cut off that person's narrative and begin his own. A quiet, compassionate, involved listener is indeed a rare thing and will be duly appreciated by anyone seeking therapy.

GAUGING YOUR UNDERSTANDING

How do you decide when to speak, and where is a good place to start? Clients will tell you when they are seeking a response by stopping talking. They may look at you directly with a questioning look on their faces. Or they may directly ask if you are getting what they are saying. Brief, empathic statements early in therapy usually work well to facilitate the client's further exploration. A benchmark for successful listening that I have used for as long as I can remember is my client's affirming response of "Exactly" or "Yes, that's right" when I express my understanding of what he is saying or feeling.

In my first techniques class in graduate school, the professor had us interview and audiotape volunteer clients from an agency, choose 10 minutes from that audiotaped session, and transcribe it. We were instructed to construct two columns, with the transcribed client statements on the left and our responses on the right. This exercise was invaluable because I was able to "read" things I didn't know from simply being in the session. I had instinctively felt that the session had gone well and that I had understood my client's concerns. But reading that transcript was like being struck by lightning. It was suddenly clear where I had given a therapeutic response and where I had missed the boat. When I was dead on, the client responded quickly with "Exactly," "That's right," or some equally affirming phrase. If she said, "Kind of" or "I guess so," I knew I was slightly off. If she looked away, said nothing, or changed the subject, I knew my performance was off the mark.

What was especially revealing were the times I actually changed the subject due to my own lack of interest or defensiveness. My client's response surprised me: she did not give up. Within a few minutes, she returned to the same subject and gave me another chance to respond.

As my professor said then, which was confirmed by my subsequent experience, this is almost always the case. Our clients do not typically give up trying to communicate something important. They keep trying to elicit the response they need. From this early training episode, I gained a whole new respect for even the most disturbed client's resiliency. Understanding that my clients would always give me another chance was a great comfort. My anxiety lessened and I worried less about missing something important and ruining the therapy. The less anxious and worried I was, of course, the more emotionally present and attentive I could be.

I encourage new therapists to record their sessions because the results are so informative. Not only can we determine when our responses missed the mark, but we can focus on what was going on in the interaction between client and therapist that caused us to veer away. I can ask myself, "Why did I change the subject? What was the client talking about or what was I feeling toward him or her that disturbed me or failed to engage me?" A therapist who is courageous enough to see his or her own weaknesses can gain substantially through this type of rigorous self-examination. Knowing that facing your own pain and weakness can only make you a better therapist serves to motivate therapists to face themselves. Seeing the moments that you understood the client and gave him profound relief or insight helps make the self-evaluation process gratifying as well as sobering. Establishing a pattern of examining the *interaction,* rather than the client, opens up a new world to discover.

BASIC EMPATHY

Most students of psychotherapy become familiar with the basic concept of empathy early in their training. They practice rephrasing other people's statements, focusing particularly on the emotion that is direct or implicit. Higher levels of empathy require transcending the parrot-like responses practiced by new trainees, integrating observations of the client's body language, facial expression of emotion, and the implications of the client's expressed thoughts. When the client is in denial, or feels guilty about his emotions, the therapist's ability to reflect what he is really feeling can be extraordinarily liberating.

Occasionally, some clients reject the therapist's expressions of empathy (McWilliams, 2004). It seems illogical that some people reject empathy, and it certainly makes the task of the therapist substantially

more difficult. Clients who actually become prickly and irritable in response to empathy cannot acknowledge any weakness or pain, as it makes them feel inferior. For these people empathy equals pity, and no one wants to be pitied. So empathy must be titrated—given in small, incremental doses.

Rebecca, whom I introduced earlier in this chapter, said she chose me to be her therapist after interviewing several others, and because I didn't have "the therapist voice." When I asked her what she meant exactly, she imitated a person being overly solicitous in a low, soothing voice that obviously smacked of insincerity. She was of the opinion that many therapists were patronizing in their approach, creating an instantaneous one-up position with their clients. She said she didn't need a therapist whose emotional tone was the equivalent of "poor baby." She wanted a more respectful, egalitarian relationship. Moreover, because she was emotionally reserved, she preferred empathic statements that were not too emotional in tone.

