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CHAPTER 1

Emotional Engagement in the Therapeutic Process

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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 emotions and the natural human responses we are likely to have. Rather, we seem to cling to the notion that we can somehow transcend our humanity.

In day-to-day practice, this, too, often translates into denying our negative feelings toward our clients. It may also include denying the deep gratification we receive on a very personal level while conducting our clinical work. Legitimate gratification from the daily experiences of being a therapist should not carry the stigma of shame. Nor should being bored, irritated, angry, depressed, feeling overwhelmed with sadness, or feeling sexual attraction. We tell our clients there is no shame in what they feel. It is how they manage and express those feelings that determine the quality of their lives. The same is true for us.

We can defend ourselves against our clients' emotional experiences for a variety of reasons. Many of those reasons are tied to our own childhood. Therapists tend to repeat their roles in their families of origin, being the parentified child who takes on too much responsibility for being the family peacemaker and emotional caregiver. We may take pride not only in our ability to fulfill this role, but also in the martyrdom that accompanies it (Maroda, 2022). Unfortunately, this expectation of being a long-suffering soother and fixer interferes with a healthy recognition of the normal negative feelings that arise in any ongoing relationship. (I focus here on negative emotions because they are the most likely to be ignored, rejected, or denied. They are also the source of most impasses and premature terminations [see Chapter 8].

Positive feelings rarely create the same difficulties, apart from intense overidentification or intense erotic countertransference [see Chapter 11].)

We tend to believe that we should tolerate negative client behavior, up to and including verbal abuse, as evidence of our moral superiority and our capacity for unconditional acceptance. We often rationalize our neglect of negative feelings toward our clients, believing that they are too fragile to bear them and will be harmed by our admission of these feelings. This ongoing infantilization of our adult patients blocks an essential path for emotional growth.

We tend to avoid conflict because we acted as soothers and peacekeepers in our families. As a result, we naturally had little-to-no real power and felt guilt at being angry at our parents for burdening us with this role. Despite being successful momentarily, we were doomed to fail in our attempts to rescue and heal our suffering family members, as others have noted (Jacobs, 1993; Miller, 1997; Olinick, 1980; Prodgers, 1991; Sussman, 1992; Searles, 1979). Unsurprisingly, those early feelings of guilt, shame, and inadequacy are prone to being reenacted in our work with clients. Being reluctant to confront damaged clients with their bad behavior can be observed when therapists passively accept whatever the client is feeling, as well as how they a behaving—even when those behaviors are offensive to everyone in the client's life. (Please keep in mind that these are generalizations, and all aspects of this description do not apply to every therapist.)

Failing to call out the client on insulting, overly critical, or intrusive behavior, primarily when it is repetitive and serves no useful purpose, can be rationalized as unconditional positive regard. It resembles masochism more than empathy, with the expected consequences of building countertransference animosity. Our clients naturally repeat maladaptive patterns of relating, hoping that therapy can help them. But if we simply accept those patterns in the name of validating our clients' experiences, how will change occur?

Enhancing therapists' tendency toward passivity is our heightened role as "good-enough mother." This persona has emerged through the increasing awareness of early attachment issues, as well as the work of Winnicott (1960, 1971). Understanding the value of providing an atmosphere where the client can potentially become more securely attached has led to a de-emphasis on the issues of sex and aggression within the therapeutic relationship in favor of viewing the client as a fragile child who primarily needs a sense of safety and acceptance. Although this is often the case early in treatment, once a sense of safety and trust has been established, perpetual harmony is not the test of a strong relationship. Rather, the ability to weather differences, confrontation, the challenge of erotic feelings, and conflicts of all kinds is more the measure of a truly healthy attachment.

Therapists remain conflicted about how to deal with negative emotions that arise toward clients, fearing that they will destabilize the therapeutic relationship at best, and do harm to the client at worst. We have yet

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to determine how to use our emotions, particularly our negative ones, for the purpose of facilitating the client's growth and development. We also can be overwhelmed by the depth of our clients' pain and suffering, resulting in unproductive attempts to soothe and comfort them—something we became experts at in our early lives. Therapists struggle to manage their own emotions when treating clients in a variety of ways. To the extent that we are not able to manage and accept our own feelings, we will fail to help our clients to do so.

In supervising a number of early-career therapists over the last decade, I have observed a notable pattern of responding to clients' expressions of emotional pain. First is the urge to take that pain away, to "fix" whatever is ailing the client. Second is withdrawal from the painful experience to avert a "rescue" effort or escape the shared misery and despair. Neither position allows for a therapeutic response. They are basically defensive positions aimed at minimizing the client's or the therapist's emotional pain.

