CHAPTER SAMPLER

Enhancing Your Therapy Practice

Tips and Techniques for Psychotherapists and Counselors

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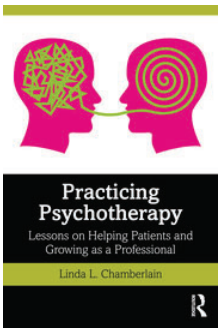

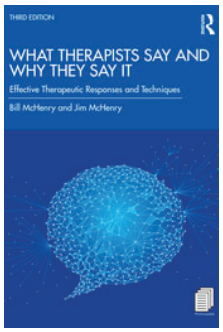

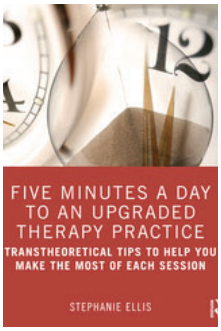

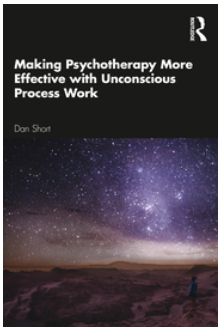

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HEALING THROUGH CONNECTION

Compassion in Action

There's something about how we engage with other people that has a profound effect on our health and sense of satisfaction with life – we do best in connection to others (Pilgrim, Rogers, & Bentall, 2009). Research has consistently shown that a critical factor in the effectiveness of psychotherapy is the client's sense that the therapist genuinely cares about them (Duncan, Miller, Wampold & Hubble, 2010; Hoglend, Monsen, & Ronnestad, 2013). In Chapter 5, I explored the importance of developing a compassionate mind and attitude toward our work with others. In this chapter, I'll examine how we bring this into our relationship with patients. Demonstrating acceptance, compassion, and respect is intrinsic to helping others as a therapist. I agree with Kottler and Carlson (2014) that "…it is love that drives a lot of our therapeutic work" (p. 52). We usually avoid using that word when we talk about our professional work but in Buddhist philosophy, love is the wish to help others be happy. It's a love that is generated by a recognition of

our shared humanity, equanimity, and connection to our shared experiences as human beings.

The therapist's most valuable resource is our sense of self and our ability to bring that to the therapy relationship. "We must demonstrate our willingness to enter into a deep intimacy with our patient, a process that requires us to be adept at mining the best source of reliable data about our patient – our own feelings" (Yalom, 2017, p. 40). We must commit to being open to bringing not just what we know but what we feel and our immediate sensations and reactions when we are in connection to our patients. The collaborative work of therapists and patients to transform or relieve suffering is central to our effectiveness. Psychotherapy is done *with* people, not *to* people. We learn to translate the love and care that we feel into actions that demonstrate deep compassion to our patients.

How we react to patients is usually a good indicator of how others experience them. The therapy office becomes a microcosm of the patient and therapist's worlds. Patients will not just tell us, they will show us what contributes to the problems they grapple with in life. Master therapists have learned to share with patients how we are impacted by their story and how it feels to be with them in the here-and-now. We must be aware of our reactions in order to give them honest, compassionate feedback about how we see them and how we feel about our encounter in therapy. For example, if a patient is going off on tangents or getting lost in the details of a narrative, I might respond that "I'm having trouble staying on the path with you because of the detours. Help me stay with what's important in your story so I don't get sidetracked. I don't want to get lost, so remind me of the purpose of what you're sharing." It may give me a sense of how others in their life may get lost or overwhelmed when they're speaking.

Being Present – Mindfulness in the Office

We let our patients know that we care about them by being fully present, listening attentively, and sharing our thoughts and feelings in the immediacy of our encounter. Fully present means that I commit to eliminating distractions; the phones and screens are put away (both mine and the patients) and the "In Session, Please Do Not Interrupt" sign goes on the door. More importantly, I spend a few moments before the session making an internal commitment to set aside distracting thoughts that might

interrupt my concentration. I engage in a few moments of mindful breathing and focus on preparing myself to pay attention. Mindfulness practice creates a gap between my perception and my response which allows me to consider how to react and decide what to bring to the relationship at any given moment. Research (Aiken, 2006) has shown that psychotherapists who incorporate mindfulness practice into their work are more perceptive of their patient's inner experience and have a positive influence in cultivating empathy and building a more compassionate presence. Bishop et al. (2004) found that a more mindful state helps therapists become better able to connect to patients more dispassionately, without attachment, and to remain more reflective and less reactive. I have come to believe that creating a compassionate presence with patients is a critically important part of what I can offer.

After some discussion of mindfulness, if a patient is interested in doing so I begin sessions by sharing a brief mindfulness exercise with them. We devote a few minutes to focus on increasing our presence with each other. I will ask the patient if they would like to join me in preparing for our meeting by bringing our attention to the time we will spend together. To begin or session, I will use a mindfulness exercise like the following.

> Let us stop and become aware of our breath as we come together for our time today. We can gently close our eyes or let our focus soften as we sit comfortably, back straight but not rigid, feet on the floor, and hands resting on our lap. We'll follow our breathing for a few moments; breathing naturally, aware as we inhale of the air coming into our body and, as we exhale, of the breath leaving. As we become more aware of our breath and let our minds stay gently focused there, we commit to being fully present, to a full acceptance of the present moment, including how we feel and what we perceive. We give ourselves permission to let each moment be exactly as it is and allow ourselves to be exactly as we are. We breathe and let be. We move in the direction that our heart tells us to go with resolution and compassion for ourselves and others. After three more breaths, we'll open our eyes and begin our session.

I like sharing this practice with patients. It seems to create a break in the busyness of the day for both of us. It strengthens our commitment to the

time together and helps us proceed with the intention to focus on compassionate interaction and contemplation. It's an invitation to be present with each other in a mindful way. It's never anything I would insist on as there are patients who might be uncomfortable with the practice for a number of reasons: It seems outside their religious or spiritual beliefs, they feel anxious about closing their eyes, being in their mind without distractions is highly stressful, and so forth. Even if the patient doesn't want to engage in this bit of mindfulness, I still silently bring myself to the session by slowing my breath and committing to the time I will be spending with the patient. I notice that even when we don't engage in the mindfulness exercise together, if I create a more relaxed, open presence, the patient often does too. There's a different energy in the room.

The Groucho Marx Dilemma

Groucho Marx (a comedian in the 1940's) once said, "I wouldn't want to belong to a club that would have me as a member." When we are at our worst and struggling with self-acceptance, it's hard to imagine that someone else could care about us. We've all been members of the Groucho Marx club at some point. It's a steep price for admission – a loss of self-respect, fear of intimacy, isolation, and, sometimes, self-destructive behaviors. When we don't want to be present in our own life, it's hard to imagine someone else would want to be around us. If I don't care about myself, only a fool would care about me. I think a lot of what is described as "resistance" is a fear of someone else seeing us as we see ourselves when we are in a dark place.

Finding the courage to invite someone to listen to our story is daunting when we feel more like the villain or victim than the hero of our narrative. We keep some things secret because we fear rejection and feel ashamed. We are already hearing the critic in our thoughts and don't want to face that same disapproval from anyone else. It still surprises me that we can do the work we do because it relies on people being willing to openly share the most painful, embarrassing, negative aspects of themselves. We invite those who seek our help to confront their hurt, fear, and anger through connection with us. We ask to be let into the places people hide, where they sit with their fears and hurt. It's an act of courage for both of us when we commit to the patient and therapist relationship and agree to visit those places where the pain lives.

What You Feel Matters

Practitioners new to the big chair often feel that they need to overlook or ignore their here-and-now reactions to patients during sessions and maintain a neutral façade. I believe that trying to create a blank slate of neutrality is a disservice to the process of psychotherapy. Being the "duck" (Chapter 4) doesn't mean you ignore your feelings and reactions. Psychotherapy is unique in that we focus on the here and now and provide immediate feedback to our patients about how we are impacted in our relationship with them. That is something we rarely have access to outside of the therapy office. Behaviors that are destructive or manipulative are usually met with fear, anger, or avoidance; when we are suffering from severe anxiety or depression, people may shy away out of ignorance about how to respond or because they feel overwhelmed. Rarely is there a compassionate, honest response from someone who is focused on our well-being.

Our willingness as therapists to share what we feel in the encounter with our patient is how we establish an empathic, healing connection. It's not a comment about what the patient is doing, it's about how you are affected by their behavior. Are you bored? Intimidated? Confused? Sad? Fearful? Compassionate self-disclosure of our reactions and feelings in a session is often what clients find most illuminating and useful. If I find myself feeling that I would rather be sitting in the dentist chair getting a tooth drilled than in my office with a patient, I need to pay attention to what is happening between us and stay present with that feeling. When a patient is wondering why they can't get further than a third date with someone, watch how they treat you during their third session and share your observations and reactions. The challenge then is to find a loving way to express my awareness to the patient so that he or she can hear it as useful information about how they are affecting me and possibly others.

No Matter Where You Go, There You Are

One aspect of being in the big chair that experienced clinicians are aware of is the almost constant sense of encountering our own dilemmas in our patients' narratives. It's eerie at times how patients' concerns reflect the exact issues that I am going through or surface unresolved issues in my life. We must be able to go where the patient goes, even when that leads

us to a confrontation with our own shortcomings, faults, and heartbreaks. Being a psychotherapist requires us to become adept at establishing and maintaining a connection with others, but I inevitably find that it also entails an ongoing commitment to how I connect to my own life. If I'm working with a patient to help them relate more honestly with a spouse, I can't escape reflecting about my own relationship and how able I am to be open and truthful with my partner.

I find it especially challenging when a patient's struggles closely resemble my own. It's easy for me to get distracted, make assumptions, or jump to conclusions. I want to be exquisitely aware of feelings and projections that come up in those sessions and be conscious of how that is influencing or impacting our connection. I remember a young couple coming in to discuss their marriage plans and how to resolve some issues with the recently divorced parents of the groom who they worried might create problems at their wedding due to their ongoing anger and squabbling. The couple was so in love and excited about starting their life together as husband and wife. I met them as I was going through a painful, confusing, unexpected divorce when after a decade together, my husband had fallen in love with someone else. It was all I could do to not grab the young woman by the arms and tell her "RUN, JUST GO NOW!" I needed to be exquisitely careful that I didn't let my distress interfere with being happy for them and dedicating myself to helping them with their concerns. I remember them because working with them was actually helpful to me. It reminded me of how wonderful being in love was and the sensation of being excited and hopeful about the future. I hadn't felt that for a while, and it let me remember my former husband in a more kind and caring way. For many years, he had been a loving and devoted partner and we had enjoyed each other's company on many adventures. Although they never knew it, they assisted me in feeling grateful for what I had experienced in my marriage and in letting go of much of the pain I had been feeling. I did tell them how much I enjoyed working with them and that I would remember them with great fondness when we concluded our work together. That has certainly been the case.

We must care enough to tell our patients how it feels to be with them. We most effectively connect to patients when we compassionately share how we feel about our work together, not about what they are doing. I might tell a client that I'm very honored by their trust in disclosing something

painful or secret or that their willingness to take a risk with me helps me feel more connected. "One just cannot see clients week after week, listen to their stories, and dry their tears without being profoundly affected by the experience" (Kottler, 2017, p. 10). It's both the blessing and curse of our profession that we are vulnerable to being emotionally impacted by our patients. It's what I love and fear the most about being in the big chair. Most of us have cried with our patients, laughed together, and shared in their anxiety about dangers present in their lives. I keep two boxes of tissues in the office, one for me and one for the patient. That deep connection to someone in pain is a transformative experience. Over time, it's made me much more tolerant of the mundane miseries of life such as bad drivers, long lines, and small aches and pains that I commonly encounter.

The Art of Confrontation

We establish trust by being courageous. Learning how to confront patients is a vital aspect of what we do in therapy. I describe confrontation as holding up a mirror, so the patient has a better idea of how their behavior is impacting both themselves and others. It is not the aggressive, self-serving type of encounter that is often our image of a social confrontation. Therapeutic confrontation is essentially helping the patient to engage in self-confrontation. The therapist is on the patient's side; it is done empathically with the goal of helping the patient face the impact, feelings, and reactions that their behavior is generating. The honesty and immediacy of an observation that a patient can get from a therapist is a rare opportunity to see themselves more clearly and take that information into consideration in determining their choices. There's no blaming or shaming, no "should" or "if you don't…," no anger or angst that accompanies the observation, just "Here's what I'm seeing or hearing," "How does that fit with what you want more or less of in your life?"

I look for the discrepancies between what a patient says they want and the behaviors that interfere with them meeting that goal. The purpose of confrontation is to empower the patient; to give them feedback that can assist them in making decisions about what to do. "There are often discrepancies in what clients say, and it can be deeply empathic to help the person articulate those discrepancies without judgment" (Martin, 2016, p. 55). I like to use a "Columbo" approach. Columbo was a television series about

a seemingly bumbling detective who was a master at using his confusion as a way to confront crime suspects. He looked for the discrepancies: "You're saying you have insomnia and usually can't get to sleep until 3 a.m., but when your girlfriend called you at 10 p.m. and asked you to come over because she had gotten a threatening phone call from a neighbor, you said you were sound asleep. I'm confused about what happened there?" For me, it may be "You say you want to stop getting drunk but you're making plans to go out to the bar with your friends tomorrow night. How does that fit with your goal of sobriety?"

Most of us are understandably uncomfortable sharing a reaction that might sound negative. Confronting a patient with an observation that is challenging to them is risky. Confrontation that is therapeutic is a bit like stand-up comedy, it takes practice and a sense of timing. Avoiding it when needed, however, undermines our effectiveness and contributes to a lack of trust. Most of us know when we are behaving poorly and making choices that work against our best interests. To pretend with a patient that there's nothing problematic going on during our meetings with them undermines trust. If a patient has some sense that they are acting in ways that contribute to difficulties in their relationships and we don't acknowledge that in the therapy relationship, that sends the message that we're not willing to really engage and be honest. Confrontation is an important element of building trust; the assurance that we won't let our patient get away with behaviors that are harming them. We must be able to speak up when our patients are acting in ways that feel threatening or keep us in the dark about what's really happening. If we don't confront them, we are withholding critically important information that they are unlikely to get elsewhere.

Much of what I admire in my highly skilled colleagues is their ability to know what to share with a patient and, most importantly, how and when to offer a critical observation. Empathic confrontation is an art, one that takes a great deal of practice and a willingness to take risks. In our personal lives, sharing something with a loved one that you know may cause them distress is tremendously difficult for most of us. Those are situations that we prefer to avoid. Consequently, the art of compassionate confrontation is something that we must learn and practice if we are to be effective therapists.

Good supervisors are invaluable in helping us develop the skill of compassionate confrontation. I'm especially fond of either live supervision behind a mirror or reviewing videos of sessions when training new

colleagues. We can begin to identify the "tells," those signs that the trainee is becoming disconnected or uncomfortable. I recognize my most common signals are looking repeatedly at the office clock, changing the subject, and spending more time talking in the session than the patient does. When I engage in those, I know it's time to pay attention to what I'm feeling in the session. There are clues that supervisors can see that may be out of our awareness. If you haven't already, find a supervisor who can spend time helping you learn your signals. Being able to recognize, acknowledge, and process that information with a patient is likely to be valuable.

Finding the Pony

One of the most important things that we can offer our patients is hope. Hope is what empowers us to take risks and change course. During a crisis, we all struggle to imagine a life we can find satisfying and meaningful. When you're afraid you are drowning it's hard to recall sitting safely on the shore. Entering psychotherapy is often the last resort for people; they have already tried other solutions that didn't help. "Because people are coming to therapy for their problems, it is easy for both client and therapist to get tunnel vision and forget to see the positive aspects of their lives" (Cozolino, 2004, p. 53). One of the most important things a therapist needs to learn is often overlooked in clinical training programs: How to look for the pony. I share the following story with my students.