It can be difficult to predict which clients will reject the therapist's attempts at conveying empathy and understanding. Some clients who are narcissistic or borderline not only want empathy, they may complain bitterly if it is not forthcoming in large doses. Diagnosis does not necessarily predict who will accept or reject the therapist's empathic responses. Most clients will let the therapist know quickly what he or she *experiences* as empathy versus what the therapist *intends* as empathy.

For example, when Rebecca described how her mother would insult her and verbally abuse her at times, I said, "That must have hurt your feelings." She replied unenthusiastically, "Yes, I suppose it did." Then I said, "And made you angry." She immediately said that she was not aware of being angry, and turned her body away from me. She said that, after all, her mother only derided her when she had, in fact, disappointed her in some way. Her mother was entitled to her feelings. She was definitely *not angry with her.*

As we spoke further it became evident that she blamed herself for any mistreatment at her mother's hands. Blaming her mother would have interfered with her endless longing for a loving relationship with her. Therefore, any empathy that involved reflecting negative feelings Rebecca had toward her mother was rejected out of hand. It can be confusing to a new therapist when accurately understanding and mirroring what her clients are feeling is responded to negatively.

A client may reject our empathy because it is inaccurate (misplaced), or because it is accurate, but makes him or her uncomfortable.

I mentioned earlier that we should look for affirmation from our clients that our responses are accurate and helpful. Doesn't the empathy-rejecting client contradict this general rule? Yes and no. When the therapist simply misses the mark, the client's response is lukewarm or mildly negative. As I stated earlier, failing to get the response they are looking for, some clients will just change the subject or look away in silence. However, the client who feels anxious, guilty, or humiliated by empathy has a strong defensive response that cues the therapist that she has hit a nerve—and that doing so is not welcomed by the client.

So what does the therapist say to the client for whom empathy can feel like a spear rather than a balm? From my experience, the fewer words the better, and the less dramatic the better. Saying something like "That must have been difficult for you" is often quite enough, even when the client has been severely traumatized. It will not be lost on her that you are listening, asking questions, encouraging her to say more, and registering empathic facial expressions. With this type of person, less is more.

The rare client who routinely rejects even the most minimal empathy has a poor prognosis. One woman I treated could not articulate any real emotion other than anger (alexithymia). She responded to my statements of "You seem sad" or "You look angry" with sarcasm, often turning my comments back on me and asking if I was sad or angry. I found this practice quite irritating and grew weary of trying to verbalize what she seemed to be feeling. Clients who perceive almost every encounter as a power struggle have serious problems with basic trust and rarely make themselves vulnerable enough to change.[1]

EXCESSIVE DEMANDS FOR EMPATHY

Nancy, a client I saw for several years, clamored constantly for expressions of exaggerated sympathy—even pity. When these were not forthcoming, she became angry and accused me of withholding and being cold. Nancy had been traumatized as a child, both emotionally and physically, and had not learned how to interact with others in a healthy way. Her mother was domineering and controlling. For some time Nancy was oblivious to the same traits in herself. Because her demands

[1] I documented this case in my book *Seduction, Surrender, and Transformation: Emotional Engagement in the Analytic Process* (Maroda, 1999). The treatment was mildly successful, but ultimately ended in impasse over her desire for physical contact.

took the form of asking for comfort and sympathy, she was convinced that her expectations were reasonable. She became indignant and self-righteously angry when she did not get what she wanted.

For example, Nancy routinely complained about her husband and held him responsible for her feelings. If she had a hard day at the office, it was his job to know this when she walked in the door. She expected her husband to do an immediate empathic "read" on her, even if she had not spoken a word. If he failed to notice her distress, or failed to immediately focus on relieving it, she accused him of being insensitive and unloving.