The notion of simply sitting with overwhelming emotions, those of the client, and the therapist's internal responses, is something rarely addressed in training. I try to help my supervisees accept whatever they are feeling without a need to *do* anything. When emotional scenarios are repeated, which they will be, I ask them to explore their internal world and think about how they might constructively use their emotions to formulate good interventions. Simply blurting out your feelings is likely to be regretted later. (See Chapter 6 on self-disclosure.)

THE THERAPIST'S NATURAL DEFENSIVENESS

As an extension of our tendency to feel guilt and shame, it is unfortunate that we speak so little of how perfectly natural it is to feel defensive when we are criticized or rejected. Part of the therapist's persona I have been describing here includes the idea that because we intellectually understand why our clients are angry or even abusive, or condescending, we should be able to take whatever they throw at us in stride. It is hard to argue with the idea that it is incumbent upon us to step back and try to understand what is happening, how it reflects both the client's past and our own, and what stimulates it in the moment. That is our job.

Yet at the same time, I feel we have neglected an essential aspect of this process. I do not believe it is possible to move immediately from feeling injured or unjustly criticized, or intruded upon, to empathy and insight. What usually happens first is that we feel defensive—especially in the face of derision, insults, or the more common everyday complaint of "this therapy isn't really helping me." Therapists can, and do, become demoralized when clients are not improving or, even worse, *are improving but need to deny their progress for a variety of reasons.* I cannot emphasize enough how normal

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and natural our emotional reactions and defensiveness are and how equally impossible it is to avoid.

Only when we anticipate feeling defensive can we fruitfully address it. Feeling defensive is likely to produce either withdrawal or counter-aggression. Most therapists withdraw into silence, which rarely produces a positive result. Guilt over any defensive anger does not help. Thinking about how unfair the client is being (whether they are or not), imagining retaliatory insults, and imagining ending the treatment are natural defensive reactions we all have. I find that therapists can easily shut down in response to their own negative feelings and fantasies rather than explore what is happening in the moment with a particular client. They can become so fearful of saying or doing the things they are thinking about that they effectively become paralyzed. Translating anger into productive interventions, as I said previously, is not typically taught and is a skill set that takes practice to develop. (See Chapter 4 for examples of interventions.)

Ideally, we do not waste precious time on our neurotic guilt. Instead, we move to the next step. We silently confront our own defensiveness, accepting and processing our hurt and anger, integrating it with insight into what is happening in the dyad, and then deciding on what the best course might be. Achieving this level of control and insight may take time. The sooner we can be in control of our feelings and have a healthy perspective on what is happening in the room, the better. But this is not always possible.

I advocate for going home and thinking about what happened, examining what emotions you are struggling with, and how you might approach this in a constructive manner with the client. This may mean an interpretation, or an invitation to explore the client's' feelings more deeply, or a self-disclosure and limit setting. If the client asks why you are so quiet and wants to know what you are feeling, you can just say you are having feelings and thoughts that you need to process more and will take this up in the next session. Delaying rarely causes a problem, while responding impulsively usually does.

This may seem obvious to experienced therapists. Yet in supervising early-career therapists, I find that they often withdraw when they feel hurt or angry. What follows are feelings of guilt, shame, and inadequacy. Rather than facing the fact that they have been hurt and are vulnerable in the relationship, they either remain withdrawn or retaliate with condescending comments about the client's anger. (This includes disingenuous, patronizing statements about how healthy it is for the client to express their anger.)

Russell (1998) famously said the greatest resistance in the treatment is the therapist's resistance to what the client is feeling. The beginning of this chapter reflects the frequency with which our own emotional reactions interfere with, rather than facilitate, the treatment process. Understanding and managing our emotional responses are highly dependent on our ability to recognize our individual sensitivities or weakness, along with the inevitability of responding internally with defensiveness. Livingston (2003), Kravis

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(2013), and Chused (2003) have eloquently argued for greater appreciation for the efficacy of accepting our vulnerabilities, yet in practice this seems easier said than done.

I advise early-career therapists to focus on the vulnerabilities they bring to any relationship, which they have hopefully identified in their own treatment. Expecting personal impact from clients, and believing defensiveness is inevitable, make it easier to shift perspectives. We want to waste as little time as possible on unnecessary guilt. The bottom line is: Prepare to be wounded at times, prepare for the natural instantaneous withdrawal that will occur, then use your knowledge of yourself and your client to reengage and process the preceding event. What that will look like varies according to the phase of treatment, the client's and therapist's motivations, and the events leading up to the encounter.

Immediate feelings of admiration, excitement, and attraction toward an interesting client, with or without any erotic component, can also be destabilizing. Overidentifying with a client in pain can produce both an intense desire to rescue and cure that person as well as excessive idealization. It can be all too easy for the appealingly pained client to become a surrogate for our own injured selves. I discussed this topic extensively in my book *The Analyst's Vulnerability: Impact on Theory and Practice* (Maroda, 2022).