> Some behavioral researchers were interested in finding out how children cope with highly negative environments and designed the following study. There was a door with an observation window leading into a large room where the researchers could observe their subjects. Two subjects were selected, both 11-year-old girls who were of the same height. They were told that they were going to be placed in the room one at a time and observed, but that they could leave any time by knocking on the door. The first little girl is led to the door, the door opens, and she is pushed into the room. To create a negative environment, the room was filled with horse shit up to chin height for the girls. After just a few seconds in the room, the first girl is screaming to be let out and pounding on the door. The researchers let her out and ask her about her

> experience. "It was HORRIBLE, I can't believe you did that to me!" She's crying and very upset. They calm the girl down, gather their data, make their notations, and send the first girl away. They then bring the second girl to the door. The door is opened, and she is pushed into the room filled with horse shit. Through the window, they see her beginning to move slowly around the room, but soon, she begins to laugh and starts flinging horse shit in the air as she moves everywhere in the space. After 20 minutes, she's still laughing and flinging horse shit and they decide to invite her out. She reluctantly comes to the door, covered in horse shit but smiling and still giggling. They ask her about her experience, and she tells them simply, "I was looking for the pony."

It's a therapist's job to look for the pony, even when it appears that it's just a room full of shit. I believe that one of the most overlooked aspects of clinical training is that we are not very well prepared to recognize and assess the positive, effective, healthy behaviors and beliefs of our patients. If we don't recognize what those are in our patients, we certainly can't help them be more aware of their strengths. I often determine whether a counseling skills textbook will be adopted for my courses based on the subject index. Is there compassion, confrontation, and hope in that index? Those are vital attitudes and skills to learn in order to become an effective psychotherapist.

Employing a more positive vocabulary is an important part of introducing hope and building confidence. Therapists have established an enormous, nuanced, detailed dictionary to describe pathology and problems. We need the equivalent of a Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) that focuses on assessing the positive aspects of who we are. Is our patient creative? Resilient? Persevering? Do they have a good sense of humor? Can they tolerate discomfort and uncertainty? Are they compassionate and connected to others? Do they assume responsibility for their behaviors and choices? Are they kind? Generous? We need to have the ability to get in the room full of shit with them and search for the pony. Establishing hope relies on our ability to hold a mirror up to patients that lets them see what helpful experiences, traits, and beliefs they bring to psychotherapy. In addition to confronting the discrepancies, I want to confront them with their strengths and examples of good choices they've made. We both acknowledge the shit in the

room but believe firmly that there's a pony in there somewhere. That's my foundation for finding hope.

So, how do we find the pony? First, we must have an unshakeable belief that there's one there. Regardless of how messy and problematic a patient's life has become, the reason they are with me is to clean up that mess. We learn to look past the chaos to find order. It helps to appreciate that chaos, and the crises that spin out of it, actually set the stage for new order and stability to emerge (Butz, Chamberlain & McCown, 1997). When we simply can't keep doing what we've been doing, it's time for a change. As the Asian symbols for the word crisis indicate, crisis is a combination of danger and opportunity. If we get caught in the illusion that there's nothing useful in a patient's life, that it's just a room full of shit, then we will also run crying from the room at some point. Believe in the pony, it's there somewhere.

The first step in finding the pony requires being intently focused on listening for information about the patient's life, both past and present, which has a positive, healthy aspect. Are they resourceful? Engaging? Funny? Thoughtful? Some questions to elicit this information are, "What would someone who knows you well tell me that they like most about you," "What is an aspect of yourself that you would never want to give up?" "What are some things that you regularly do that make you happy?" I want them to give me a description of the pony from their perspective. It's important for me not to get locked into a description of their best self that doesn't fit with what they believe. Most of us endure some level of annoyance when someone attempts to compliment us in a way that simply doesn't fit our self-perception. The pony can't be phony, it must resonate with how the patient sees themselves. Effective therapists know how to work with what they've got, not with what they might want.

Finding the Positive with Reluctant Patients

I believe that even with involuntary patients, those who are with us because someone else thinks they need help, we must search for the pony. People are always free to ignore a court order or ultimatum from a boss or partner. Certainly, there will be consequences for that choice, but many take that path rather than getting involved in therapy. With those patients who do choose to see me, regardless of how reluctantly, I invite them to join me on the search for the pony. I ask them, "What is something you're

proud of that you want me to know about," "Tell me about a bad decision you made and how you overcame that?" or "Think of a problem that you have successfully resolved." I've yet to meet anyone who doesn't have some experience of feeling competent or proud of an accomplishment in their life. Look for ponies both large and small: They learned to speak a second language, they left an abusive relationship, they helped their son learn to ride a bike, they figured out how to stay alive on the streets during the winter. Everyone has something they like about themselves that they wish other people could see in them. I want to know what that is and make it an important part of building our connection.

I encourage reluctant patients to share things that they feel good about in their life, what they like about themselves, what they wish others knew that would help them feel more understood. Particularly with patients who might be hesitant or even hostile to being in therapy, connecting with positive aspects of themselves can help to reduce the fear that I'm just another "expert" who is going to blame or label them. Even if they can't or won't engage with that exploration, I point out that "It takes a lot of courage to even come to meet with me. I know you didn't have to; you could have instead taken whatever consequences came your way. I appreciate that you're here." I also want to be clear that I'm on their side and I'm working for their welfare regardless of whether someone else made them seek help. I'm very clear about what I may be required to disclose to others (e.g., the court or their employer) but that my main purpose is to help them in any way I can. I assure them that they will have access to any reports or information about them that I'm sharing with others and secure a release of information even when it's already clear that the judge or their boss has access to my findings. Establishing trust with reluctant or involuntary patients is critical for any meaningful work is to occur.

I also want to know about any time in their life that they felt safe, competent, understood, happy, or satisfied. Have they found the pony before in their life? I might encourage them to "Tell me about a time in your life that you felt safe or happy." "If you could go back to any single experience in your life, what would it be?" "What about that time was most important for you?" I particularly focus on how they contributed to those positive experiences and what they did to make those times happen. Most likely, they haven't always been in a room full of shit. At some points, they were able to enjoy a ride on the pony.

Finally, I build with them a sense of hope that they can clean up the mess. I've learned to be clear in my thinking that I am not the one responsible for fixing someone else's life. If we approach patients as people who need to be "fixed" that means we will treat them as if they are broken. We are a character in their life story, but they are the author. Often, you will see hope for a patient before they do. As you get a better picture of the pony, share it with them with conviction and enthusiasm. Most of us have had the wonderful gift of someone who believes in us, who sees the potential and the good in us. I sometimes lament that there aren't cheerleaders for those of us who got through a betrayal without becoming bitter and vindictive, who experienced profound losses but didn't fall into despair, who reached out to help others even when we were suffering. Those things are truly worth cheering about so keep some pom-poms in your office and use them.

NOTES FROM THE BIG CHAIR

We use the power of our presence to build connection. "A therapist who is vibrant, inspirational, and charismatic; who is sincere, loving, and nurturing; and who is wise, confident, and self-disciplined will often have an impact through the sheer force and power of her essence..." (Kottler, 2017, p. 3). Your theoretical orientation and the specific techniques that you've learned aren't the important factors in making an effective connection to a patient: You are. You can't fake this stuff. Empathic confrontation, empowering patients, and bringing hope to our work are important skills, but more importantly, they're reflections of who we are. We are people who engage in the hard work of loving those who may feel unlovable. We are brave companions to others who are in horrible pain and despair. Our healing presence is a mixture of compassion, curiosity, confrontation, courage, and hope. That's what a therapist's pony looks like. Saddle up and ride in.

Lessons from the Big Chair: Chapter 6

- Connection is based on trust and hope.
- My job is to be present and aware of myself in the relationship – how I'm being affected, how it feels for me to be with a patient, and what

I might be bringing to the relationship that will help or hinder their progress.

- It takes courage to be connected to people who are suffering and to confront the ways in which they create aspects of that suffering.
- We must be willing to acknowledge and share our perceptions and reactions for the benefit of the patient.
- As a therapist, we must have an unshakable belief that there's a pony in the messiness and chaos of our patients' lives and be able to dig in and help them find it.

Case Study: Theresa

Theresa was referred to me by her physician following a car accident in which she was seriously injured. Following the accident, she developed panic attacks and a degree of anxiety that made her unable to drive and it was difficult for her to even be a passenger in a car. Because the physician knew I practiced EMDR (Eye Movement Desensitization and Reconstruction) (Shapiro, 2018), she referred the patient for help managing her anxiety. EMDR therapy is an interactive psychotherapy technique used to relieve psychological stress based on trauma. I had trained with its founder, Francine Shapiro, and used it successfully with many patients who were suffering from Post-Traumatic Stress Disorder (PTSD).

When I went to meet her, Theresa was seated in the corner of the waiting room, hidden behind a large magazine she was reading. When I approached her and spoke her name, she was clearly very uncomfortable. As I shook hands and introduced myself, I could feel her hand trembling and was aware that she looked at the floor as I led her to the office. She was a single, white woman in her early 30s, moderately overweight, with curly blond hair. In the office, she again sat in the corner of the couch, as far away from me as possible. Her anxiety was like a force field that surrounded her. I worried I might scare her away like a deer that gets startled if I come to close.

During the initial interview, she spoke in a quiet voice and rarely looked up from the floor. I always invite new patients to ask me any questions they might have before starting the interview. She had never seen a therapist

before but had no questions for me. Theresa shared that she was coming to see me only because her physician had asked her to and that she didn't think I could be of much help. I assured her that our first meeting would help us both determine if working together might be useful for her. Theresa reluctantly described the car accident and the anxiety that had invaded her following that event, making it almost impossible for her to function. Theresa was missing work, isolated, and fearful she would lose her apartment if she lost her job. Driving was a nightmare for her. She clearly had Post Traumatic Stress Disorder (PTSD) symptoms: Nightmares, situational triggers that made her feel unsafe (such as driving or being in a car on busy streets), flashbacks to the accident, and difficulty in sleeping and eating. In the accident, her pelvis had been crushed and she required both surgery and physical therapy for many months before she was able to return to her apartment where she lived alone. She had stayed with a sister during her recovery.

When I asked about her family, she again became very anxious and I noticed her hands shaking again. She was the youngest child with an older brother, Jim, and older sister, Arlene. She related only basic information about her family and declined to answer some questions. She did admit that there were addiction problems with her brother and possibly with an uncle on her mother's side of the family. Along with talking about the accident, sharing information about her family also created a great deal of discomfort for her. I tucked those observations away to return to later if she stayed with me in therapy.

Her main concern and the reason for the referral was to reduce the anxiety so that she could resume functioning independently. We reviewed the procedures for EMDR, I gave her some information to read to help her determine if she wanted to try the process if she chose to return. By the end of the interview, Theresa was comfortable enough to say she would come back again, and we set up an appointment for the following week. At the second session, she committed to trying EMDR and we began that process. In the screening, she stated she didn't have any other history of trauma other than the accident. She was a good candidate and responded well to the initial trial using the technique. Theresa stayed with the process during that session and was able to get some reduction in her overall anxiety about the accident. She decided she wanted to continue our work and during the next few EMDR sessions, she was able to recall images of the

accident without severe anxiety and reported fewer nightmares and enough comfort to drive herself to work and to shop for groceries.

During what was to be our final session of EMDR, we were working on reducing the body discomfort that she had experienced in her pelvic region since she carried a lot of her physical tension there and still had residual pain from the accident. That session provoked a very strong response as I asked her to focus on the physical sensations in her pelvis, abdomen, and groin. She started shaking and sobbing uncontrollably. We stopped the EMDR and I asked her what had come up for her. Theresa shared that she had been sexually assaulted as a child at about age 10 but hadn't recalled any memories or thoughts about that for a very long time. That confession certainly helped me understand her initial fear about seeking therapy. She must have worried that at some point we might uncover her hidden history.

Rather than opening that issue further, I helped her to calm down and we set another meeting with the understanding that she could share more about that if she wanted to in the next session. I reminded her to write down anything she wished to talk about with me in her journal. At our next session, she was very reserved and quiet again, avoided eye contact and was clearly anxious, much as she had been at our first meeting. In a way, it was a first meeting with the Theresa who had been harmed as a child. All the trust we had built together through the EMDR sessions would need to be rebuilt and be much stronger if she was to tolerate opening the secrets about her abuse. It's often the case that current anxiety and pain (for Theresa, the car accident) link us to times when we had those feelings previously.

That was certainly true for Theresa. She had been depressed for much of the prior week and had some trouble with nightmares again, but the current dreams were about the sexual abuse. She was a very modest, shy woman, and didn't want to go into any detail. I wanted to establish that both she and others were not in any danger from her attacker, so asked if she could disclose who it was. Theresa said it was an uncle, her mother's brother Luke, who had visited her family and that it had only occurred on one occasion. She claimed that the uncle had been deceased for over 20 years; he died in a car accident while he was intoxicated.

Theresa was very reluctant to talk about any details of what happened. My approach is to be very respectful and patient when beginning to talk about trauma history so long as there is no immediate or ongoing threat.

I appreciate how painful this type of work can be. She never told anyone about the sexual assault but did tell her mother after the incident that "I don't like Uncle Luke" and he was never invited back to their home. She said that she remembered her mother becoming angry when she told her she didn't like him, but she wasn't angry with her, she was angry with Luke. I wondered if Theresa's mother had also been victimized by her brother when she was young. Fortunately, Uncle Luke didn't visit the family again. Theresa remembered when she heard that he had died. Her family didn't go to the funeral and she remembered her mother saying, "Good riddance."

Theresa and I continued working together for the next 3 years. She was one of my longest-term patients. We worked together on processing the sexual abuse and how that had affected her development, particularly her social life. She had never dated and avoided any intimate contact. She felt ashamed of what had happened but was able to appreciate that she was a child who wasn't able to protect herself when the abuse occurred. Theresa had, however, protected her mother, who had bouts of depression and anxiety, by not telling her about the molestation. During our work together, Theresa became more involved in social activities through her church and met a man named Jim who asked her out. When Theresa told me this, she broke down in tears and couldn't speak for some time. I handed her tissues and waited until she could catch her breath. "What happened Theresa? It's clear that there's something very upsetting about meeting Jim." She was again shaking, something that I hadn't seen for almost 2 years. "Jim is my brother's name" she said as she stared at the floor. I asked, "Can you tell me what's happening. Do you feel safe sharing with me what brought up these tears?"

Her first response was, "I'm sorry, I hope you won't be angry with me." I assured her that I wouldn't be upset with her regardless of what she shared. Theresa finally had the courage to tell me that "I wasn't molested just by my uncle, it was also my brother, Jim." Her older brother, Jim, had begun sneaking into her bedroom when she was five and his abuse continued until she was 12 and started having her menstrual periods. He kept her quiet by telling her that their parents wouldn't believe her and that he'd kill her and her sister if she told. Jim had a rifle that he threatened her with many times. For most of her childhood, she feared for her life as she struggled to keep a horribly painful secret.