Whenever Nancy finished her litany of complaints about her husband, I did not feel sympathetic toward her. In fact, I usually felt bad for her husband, wondering how he tolerated being held responsible for Nancy's feelings throughout their long marriage. My lack of empathy was not lost on Nancy. She often looked me right in the eye and asked me to say something. I usually said something like "I can see you are really upset and wish that your husband could take away your pain." She would then respond, "That's all you have to say? I tell you how absolutely terrible I feel and you sit there calmly and say you can see I'm upset?" I asked, "What would you like me to say?"

As she did with her husband, Nancy illustrated for me exactly what she expected. She said, while adopting a facial expression of exaggerated sympathy, akin to what mothers of young children might do with an injured preverbal child, "Awwww, I'm so sorry that you are feeling so bad. That's terrible." As she said these words she motioned in the air as if giving someone a comforting pat on the back. I said, "So that's what you really want me to say and do?" And she answered, "Yes."

I proceeded to tell her that I couldn't possibly do that, both because it was condescending—more like pity than empathy—and because it would be emotionally dishonest on my part. She said she didn't care. She wanted it anyway—because that's how she had defined caring and how she responded to her husband and children when they were upset. Was it really too much to ask?

I have this client's permission to write about her and plan to discuss this case throughout this book, but I think this example illustrates some of the complexity involved in doing therapy and how therapists can find themselves in a quandary when the client wants something we cannot honestly give. Nancy's pain was real, and she needed me to understand that, yet I could not give her the type of response she demanded. What I did was explain that I had no interest in feeling sorry for her, but that I understood that she experienced significant pain on a

regular basis and was frequently inconsolable. Gradually, as she could tolerate it, I introduced the idea that she was convinced that someone could rescue her and take away her pain. As a result, she placed responsibility for her feelings on others—chiefly her husband and me.

ASKING QUESTIONS[2]

A truly interactive treatment relies on the skill of the therapist to tease out what the client may be hiding—even from himself. A good therapist is a lot like a detective. You keep looking for clues everywhere, and do not hesitate to inquire further, even when the topic is potentially embarrassing or uncomfortable for you and the client. New therapists may be reluctant to be this direct. The tentative new therapist may respond to the client's reluctance with reluctance of her own, creating an unproductive mirroring. If the therapist's inquiries are ignored or rejected, the therapist can simply move on. However, failing to pick up on something that the client is afraid to reveal can translate into a stalled or incomplete therapy.

I was struck by Farber, Berano, and Capobianco's (2004) report that clients were not sufficiently aware of the expectation that being forthcoming was part of their role in treatment. I have found that even in psychoanalysis, where free association is encouraged, clients only tell their secrets when they are ready to do so. Impediments to being more transparent include guilt and shame over feelings and behavior. Clients may drop an occasional hint as to what they are omitting and wait for the therapist to notice and bring it up. Farber et al. report that in their study "over half the participants wished their therapist would pursue their secrets more actively" (p. 343).

The following case example illustrates the notion of the client who comes with a secret, with varying degrees of conscious awareness. Jennifer, a college student, came for therapy because she realized she could not marry her high school sweetheart, and was guilt-ridden and suicidal over the thought of ending the relationship. When someone is suicidal over *ending* a relationship, rather than suicidal over *being*

[2] Casement (1985), Langs (1978), Hedges (1983), and others have covered the broad and very important area of active listening admirably, so I will not delve into it here. Langs's work on manifest and latent content is particularly valuable because it teaches therapists how to identify the client's unconscious references to both himself and to the therapist. Stern (1997), McWilliams (2004), and others have written on the importance of curiosity, and I can't agree more.

left, there is almost always something else going on pertaining to that person's ability to maintain a relationship. Upon further questioning, Jennifer said she felt like a terrible person for being with her boyfriend for years, basking in his love and acceptance, and then "dumping" him. Wasn't she a terrible person for doing this? How would she ever find love? What would become of her dreams of finding Mr. Right and living happily ever after?