Finally, it goes without saying that sitting with a client who is frequently immersed in despair can be extraordinarily difficult. It is natural to want to move the person out of this deadening state, both to provide comfort and relief for them, but also for us. Therapists often step in to offer everything from reassurance, to breathing exercises, to noting the good things about the client and their life, to changing the subject. Sitting silently for extended periods of time while the client is immersed in despair ranks as one of the most difficult tasks for any therapist. Yet some clients absolutely need to have this experience before they can move forward into a more hopeful state. The therapist naturally feels not only despair but also helplessness and even a deep sense of inadequacy in the face of this wall of misery—something we must train ourselves to bear with certain clients.

THERAPY AS A RELATIONSHIP

In the last several decades, the importance of the therapeutic relationship, as opposed to any approach or theory, has emerged as the pivotal factor in treatment outcome. A successful treatment has more to do with the therapist–client relationship than with anything else. Cuijpers et al.'s (2019) research on common factors states that the therapeutic alliance or relationship is consistently reported to be the most crucial factor. They state that a meta-analysis of more than 200 studies supports the notion that a strong alliance indeed results in better outcomes. But in a chicken or the

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egg conundrum, Zilcho-Mano (2017) notes that clients with the capacity to form and maintain relationships *prior to treatment* are more likely to form a change-producing alliance with their therapists. This is hardly surprising yet illustrates the challenges of treating clients who have never achieved this capacity.

When reading this research, I was reminded of when I was a young therapist right out of training and was recruited by the new analytic endeavor in Milwaukee to screen patients for low-fee analysis. They were to be training cases for candidates and, as such, needed to be deemed "analyzable." I was trained for this task by a very experienced person at the Chicago Institute for Psychoanalysis and learned early on that "appropriate" clients for analysis relied heavily on the absence of severe trauma and evidence of the ability to form and maintain attachments to others.

Over time, this cherry picking of the clients most likely to succeed hit the wall of both declining numbers of people seeking psychoanalysis, as well as an increasing awareness of just how pervasive traumatic experiences are. Soon psychoanalysts were focusing more on the realities of the patient populations and writing about the more intense transference–countertransference encounters that were occurring. Increasingly intense countertransference reactions to this broader array of patients, including those with severe trauma that had previously eliminated them from consideration, gave birth to a new relational and intersubjective approach to psychodynamic treatment. This approach brought the therapist's inevitable participation to the forefront, emphasizing that psychodynamic treatments were, indeed, determined by the emotions and actions of both therapist and client. (See Aron, 1996; Mitchell & Black, 1995; and Kuchuck, 2021, for excellent histories of the developments in psychoanalytic theory and practice.)

As the exclusive focus on the client's pathology gave way to acknowledgment of a mutually created and influential relationship, we began to ask the question: What is it about the therapy relationship that is curative? Determining therapeutic action became heavily weighted by the therapist's emotional responses once we recognized our inevitable influence. Although this exploration began more than 30 years ago, we remain largely in the dark about how and why psychotherapy works (Miller et al., 2013).

The relational and intersubjective schools of analysis tend to focus on what the therapy relationship can provide that was missing in the client's early relationships—often referred to as the "deficit model (Mitchell, 1984). These deficits center on the client's lack of object constancy, trauma-induced dissociation, attachment disorders, and fear of abandonment. An essential aspect of this model is the notion that we can somehow fill in the developmental gaps within the client's early experiences through our emotional availability, empathy, caring, and stability. The analyst's role in the therapeutic relationship was thus focused on acceptance, validation, and a form of curative parenting.

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WHEN ENACTMENTS APPEAR

When conflicts did arise, threatening the idyllic "good-enough mother" bond between client and therapist, they often appeared (and still do) as "enactments." Although the definition of enactment is elusive, with authors taking increasingly varied positions (Aron & Atlas, 2015; Bass, 2003; Bohleber et al., 2013; Boston Change Process Study Group, 2013; Ivey, 2008), the original definition by Jacobs (1986) centered on mutual projective identification. That is, enactment is an unplanned and often disturbing expression of negative emotions between therapist and patient, with the therapist feeling out of control and taken aback by their own expressions of negative countertransference. They are seen as unconscious-to-unconscious repetition of the client and therapist's pasts that generates an unplanned and emotional event between them that must then be processed and understood. I have written extensively on this topic (Maroda, 1998b, 2022), which goes beyond the focus of this volume. Suffice it to say that there are little to no deliberate interventions involved in enactment other than focusing on processing it after it has occurred and hoping for a good outcome.