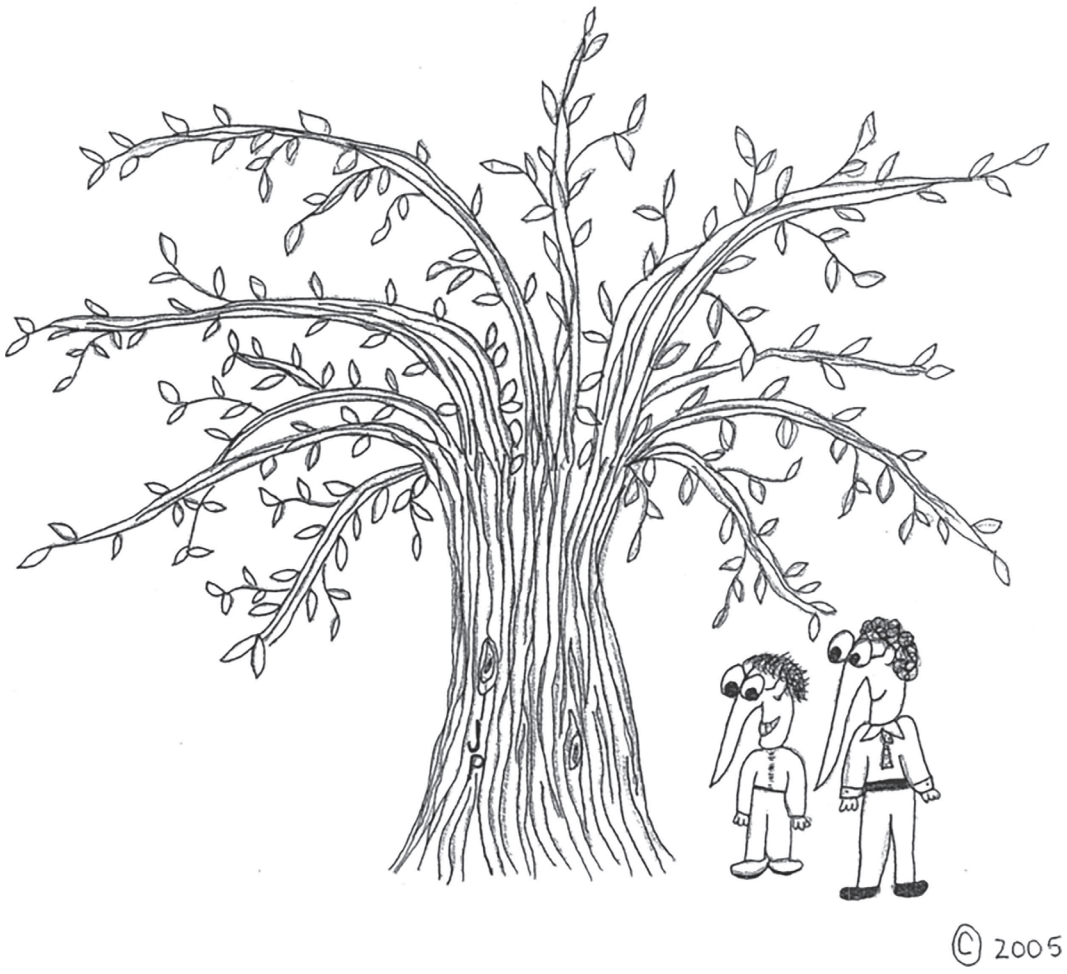
After almost three years, she finally was able to tell me about his sadistic abuse and her childhood filled with fear. As an adolescent and adult, Jim was addicted to alcohol and drugs and ran away from home shortly after he stopped abusing her. She had no contact with him after he left and found out that he had died almost 10 years ago while in prison. When her new friend, Jim, asked her out and kissed her at the end of their first date, she found herself overwhelmed by guilt and fear. We continued together in therapy for another year to work through her childhood trauma and help her make a healthy adjustment to the new aspects of her life including her first romantic relationship with James. She asked Jim if she could call him James instead and was able to share some of her backgrounds with him over that year. When we finally ended our work together, she and James were living together, Theresa was back at work, and she was planning her wedding.

Lesson from the Big Chair: Patience

I was so grateful that Theresa had the courage and determination to stay with me in psychotherapy for the four years that it took for us to sort through all that she brought to that endeavor. Although she came in at the request of someone else, finding some relief from her immediate anxiety helped her be more willing to engage with psychotherapy. It was an important lesson to me in patience and letting the story unfold in its own time. When someone has a long history of traumatic abuse, trusting others is a terrifying leap of faith. It was an honor that she let me be the one to hear her story and that she was also willing to be patient with me. I'm so grateful that we both were able to stay connected long enough for Theresa to finally tell her true story.

Chapter 4

The Questioning Tree



The therapist uses questions to retrieve information, acquire insight, move to a deeper part of the client's story, or suggest that the client consider things in a different way. This technique is sometimes overused, especially by inexperienced therapists. Excessive questioning may also send the message to the client that his role is simply to answer such queries. Those significant cautions noted, however, questions still form a cornerstone for many theories of therapy. Questions may range from those that elicit short client responses to advanced inquires designed to prompt the client to assess or challenge some significant behavior.

The wording of the question is absolutely critical. For example, skilled practitioners understand that asking a question about the past versus the future can have a significantly different

impact on the response by the client. And based on what we are learning regarding neurobiological implications of the counseling process, these two distinct directions also target very different parts of the brain. This is interesting when you consider the fact that between the two questions are only a few different words. Along with tense (past, present, future), there are also different types of people to ask about, such as self or others. These two categories also provide differing responses, even if the therapist is asking about the same subject.

Most counselors will suggest that good questions have an anchor in the client's story. Because questions ask the client to reveal or discuss possibly some new information, questions that come out of the blue at the client may not be as successful as those that have a point of reference for the client to understand the meaning and purpose of what is being asked.

Finally, a word of caution for beginning therapists. We have found that some counselors can lean heavily on questions as a crutch to either avoid topics with the client or to avoid making mistakes by labeling things like feelings, meanings, etc. We strongly encourage the use of questions with moderation and with care as not to be overused or relied upon to avoid the hard work of taking therapeutic risks with your clients.

CLOSED QUESTION

Approach aligned with: Universal skill

Purpose: To have the client provide specific information. These questions usually promote brief client responses—one word or a short phrase. They are useful for retrieving pertinent, specific information and/or highlighting material the therapist believes the client should know or make use of in the moment, later in the session, or in subsequent sessions.

What the therapist does: The therapist asks the client a question that is intended to generate a short answer of one or a few words. Usually, these questions start with "who," "is," "do," "did," "are," or "does."

Examples

245. Did anyone help you?
246. Do you get a break during the evening at all?
247. Are there times when you get a chance to sit down and relax?
248. How long does it take to finish all of your stuff?
249. Do your kids notice all the work you are doing?
250. Are you thinking about changing your schedule?
251. Are there days when you don't get everything done?
252. Do I understand that you do all of this alone?
253. Is there a way you can change your schedule at all?
254. Are things bad enough yet to change?
255. What percentage of your activities involve doing things for others?
256. Who treats you with the most respect and dignity?
257. Are you thinking about quitting?
258. Have you considered not doing so much for others?
259. Do you think anyone else working there is treated like you?
260. Who can give you a clearer job description?
261. Can you get along in your job as it is now?
262. Are you thinking you want a new position in the company?
263. Do you need my help in changing your role with the company?

Client:	I guess I just never got a chance to learn how to handle stress in a good way.
Therapist:	Of the people you know who handle stress well, who would you like to model yourself after? *or*
Therapist:	Among everyone you know, who handles stress the best? *or*
Therapist:	What one word best describes how you handle stress right now?

OPEN QUESTION

Approach aligned with: Universal skill

Purpose: To promote a detailed discussion pertaining to a part of the client's story. The intent of these questions is to elicit lengthy responses from the client. In helping the client relate her story, further questioning on specific aspects of the client's life may be appropriate.

What the therapist does: The therapist asks a question that is intended to get the client to discuss an issue in greater detail (more than a few words). Open questions usually start with "how," "why," or "what."

Examples

264. What is it like to be so busy?
265. How do you get all of that done?
266. What would happen if you refused to do the chores?
267. When the evening goes well, what is happening?
268. What is it like to have so many things waiting for you when you get home?
269. How might the family react if you suddenly stopped doing so much?
270. How would the family react to you if you refused to do the laundry?
271. Can you tell me what you feel after you finish all of your chores?
272. What have you tried to get the kids to help around the house?
273. What would have to happen for you to decide you have done your last chore?
274. What is it like for you when people notice what you do?
275. What options have you explored in relation to your problems at work?
276. How do others respond to you when you don't do their work?
277. What are some of the expectations placed on your coworkers?
278. What has been the worst experience you have had at work?
279. What has been the best experience you have had at work?

Client:	Sometimes work is good, but most of the time I hate being there and really don't like the people I work with.
Therapist:	When things are going well at work, what is happening? *or*
Therapist:	How do your coworkers relate to one another and to you while you're at work?

CHECKOUT

Approach aligned with: Universal skill

Purpose: To ensure that the therapist is hearing the client correctly. The technique can be linked to other skills such as confrontation, questions, or reflecting material back to the client; however, the key ingredient in this skill is making sure what has been sent by the client has been accurately received by the therapist.

What the therapist does: The therapist asks the client if what he has heard is correct or if the client is feeling that the therapist has understood him.

Examples

280. Okay, let me see if I have this right . . .
281. Am I hearing you correctly that . . .?
282. Did you say that . . .?
283. Let me check something . . . did I hear that right?
284. So do I understand you right that . . .?
285. You are saying that . . .
286. You said . . . am I hearing that right?
287. You said that you felt . . . am I hearing how you feel correctly?
288. You gave several examples there; they were . . ., did I catch all of them?
289. Do I have it correct that . . .?
290. All right, is what you just said similar to . . .?
291. Would I be correct to say to you that I heard you say . . .?
292. Let me check out whether I caught what you were saying right; was it . . .?
293. I want to make sure that I am hearing you correctly; your story is that . . .
294. In essence then, you're feeling that . . . right?
295. Okay, so what you would like is to . . . did I get that correct?
296. Let me check something out with you; you feel that . . .
297. Okay, do I have it right that you want to be . . .?

Client: So after I got done telling her about it, she just looked at me and walked away. I was hoping she would say at least something about it.
Therapist: So, if I understand it right, you wanted to hear her reaction to what you said.

ASKING THE QUESTION

Approach aligned with: Individual psychology

Purpose: To bring to the surface client goals and objectives, the price paid for the behavior, and the payoff for continuing the behavior.

What the therapist does: The therapist asks a question similar to the core question: "What would be different if you were well?"

Examples

298. What would be different if you were well?
299. How will your life be different when the problem is no longer in your life?
300. What will be different when you are well?
301. What effect on your life will getting well have?
302. When you are better, what will be different?
303. What will change when you are better?
304. When things improve and you are well, what will be different?
305. How will improvements and your increased wellness change your life?
306. As you improve, what will change in your life?
307. Now that you are on your way to being well, what will change in your life that you are most aware of?
308. What do you imagine will change when you are well?
309. When you are no longer depressed, how will your life change?
310. If things change for the better, how will your life be altered?
311. Thinking for a minute and just hypothesizing, how do you see your life improving as a result of getting better?
312. What things will change in your life when you get to feeling better?
313. What would change if things were good in your life?
314. If things keep improving and you get to feeling even better, things will obviously change. In what ways will your life be different?
315. Over time, as your life comes back to where you want it, things will change. What things are you most expecting to be different at that point?
316. You have been working really hard at improving things in your life; how do you see things changing as a result of your effort?

COGNITIVE DISPUTATION

Approach aligned with: Cognitive-Behavioral Therapy

Purpose: To help the client understand the faulty assumption on which the client is basing her belief and the subsequent thoughts and actions that occur as a result of that belief.

What the therapist does: The therapist asks the client to provide evidence or proof that the belief behind the maintenance of her fear, anger, hurt, embarrassment, etc., is actually logical or rational.

Examples

317. What proof do you have that you are correct in assuming that no one at the party would like you to dance?
318. Does it make sense to you to believe that if you are embarrassed once at work, you will always be embarrassed at work?
319. Can you give me some evidence to support your notion that you are the worst student in the class?
320. You said that you feel as though the world is always watching you and waiting for you to make a mistake. I am curious, if this were an absolute truth, would it not be safer for you to hide in a cave away from others?
321. If you continue to believe that you were the reason your parents got a divorce, what effect will that have on the rest of your life?
322. How realistic is it to believe that you and your sister will never again talk or share anything important?
323. How can you show me that your belief about yourself is actually a fact and not just imagination?
324. What would someone else say in defense of your logic in regard to your statement that if you fail to pay one credit card on time you will always be in debt?
325. As you said, you are always the life of the party and that sometimes gets you in trouble. I wonder what proof you have that you must always be the life of the party?
326. What effect will it have on the rest of your life if you continue to tell yourself that you always must be perfect?

Client: Having depression is the worst thing in the world. It is like having a scarlet letter *W* for worthless.

Therapist: What evidence do you have to support this idea that depression equals worthlessness?

CIRCULAR QUESTIONING

Approach aligned with: Individual therapy and family therapy

Purpose: To incorporate alternatives into the client's or family's story. The technique uses questions framed in a way that asks client(s) to think about the connections between and among family members. Rather than direct didactic questioning, this technique encourages the client to focus on the function of the problem within the entire system.

What the therapist does: The therapist asks a question rooted in surfacing the relationship others have with the issue.

Examples

327. Who among everyone in your family has the clearest picture of the issue?
328. Who among everyone you know has the most hope for the family?
329. Among your immediate and distant family and all of your friends, which people have the least amount of hope for the relationship to succeed?
330. What does the person who knows the most about the situation know that the rest of the family doesn't?
331. Who sees how close the two of you really are?
332. Which of your children is most apt to pick up on your subtle language?
333. When things are really going well, who is most often promoting the happy times?
334. Which family member has the keenest eye for changes in the family?
335. How might someone from outside the system be making sense of the changes you have described?
336. Thinking back to when the problem started, who in the family was the first to notice how it was affecting the family?

Client:	It's hard for us to even be in the same room. It's like mixing gasoline and fire, and it has been like that for as long as I can remember.
Therapist:	Who is most affected by this combustible situation? *or*
Therapist:	Besides you two, among everyone you know, who is the most affected by this volatile relationship?

EXTERNALIZING THE PROBLEM

Approach aligned with: Brief therapy

Purpose: To help the client see the problem as a separate entity from herself. It is used in family therapy to help the family focus less on who owns the problem and more on how to unite as a unit and resolve to defeat the problem.

What the therapist does: The therapist encourages the client to view the problem as outside of herself. This is done by statements and questions that focus on the effect of the problem as an entity unto itself. The therapist can also try to shed light on the amount of energy the problem has taken from the client or the way in which the problem tricked the client to join it.

Examples

337. When you think of this depression thing—what color is it?
338. In terms of your relationship to being afraid of being in a large group of people, what name would you give it?
339. Now that you have named your sense of depression as the blob, I'm curious how it recruited you into being a willing partner?
340. As a family, what name would you give to this difficult morning routine you described?
341. What color is this thing that tricks you into believing you are not worthy of love?
342. Okay, now I want you to tell me what shape you see when you think about the pain of losing your job.
343. How did this lumpy, yellowish-green thing convince you to do that against your better judgment?
344. Who among everyone you know has the best view of what the "ugly messy anger thing" does to get you to act out?
345. Okay, so now let's work together as a family. Who will sound the alarm when they see that the morning gremlin has returned?
346. What smell do you associate with this "gloomy monster"?
347. How did the problem trick you into believing it was a friend?
348. In which instances did the problem convince you to do things that were against your better judgment?
349. How much of your time and energy has this problem talked you into spending on it?

MIRACLE QUESTION

Approach aligned with: Brief therapy

Purpose: To have the client envision the world as if everything is okay. It also helps the therapist hear the core or critical issue for the client.

What the therapist does: The therapist asks the client how his life would be different or what he would notice to be different if the problem were to suddenly go away. This question is anchored in envisioning that a miracle has occurred.

Examples

350. If you were to go to bed tonight and sometime during the night a miracle happened that caused your problem to disappear, what would be the first sign that things had changed when you woke up?
351. Let's say that tonight after you go to sleep, a miracle happens. You are not sure exactly how it happened, but your problem suddenly goes away. When you wake up tomorrow, how will your life be different?
352. If a miracle happened after you went to bed tonight, what effect would that have on your problem?
353. How would your problem change if you went to bed tonight and while you slept a miracle happened?
354. What would change in your life if, say, during the night tonight, something happened and there was a miracle?
355. Now, I'm going to ask you something kind of strange . . . what if you were to go to sleep tonight, just as you normally do, and something different happened. A miracle took place while you slept. What would that miracle be?
356. If a miracle happened tonight and you woke up tomorrow and the problem was solved, outside of you, who would be the first to notice the change?
357. If a miracle happened tonight and you woke up tomorrow and the problem was solved, how would the world be different?
358. I know this is a goofy question . . . but if you were to suddenly realize that a miracle had taken place and the problem went away, what would be the change in your life?

PROBE

Approach aligned with: Universal skill

Purpose: To bring to the surface specific information germane to the issue being discussed.

What the therapist does: The therapist asks the client about specific information. Questions usually start with "who," "what," "when," or "how." Questions are asked in a way that elicits one- or two-word responses. These questions are a form of Closed Question.