The first few months of therapy centered on listening to Jennifer and helping her to manage her guilt and anxiety. Her family had been dependently enmeshed, which was the root of the separation anxiety and guilt Jennifer experienced over breaking up with her boyfriend. She had never really separated from her parents, and her guilt feelings were due to her belief that separation meant abandonment and lack of love. She came for sessions twice a week, began to feel better, and managed to go through with the breakup even though it was effortful and painful. Once that was done and she settled down, we could start working on her internal emotional issues.

I had the sense that Jennifer had issues she was not addressing, but her emotional crisis over ending her relationship left little room for anything else. As she recounted the details of how things had deteriorated between her and her boyfriend, she sadly noted that her interest in him had been declining for some time. Here is an example of a simple restatement of the client's position that might be taken at face value. *Her interest in him had been declining for some time.* The meaning seems obvious, and in a sense it is. But a therapist is looking for more than the obvious meaning. Our job is not just to understand what the client is saying, but to help the client to explore issues that are threatening to her, may be threatening to us, and lie just beneath the surface, waiting to see the light of day. We get to these issues frequently by asking simple questions in response to simple statements.

In this case, I asked, "What did you experience that let you know you were losing interest?" Jennifer brightened up at this question, eager to explore this issue more fully. (Had she brushed off the question or changed the subject, I would not have continued.) She said that she was much less interested in sex, and often didn't want to go to bed at the same time as her boyfriend. She stayed up and surfed the Internet instead of joining him. I asked her what sites she went to. She blushed and said she often went to soft porn sites. I noted that she was interested in sex, but not sex with her boyfriend. She agreed and seemed relieved that I did not express any shock or disapproval about her interest in looking at nude pictures. I asked her about what kind of nudity

it was, and she replied that she looked at pictures of naked people and some sexual scenes, but nothing kinky or weird.

I want to note here that Jennifer was not reluctant to answer my questions, but she also did not volunteer anything that wasn't asked. So I asked another very important question that I almost always ask when any client mentions looking at sexual pictures or films, or mentions having sexual fantasies. I ask what the preferred scenario is. Who is in the "picture" and what is happening? My focus is not on graphic sexual material, but on the characters and the emotional scenario being played out. Jennifer replied that she liked watching people who had really nice bodies kissing.

I noticed that she had used the word "people" several times, avoiding any direct reference to men or women. So I asked her *who* was kissing in these scenes. She blushed again and said, "Oh, you know, lots of different people. Men, women, occasionally groups." Then she looked away. "Anything else I should know?" I asked. She replied, "Well, I look at women a lot." This was the first time that Jennifer had made any reference of any kind to being interested in women. When I asked her about women she reluctantly admitted that she had been looking at women more and more and would spend hours online doing so after her boyfriend went to bed. She found scenes of women kissing to be very arousing.

I was cautious during this questioning, which took a half hour or more, because I didn't want to threaten her by probing too deeply into what was a delicate issue for her. I wanted Jennifer to feel safe talking about it and know that I would treat her interest in women as calmly and matter-of-factly as I would treat her interest in men. I asked her if she had ever had any sexual experiences with women or with girls when she was younger. She answered that for a couple of years she and another girl would occasionally lie on top of each other and rub their bodies together. These episodes began when she was nine years old and ended when the other girl's mother walked in on them one day about 2 years later.

She reported engaging in sexual exploration with another female friend a few years later. I asked her if she knew this was sexual at the time. She said she did, but just wrote it off as early adolescent curiosity. I asked her what she thought about her current interest in women. She said she definitely was not a lesbian and really didn't know what to make of it.

Jennifer had been in therapy for a couple of years prior to coming to me. I asked if she had explored this issue with her previous thera-

pist. She had not. When I asked why, she said it had simply never come up, and I believed her. She let me know early in the treatment that she felt much safer with me than with her previous therapist, who would extend the sessions when Jennifer was upset, and one Friday night talked to her on the phone for 3 hours. In fact, the poor boundaries of the previous therapist made Jennifer uncomfortable and illustrates how boundary maintenance impacts every aspect of treatment.