Although I acknowledge that enactments are inevitable, particularly with clients who cannot be aware of and express their emotions, I object to therapists' reliance on enactment as the primary or only path to facilitating needed conflict. From my perspective, it places too much emphasis on the "goodness" of the therapist, with negative feelings without conscious intent, in the spirit of "the devil made me do it," as opposed to deliberate self-disclosure. I remind my supervisees that we are the ones in charge and have a fiduciary responsibility to actively facilitate the treatment.

While there is little doubt that there is something inherently therapeutic about having a therapist provide a relatively safe environment over time, combined with genuine empathy and a sincere interest in listening and connecting, too little is said about how this gets translated into our day-to-day interactions. And even less is said, or taught, regarding how to navigate conflict or rupture. What does a therapeutic environment consist of? Since we cannot go back and reverse the pains and losses of either our clients' childhoods, or our own, what exactly is it that we can offer?

ELEMENTS OF CHANGE

Identifying the missing elements needed for change remains challenging. Even after decades of behavioral research focusing on relaxation, controlling negative thoughts, affect regulation, and mentalization, to name a few, have resulted primarily in the conclusion that *the relationship is the most important variable.* And, increasingly, the role of the client's emotional experience is viewed as vital to a transformative experience. More importantly, even less has been

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documented regarding how therapists can successfully intervene in their clients' lives. Is it our job to provide what the client's parents did not? If so, what does this look like in daily practice? If not, then what is it that the therapeutic relationship has to offer that is curative? Miller et al. (2013) note the efficacy of psychotherapy is well established, yet we still do not know how it works.

A research finding noted by Norcross and Lambert (2018) in their ongoing American Psychological Association task force on psychotherapy outcome was that 0% of the outcome variations could be attributed to specific treatment methods. Yet outcome studies continue to focus on methods, despite the underwhelming evidence of their importance. Additionally, despite the popularity of what is called the two-person or relational approach, almost no studies actually focus on the interplay between therapist and client.

New research on the therapeutic process has begun to identify factors that have long been ignored. These include the attachment style of both therapist and client (Wiseman & Tishby, 2014), the client's motivation for treatment Wolpert, 2016), the gender of the therapist (female therapists have slightly better outcomes than their male counterparts), the age of the therapist (Berghout & Zevalkink, 2011; Tracey et al., 2014), the degree of self-awareness and the willingness to admit to mistakes on the part of the therapist ("a welcoming attitude toward errors"; Miller et al., 2013, p. 94), overall countertransference awareness (Farber et al., 2004; Abargil & Tishby, 2022), quality of the alliance, slight superiority of psychodynamic treatment versus cognitive-behavioral therapy and other forms of treatment (Abbass et al., 2012; Shedler, 2010; Levy et al., 2014, Steinert et al., 2017; Gelso & Kline, 2024), the therapist's capacity for "having unpleasant feelings and problematic cognitive reactions" (Hayes et al., 2015, cited in MacMahon, 2020, p. 42.0), and the ability to "facilitate affective experience/expression" (Diener et al., 2007, p. 939).

Expanding on these factors, psychodynamic treatment has proven to be as, or more effective than other forms of treatment, with studies demonstrating that benefits endure, or are even enhanced, following termination (Driessen et al., 2015; Shedler, 2010; Steinert et al., 2017). Levy et al. (2014) suggest that the longer duration and depth of psychodynamic treatment prevent the relapse of anxiety and depression occurring in other modes of treatment, where benefits erode after treatment ends. These results, they say suggest, "the need for longer and more intensive treatments" (p. 402). Their observations fit with those who challenge whether this extended benefit results only from psychodynamic treatment, noting that equivalent long-term studies of other modes have not been conducted.

Although we analysts might prefer to believe it is our method that accounts for longer-lasting results, I am open to the idea that longer-duration treatments may be a significant factor. If you consider the neuroscience research regarding the need to change neural pathways in the brain, it makes sense that this requires more than short-term treatment.

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The research also supports digging deep into emotion, provided the therapist is sufficiently self-aware to facilitate the inevitable conflicts that will occur. Diener et al. (2007) point out that emotion is crucial to therapeutic change, and that therapists who facilitate affective experiences in treatment have better results. Again, the emphasis on the vital role of emotion is undeniable.

Countertransference dominance (Maroda, 1991), destructive enactments, and even client abandonment can result from the therapist's inability to manage both their own and the client's feelings, as noted previously. Miller et al. (2013) suggest that it would be fruitful to further study the patterns of the most successful therapists. They cite Najavits and Strupp (1994), who found that "effective therapists report making more mistakes and being more self-critical than their less effective counterparts" (p. 94). They note the desirability of conducting "studies exploring methods for helping practitioners develop an open, even welcoming, attitude toward errors" (p. 94). In other words, successful therapists eschew the notion of the good or perfect mother in favor of being a flawed human being who is self-aware.