Examples

359. Who among everyone you know has a good sense of what is happening?
360. Where were you when you heard that news?
361. What was the strongest emotion you had when you learned that you had been accepted into graduate school?
362. How many people do you know that have a similar set of beliefs as you?
363. What one word would you give to describe how your mother felt about you leaving home at that point in time?
364. Who provided the most hope for you when you were going through this before?
365. If you could connect the past and present versions of this dilemma in one or two words, what would they be?
366. Which of the resources you mentioned you have will be most important to you as you set off on a new career?
367. In thinking about your future, who do you think will be most important in making a strong case for you remaining in school?
368. What was the thing that first caught your eye as being a positive in her?
369. You mentioned wanting to understand her perspective better. Can you give me a word or two that defines where she is at with all of this?
370. When did you start to know that things were going to be all right in your life?

Client: As I thought about it, I wasn't sure whether or not to stay and try to figure it (the relationship) out.
Therapist: What signaled to you that it was worth it to stay in the relationship?

FORCED CHOICE QUESTION

Approach aligned with: Universal skill

Purpose: To have the client articulate direction or have the therapist embed positive reframes.

What the therapist does: The therapist asks a question that forces the client to choose between two or more options, choices, or alternatives.

Examples

371. Who do you believe will be of the most help to you as you begin the process of healing?
372. As we have spent our time together, we have discussed a number of different issues. We have discussed anger management, decision-making, communication skills, and awareness of nonverbal interactions. Which of these areas would you like to discuss as we proceed?
373. So as I hear you talking about the issue, I wonder which of these two things people notice most quickly about you. Is it your good intentions or your strong level of effort?
374. Was it that your mother was upset with your desire to be independent or your willfulness in expressing your opinion?
375. As you think about the things your parents did to you growing up, it seems you discuss their desire to keep you from your dreams. Was it that they wanted you to learn to work for what you wanted in life, or was it that they wanted to help you learn to overcome difficulties in a safe place?
376. There have been several things that you have talked about in relation to having depression. I want to take a minute and hypothesize about how this depression thing came into your life. Was it that it weaseled its way in when you weren't paying close attention, was it that somehow it tricked you into thinking it was a friend, or was it that it destroyed another part of your life that you had not been living to its fullest?
377. As we have talked about different career options, I want to hear about which is most important to you right now—working with people, working with ideas, or working with things.
378. When things get back to better for you and the problem goes away, what will you notice first—feeling more energetic, feeling happier, or getting along with others better?

THE TERRIBLE QUESTION

Approach aligned with: Universal skill

Purpose: To have the client consider that he will have to be diligent to prevent a relapse and/or to have the client make overt any hidden agenda or intentions (many times unknown to them) that might cause them to return to the previous state.

What the therapist does: The therapist asks the client a question that asks what would have to happen for the previous state to return. Variations of this skill may include questions that ask what the client or others might notice if the problem returns.

Examples

379. Okay, I am going to ask you a terrible question. What would have to happen for the problem to return?
380. This is a terrible thought, I know, but what would you have to do to have the problem come back into your life?
381. We need to discuss for a few minutes the fact that sometimes problems return to us even when we do not expect them. What will be the first thing to alert you to the fact that the problem is back in your life?
382. I have a terrible thought here, but I want to have you talk about how you will defeat the problem when it starts to creep back into your life. What will you use to combat such a sneaky force?
383. As we know, problems may sometimes reinvent themselves and take on new forms as we go about our busy lives. This is a bad thought I have, but I suspect the problem you have just defeated will do its best to make things rough for you again. If I am right, you will need a plan to stop such an infestation. What things in your life will be most affected if this problem returns?
384. This is a terrible question. What would have to happen for you to have a problem similar to the one you had when you started therapy?
385. I have a terrible question here, but I'm curious. You said that your wife noticed the changes you described in your affect and mood even before you did. What will she notice happening if the problem returns?
386. How will others around you become aware of the problem returning, that is, if it returns?

TRIADIC QUESTIONING

Approach aligned with: Family therapy and Group therapy

Purpose: To bring to the surface new insight and meanings to discussions and connections between and among individuals.

What the therapist does: The therapist asks one member of the family or group how two other family members or group members relate and function together.

Examples

387. Okay, Monique, I want to hear from you about the way your mom and dad talk to one another. What are you hearing them saying?
388. Now, let's take a minute and hear from someone who has been observing this interaction. Marg, what are you hearing Jim and Julio say to one another?
389. As we have been talking about how the family gets along, I want to know what you are seeing in the interaction between your brother and sister—how are they getting along?
390. I wonder what the other group members are seeing and hearing right now. Kenneth, can you describe how this interaction is going right now? What are you hearing them say to one another?
391. Okay, things are really getting heated. Bobby, you seemed to stay out of this mess. Be as detailed as you can be—what did you see happen?
392. If I understand the problem right, you are describing how when you wake up your son, he talks back to you, which causes you to get upset, and then the morning goes to hell rather quickly. So Kelly, you share a room with your brother—what do you see and hear happening between your mom and brother?
393. I wonder what the voice of an observer would provide us with. Billy, you have been watching this interaction all group. How are you seeing Anne and Meghan relate today?
394. As you reflect on the last week, keeping in mind that things are getting better in the household, what has changed in the relations between mom and dad? Let's start with Ahmad.
395. When you think about the last exchange we just saw between these two, who can share an observation of how they were getting along with one another?

SCALING QUESTION

Approach aligned with: Brief therapy

Purpose: To identify the level or degree of intensity of the problem. These questions may also be used to discern changes in the magnitude of the problem.

What the therapist does: The therapist asks the client to put the problem, issue, or resolution on a scale, usually from one to ten. Then the therapist may explore actions the client could take to change his number.

Examples

396. So we have been talking about how difficult this problem has been for you. It seems, as you said, that you have never felt this way. On a scale from one to ten—ten being the most—how much hope do you have for getting through this?
397. Obviously, as you just expressed, things are getting better. You must feel excited about that. On a scale from one to ten, how would you rate your sense of positive movement right now? Okay, then if you are a six right now, what would you have to do to go to a seven?
398. Last week you were a four on the scale, this week an eight. According to my math, that is a 100 percent gain in seven days. So in seven more days, at this pace you will be a 16. . . correct?
399. I would like everyone in the family to take a turn and rate, on a scale from one to ten—one being poor, ten being excellent—your own level of effort in resolving this family issue.
400. As group members, let's each take a minute and quantify the level of trust we feel right now within this group. Let's use a scale from one to fifteen, with fifteen being absolute, complete trust. Where are you on that scale?
401. Before we get going, I wanted to have you self-assess your level of effort in finding a job. On a scale from one to ten—one being low, ten being high—where are you?
402. One of the things I am interested in finding out is your level of pain and discomfort regarding your last depressive episode. You said that when you realized it was upon you, you were really low. On a scale from one to ten—one being the lowest you have ever been in your life—how would you rate it? Okay, so on that same scale, where are you as you sit here today?

COLLABORATIVE EMPIRICISM

Approach aligned with: Cognitive-Behavioral Therapy

Purpose: To have the client consider whether what they are thinking is accurate and logical. This technique is used to help the client stop automatic thoughts that are illogical and/or based on false conclusions.

What the therapist does: The therapist asks the client to examine thoughts from a researcher's perspective. The client is taught to actually look for evidence regarding the particular thought in question.

Examples

403. So what I heard you say was that everyone at work hates you. Let's see if we can find facts to support that. What evidence do you have to support that everyone hates you?
404. You mentioned that you were interested in asking him out but felt that you didn't look pretty enough. So I want you to ask at least seven people who would not lie to you about this question, whether or not this is true.
405. I heard you mention that you believe that your husband will never come around to understanding your position on this. I want you to go home tonight and make a list of at least ten things that have been really important to you that took some time for your husband to comprehend.
406. If it was true that you always make mistakes and get things wrong, shouldn't we be able to find all sorts of evidence of that in our therapy sessions? Can you help me see when you have done these things in here?
407. You seem to have some knowledge about the subject of friendship, right? And I heard you say that it is impossible for you to make new friends. I wonder what evidence you have to support that position.
408. When we talk about that issue . . . you seem to have a strong sense that nothing you ever do will have an effect on it. I am curious what support you have to offer in proving that this is true . . . that you have no effect on it.
409. You said that there is no way you could exercise three times this week. I want you to try an experiment. Exercise twice and then see what happens when you try to exercise the third time—see what gets in your way and makes you fail.

COMMUNICATION CLARIFICATION

Approach aligned with: Group therapy

Purpose: To enable clients to hear one another better. This technique is intended to focus group members on interactions and exchanges between and among them.

What the therapist does: The therapist asks the people involved in the discussion to make sure that they are being heard and that the other person is hearing the message that they intended to send.

Examples

410. Janie, what did you just hear Jimmy say?
411. Okay, so I'm wondering what the core message you are trying to send is.
412. I know that there is something useful in what you just said, but right now I, and perhaps the other group members, are a little unsure of what you mean.
413. Chrissy, you just got some strong feedback from Selina. What did you hear her say?
414. What are the other members of the group hearing in this conversation?
415. Liza, I want to make sure that you are being heard clearly. Who in the group got what you just said the clearest and how would they phrase it?
416. What is the main purpose behind what you are saying?
417. Can you clarify that statement?
418. So Amy and Erika are having a deep discussion. What are you hearing them say to one another, Fran?
419. Can anyone clarify the message Linda is sending to Kristen?
420. What are you all hearing as the message from Sedona to Kay?
421. I hear you saying something that seems important, but I'm unsure the message is being received as you intend it. What is it that you want Fran to hear from you right now?
422. As we are all hearing this conversation, I am wondering what you all are hearing Mary say to Ray?
423. We just had an emotional interaction. I'm sure each of you had your own personal reactions to it. If you could take a minute to set that aside, tell the group what you heard being said by these two.

PARTIAL TRANSCRIPT OF QUESTIONING TREE SKILLS AND TECHNIQUES

Note: Both this partial transcript and the full transcript in Chapter 13 show the use of questions. It is wise and warranted that therapists, especially those in training, understand that asking a lot of questions in a session is usually counterproductive. To this end, we suggest that real sessions should have very few questions as compared to the following fictional partial transcript. We have created our transcript to provide you with examples of the questions in context as opposed to suggesting that good therapy is similar to an interrogation or rapid-fire succession of questions directed at the client.

The following fictional transcript depicts a session with a couple.

Th = Therapist

424. Th: So, looking back over where we have traveled (to Mike), we have discussed your desire to be stronger in sharing your feelings and (to Sue) we have discussed your interest in sharing the household duties and responsibilities. (Summary) I want to know which of these two directions we would like to begin with? (Forced Choice Question)
Sue: We spent a lot of time talking about me last week. I think it would be nice to focus on Mike this week.
425. Th: Okay, Mike, is that okay with you? (Closed Question)
Mike: Yeah, I guess, I mean I think I am doing a lot better this week with it.
426. Th: Mike, can you describe for us how you were able to better share your feelings this week? (Open Question)
Mike: I just talked about stuff that was bothering me when it came up. I didn't keep it in.
Sue: I noticed that too; you shared with me that you didn't want my parents to come over Wednesday night. You wouldn't have done that before.
427. Th: Okay, so let me check out something here with you two. I hear both of you saying that Mike was really different this week and shared how he felt about your parents coming over. (Checkout)
Sue: Yep.
428. Th: So, Mike, in thinking about Sue and the kids, who was the first to notice that you were different in this way? (Circular Questioning)
Mike: Definitely Sue. She pays very close attention to what I say and do around the house.
Sue: Are you saying I pay too much attention to you?
Mike: No, I just know that you're good at noticing things.
429. Th: Okay, so Sue, there was something in what Mike said that made you think it was not a compliment. What did you hear Mike say? (Communication Clarification)
Sue: I heard him say that I notice things, but I also know that he tells me a lot of times to mind my own business.
430. Th: So, Sue, just now you heard him say to you that you should mind your own business more? (Probe)
Sue: Yes.
431. Th: Okay, so I wonder what evidence you have to support your idea? (Cognitive Disputation)
Sue: Well, I guess it is just what he has said before about me.
432. Th: Mike, could Sue be correct that you were telling her to mind her own business? (Closed Question)
Mike: No. I like that she pays attention to me.

433. Th: So Sue, having heard what Mike said and thinking of this as if you were outside the issue and it wasn't about you . . . (Sue interrupts)
Sue: Okay, yeah I get it, I see what you're saying. I guess you (to Mike) weren't really yelling at me right then.
Mike: No, no, I wasn't.
434. Th: When we started therapy, you two told me that your main goal was to communicate better. You said that you were a three on a scale from one to ten—do you remember? Okay, on that same scale—ten being exceptional at communication—what number do you both put on the last part of that interaction? (Scaling Question)
Mike: Five.
Sue: Six.
435. Th: Okay, so what was different? (Open Question)
Sue: You made us look at what we were both saying.
Mike: Yeah.
436. Th: So, here is a terrible question. What would make you go back to communicating at the three level? (The Terrible Question)
Sue: If we assume things.
Mike: I agree, if we don't take the time to listen and check things out with one another.

LEVEL OF SKILL

Along with a basic understanding of skills and techniques is also an understanding of the level of acumen needed to effectively and skillfully incorporate any one particular technique. As authors, we have provided the following table to provide a starting point for consideration and thoughtful discussion. The "level" identified is based on a number of criteria—including the depth of knowledge needed to successfully utilize the technique, the amount of follow-up needed after the initial start of the use of the technique, and the potential depth to which the successful use of said technique might have on the client.

Basic	Moderate	Advanced
Closed Questions		
Open Question		
Checkout		
	Asking the Question	
	Cognitive Disputation	
		Circular Questioning
	Externalizing the Problem	
	Miracle Question	
Probe		
	Forced Choice Question	
	The Terrible Question	
		Triadic Questioning
	Scaling Question	
	Collaborative Empiricism	
	Communication Clarification	

STOP AND REFLECT

The use of skillfully developed and communicated questions in the moment with a client or group of clients requires practice and understanding of the needs of your client. Stop for a moment and reflect on which of these questions come most naturally to you and which ones seem to be more challenging for you in your current or future work. On the following lines, note your responses.

I believe currently I am quite effective in using the following question(s):

_____

_____

Now, how did you become skilled in the use of these questions?

_____

_____

I believe currently I struggle to effectively use the following questions(s):

_____

_____

Now, what means do you plan to undertake to acquire greater skill in these areas?

_____

_____

CONCLUSION

There are a multitude of different ways that good questions can be highly effective in the therapy process. Most theories utilize different varieties of questions to highlight and pinpoint problems and solutions for the client. We have found it useful for beginning counselors to enter sessions with a few questions (well formed) in mind or even written down to help focus the work with the client.

Psycho-dentistry is a nice way to consider the useless process that some beginning counselors get into with clients (especially children and teens). Through the guise of wanting to help, and we suggest with very good intent, some therapists start their careers thinking that good questioning—especially the kind that really drills into the clients and their issues—has the greatest success rate. This, in fact, is not the case. In reality, questions, just like the techniques in Chapter 4, can be used to increase the positive relationship between therapist and client. Or they can be used to distance oneself or frustrate the client. Therapists are not interrogators, and clients rarely benefit from feeling overly questioned about their personal thoughts, feelings, decisions, or emotions.

PRACTICE EXERCISES

Write your response, label the skill or skills used, and then indicate your purpose for saying what you said.

Client: My boyfriend and I have been talking about marriage. But I'm not sure that's what I want.

Response 1

_____

Client: Ever since I retired, I've found myself floating away from people. No one is around to talk to or share moments with. I really miss Richard . . . I really miss how we were.

Response 2

_____

Client: The principal wanted me to come see you. She said you would listen to me. I just wish that my friends would stop telling those lies about me.

Response 3

_____

Client: When I found out I was pregnant six months ago, I thought that I would love being a mom. But now, I'm not sure that I will be any good at it. You know, my mom made a lot of mistakes with my brothers and me.

Response 4

_____

Client: I went to the gaming meeting like I said last week. And when I got there, the other kids didn't want to play with me. They said I was too rough and stuff like that.