I think it is important to keep in mind that sensitive issues like sexual orientation are often hidden and can remain buried over the entire course of therapy if the therapist does not ask the right questions. If there is any magic in what we do, it is in our ability to bring important issues or feelings to the surface that have caused the client anxiety, shame, guilt, and confusion. Working to keep such matters out of consciousness is tiring and burdensome. Most people cannot get to these issues and explore them on their own. Perhaps that is why Freud likened psychoanalytic exploration to an archeological dig. (Jennifer surprised me one day by saying she had met and kissed a woman, and from that point on we worked through her difficulties in accepting her homosexuality. She eventually met and fell in love with another young woman and they moved in together.)

The therapist has to be fearless, in a sense, to pursue the material that the client is not readily talking about. Often a client's discomfort adds to the beginning therapist's anxiety, and the matter may be prematurely closed so they can both be more comfortable. I encourage new therapists to be brave and persevere when they believe they have tapped into something important that the client is reluctant to discuss. If the client refuses, or becomes defensively angry, it is a simple matter to take that cue and wait until she is ready.

SETTING GOALS

Behaviorists see setting goals as essential for defining the purpose of the treatment, establishing a cooperative, focused relationship between therapist and client, and evaluating the outcome. Psychodynamic clinicians have been slower to recognize the need for goals, preferring to believe that insight and understanding would either be enough or would naturally lead to needed change. The tide is turning, however, and analysts like Renik (2002) have been calling for psychoanalytic clinicians to embrace both goal setting and elucidation of technique.

Given the evidence for the therapeutic efficacy of goal setting, goal

revisiting, and shared goals between therapist and client, there is no logical reason for not setting them. Even analysts who may share with their clients the general goal of achieving greater insight and understanding will benefit by stating that goal at the outset of treatment.

Goals often change as the therapy progresses, of course, and depend on how long it lasts. The goals for a 10-session treatment of depression will differ from the goals for a several-year psychodynamic treatment. Sometimes a client intends to stay only for symptom relief but changes his mind when he discovers that more is available to him. Symptom relief is a great place to start, and few clients will complain if their therapist says something like "So it seems that what you are wanting from therapy right now is help in relieving your depression." If the client agrees, then the therapy proceeds, usually after a discussion regarding the appropriateness of medication.

As the therapy progresses it is natural for new goals to appear. Again, the length of treatment remains a mitigating factor. Once a client's depression has lifted, he may be interested in talking about realizing his potential, wanting to improve his social skills, or becoming more fit and healthy. (I always encourage my clients to exercise, especially if they suffer from depression.) Setting goals enhances the therapeutic alliance and reminds both participants that they are working together on a defined project, each with their own responsibilities. Realistic goal setting aids in grounding the therapy project in the real world.

As the therapy continues, we typically revisit the goals, particularly when my client reports feeling better or having made significant progress in an area where a goal has been set—for example, becoming more assertive, expressing emotion more freely, or being more self-aware. Evaluations can be formal or informal. For myself, I find that the topic of goals comes up naturally as does everything else that is important. My client may say he is frustrated and doesn't feel like he's getting anywhere—what do I think? Or he says he feels different inside and knows he is far from the person he was when he began therapy. That's my cue to note what I have observed that confirms his progress. In this way, evaluating therapy flows naturally. But it is just as useful, and certainly not harmful, to set up a time frame for regular evaluations. If a client feels the intervals are too short or too long, he will let the therapist know and changes can be made.

As I stated previously, there are always exceptions to the generalities I describe here. While clarifying what my client wants from therapy and defining realistic goals has worked well with everyone I have treated, evaluating those goals may be a different story. The client

I mentioned previously, Rebecca, who did not want me to acknowledge her anger at her mother, also hated any reference to her improvement—even simple symptom relief. So I learned to stop saying anything about it and just note it silently.