The literature places little emphasis on the reality of everyday errors. I rarely, if ever, hear the use of the term *therapeutic error*. Rather, therapists are too often encouraged by their peers and supervisors to believe they did the right thing, even when they themselves are reporting a poor response from the client and questioning the efficacy of their interventions. Perhaps because we are so guilt- and shame-prone, we reflexively rush to relieve our colleagues of the notion that they did something wrong. It is as though we will be crushed by acknowledging our mistakes, rather than relieved by admitting them and working toward corrective action with the client.

I supervise a sizable number of therapists who have sought me out because they believe I can provide a respectful, but honest critique of their work—something often lacking in their previous supervision experiences. And I do not hesitate to let them know when I believe they have erred, noting the impact of their intervention on the client. Then I ask them to think about why they chose to intervene as they did, which includes an exploration of the countertransference. Then we explore what might have worked better.

The premise of this book is that therapists need more insight and more effective strategies for actively responding to their clients' emotions. 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. Often ignored is the reality that the relationship develops over time and what might be highly therapeutic as treatment begins may not remain so in later stages. The therapeutic relationship is organic and ever-changing, and our therapeutic interventions need to accommodate that reality. Adding to this complexity is that different clients need different responses. There is no one size that fits all.

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COMPASSIONATE AUTHENTICITY

What I see as the core of all successful treatments is creating a safe environment where clients can become more aware of their emotions, name them, and learn to express them constructively, as Krystal (1988) explains so well. The first step in this emotional reeducation is helping therapists to become better at these tasks themselves. Later in this volume, I will explore the therapeutic value of authentic emotional responding and the attendant ethical concerns that arise with the prospect of self-disclosure.

Suffice it to say, I believe a position of *compassionate authenticity* (Maroda, 2022) that involves constructive emotional and behavioral feedback is at the heart of the therapeutic endeavor. Throughout this volume, I stress the need for the therapist to be as self-aware as possible, using their own emotional responses as a guide to both the client's internal experience as well as their own. Deciding when and how to use our own internal experience remains challenging. However, we do know that the build-up of strong emotions in the therapist over time, especially negative ones, will eventually lead to an enactment, which is an uncontrolled event that can have disastrous outcomes as well as therapeutic ones. A close read of case reports shows that, without exception, therapists are consciously aware of their negative feelings prior to enactment, regardless of repressing them during the actual enactment event. I argue that controlled expression of these feelings serves both the client and the therapist and can be extremely effective in avoiding enactments. Emotional engagement, both silent and expressed, is at the heart of a successful treatment.

WHAT SKILLS DO THERAPISTS NEED?

What skills and insights do therapists need to be sufficiently adaptive to our clients' needs? I have written recently (Maroda, 2022) about the strengths and weaknesses that most therapists, regardless of theoretical orientation, bring to working with clients. These include the parentification of the therapist as the sensitive, empathic child who naturally soothed and comforted others in the family. Being sensitive, empathic, and curious about others are obvious strengths that most therapists bring to their work as therapists.

However, there is a dark side to our early role as caregivers as well. Our vocational choice is not only overdetermined by this role in our early childhood experience, but so is the inevitable guilt, shame, and overdeveloped sense of responsibility for others that we bring to our work. It is this irrational level of guilt, stemming from not wanting to be angry with our parents, and feeling that we somehow failed in making them happy, that serves as an obstacle to managing negative feelings toward our clients. Our tendency to deny negative countertransference feelings is perhaps our greatest weakness.

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The task of managing emotion in the therapeutic relationship can only be fulfilled through emotional honesty—which begins and ends with the therapist's capacity for self-awareness, reflection, and the ability to constructively express their feelings.

I firmly believe there is no substitute for getting your own long-term treatment in terms of the needed self-awareness. Hayes et al. (2018) are two of many authors promoting the critical importance of self-awareness yet stop short of recommending personal treatment. What they do say is that "it is incumbent upon therapist to understand themselves, their own inner workings, and to know what types of clients will provoke their CT [countertransference] reactions" (p. 504). I am at a loss for how therapists could acquire this degree of self-awareness without their own therapy.

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EMOTION AND MUTUALITY

The literature on affect confirms that, in a relationship, the more one person expresses emotion, the more likely the other person is to share that experience, both consciously and unconsciously (Sullins, 1991). Also, we are more likely to be empathic if we like and identify with the person we are treating (Knox, 2011; 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 term for this in the social science literature is *personal distress* (see Maroda, 2022, on empathy) and often produces rejection or a desire to flee in the therapist. Understanding this natural response to a client's aggression and/or disturbingly intense affects can go a long way in aiding therapists' own self-acceptance, resulting in more therapeutic responses. Although the notion that strong countertransference feelings could be "analyzed" away went by the wayside decades ago, we have failed to create constructive approaches for managing and expressing these feelings in treatment.