Response 5

_____

SECTION THREE

Watch Your Mouth! (Therapeutic Language)

Therapists know better than most people how important language is; it's an incredibly powerful tool that helps us to structure our world and internal experiences. Even linguists agree that "natural language is not only a social, but also a psychological phenomenon" (Dik, 1980). We know the literature on how language can change our perceptions – the word "crash" leads us to overestimate a car's speed (Loftus & Palmer, 1974) and the mere verbal suggestion of pain relief reduces pain perception (e.g., Craggs, Price, & Robinson, 2014). We have emotion lists and wheels at our disposal in every session because we know how accurate emotional vocabulary helps clients to process (e.g., Wotschack & Klann-Delius, 2013). We see firsthand the difference that well-considered words can make in a marriage conflict (Gottman & Silver, 1999) or in a parent's discipline (Gottman & DeClaire, 1997). We see even more clearly how much damage can be done with ill-considered words.

Thankfully, much of our training and experience focused on learning to speak therapeutically. It is likely we are already the best models for healthy language in our clients' lives. These next ten chapters will explore some of the sneaky language traps that even the best of us might miss, and how to outsmart them using insights from current and classic research and theory.

CHAPTER 21
"MAKE YOU FEEL"

Let's start with a big one. It's an unfortunate cliché, the therapist's refrain of "How does that make you feel?" When we ask it, with only good intentions, we don't realize that it may contribute to clients developing an external locus of control. *External locus of control* is the belief that life is controlled by outside factors that a person cannot influence (such as other people, situations, chance, or fate); *internal locus of control* is the belief that one has power to control one's own life (Rotter, 1966). In general, a strong internal locus of control is associated with a host of positive outcomes, including higher resilience, lower depression, and more effective health behaviors. We want to honor and support the development of clients' internal locus of control by emphasizing that circumstances alone, while an important part of the equation, do not *determine* clients' feelings.

Yes, emotions are somewhat predictable. If we perceive an injustice, we feel anger. If we perceive a loss, we feel sadness. If we perceive a danger, we feel fear. That's good for therapists to know; for example, it can help us recognize when we're dealing with secondary emotions (e.g., a client who says they feel angry, but the cognitions are more about pain or shame). When, for example, a partner utters harsh words, certain perceptions may be activated, but the feelings are not *caused.*

It's beyond the scope of this little chapter to talk through how to teach clients to recognize their own cognitions and cognitive distortions, but it may be enough to say that the external situation is never the sole determinant of a client's emotional experience. (That is, it's never only the proverbial spouse – no matter how carelessly they speak – who "makes me mad.") Every emotion is felt in part because of the external environment (including insensitive partners!), but also through the filters of clients' histories, their particular vulnerabilities and conditions of worth, their own cognitive biases, their level of motivation and investment, their current levels of ego strength, their physiological states, anything that has primed them subconsciously, etc.

Most clients come to therapy with a sense that they don't have much control. When we use "make you feel" language, we may accidentally confirm to them that they don't have control over one of the few things they actually have some control over. We say to them, "Yes, you are a victim of circumstance, so there's not much to be done." Of course, that's not the message we intend.

We want to practice validating their emotions and experiences, without diminishing them or casting blame. So, we also don't want to say, "You choose how you feel, it's no one's fault but yours – so just feel differently!" We know that blaming isn't a good way to empower. So, we can practice replacing this language in our vocabularies when we find it there. The easiest option, and the one that almost certainly asks what we want to know, is: "How did you feel when …?" This conveys genuine interest, without blaming or disempowering. This is a small change, but it's very impactful.

PRACTICE TIP

Here's a metaphor I sometimes use with clients: If someone throws a baseball at a house, what determines if a window gets broken? (Hint: The client is the house!) Three kinds of things. One, the thrower (the other person or circumstance). What did they throw, how hard, with what kind of aim? Was it an insult? A particularly nasty insult? Was it targeted at the client's vulnerable spots? Two, the actual house. How many windows (i.e., vulnerable spots, conditions of worth) does it have? How big are they? What are they made of? Are there walls, fences, or trees blocking the vulnerable areas (i.e., defenses)? Three, the intervening space (how accurately does the listener perceive the speaker's intention?). Is it windy that day? Does/can someone else catch the ball? A baseball thrown does not a broken window make.

CHAPTER 22
"BUT"

We need to be careful with this little word! While it has many formal and old-fashioned linguistic uses, the primary way it is used in conversation is as a conjunction – it connects two thoughts together. Specifically, the word "but" is an *adversative conjunction* – it connects in a way that disqualifies what comes before it. It is meant to express opposition or exception, not mere contrast (Garner, 2016; Saitō, 1899). For example, we could say, "My theoretical orientation is existential, but his is behavioral." However, it's likely we mean something closer to "My theoretical orientation is existential and his is behavioral" or "My theoretical orientation is existential; his orientation is behavioral." (Unless, of course, we're making a referral for behavior therapy and *want* to disqualify ourselves!)

In another example, if I say, "I'm glad you bought this book, but you really should have gotten it on sale," the take-away message is that you overpaid. If I say, "You really should have gotten it on sale, but I'm glad you bought this book," the message is that I'm happy you have it, regardless.

Here are a few therapy examples when we might use "but" (but probably shouldn't):

- "I hear that you want to connect with me outside of session, but I have to hold that boundary to protect us both."
- "I know you were really angry, but that sounds like an ineffective way to show it."
- "I care about you and want you to be successful, but I see you getting in your own way."

All that great work we might have just done reflecting the client's content and emotions, working the perfect paraphrase, or making a spot-on interpretation – poof! Everything we say before the word "but" effectively disappears.

To make matters worse, the better we did crafting the first part of the sentence (clarifying, reflecting, etc.), the more invalidating it might be after the little eraser does its work. The client thinks, "They really, really get me … but it doesn't matter." How likely are they to hear the important message we have for them in the second half, if they're busy feeling diminished or disqualified?

PRACTICE TIP

If you simply attempt to reduce your use of “but,” you may find yourself accidentally just using synonyms such as “however,” “yet,” and “though.” (Clients do this all the time when they are first learning this skill!) There are a few useful options that can help you clearly express your intent and save “but” for when you really mean it. Experiment with these and when they might fit better:

- Use “and.” (This is a *copulative* conjunction that emphasizes joining or accumulation. The words “too” and “also” have a similar effect and may fit a particular sentence better.)

  “I hear that you want to connect with me outside of session, and I have to hold that boundary to protect us both.”

- Use a period. (This allows you to offer both thoughts without determining the specific connection between them. A semi-colon serves almost the same function.)

  “I know you were really angry. It sounds like you used an ineffective way to show it.”

- Use “so.” (“So” is an *illative* conjunction which implies inference or consequence. Its cousins are “then” and “therefore.”)

  “I care about you and want you to be successful, so I want to let you know when I see you getting in your own way.”

CHAPTER 23
"OR ..."

We know the value of open-ended questions (as discussed in Chapter 16). They give us rich, detailed pictures of the most salient parts of our clients' worlds. They help us avoid sounding like interrogators or attempting to guess our way into understanding our clients' perspectives.

We also have experiences in therapy when, despite our best efforts, it just doesn't work. It may be because clients are depressed, and don't have enough internal energy to drag out a clear explanation of their experiences. Clients may have a limited vocabulary for explaining their internal worlds, perhaps because it's something they've never done in their families or cultures. It may even just be because clients are young – children or teens – and haven't had much practice.

In these cases, closed-ended questions may get a little more response, but the danger of using them remains. Closed-ended questions like "Did you feel such-and-such?" and "Was it like thus-and-so?" open the door for yes-or-no answers that don't get us much further with clients who are already having trouble disclosing. An additional risk of questions like these, especially when we're not just repeating back what clients have said, is that we might put words into their mouths (and thus, into their experiences) that may not really belong there. When we do that, most clients either don't want to correct us, or (worse!) don't even realize that they should.

We may want clients to hear us use some emotion words to help increase their vocabularies or model an insight-focused summary because they don't yet have those skills. But we don't want to lock them into our choice of words and take away their power and opportunity for growth. Effectively, we want to harness Vygotsky's concept of the *zone of proximal development* (1978). This is the space between what a client (in Vygotsky's writing, a child) can already do alone and what they can do with our help. Here is a delightfully simple option for balancing in that space: We can ask an "or" question, but not in the traditional way (between two choices). We use it at the end. Like this:

Imagine a social anxiety client has said, "I wish I were just different," and we've said, "Tell me more about it" and gotten nothing else, and we've asked "Different how?" and gotten nothing else, and we're at a loss. The next thing we might say is, "Do you wish you were different like less anxious or different like you wish you looked physically different?" Instead, we might

get a richer or more accurate response if we said something like, "Hmmm ... different like less anxious or like physically different *or …?*" Bonus points when we say that final "or" with an inviting tilt of the head and let it linger in the air.

PRACTICE TIP

A really profitable use of this technique is when asking about client emotions. When clients have a limited emotional vocabulary, you'll hear a lot of answers like "I just feel bad" or "I was so upset." After you've tried your open-ended follow-ups, you may want to start giving them some emotion vocabulary.

"You said you feel bad. There are lots of ways of feeling bad, and I'd like to get a good picture of your kind of feeling bad. When you think about that bad feeling, is it a little more like bad-angry, or like bad-scared, or …" (let it linger!) If clients are silent, remember to give them time. If they're silent for a long while, consider following up in the silence with a quiet invitation like "Maybe more than one of those? Or something different? Or …?"

CHAPTER 24
"WHAT" (INSTEAD OF "WHY")

Have you ever accidentally bitten a fingernail too far and had the soft tissue beneath become exposed? It is painfully vulnerable and sensitive to even a breath of air. Clients come into therapy similarly vulnerable. It is rare for a person to utilize therapy as their first-choice coping strategy, which means many people come to us after having tried "everything else." They're vulnerable from their distress, or maybe from being "forced" into therapy by a loved one or the court system. They're vulnerable because they've been working hard for a long time, in a lot of ways, and nothing has helped enough yet. They often feel they have exhausted their own resources and they weren't enough – not strong enough, or smart enough, or just enough – to do it on their own.

When your fingernail has been torn off, you protect it, right? So, in addition to being vulnerable, clients are also guarded, often against two very profound fears: "This is all my fault" and "It won't ever get better." Considering these fears, even the highest functioning clients are primed to take things the wrong way, to be bruised or offended by even carefully chosen words. Without delving too far into Aristotelean ethics, a "why" question asks, "to which purpose?" or "in service to what?" (Sloan, 2010). These questions imply *intention*, and that often hits too close to home for someone who (reasonably!) doesn't want to take full responsibility for their current, painful situation. Remember our discussion about locus of control (from Chapter 21)? While it is important to emphasize internal locus of control, we don't want to dismiss external sources of control completely. So, we can reduce the risk of unintentionally hurting a vulnerable client, and we can get a less defensive and more complete answer if we structure our questions with "what" instead of "why."

For example:

Instead of "Why did you do that?":

- "What led you to that?"
- "What factors were at play there?"

Instead of "Why didn't you do that?":

- "What has kept you from doing that?"
- "What barriers have there been?"

When clients ask "why" questions (e.g., "Why did she have to die?" "Why do bad things always happen to me?" "Why did I lose that job?"), it's important for us to determine the intention behind their question.

- They may actually be looking for reasons or causes. For example, "Why did I lose that job?" In this case, we may want to switch them to "what" questions, such as "What factors were involved?" because it's unusual for there to be a single, knowable cause for anything.
- They may be expressing their perception of external locus of control. For example, "Why do bad things always happen to me?" In most cases, there will be some aspects of difficult situations that are external and some that are internal, and we'll want to explore both. We could initiate this discussion by saying something like, "What parts of this seem out of your control?"
- They may simply be expressing their distress at the uncontrollability of genuinely uncontrollable circumstances. For example, "Why did she have to die?" At these times, supportive listening and reflection is probably the safest bet.

PRACTICE TIP

This is another one of those techniques that is entirely about practice, just building your therapeutic vocabulary. Make this a little game with a colleague: The two of you can practice catching each other asking "why" questions and then rewinding to say it a different way. This is much easier than working on it in session. Although, as you change your vocabulary in this way, you're bound to accidentally drop a "why" into session and notice right away. No problem – just say, "oops, I meant to ask …" Clients will benefit from your modeling!

CHAPTER 25
"FEEL LIKE"

This phrase is a trap! And it's a sneaky trap because we usually don't notice it. It goes like this: First, we ask something like, "How do you feel about that?" Then, the client answers. Suddenly, it's 11:49 and we don't know how they feel!

This is what happened: See, we asked, "How do you feel about that?" and the client (probably unknowingly!) slid the trap closed with, "I feel like …" and then the session disappeared while we were searching for the feelings. But what clients are usually telling us when they say "I feel like ... " is actually "I think …" or "I believe …." Let me give some examples:

- "I feel like this is all my fault."
- "I feel like there's nothing else I can do."
- "I feel like he hates me, but just won't say it."

In English, "I feel like…" has become a softer way of saying what we are thinking (which is not necessarily a bad thing). When we hear what a client thinks or believes in those statements, it could be very rich and powerful information. Absolutely, we want to honor that and move toward it therapeutically – *with cognitive work, recognizing that it is a thought*. We have well-established strategies for working specifically with cognitions (e.g., Beck, 1979) and for working specifically with emotions (e.g., Greenberg, 2009). And while the two are definitely interconnected (e.g., Storebeck & Clore, 2007), they are separate enough that they both deserve attention.

So, we just want to be careful that we don't confuse clients' thoughts with their emotions. That's how we lose track of the session – believing we're doing emotion-based work when the client is working in the sphere of cognitions. Paying attention to this misused phrase can help us stay on the same page. And it might just remind us not to let them "get away with" not telling us the emotion!

If we want to do emotion work, we may have to go so far as to explain this concept to our clients and demonstrate the difference. Sometimes clients will get this right away, and we can simply give a quick correction (e.g., "Oops! That wasn't an emotion…") or corrected-reflection-with-follow-up (e.g., "I hear that you believe you're responsible for what happened. And what are the feelings that are going along with that belief?"). Sometimes clients will really struggle because they aren't used to attending to or

expressing their emotions. In this case, it might be time for us to pull out our trusty emotion-words wheel.

(As a side note, this is also a problem in couple's work, when clients will avoid exposing their own emotions and slyly accuse their partner at the same time. For example, "I feel like he doesn't take me seriously" instead of "I feel sad and worthless when I think my opinion has been dismissed." More about this in Chapter 27.)

PRACTICE TIP

There's an exception to this rule, and it's when a client says, "I feel like …" and then gives you a simile or analogy. For example, "I feel like a bear who has been hibernating and just awakened to the first beautiful spring day" or "I feel like I am a rope that has just been fraying and fraying from overuse." If they give you a metaphor like these – first, count your lucky stars for this client. Then, just say, "Tell me more about that."

CHAPTER 26
THE GENERIC "YOU"

Linguistically, the "Generic You" is the use of the pronoun "you" that is meant to refer to an unspecific or indefinite person. It is a less formal way of stating something universal, a more casual thing to say than "one" (Huddleston & Pullum, 2002). For example, "You know how it's really hard to find great therapy books that you actually have time to read?" That sounds so much more natural than "One may know how difficult it is for one to find a great therapy book that one actually has time to read." Clients use this often, and we rarely realize it, because it is so pervasive in our speech. But we want to listen for it very carefully, because clients are often using it to avoid saying "I" and "owning" their thought, feeling, experience, etc.

The Generic You is a deeper issue than it may seem up front; it deals with existential aloneness and personal responsibility. As Viktor Frankl says, "Each man is questioned by life; and he can only answer to life by answering for his own life; to life he can only respond by being responsible" (Frankl, 1959).