One day I said, "So you seem to be feeling much better lately. Is that true?" She looked at me and said, "Don't flatter yourself. Yes, I'm feeling a little better, but it's not because of you, it's because of my boyfriend." Control was a huge issue for Rebecca, and she loathed and feared the possibility of anyone having any power over her. She was reluctant to admit to having any attachment to me or that working with me was benefiting her. We had established goals. She knew them. I knew them. So I just forgot about regular evaluations because, unlike most clients, for her they were not helpful. She could be quite assertive and always let me know when she was unhappy with a session or something I said, and this is how we stayed on track. Again, the operative policy is listening to what a client needs and responding accordingly, while remaining flexible enough to adjust to the complexities of each individual and each therapy relationship.

DEALING WITH THE LULL

A new client may have begun therapy filled with emotion, perhaps crying copiously in the first few sessions. Her therapist had been empathic and effective in helping her to tell her story and feel relief. This relief came after a brief period, anywhere from two to 10 sessions. One day she began her session by saying, "I feel much better. And I am not sure what to talk about today. There's really nothing new that's happened. Can you give me some direction?" Not all clients do this, but many do. Without the pressure of an emotional crisis they suddenly become self-conscious and concerned about how to proceed. Should they keep talking about the same issues, or will that be boring and unproductive? They may say they have several things they could talk about, but don't know what to select. How do they know what is most important?

There are no rules for dealing with what a colleague of mine (Brian Smothers, personal communication) calls "the lull," but generally clients are looking for some education about the therapeutic process, asking what to address and what to expect. Some clients may actually have nothing more they wish to pursue and will leave at this point. Others will want to stay and go deeper, but are unsure of how to proceed.

I usually assure my clients that they needn't worry about being

repetitive. I tell them that we all have a certain set of problems that we revisit constantly and that the therapeutic process is about depth, not breadth. Working through and gaining insight, learning to manage feelings, strategizing new behaviors—all require revisiting the same basic issues.

If my client does not know which of many topics to discuss, I always advise him to choose the one that will produce the most feeling. I educate and enlist him in this regard on a regular basis. If he asks me to tell him more about how therapy works and what he can expect, I am candid regarding both the potential gain and the potential pain. Even shorter treatments aimed at symptom relief require the experience of emotion for lasting effects. Longer-term treatments with more complex goals like removing blocks to achievement, significantly improving affect management, and altering patterns of relating usually require periods of deep pain.

I explain that change begins with the letting down of defenses, or emotional "surrender" (Maroda, 1999), and then I talk about that particular client in terms of her history and what type of emotional experiences she is likely to relive in the therapeutic process. I talk about this subject more in Chapter Six, but I let my clients know that what they defend against feeling is exactly what they need to feel to get better. I am not quoting the literature here, but rather expressing what therapists know from experience. Paraphrasing Winnicott (1974), I say that we always fear most what has happened to us already. Our greatest fears revolve around reexperiencing the most painful moments in our lives, whether we realize it or not.

"Lulls" can occur at any time and may appear frequently with some clients. The important point for therapists is that they need to work to get the process moving again. It may be tempting to respond to the client's lack of direction or pleas for assistance by taking responsibility for the session. Asking questions like "What could you talk about where you would feel some emotion?" or "What thoughts or events or dreams have occurred since your last session that stimulated some feeling in you?" places responsibility for generating material on the client rather than the therapist.

SUMMARY

Beginning therapy can be a daunting event for both therapist and client, as each attempts to be emotionally present and responsive. Viewing

therapy as a relationship requires therapists to examine their own emotional histories and patterns of attachment as they embark on the therapeutic endeavor. Understanding mutual influence and the importance of affective communication can facilitate the therapist's self-awareness and help him or her make good clinical judgments in the moment. The first assessment involves deciding whether client and therapist are a good match. Once therapy begins in earnest, the therapist listens carefully, tracking the client's line of thought and feelings. Assessing the impact of each intervention places the emphasis on what is happening within the therapeutic relationship. Using the client as a consultant removes the therapist from the burdensome position of attempting to navigate the relationship through independent, authoritarian decisions. Rather, the therapist combines legitimate authority for maintaining proper boundaries with following a course jointly determined by therapist and client as they work together.