Trauma counselors were at the forefront in discussing 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 the phenomenon known as "vicarious traumatization" (Pearlman & Saakvitne, 1995). Although the experience of shared affect in nontraumatized clients is not so obviously difficult to manage, it nonetheless exists, particularly in the treatment of those with borderline and narcissistic personality disorders.

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 been confirmed by affect research, demonstrating that emotions are *meant to be received and responded to* (Kemper, 2000). A primary function of affect 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 and repeated unconsciously in adult relationships, simply because they are familiar. This is a restatement of the concept of transference, of course, but with a major difference.

Relational theory states that the need to maintain primary attachments, adapting as needed, is the driving force in establishing the transference. Classical analytic theory, in contrast, emphasized the intrapsychic, focusing on innate drives (like sex and aggression) and conflicts (like the infamous Oedipal one). Relational theory says we need to maintain our attachments, even if this comes at great cost to our own mental health.

Neuroscience confirms that these patterns are, indeed, laid down in the brain at an early age and do not change easily (Griffiths, 1997). Solms (2018, 2020) eloquently describes how we seek homeostasis and that our survival is dependent on our ability to "predict" what will happen next (e.g., "I see a lion, who I predict will attack and eat me if I do not escape"). Our predictive patterns are determined early in life as our brains encode threat. In the present, those past predictions are overlaid onto current situations that have enough commonality to stimulate them. Again, this is another explanation of "transference."

For example, a client who reports having had a mother who was overly critical and demanding may well imagine that their therapist will also be critical and demanding, regardless of the reality. The more the therapist "resembles" the critical parent, the more likely that the client will perceive the therapist as critical. What can be maddening for therapists is being accused of critical or judgmental attitudes when they do not feel that at all. One of the most common therapeutic errors is rushing to "correct" the client, rather than accepting and exploring their perceptions and accompanying feelings. Not only does this negate the client's reality but also robs them of the opportunity to come to their own conclusion about who the therapist really is, for better or worse.

A benchmark of classical psychoanalysis was a basic denial of mutual influence in the therapy relationship. With the advent of relational and intersubjective theories, this notion was turned on its head. Over the past 30 years, the impact of the therapist on the process has been established as

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undeniable. Mutuality rules the day. In Lewis Aron's classic work (1996) on the development of analytic theory, he emphasizes the major paradigm shift once the analyst's participation becomes part of the equation. Rather than being an objective observer, he notes that the analyst is now sharing affective exchanges with the patient in an ongoing conscious and unconscious interchange. This ongoing exchange then becomes a major focus for investigation.

Although these past three-plus decades have produced endless articles and books exploring relational issues, and the research cited here confirms without a doubt that the relationship is the most key factor in treatment, parsing out the therapeutic action involved remains illusive. Part of the mission of this book is to help clinicians tease out and think more deeply about what is therapeutic and what is not. My own work consistently focused on the role of affective communication, affective attunement, and affect regulation. Yet these issues only become relevant once the therapeutic relationship is established.

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. However, recent research indicates that anxiously attached clients do not match up well with anxiously attached therapists (Wiseman & Tishby, 2014). On that point, anxiously attached therapists also tend to have worse outcomes with clients, regardless of their attachment style.

Intellectual discussions of a good match (Kantrowitz, 1995, 2002) make these points but predictably cannot offer substantive advice to therapists regarding whom they should treat and whom they should not treat. Matching based on 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 the same diagnosis. 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.

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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 make them 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, 2022) that gratification for the therapist is necessary for the treatment 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, 2022).

Given that the literature has shown that all people, places, and things evoke an immediate positive or negative response (Andersen et al., 2005; also see Bargh et al., 1992; Fazio, 1986; and Russell, 2003), perhaps therapists need to be more self-aware of the potential for not working well with certain clients. Crastnopol (2019) makes the excellent point that we may match well with one type of client and not at all with another. And Kantrowitz (2002) wisely points out that the match may be beneficial in one phase of treatment but not in another. When consulting with clients over previous failed treatments, it is not unusual for the match to be therapeutic during the honeymoon phase of empathy and attunement, only to be followed by withdrawal and impasse once conflicts arise.

Therapists who believe they can transcend their immediate dislike of a client and provide needed empathy almost always prove themselves wrong. 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 occur 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 is 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

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curiosity and whom they do not like are doing an injustice to the clients as well as to themselves.