Clients pull the Generic You into service primarily in two ways – one in group therapy and one in individual. In group therapy, when clients use the Generic You, they're often seeking the approval or understanding of the group members by phrasing their experiences as universal truths. For example, they may say, "When your boss is so demanding, you just get burnt out." They usually don't realize it, but this can be an attempt to get other members to normalize their feelings, to create a sense of "we" in the group, where it might not actually exist. They especially do this in the beginning stages of group and if we allow that to happen, we never get to the "storming" phase and beyond. Everyone will feel artificially connected, rather than experiencing the real cohesion that happens only after they've recognized and appreciated their differences. Dangerously, this may also isolate and silence any group member who feels differently!

In individual therapy, clients often use the Generic You when they're transitioning into something that's difficult for them that they don't want to internalize. This is also typically outside of their awareness. Here's an example:

> "It's hard being a mom now. I don't have as much time as I used to. I'm tired a lot, mostly. I don't know what I'm doing all the time. You know, you feel inadequate when you're a new parent."

In this example, we want to go to the feeling of inadequacy. That's where the work is. This client showed it by transitioning to the Generic You because that content was uncomfortable, and we know clients can't work on what they aren't holding, what they aren't owning.

PRACTICE TIP

When clients begin using the Generic You, it is often necessary to stop and ask them if they mean "I." Perhaps they don't, and they really are explaining what they see as a universal experience. (Not likely, though.) Be prepared to gently explain why you've asked, and then develop a shorthand with clients who do it often so that you don't have to interrupt sessions multiple times to talk about it. If need be, you can always say, "Can you repeat that, and say 'I'?"

The most important thing is that you are noticing it when it happens. If a client says "you" in session, they should be referencing the very specific, completely un-generic, identifiable You – the person they are speaking to. If they aren't, it's worth some extra attention.

CHAPTER 27
"I" STATEMENTS

We all know the beauty of the traditional "I" statement, popularized by couples' therapists (e.g., Gottman & Silver, 1999) and family therapists (e.g., Ginott, 1965). It's a classic for a good reason! Instead of the client saying, "You make me so angry" or "My boss drives me crazy," we artfully get them to say, "I feel angry when you _____" and "I feel a little crazy when my boss _____." This technique reduces the listener's defensiveness. We can power up this formula with this extra step:

> "I feel (emotion) when (situation) because I (personal experience/ vulnerability)."

Here are a few examples:

- "I feel sad when you come home late because I worry that I'm not fun to be with."
- "I feel angry when my boss says I have to work late because I think the people without kids should be the ones who work late."

Yes, this can feel very artificial at first. That's ok. It's basically a completely new way of communicating, which means a completely new skill set. Any time we begin practicing something new, it's stilted and feels awkward. It's useful to let clients know this, and to have them practice correctly anyway. Once the skill is mastered, that's when we can play around with it. We have to practice scales, then practice songs, before we write our own music.

There are two main reasons it's important to follow the script at first. One, it makes it easier to hear. If the situation includes the word "you" (e.g., "I feel sad when *you* come home late"), the personal vulnerability that follows can really help the offending "you" (the listener) get into the speaker's phenomenological world. It keeps the focus on the speaker's experience and gives the listener less fuel for gearing up to be defensive.

Two, it gives the speaker more power. If they are able to link their feelings to their personal experiences and vulnerabilities, it means they don't have to rely on the (highly unreliable but ever popular) strategy of attempting to change other people or the world. They give themselves the opportunity to realize, as we discussed previously, that they have some power in how they experience things and that circumstances don't simply "make them feel."

PRACTICE TIP

Remember "Mad Libs?" (This is the game where you're asked to give a random noun, then a number, then an adjective, and so forth, and after you're done, the other person reads a story that uses your silly words to fill in the blanks and it's suddenly hilarious.) This technique is a therapeutic game of Mad Libs, so be sure to follow the rules. The most important rule of Mad Libs is that you fill in the blank with the right kind of word. It really messes up the whole thing when the story goes: "and the _____ went back to work and showed off his new top hat" and you accidentally said "yellow" when you should have said "squirrel."

When we ask clients to engage in this kind of activity, we need to listen very carefully – it's easier to hear mistakes in Mad Libs than in therapy. Make sure clients are using emotions (not cognitions), situations (not character traits), and vulnerabilities (not excuses) to fill in the blanks of the formula. It works like magic when they do.

CHAPTER 28
THE PARROT

The art of "parroting" (that is, tracking clients verbally by repeating the important words they say in a low, un-interrupting voice) seems largely left untaught these days, replaced with the non-verbal skills of head-nodding and therapeutic mumbling (i.e., minimal verbal followers, or "mmm-hmmm'ing") and the more sophisticated skills of reflection and paraphrase.

Often, when therapists are taught the skills of reflection and paraphrasing, we are taught not to repeat back clients' words verbatim, but to use synonyms. (In a textbook world, clients give a rambling, alexithymic monologue and then we brilliantly summarize with the "perfect" emotion word or phrase, building trust by our almost mythical levels of understanding. And if you're Carl Rogers, possibly you can do this.)

But here's the thing about synonyms. They don't really mean the same thing. Discomfort, pain, and agony aren't the same thing. Sad, depressed, and miserable aren't the same thing. Neither are difficult/problematic, angry/irritated, guilty/ashamed, or upset/bothered. Language wouldn't have developed these fine-grained synonyms if they didn't have different meanings. Moreover, clients may not have the same internal definitions as we do, and we cloud those issues further when we add new words. Our textbooks also rarely discuss what happens when we reflect, paraphrase, or summarize *badly.* These kinds of misunderstandings lead to therapeutic ruptures, and they are dependent on the client mentioning that it happened, which they typically do not do (Rhodes et al., 1994). When in doubt, use the language clients have already used. When we repeat a client's most important word every couple of sentences, not only can they be sure we're tracking them, but they know we're paying close enough attention to pick out what's most important, without changing it.

We need to be careful with the head-nodding and therapeutic mumbling, too. We intend it to show that we are paying close attention and following the client reliably. Actually, these non-verbal behaviors are very easy to over-use and then we risk signaling to the client: "I hear you, I hear you, hurry up; it's my turn to talk." (If you haven't noticed this, ask a therapist friend to demonstrate it to you – you'll be shocked!) Another risk of the chronic head-nodding is that some clients interpret it as agreement or reinforcement (e.g., Verplanck, 1955). When using the parroting technique, we don't have to worry about that.

There are two times that parroting works well. First, you can do this as the client is speaking, if they're monologuing quite freely. For example:

C: When I was young, she was really hard on me. She used to smack me in the back of my head. It didn't really hurt, but it was like she was telling me all the time that I was stupid. (T, quietly: stupid) She was annoyed with me all of the time, with my homework and the way I cleaned up the kitchen and even the way I played football! She doesn't even know anything about that! She just criticized everything I did. It was just like I was a bother to her (T, quietly: a bother), nothing I did was ever right, ever good enough.
T: She was really critical, about everything, and you got the impression that you were a bother to her, that she thought you were stupid.

The other time that this technique works especially well is when the client has ended a sentence or taken a pause. In this case, using a slight question tone can make the parrot function as a clarification and help the client take their thought farther.

C: When I was young, she was really hard on me. She used to smack me in the back of my head. It didn't really hurt, but it was like she was telling me all the time that I was stupid …
T: Stupid?
C: Yeah, she was annoyed with me all of the time, with my homework and the way I cleaned up the kitchen and even the way I played football! She doesn't know anything about that! She just criticized everything I did. It was just like I was a bother to her …
T: A bother.
C: Yeah, nothing I did was ever right, ever good enough.

PRACTICE TIP

Parroting feels strange in the same way that standing with your arms at your sides feels strange – only to you. It seems natural to others and gets easier with practice. You're probably already mentally holding on to those important words and emotions, so that you can paraphrase or summarize, so you know what they are. Experiment with it, adding it to your current active listening skills (not replacing them!). Do this with a colleague or partner first, if that's more comfortable.

CHAPTER 29
"DON'T"

One of the most problematic little words in a client's vocabulary is the word "can't." What a disempowering, distorted, irrational word! And sometimes they *can't* seem to give it up!

First, let me be clear that I'm not talking about those clients who are recognizing legitimate limitations. For these clients, sometimes learning to use the word "can't" is a powerful, healthy departure from the early learning that they can do anything, should be able to be anything, and must be all things to be deserving of love.

I'm thinking here about the clients (and this is most of those who use the word) who actually mean "it would be uncomfortable to" or "I would feel scared" or "some important person would be upset" or "a long time ago someone told me that I couldn't." When they use the word "can't," they aren't addressing legitimate limitations, but have often made something seem impossible in their minds that is really quite attainable.

What options do we have? One option is to change the language to "won't:" "It's not that you can't talk to your mother or ask your boss or use the new behavior or sit quietly with an emotion – it's that you won't." But … ouch! Clients who have disavowed personal power and responsibility by using the word "can't" often respond poorly to the word "won't." It feels harsh and blaming and far from their personal experience. We want to find the balance (or the tension, perhaps) between two of the primary therapeutic factors: Instillation of hope and existential factors (i.e., personal responsibility; Yalom, 1995). With "can't" and "won't" language, the balance is all tipped in the direction of responsibility – if they can't, they have no responsibility and if they won't, it's completely their responsibility. There is little emphasis on hope, and therefore, less room for therapeutic movement.

I'd like to offer an alternative that may help to balance all of these out. How about the word "don't?" It carries a connotation that is about midway between the helplessness of can't and the willfulness of won't. When we offer it gently, and pair it with a solid reflection of clients' content and emotion, it doesn't come off harshly. Then, we can follow it up with some open-ended questions to get more information about the disempowerment and the legitimate obstacles, and clients' abilities, resources, and strengths – that brings in both internal locus of control as well as hope.

A close cousin of the word "don't" is the word "haven't." It captures a similar balance of responsibility and hope, and carries a connotation that there are understandable reasons that change isn't yet apparent. An especially nice thing about "haven't" is that it adds the explicit implication that it will or may change in the future, without adding a lot of demand.

PRACTICE TIP

You don't need to beat them over the head with it. You don't even need to make the change explicit, though some clients will benefit from an overt appraisal of the (in)effectiveness of their language. But you can just drop it in, casually.

C: I just can't bring it up! I'd be mortified!
T: You don't bring it up, to protect yourself. What's scary about it?

Or

C: I can't do it; it's too hard. It'll never work out.
T: You haven't done it, because you don't feel up to it. Tell me about what seems difficult.

CHAPTER 30
"TRY"

This one is a secret from the hypnosis literature. During hypnosis, clients take everything quite literally. Here's an example: If you tell a class full of students to "raise your hand," they'll all do exactly what you expect – some students will have hands high in the air, some will have elbows on the desk with hands lifted, and everything in between. But if you tell a client during hypnosis to "raise your hand," they will lift just the hand, at the wrist. It's a very concrete understanding.

This is why, when using hypnosis, therapists either refrain from using the word "try" or use it in a very specific way (Hammond, 1990). Like this: "Now that you are very relaxed, *try* to open your eyes, and realize you just can't. And enjoy how complete the relaxation feels." Or, after suggesting that a client's hands are locked together, as if by a magnet: "Now *try* to pull your hands apart and find that you cannot." The word "try" is only ever used in hypnosis to confirm that a client *cannot* do something. This is because failure at the attempt is implied in the word "try."

Are you thinking of Yoda's famous quote right now? "Do or do not; there is no try." It's a good example of this idea when it's taken in context, because Yoda is likewise suggesting that *trying* is acceptance of failure from the start. While he is – in his mysterious way – demonstrating his confidence in Luke's ability, it's also a good example of what we as therapists *don't* want to do, because he wants Luke to map his experience lifting a rock to his experience lifting a spaceship with no intermediate building of strength, skills, etc.

If we want to demonstrate our confidence in a client's ability, we – like Yoda – should not ask them to try. If we ask a client to try to do their homework, we may be implicitly suggesting that it won't get done. If we ask them to try to relax their body or take a deep breath when they are panicking, we imply that they won't be able to – and they're already quite invested in the fear that they can't.

Instead, we can use language like "when you complete the homework …" and "next time you feel anxious, you can apply these techniques and notice an increase in your relaxation." See? It can sound natural and easy. Don't believe me? Re-read this section of the book. It's full of things for you to "try," right? See if you can find that word.

Spoiler alert: You won't. When I write about something that I know you can do, I encourage you to do it. I'm not asking you to *attempt* things. When

I want you to play around with something *that has no criteria for success or failure* just to explore what happens, I ask you to "experiment with" it, which takes away the potential evaluative component of asking you to "try" (more on the scientist mindset in Chapter 77).

PRACTICE TIP

Clients will make more progress when they take the steps they know they can take (at least, more progress than not taking steps they believe they'll fail!) When clients express concern about their ability, competence, motivation, etc. – that is, when they hedge by saying, "well, I'll try …" – just change the assignment to something so small and manageable that they really can't not comply. Then neither you nor the client needs to really worry about "trying." As the solution-focused (e.g., de Shazer et al., 2007) and strategic theorists (e.g., Haley, 1963) agree – small changes lead to big changes.

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23

Don't Rush to Therapeutic Judgment Until You Get All the Facts

It was Brett Park's first day as my supervisee and it was quite evident he was trying to impress me with his therapeutic judgment and his clinical savvy. As Amy, a 32-year-old teary-eyed female in our hospital group talked about her tendency to feel trapped, Brett glanced at me and lifted his eyelids as if to say, "I know exactly what's troubling her, watch me put her out of her misery." With his holier-than-thou mentality, he abruptly interrupted her.

"Amy, Amy. Stop. What I want to know is why are you staying in a relationship with a man who physically abuses you? Why don't you get out?"

Amy as well as the other members of the therapy group looked spell-bound. "What?"

Again Brett checked eyes with me to make certain I was witnessing his city-on-a-hill interpretation of the century.

"Amy I repeat, why are you staying in a relationship with a man who is abusive?"

I knew what was coming but I figured Brett needed to learn a lesson and he'd find out soon enough anyway.

"Brett," she said sheepishly, "I'm not in a relationship with a man, I'm a lesbian."

Think back to when you were a teenager and you were trying to act really cool and impress somebody. Most likely you did appear really cool until you did something stupid like spilling a soda on your date or walking face first into a closed door.

Brett later admitted that he felt foolish for not waiting to secure all the facts, not to mention the fact that he obviously hadn't read the client's hospital chart. The worse part was that Amy told me privately that she immediately lost faith in him as a therapist because he seemed to be analyzing her situation before he knew anything about her.

Don't try to be a guru or a palm reader because I can almost assure you that sooner or later you'll end up with a face full of tea leaves! Listen to the client and by all means resist the temptation to rush to judgment. You'll be a much better helper and you'll avoid a slew of bumps on your forehead.

24

The Number One Therapeutic Blunder: Confronting Sooner than Later

I have to chuckle when I hear new students talking about what makes a counselor an effective helper. The following statement is a generic version of something I frequently hear.

"Man, I'll tell you that therapist is a lot better than all the rest. I mean he got right up in that guy's face and chopped him down to size with a few well-chosen curse words. It was fabulous. The therapist was yelling so loudly you could hear him in the next suite of offices."

Not only is this style of combat intervention not good therapy — it probably isn't therapy at all. Helping isn't about "chopping the client down to size." Most of us know at least one spouse, son, daughter, boss, teacher, or mother-in-law who can do that quite effectively.

A landmark movie loosely dubbed the *Gloria Film* (the actual name is *Three Approaches to Psychotherapy*) is illustrative of this fact. Gloria, the client, is given a brief psychotherapy session with the three greatest living therapists at that time: Carl R. Rogers, Albert Ellis, and Fritz Perls. Rogers was kind and empathic to Gloria. Ellis came across somewhat didactic and intellectual. Perls on the other hand was sarcastic, overly confrontive, and quite belligerent. During the first few minutes of the interview he forthrightly called Gloria a phony for smiling when she purported that she was nervous. When she was interviewed after the movie, Gloria asserted that overall she liked Perls the best. Years later, however, she reflected on the experience and stated that Perl's intervention was psychologically damaging and had a profound negative impact on her.

Please don't misunderstand me. It is certainly appropriate to confront your clients. However, I would suggest to you that in terms of confrontation, timing is everything. A confrontation that would be inappropriate during your initial meeting with the client could be right on target during perhaps the eighth or tenth therapy session. When I took back I am convinced that the number one factor that produced disastrous outcomes resulted from confronting clients too quickly and with too little tact.