Just as diagnosing clients has fallen out of favor over the past 20 years, now viewed as pejorative and reductionistic, so has the determination of "treatability." I spoke at a conference in Poland about 5 years ago and a Polish psychologist asked me whether I believed that some people were untreatable. There was a notable hush over the large group assembled for this 3-day conference, as they waited for my response. As I looked out on a sea of curious and anxious faces, I replied, "Yes." What followed was an immediate irate challenge from one of the other speakers. He said my answer was unacceptable and judgmental. Who was I to decide whether someone could receive therapy? He deemed me unethical and irresponsible.

I simply said that I did not make a global determination that a single individual was untreatable. Rather, I believed that some people are untreatable, but that this was difficult to determine and would only become evident after numerous failed treatments. But I added that I felt comfortable deciding whether I *could treat a particular individual and* would leave it to the next clinician to make that decision for themself. Nonetheless, I maintain that people who are too rigid, lacking in the capacity for self-awareness, and/or unmotivated to change are not likely to make effective use of therapy. Sometimes this is evident at the first meeting. At other times, it slowly becomes evident. Wolpert (2016), noting the unpopularity of this idea, encouraged clinicians to consider that "failure is an option" in his *Lancet* article of the same name. He says,

> The largely unchallenged shared belief that everyone can potentially be helped is a powerful disincentive to genuine learning and service development. I would argue that stopping the provision of ineffective intervention does not equate to stopping caring. (p. 511)

However, this does not mean that you should not take on a client who has negative traits or behaviors—or terminate someone out of frustration and anger. Most 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.

Orange (2016), known for her ideals of sacrifice, nonetheless sees acknowledging the therapist's limitations as an essential factor in therapy. Orange bemoans the fact that early-career clinicians tend to believe they should be able to treat anyone, and are rarely disabused of this idea in their training. She sees this as a major omission, noting the importance of assessing the quality of the match both at the onset of treatment and when it stalls. One could say that knowing when to quit is as important as knowing when to start, as well as if you are competent to treat.

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The Case of Debra

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 the 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 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 well. Since she presented herself 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 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.

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I tried 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 mindset 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 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 asked.

"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 did not 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.

The Case of Rebecca

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 immediate 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."

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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 was not 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 did not want to be rejected. But I gradually realized that she was not just like Debra. Despite all they shared, they were also quite 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 as 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.

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 for you, at some level the client knows it, too.

The primary responsibility for assessing the match belongs to the therapist. 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 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

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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 think of 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 offer 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 down someone 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 et al. (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 basic behavioral intervention. These figures apply to both institutional and private practice settings, and the 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. More recent research (Alfonsson et al., 2024) indicates that little has changed. They report that 50% of patients do not benefit from treatment and 20% terminate prematurely. They acknowledge that it is unclear what skills therapists need to improve the therapeutic alliance.

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 are 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 do not like and cannot 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?

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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 result from either a failure to engage or a failure to address deterioration or rupture in the therapeutic alliance. They acknowledge the difficulty, however, in pursuing negative feelings. They note that therapists tend to have problems not only with negative feelings but also gentle confrontations, especially with new clients. They believe this makes it more difficult to form a therapeutic alliance: Their observations are in sync with the research reported by Regan and Hill (1992). In their study of therapist's awareness of clients withholding negative feelings, they found that only 17% of new therapists knew that their clients were withholding negative feelings and even experienced therapists could only identify withheld negative feelings less than 50% of the time.

Another obstacle to building a strong therapeutic alliance from the beginning can be 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 emerge naturally during the dialogue with him or her. I agree, and suggest that note taking, turning to lists of prescribed questions, and spending substantial amounts of time on insurance forms and other paperwork 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 about 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 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

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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 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 vital facts in the client's life, they are responding to and trying to regulate their own internal emotional experiences.

PAYING ATTENTION TO WHAT CLIENTS SAY ABOUT THEMSELVES

Clients usually tell you something 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 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 would not 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 based on 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 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 future than we imagine.

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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 and colleagues (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 with minimal interventions 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, it is underemphasized in training programs today.

If a client asks you whether you understand what he is saying or feeling, be honest. If you do not 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 cannot 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

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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 talking. 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 get 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. Similarly, if the client responds by looking away, looking at her watch, or changing her body posture in a direction away from you, you are either talking too long or off the mark.

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 did not 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 an 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

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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 parrotlike 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, clients reject the therapist's expressions of empathy (McWilliams, 2004). It seems illogical that anyone would reject empathy, and it certainly makes the task of the therapist substantially more difficult. Clients who 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.

I find the recent literature on obstacles to empathy to be of critical importance. We tend to believe that our compassionate nature automatically

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translates into being empathic with our clients, but this is not always the case. Therapist responses of disgust, dismay, anger, withdrawal, and fear are not as uncommon as we would like to believe. I have said previously (Maroda, 2022) that we can reduce our guilt and shame over not being able to transcend these feelings if we can accept that they are normal, natural, and ubiquitous.