In most cases the rule on confrontation is simple. Later is nearly always better than sooner.

1 What is Unconscious Process Work?

If the question for psychotherapy is how to best make use of a person's mental faculties, then the answer must include some activation of tacit knowledge, or what I call *unconscious process work*. Unconscious process work can seem mystical and improbable. Metaphorically, it is like lying down under the night sky and watching stationary stars pass by. You realize that during your moment of stillness the earth has moved you. In the following pages, we will see that conscious intention is a lesser thing that rides on much larger bodies of influence.

The best way I know to introduce an idea is to define it and then describe it in action. Within neuroscience, a distinction is often made between content versus process. Content relates to the storage of information, and process is the movement and transformation of information as it passes from one brain structure to another. Similarly, unconscious process work is the transformation of implicit content (e.g., memories, percepts, attitudes, emotions, expectations) in a way that affects the person's ongoing phenomenological experiences, thoughts, and actions.

To demonstrate, we begin with a case example from my clinical experience. It offers a minimalistic view of unconscious process work that does not involve complex techniques. By definition, techniques are the byproducts of principles. For depth of understanding, as you read the case example, search for underlying principles and ignore the technique. Because it was so individualized, I have rarely used this technique, but the same principles will be echoed on every page of this book (e.g., unconscious problem-solving and self-organizing change).

One of my first post-doctorate clients was a young woman who had read about Milton Erickson (1901–1980) and decided to seek out an Ericksonian therapist. Before ending her initial phone call, she asked, "Is it alright if I fax you a list of my concerns?"

The first thought that came to my mind was Erickson's admonishment to accept everything the client has to offer and then find some way to utilize it, which I did.

When her fax arrived, I was surprised to see that it was a full two pages filled with bullet-pointed items of intense concern. These included having a

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pattern of dating abusive men, feeling intensely inferior to others around her, and being unable to recall much of her childhood.

When she came in for the first time, I greeted my client with her list in hand. It seemed the best way to utilize her list was to read it with her. After she sat and gave her consent, I conducted a slow, meticulous, word-for-word reading of her statements aloud. My recitation was so slow that it took half the session. During this time she did not speak, did not blink, and hardly seemed aware of anything else.

Shortly after I read the final item, she began to search for words to express her experience. Her hesitant response was, "It all seems so different when I listen to you read it. Hearing your voice describe my problems makes them seem different."

I asked her what she wanted to do with the rest of our time together. She said that she wanted to talk a little more about her boyfriend—how she met him and how he had treated her. This part of the session was more traditional, with her talking and me actively listening. Before she left, I asked her to say when she felt it would be the right time to return—the first thing to pop into her mind. She said that for some reason four weeks seemed right.

Four weeks later, she returned and was eager to tell me about her progress. She explained that in the past she had clung to abusive boyfriends until they eventually dumped her. She was always at the losing end. Now, for the first time, she had decided to end the relationship. She explained that after her therapy, she developed the strong feeling that he was not right for her. So, she moved out of his place and rented her own apartment.

This was a big move for her because she had never lived on her own—she had never experienced the feeling of being in charge of the space around her. As she explained, "I cannot say what made me decide to do this, but I realized that I need to discover who I am and that I cannot do that while I am with *this* guy."

She was absolutely thrilled with her new discoveries. As she said,

> I went to Target and bought red drapes! No one I know would approve of me hanging red drapes. But I like them! I think that red is my favorite color … It was such a wonderful sense of freedom. I bought a CD with Native American flute music. I was so happy sitting in my new apartment listening to my music with a candle burning. It is as if I am just now discovering what things I like.

In this case, most of the process work occurred outside of the client-therapist dialogue and beyond the margin of conscious review or understanding. To understand how this rapid change occurred for the client, we start with the classical definition of process work and then progress to a more modern, scientifically informed understanding of unconscious dynamics.

1.1 Traditional Process Work is Built on Freudian Principles

Hearing the words *process work* leads most to think of Sigmund Freud (1856–1939) and a therapeutic method that seeks to increase conscious awareness of unconscious processes (uncovering work). Indeed, the term first appeared in the 1970s when Jungian psychologist Arnold Mindell used it to describe his approach to increasing awareness of unconscious emotions and cognition. Mindell's transpersonal psychology sought to help people develop personal awareness and identify with repressed thoughts, emotions, and experiences that may negatively affect their everyday life.

In the context above, to "process an issue" means helping people integrate the psychological aftermath of a traumatic event within an autobiographical narrative. Most importantly, this narrative is coherent and can be expressed in words. As you read more about the evolution of this concept, keep in mind that we will soon turn in the opposite direction.

The paradigm underlying classical process work traces back to Sigmund Freud (1915), who divided all mental activity into two complementary forms of experience—primary processes and secondary processes. Simply put, primary process describes the discharge of biologically based instincts, such as the primitive urges for sex (eros) or aggression (thanatos). But biological drives alone are not enough to govern the actions of a complex organism. As Freud (1900) puts it,

> It will be rightly objected that an organization which was a slave to the pleasure principle and neglected the reality of the external world could not maintain itself alive for the shortest time, so that it could not have come into existence at all.
>
> (603)

Thus, Freud concluded there must be a secondary process, one that is capable of binding or regulating the flow of psychic energy as the organism seeks to reconcile itself with the consequences of engaging an external world.

Freud (1924, 306) used the terms *conscious* and *unconscious* nominally and spatially, with the unconscious being a mental location that acts as a repository, a "cauldron" of primitive wishes and impulses kept at bay and mediated within a medial level of awareness. This is the preconscious, the place where thought is initially formed as ideas pass from knowledge of thing-representations to word-representations (what non-Freudian theorists, such as Prince, referred to as the subconscious). Next, at the level of conscious awareness, word-based thought is used to allow for the displacement of small quantities of energy. In sum, psychological difficulties were viewed as pent-up energy that can be safely discharged during therapeutic dialogue.

These ideas formed the basis of the talking cure. Many decades since Freud, this same basic approach has been enshrined in the popular maxim "You have to name it to tame it." In other words, the effects of raw emotional energy

become less intense when we can discuss our feelings with someone capable of empathetic understanding. Importantly, this view of process work places great emphasis on verbal expression (the client's words mediate change). Freud designed analytic therapy to be the antithesis of classical hypnotherapy (the hypnotist's words mediate change).

In contrast to classical process work, my client was never asked to describe her feelings, nor was her childhood mentioned. In contrast to traditional hypnotherapy, I did not offer any discernable suggestions for any specific change to occur. To recognize the principles at work, a paradigm shift is required.

1.2 Conscious Process Work Can Be Harmful

Freud is not the only one to argue for the importance of discussing our thoughts and feelings. From an academic perspective, cognitive scientists have found that conscious processing helps solidify new attitudes. Similarly, psychotherapy researcher Leslie Greenberg (2012) argues that a spoken (dialectical) synthesis of emotion and reason produces meaning. From this Jamesian perspective, emotion makes action possible while conscious organization adds coherence. Greenberg claims that without conscious articulation, the depth, range, and complexity of emotion cannot develop beyond its instinctual origins. For scholars such as Greenberg, emotional process work is always done at the conscious level of experience, symbolizing it with words and reflecting on it in order to create new narrative meaning. However, as with any set solution, its strength is its weakness.

Folk wisdom has long held that sometimes it is best not to "over think" certain experiences. The more complex and emotionally provocative the object of observation is, the more this seems to be true. Consequently, experiments in a wide variety of contexts have shown that attempts to put complex sensory experience into words impairs judgment and memory. Thus, there are times when words are not enough to capture the complexity of a phenomenological reality. The term used to describe this is *verbal overshadowing*.

This effect was first reported by Schooler and Englster-Schooler (1990). In this classic study, participants were asked to watch a video of a robbery and then either verbally describe the robber or engage in a distracting task. The result was that those who described the robber were less likely to correctly identify the individual in a lineup. In other words, putting an experience into words can result in failures of memory about that experience, whether it be the memory of a person's face, voice, or the color of an object. The effect occurs with a seemingly endless number of nonverbal perceptual stimuli. When conducting therapy, it is important to recognize that the client's own words can distort truth, even to the point of creating false memories.

An even more insidious problem is the distortion of spontaneity by conscious intention. This phenomenon has been named the *paradox of introspection*. While studying happiness, psychologists Schooler, Ariely, and Loewenstein (2003) found that the direct pursuit of positive internal states can produce a

negative effect. What they found was that both the active monitoring of pleasure and the deliberate intention to enjoy an activity lead to decreased enjoyment. In other words, therapy clients who are encouraged to engage in *effortful introspection* with deliberate attempts to attain a greater sense of well-being may experience the paradoxical effect of becoming more and more discontent with their emotional disposition!

For both verbal overshadowing and effortful introspection, the negative effects disappear once a person reaches a certain level of expertise and proficiency. Thus, the reason therapists love to attend workshops that offer exciting new vocabulary and introspective exercises might be because most are highly proficient in these skills. Clients, on the other hand, may not be prepared to reap the same rewards.

A third problem is emotional flooding—harm caused by excess emotion. This unpleasant experience can produce lasting negative effects. I witnessed this early in my career at a training event. A colleague came out of a psychodynamic therapy group disoriented and in a state of intense emotional distress. She could barely speak and did not know where to go. While the psychodynamic technique certainly achieves its goal of intensifying the patient's emotional arousal and uncovering old wounds, it can also lead to horrible feelings of shame and failure. This happens when all responsibility for maintaining a productive exchange is thrust upon a struggling client.

As for my friend, I walked her back to her room and suggested she could find privacy and safety there, especially in the bathtub with warm water all the way up to her neck and all the lights off. I called it a "return to the womb experience" (her mother had committed suicide when she was 14 years of age). The next day she smiled and told me she had an amazing return to the womb experience.

Clients become emotionally flooded when pushed too far too fast. As I learned while working in the field of domestic violence, the consequences of emotional flooding can be significant. Those who become overly angry may leave therapy and harm themselves or others. Similarly, therapists who work with complex trauma are aware that clients who uncover too much repressed emotional pain may sink into a long-term state of clinical depression. And as with any disorder, those who experience excessive shame may never return to therapy.

Wurmser (1981) observed that shame tends to follow the exposure of something we would have preferred to keep private. This shame can then lead to other intense emotions, such as demoralization or rage. As an interesting example, I had a client comment on the superficial nature of his relationship with his mother, whom he did not trust. As a 35-year-old man, he was still angry at his mother for something that happened when he was in middle school. When I asked him to explain, he said that he had really liked a girl in his class and told his mother. His mother mentioned it to a close friend, who then went and told the mother of the girl. A little later, when the teens were at a bowling alley, the girl approached my client to find out if it was true that he

liked her. He felt such sudden and intense shame that he walked off and never again spoke to her. Consequently, he decided to never again trust his mother. In this instance, and many like it, the shame reaction was covered by subsequent emotions (anger and disgust).

This same type of avoidance can be triggered within therapy. After talking to colleagues, I know that I am not the only therapist to have a client open up and reveal compelling personal secrets, only to never return. The promise of confidentiality is not enough to ensure that shame will not prevail.

This prompts the question, When should something be declared out loud or left private? According to Donald Nathanson (1994, 319) "uncovering therapies produce an 'arena of shame.'" I have heard some equate it to psychological nudity. When conducting depth work, if the suddenly exposed emotions have been kept private from the individual's own conscious awareness, then the result can be sudden and intense shame.

Unless there is room for maintaining one's privacy, exploratory work could result in avoiding important content or quitting therapy. As Nathanson (2000) puts it, clients who are already overwhelmed with negative self-images cannot stand any new emotional insight because it only brings more shame. Accordingly, Erickson would instruct his clients to only tell him the things they are ready for him to know and to keep the rest private. Of course, this creates a moving target. The more his clients would share, the more comfortable they became with sharing just a little bit more. Erickson's general strategy was to create an atmosphere of protection and respectful attentiveness.

When a client suddenly becomes silent, this can be indicative of shame. Though the shame may not be consciously experienced, the body and behavior speak to the deeper affective experience. Like jealousy, shame is often concealed by anger. Under such circumstances, a traditional analytic posture (wait in silent neutrality) is not helpful. I had one client complain that a therapist spent the entire therapy hour sitting in silence with a blank expression. In addition to quitting therapy, he said he wanted to punch her in the face.

Whenever a client becomes emotionally disoriented or starts to experience the effects of shame, my tendency is to take responsibility for initiating a meaningful exchange. I take pressure off the client by moving the focus of attention back to myself and the question of whether I am performing adequately.

For example, I might say to a client, "I am not certain what to say. I need a little more time to process what we have been discussing. Please excuse me if I am silent for a while. My unconscious mind is working on something." As the client sits and watches me gazing toward the ground in a state of quiet reflection, it primes (prompts) the client with same behavior. Soon, the indirect suggestion for process work takes effect, and the client declares, "I just realized something important …." Although this technique also involves the use of silence, as does the analytic posture, it operates under the principle of protection and thereby shields the client from shame.

Social scientists have concluded that people are foremost relational beings, which means that we (unconsciously) define ourselves, and our

circumstances, in large part by others' responses to us. This is why it is helpful for those who are struggling to find a wise authority figure with whom they can become emotionally invested. With kind, empathetic engagement there is a greater sense of safety and personal significance. If the client's unconscious sentiment could be heard, it might sound something like, "This doctor wants to be with me and thinks that my experiences are important!" This positive relational experience helps reduce insecurity and negative affect.

When we look at process work within the context of traditional therapies, we clearly see the importance of being known by others. The acknowledgement and validation that comes from a capable therapist can have powerful emotional effects. But this does not mean that every client needs to consciously process and disclose deep content. As demonstrated in the opening case example, a carefully crafted therapy session can include conscious as well as unconscious process work.

1.3 Positive Depth Psychology Emphasizes Unconscious Capabilities

For most of recorded human history, only the concepts of conscious thought and intentional behavior existed. Then in the 1800s, three very different developments—hypnotism, parapsychology, and evolutionary theory—all pointed to the possibility of mental processes that were operating outside the margins of conscious awareness. As scientists and clinicians began to investigate the former, new theories were developed to explain the experience of non-volitional behavior (suggestion effects), alleged psychic abilities (subliminal perception), and automaticity (genetic transmission of behavior).

Although the public at large only knows Freudian depth psychology, earlier in the nineteenth century there was another more positive theory of unconscious operations. The philosopher Eduard von Hartmann (1869) and the philologist Frederick W. Myers (1886) both wrote about the superior abilities of unconscious intelligence (Gurney et al., 1886). While Freud acknowledges having been influenced by Hartmann, James gave special attention to articles published by Myers (1892), who argued that the phenomena of Spiritualism (e.g., automatic writing) were not caused by an external intelligence but instead by an internal intelligence operating outside of awareness. Speaking of Myers, James (1902, 229) described his theories as "the most important step forward that has occurred in psychology since I have been a student of that science." As James (1902) describes it:

> there is not only the consciousness of the ordinary field, with its usual center and margin, but in addition thereto in the shape of a set of memories, thoughts, and feelings which are extra-marginal and outside of the primary consciousness altogether, but yet must be classed as conscious facts of some sort, able to reveal their presence by unmistakable signs.
>
> (229)

With this endorsement, Myers's theory became influential and was cited by several pioneers in clinical psychology, such as Pierre Janet (who developed the clinical concept of engaging the subconscious mind), Theodore Flournoy (whose concept of a prospective element in the unconscious had a significant impact on Carl Jung) and Boris Sidis (one of the early architects of clinical psychology in America and author of the seminal textbook, *The Psychology of Suggestion: A Research into the Subconscious Nature of Man and Society* [1889]).

A key point is that Myers's concept of subliminal intelligence was more expansive than Freud's subsequent formulation of an animalistic unconscious. According to Myers (1892, 350), "a stream of consciousness flows on within us, at a level beneath the threshold of ordinary waking life … this consciousness embraces unknown powers of which these hypnotic phenomena give us the first sample, the scattered indications."

Similarly, James (1902) argued that the presence of unconscious intelligence also helped explain many religious phenomena, such as hearing instructions from God, being controlled by outside spirits, or experiencing faith healing. As outlined by Janet (1925), Myers's subliminal intelligence was not only capable of subliminal perception and regulation of autonomic processes, but also of engaging in higher cognition, such as goal formation, moral decision making, tracking time, and making complex predictions. Janet also credits Myers with the argument that these unconscious tendencies exist in all of us at all times. In sum, Myers argued that we are more intellectually capable than we can consciously know.

Like the modern positive psychology movement, positive depth psychology examines the vital contribution of unconscious processes to everyday life. From this perspective, this mysterious part of the mind is seen as having processing capabilities that are equal, if not superior, to conscious reason. In the words of William James (1982, 91), unconscious processes are "the organizing center of personality." While James (1890) believed that the terms *thought* and *emotion* should be restricted to descriptions of conscious awareness, he also argued for the intellectual capabilities of unconscious problem-solving, describing them as "far wiser than and superior to that of normal, waking, rational awareness" (Taylor, 1982, 91).

These ideas seem to have formed the foundation for the clinical innovations of another iconic figure, Milton Erickson. Rather than embracing Freud's wildly popular description of the unconscious as something that is irrational and destructive, Erickson embraced a more positive view of unconscious capabilities.

In fact, Erickson took the Jamesian model a step further by arguing that unconscious processes include superior cognitive skills (as used in goal setting and problem-solving) and superior abilities for mentally representing and working toward the integration of emotional experiences. As Erickson (1948, 577) stated early in his career, "Good unconscious understandings allowed to become conscious before a conscious readiness exists will result in conscious

resistance, rejection, repression and even the loss, through repression, of unconscious gains." This brings us back to Freud's (1915) observation that some events and desires were too frightening or painful for his patients to acknowledge. Thus, Erickson accepted Freud's theory of repression, which has since been demonstrated in well-controlled studies (for an example, see Williams, 1994).

What makes Erickson's perspective fundamentally different from traditional psychotherapy is his acceptance of the limitations of conscious awareness and his utilization of unconscious processes for the therapeutic endeavor.

Erickson believed that conscious working memory is inherently less resilient to toxic emotional states than the working memory that operates at purely unconscious levels. For example, while describing his use of unconscious process work for trauma therapy, Erickson explains, "It may be too painful a thing for her ever to recognize consciously." (Erickson and Haley, 1985, 4) Thus, extremely toxic ideas should be processed unconsciously so that their impact can be mitigated prior to emerging into conscious awareness.

Erickson believed that this approach to process work is not only good therapy but also an ethical obligation. As Erickson explains, "You protect that patient. You're protecting the conscious mind by keeping that self-understanding unconscious." (Erickson et al., 1976, 256) Thus, rather than searching for past events and seeking to bring these painful or overwhelming experiences into conscious awareness (insight therapy), Erickson's method utilizes automatic coping strategies that are already in play. As soon as a cooperative, collaborative interpersonal exchange is established, these automatic strategies are elaborated and applied toward some productive end.

For example, coping strategies might include repression, denial, social isolation, somatization, or a purely symbolic representation of the problem situation. As illustrated in the case description at the start of this chapter, this person's distillation of the problem situation was in written form, which allowed me to recognize its importance and bring it into therapy. But why did she need to present her problems to me in written form prior to our face-to-face meeting?

Thinking of your own life experiences (perhaps a love note written to a crush or a painful apology), it is easy to recognize that sometimes we can manage to put into writing something that we cannot say out loud directly to another person. That is because speaking our most private thoughts while looking someone else in the eyes greatly intensifies the emotional reality of the experience. If a client is asked to share private information in narrative form (tell me your story), the emotional arousal is intensified still further—perhaps to the point of emotional flooding.

My tactic was to utilize the client's coping strategy (her list) and only speak her words as she had written them, but in a slow, careful, and non-emotional manner. It was this extra time (30 minutes of slow recitation) that provided space for her unconscious to begin processing the deeper meaning of the ideas. Thus, *unconscious process work moves in the opposite direction of*

conscious process work. The therapy began with a conscious definition of the problem(s), but in the absence of conversation, all was ceded to unconscious processing.

My client was primed to respond with process work by the nature of the setting (a therapist's office). Because I did not engage her in a back-and-forth dialogue, no demands were placed on her conscious resources. Thus, mental energy was freed up for use by unconscious processes.

Due to the timing of the apparent changes that occurred for this client, it is reasonable to assume that the therapeutic process work was beneficial. Yet it is equally possible that her progress was caused by some other, unknown variable. As we search for ideas we can trust, the conceptual foundation for this book will be checked against a large body of well-established, empirical research.

1.4 Understanding the Science/Practice Divide

Initially, Freudian depth psychology, which was foundational to twentieth-century psychotherapeutics, was summarily rejected by those conducting research. Ignoring James's enthusiastic embrace of unconscious functionality, researchers followed the lead of William Wundt (1832–1920), who rejected making unconscious mental processes a topic of scientific psychology. These foundational differences created a mistrust between researchers and clinicians that remains palpable to this day.

The story of this schism begins in 1904 when William James triggered a fierce debate within the academic community. The intellectual dilemmas he exposed left psychologists scrambling to determine what exactly is the science of mind and whether such a thing can even exist. According to Robert Wozniak, James's (1904) exigent philosophical article "Does Consciousness Exist?" questioned:

> Was consciousness a metaphysical entity or simply a particular sort of relationship toward objects into which portions of pure experience enter? Was consciousness a stream of experience, a kind of awareness, or thought? Was it an adaptive function or a composite of states; an energetic by-product of neurophysiological process, another name for associative learning, a form of arrested movement, a regulator of future adaptation, or simply another way of describing "self"?
>
> (Wozniak, 1997)

The answer to this collective existential crisis came in the person of John B. Watson (1878–1958), the father of behaviorism. Watson (1913) blamed psychology's failure to "make its place in the world as an undisputed natural science" on the "esoteric" nature of its introspective method (asking people to report on their psychological experiences) (163). Rejecting all data based on self-report as well as the use of consciousness as an interpretive standard, Watson urged psychologists to adopt behavior as their unit of analysis.

Watson convincingly argued that the task of psychology should be to manipulate the external stimulus environment and objectively measure the subject's responses. Standardization and replicability were prized above any consideration of phenomenology, even that which is central to human existence, such as feelings of love or imagination and creativity.

1.5 Science "Discovers" the Unconscious

It was not until the fall of behaviorism and the 1960s cognitive revolution that mental processes, such as apprehension, primary memory, attention, and imagery, once again became a legitimate topic of study in scientific psychology. Almost immediately, researchers found it necessary to make a distinction of one kind or another between conscious and unconscious processing. Now the term *unconscious* has been redefined in modern studies as all the mental processes that are not experienced by a person but that give rise to his or her thoughts, choices, emotions, and behavior (Schacter et al., 2011, 188).

I say redefined because its contemporary use is as an adjective that describes a wide array of functional capabilities, rather than a nominal term that points to a region of the mind. Even Freud (1915) seemed uneasy with his categorization of "the unconscious":

> let us state the important, though inconvenient, fact that the attribute of being unconscious is only one feature that is found in the psychical and is by no means sufficient fully to characterize it. There are psychical acts of very varying value which yet agree in possessing the characteristic of being unconscious.
>
> (172)

Drew Westen (1999) explains the modern conceptualization well, writing,

> we do not group a class of cognitive processes together and call them "the cognitive," any more than we speak of "the efficient," "the adaptive," or "the distressing." Nor should we lump a large set of processes together and call them "the unconscious," as if they all do the same thing, serve the same function, or operate on the same principles. We should instead speak of unconscious processes.
>
> (1095)

One of the most familiar examples of an unconscious process is the formation of conditioned responses following a stimulus-response pairing (associative learning), resulting in behaviors that operate automatically and outside of awareness. A second widely accepted example is the presence of instinctual behaviors, which are activated by situational factors and often operate outside intentional control.

Following the lead of depth psychology, new studies have revealed a more complex and dynamic set of interactions between numerous systems.

As Elizabeth Phelps (2004) has pointed out, the unconscious emerging from research is routinely involved in affect, motivation, and even executive control and metacognition. Unconscious processes can sometimes include elements of conscious awareness, effortful processing (requiring working memory), intentionality and self-evaluation, as well as goal setting, self-regulation, and adaptive learning (Bargh, 1994; Melnikoff and Bargh, 2018).

What eventually came to be recognized was that all major mental processes and states can be *unconscious* (occurring outside of conscious awareness) and/or *implicit* (occurring automatically without attention or intention). Thus, the modern unconscious emerged as an unavoidable dimension in nearly every field of inquiry in psychology, cognitive neuroscience, behavioral economics, and the humanities. For example, in the field of cognitive linguistics, the study of generative grammar seeks to better understand the linguistic structures below the level of conscious awareness, such as presupposition and metaphoric meaning. In research on motor control and on language production, the conscious aspects of voluntary action and action monitoring are contrasted with unconscious aspects of motor programming, which includes the implicit learning of motor sequences. In modern perception research, psychophysical measurement continues to make the distinction of supraliminal versus subliminal stimulation.

In the study of attention, the term "attentional awareness" is often contrasted with unconscious, "pre-attentive" processing. Research on the social science of persuasion makes a distinction between central processing versus peripheral route (with central processing being more conscious and deliberate, while the peripheral route relies on implicit processing). And in memory research, the distinction is made between declarative memory (explicit processing) and procedural memory (implicit processing). Lastly, in various reincarnations of Freud's dual-process typology, several fields now contrast "automatic" processing (type 1), which tends to be associated with unconscious mechanisms, versus "controlled" processing (type 2), which tends to be associated with consciousness. Of all these, the research that has gathered the most attention is the work with subliminal perception, priming, and decision-making—specifically the study of heuristics and biases.

With this rapidly expanding body of research, it has become nearly impossible to ignore the significant role of unconscious processes in day-to-day human behavior. Regardless of the terminology used to describe it, the difference between conscious and unconscious processes is an inescapable contrast.

One of the most important discoveries of modern research into unconscious cognition is that all thought and behavior get their start at the level of unconscious processing. This revelation seems to have been anticipated by the German philosopher Arthur Schopenhauer (1788–1860), who was the first person to theorize about unconscious cognition. Schopenhauer (1851) wrote:

> One might almost believe that half of our thinking takes place unconsciously. … I have familiarized myself with the factual data of a

> theoretical and practical problem; I do not think about it again, yet often a few days later the answer to the problem will come into my mind entirely from its own accord; the operation which has produced it, however, remains as much a mystery to me as that of an adding-machine: what has occurred is, again, unconscious rumination.
>
> (123–124)

Perhaps because the entire scientific enterprise is based on efforts to capitalize on conscious deliberation and critical thought; the idea of an unconscious intelligence has been reflexively rejected by academia. However, during the last thirty years a paradigm shift has occurred. Not only have social psychologists, such as John Kihlstrom (1987; Khilstrom et al., 2000), argued for a cognitive unconscious and an emotional unconscious; now there is controlled experimentation showing unconscious preferences and values, questions, and conclusions that together form the foundation for unconscious motives and goals (high-level cognition).

Confirmation of this principle forced academia to abandon a central premise of cognitive psychology in the 1970s, which was that higher mental processes were almost entirely under conscious, executive control. Given technological improvements from 1980 onwards (such as brain imaging techniques), researchers discovered unconscious processes not only support but also inform our most sophisticated mental activities. As Ran Hassin (2013) argues, unconscious processes can perform the same fundamental, high-level functions that conscious processes can perform.

With these conceptual advances, John Bargh (2019) has argued that psychological science has reached a unique point in history. Only recently have all three of the past century's most important competing schools of thought converged on a single, empirically supported construct. Bargh believes that the elegance of modern research on unconscious processes is its ability to combine the most important aspects of Freudian psychology, behaviorism, and cognitive psychology.

According to Bargh, current research clearly supports Freud's position that many important affective, motivational, and behavioral phenomena operate without the person's awareness or conscious intention. This same body of research also supports the position of behaviorism that unconscious processes are often triggered by events, people, situational settings, and other external stimuli. And, in keeping with cognitive psychology, it has been found that these external stimuli exert their effect through the automatic activation of internal mental representations and processes. These new developments in social cognitive research have been described by Hassin and others as the New Unconscious (Hassin et al., 2004).

1.6 Process Work is Problem-solving

In the past, there has been some debate over whether psychotherapy most appropriately focuses on emotional coping and affect regulation, or whether it

should focus on problem-solving and direct efforts to change those factors that have created emotional distress (Lazarus and Folkman 1984). Thus, when considering the case example at the opening of the chapter, it is interesting to ask which of these was prioritized. The answer seems to be both.

Rather than thinking of emotional or autobiographical process work as being mutually exclusive to practical problem-solving, it is helpful to think of it as a pre-deliberative stage in the problem-solving process. As William James (1890) puts it, emotion prepares us for action. Later, we will examine how the process of problem-solving can be broken down into a deliberative stage (planning) and an implemental stage (executing action), each with its own distinct mindset. When I say that emotional process work is pre-deliberative, what I mean is that emotion shapes how we think about our problems, and it motivates us to action. As seen in the opening case example, once the stage is set, decisive action is likely to follow.

The findings of modern cognitive science support the possibility that unconscious process work was what enabled my client to emerge into an entirely new system of intellectual, emotional, and behavioral realities. This includes research that specifically addresses unconscious aspects of working memory as well as unconscious self-monitoring and self-regulation. This evidence suggests that during therapy my client was involved in a re-examination of the meaning of old memories and emotions, without conscious awareness.

An interesting challenge that all experts face while reading about the powerful influence of unconscious mental activity is how we reconcile our dependency on academic knowledge (as a source of authority) with the obvious limitations of conscious resources. A grave error in Freudian analysis was the assumption that the therapist, as an informed authority, could make perfectly objective interpretations while the patient presumably languished under the effects of his or her unconscious conflicts.

Therefore, as you read through this material and think about what it may mean for the people you work with, also keep in mind your own humble position as someone who is equally influenced by powerful unconscious forces. While conducting process work with the client, the ideal scenario is one in which your own unconscious processes are problem-solving the task of meeting the client's needs, both conscious and unconscious.

The thoughts of Michael Polanyi (1891–1976), a Hungarian-British polymath who made important theoretical contributions to chemistry, economics, and philosophy, provide a perfect encapsulation not only of this chapter but for the book as a whole: we know much more than we can tell.

Polanyi (1958) made this statement while introducing the concept of tacit knowledge, which is the skills, ideas, and experiences that people have, but they are not codified in cognition and thus are difficult to express. As a result, people are often not fully aware of the knowledge they possess or how it can be valuable to themselves and others. The best way to share tacit knowledge is through personal encounters that are characterized by collaborative interactions and trust (Goffin and Koners 2011)—the stuff of psychotherapy. Thus, if a

person relies entirely on conscious knowledge for individual problem-solving, then the tacit knowledge gleaned from a lifetime of learning is lost. The point to take from this chapter is that unconscious process work is a strategic problem-solving methodology that places unconscious abilities in the lead position during tandem work with conscious intelligence. Furthermore, the point to take from this entire book is the pivotal role of unconscious processes during any psychological endeavor. As stated by William James over a century ago, "the subconscious is not only the most important problem of psychology, it is the problem" (quoted in Prince, 1912, 162).

Chapter 1 Key Points

- Unconscious process work does not require conscious insight. It also does not require trance states or suggestions for change. Instead, it is an exercise of unconscious creativity and personal problem-solving (self-organizing change).
- Conscious process work can be harmful, leading to emotional flooding, shame, or interference with spontaneous, intuitive behavior.
- Unconscious intelligence has processing capabilities that are in some ways superior to conscious reason (e.g., intuitive problem-solving). But there are also unique advantages to conscious intelligence (e.g., science).
- The contemporary science of unconscious processes combines the most important aspects of Freudian psychology, behaviorism, and cognitive psychology. The methodology of unconscious process work draws on all three of these as well as Ericksonian hypnotherapy.
- People are often unaware of the knowledge they possess and how to utilize it while problem-solving their greatest challenges.

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