Rebecca, whom I introduced earlier in this chapter, said she chose me to be her therapist after interviewing several others, and because I did not have "the therapist breathy 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 perceived therapists as too patronizing in their approach, creating an instantaneous one-up position with their clients. She said she did not 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. Clients who have narcissistic or borderline personalities not only expect empathy, but they may also 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. 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 for 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, clients may just change the subject or look away in silence. However, the client who feels anxious, guilty, or

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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 was 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 4 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 suffered emotional, physical, and sexual abuse as a child, resulting in poor relationship patterns. Her mother was domineering and controlling. Throughout the first several years of her treatment, Nancy was oblivious to the same traits in herself. Because her demands 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 an exhausting 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.

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[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.

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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 could not 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 did not care. She wanted it anyway—because that is 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 this example illustrates 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

[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. Lang's work on manifest and latent content is particularly valuable because it teaches therapists how to identify the client's unconscious references to both him and to the therapist. Stern (1997), McWilliams (2004), and others have written on the importance of curiosity, and I can't agree more.

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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 notice something that the client is afraid to reveal can translate into stalled or incomplete therapy.

I was struck by Farber et al.'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).

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The Case of Jennifer

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 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 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. Having ended the relationship, 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 quite a while. 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 quite a while.* 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 become exposed. 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 did not 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 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 information easily. So I asked another especially important question that I ask whenever 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 enacted. Jennifer replied that she liked watching people who had nice bodies kissing.

I noticed that she had used the word "people" numerous 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 increasingly 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 did not 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

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of each other and rub their bodies together. These episodes began when she was 9 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 did not 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 therapist. 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.

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 critical 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 same-gender attraction. She eventually met and fell in love with another young woman, and they moved in together. (Update: As of this writing, they have been married for 10 years and are doing well. I received a Christmas card last year from Jennifer updating me on her life.)

The therapist must be fearless, in a sense, to pursue the material that the client is not readily addressing. Often a client's discomfort adds to the beginning therapist's anxiety, and the matter may be prematurely truncated in the interests of relieving their mutual discomfort. 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.

Again, based on my experience supervising early-career therapists, I find that pursuing even everyday comments by the client can be lacking. For example, a supervisee tells me her client reports feeling depressed at the beginning of the session, then remains silent. The therapist does not know where to go next because this client is chronically depressed over general

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issues like loneliness and lack of fulfillment in his or her life. The tendency can be to assume you know what the client is feeling and referring to, when you may not at all. I always ask something like "Depressed how?" or simply "Did something happen this week that really bothered you?" If one question does not hit the mark, I will try another, with the goal being the unearthing of whatever is precipitating the client's depression in the moment. Often something significant has happened that the client is reluctant to talk about, or simply isn't thinking about in the moment. But gentle probing can often reveal notable events, like a marital argument earlier in the week, or a rejection at work, and so on.

I find that therapists tend to be too open-ended at times in their follow-up questions. For example, the classic follow-up question is "Can you tell me more about that?" or "What is that like for you?" Although this type of question can be very useful, it is often overdone. Clients can feel patronized by an open-ended question that does not fit with what they were saying. If a client talks about a horrific childhood experience, with emotion, it seems disingenuous for the therapist to say, "What was that like for you?" The client is recalling a painful episode and showing the corresponding emotion, so it is more to the point to say something like "I can see how painful that was for you and how that pain still lives on." Or "I can see how that deep pain you felt as a child has made you wary of being hurt by others." The phrasing depends on the situation, of course. But therapists showing that they understand the breadth and depth of the client's emotional experience is far more effective than an open-ended question that strikes some clients as an indication that the therapist is not really listening or getting what they are saying. What works when the client has yet to delineate their experience or express their feelings is different than what works when they have. An open-ended question in the face of a clearly described emotional event can result in the client disconnecting from their emotions rather than going deeper.

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

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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 wonderful 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 considerable 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, the topic of goals comes up naturally, as does everything else that is important. My client may say he is frustrated and does not feel like he is 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 is 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 so they can be modified accordingly. 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

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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. I skipped regular evaluations since they weren't helpful for her. 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.

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DEALING WITH THE LULL

A new client may have begun therapy filled with emotion, 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 ten sessions. One day she began her session by saying, "I feel much better. And I am not sure what to talk about today. There is 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 do not 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 clients are looking for an education about the therapeutic process, asking what to address and what to expect. Some clients may 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 more than breadth. Working through and gaining insight, learning to manage feelings, strategizing new behaviors—all require revisiting the same basic issues. I also assure them that their job is not to entertain me by coming up with new things to talk about.

If my client does not know which topic 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), noting how that person's history will determine what type of emotional experiences she is likely to relive in the therapeutic process. I will talk about this subject more in Chapter 6, 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. The key 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.

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