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The Compleat Therapist

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What Therapists Actually Do with Clients That Makes a Difference

The therapist's ability to be helpful depends on more than his or her characteristic way of thinking and underlying personality qualities. There is also a consensus that some interventions are more likely than others to facilitate process goals. However, the relationship between therapeutic interventions and treatment outcomes is very complex.

As much as we would like to conceptualize therapy in terms of precise relationships between process variables and outcomes, what goes on between client and therapist is too complex, and its fabric too interconnected, to isolate single variables. That is why it has been so difficult to empirically substantiate that any single clinical action — whether it is the frequency of empathic responses or the duration of eye contact — consistently and universally makes a positive difference. Strupp (1989) believes that this search for effective technical skills has been disappointing because what is at issue is the meaning of these interventions to the client at a particular moment in time.

Another problem in identifying those behaviors, skills, and interventions that are most likely to be therapeutic is that clinicians differ so widely in their responses. Imagine, for example, a client statement such as the

following: “I’ve been coming to you for a while, and whereas I appreciate all you have been trying to do for me, I don’t feel any better; if anything, my symptoms are even worse! Do you see any hope for us continuing?”

Think about how you would respond to this client.

As is so often true in our profession, there is rarely a correct response or intervention that is called for, but rather a range of possible skills that may be employed. In the preceding example, any of these therapeutic reactions are possible:

1. *Reassurance*. “Sure. It just takes awhile. You need to be patient.”

2. *Counterquestion.* “What changes have *you* noticed since we started working together?”

3. *Reflection.* “You seem to be feeling hopeless, as if nothing will help and you’re doomed to spend the rest of your life like this.”

4. *Acquiescence or paradoxical maneuver.* “Maybe you’re right.”

5. *Distraction from challenge.* “We can discuss that later. For now I wonder about what happened this week. You obviously feel distressed about something.”

6. *Confrontation.* “I sense that you are challenging me to prove to you that this helps. It strikes me as a trap — if I agree, you will have an excuse to quit; if I disagree, you will accuse me of

pressuring you into staying."

This, of course, is only a sampling of the possibilities and may not include your preferred response. The point is that there are many interventions that can be used appropriately in this or any other situation, making the task of cataloging effective therapeutic options very difficult. Nevertheless, I do believe that it is possible, and certainly useful, to summarize those therapist actions that are considered to be universally helpful across disciplines, theoretical orientations, and therapeutic styles.

A competent therapist, whether trained in social work, psychiatry, psychology, counseling, or nursing, whether working in crisis intervention or long-term relationships, whether operating psychodynamically, existentially, or behaviorally, is still going to be relying on similar actions that have been found to be helpful both clinically and empirically. For example, gestalt therapists, behavior therapists, and psychoanalysts use empathy, clarification, and interpretation similarly (Brunick and Schroeder, 1979; Sloane and others, 1975; Kazdin, 1986). Though the various therapeutic approaches entail different theoretical constructs, they employ quite similar interventions.

The degree to which a clinician can consistently, accurately, and skillfully apply therapeutic procedures and interventions is of the utmost importance in producing positive outcomes (White and Pollard, 1982;

Beutler, Crago, and Arizmendi, 1986). Competence in therapy can be assessed according to the degree of mastery the professional has reached in each of the following clinical skill areas: selecting suitable clients, role induction, relationship building, interviewing, linguistic coaching, interpreting, confronting, handling resistance, focusing, questioning, problem solving, setting limits, self-disclosure, and dealing with endings. While hardly an exhaustive list of everything a competent therapist regularly does in sessions, these skills are representative of clinical interventions that he or she must master to function effectively. We will briefly discuss each of them in the following paragraphs.

Selecting Suitable Clients

Since it is the client who contributes the most to successful therapy outcomes in terms of a willingness to work sincerely on personal issues, the most effective therapists are those who can teach clients to optimize the benefits of their sessions. This begins with selecting the best candidates for treatment: those who are highly motivated, who have realistic expectations for what they can accomplish, who are reasonably similar to the therapist in terms of basic values, and whose style of psychological difficulty is amenable to psychotherapeutic intervention.

Effective therapists of all theoretical orientations are highly skilled at

selecting those clients who they believe they can help. There is a mutual process of "checking each other out" that determines whether a good match exists between client and therapist personalities, values, styles, and expectations. Rarely, however, is this done explicitly. The therapist would hardly say aloud, "I'm sorry, but I would prefer not to work with you. You're too crazy/demanding/frustrating/manipulative. Let me refer you to someone else." And just as infrequently would a new client admit that "I don't think I like or trust you. You're too arrogant/cold/weird/withholding. So I won't be coming back."

Yet we do notice that a very similar process does occur in a much more subtle manner. No matter how broad our experience with a range of clientèle may be, we find that occasionally, for no reason we can readily discern, a client drops out of treatment with no explanation given. We, of course, speculate on the reasons for this premature departure:

- "I probably cured her after this one session so there is no reason for her to come back."
- "She just took some time off to internalize all the provocative material we covered. She'll be back."
- "I'm too perceptive for her and she feels threatened at how well I could see through her."
- "She just doesn't have the motivation and commitment it takes to do

well in therapy."

There are, of course, many other reasons the client does not return that may have to do with the way we handled things. But some of the time, clients drop out because they have decided they do not like us, for whatever reason. It could in fact be an excuse for keeping us at a distance if we get too close. But it can also be a matter of compatibility. Clients are looking for a therapist who they believe shares their basic values in life, who they perceive as attractive and trusting. And the fact is that we cannot be everything to everyone.

It is fascinating to listen to clients tell us why they quit treatment with other practitioners, what exactly they were shopping for in a helper. One therapist seemed too aloof and unapproachable. Another had this nervous habit of clearing his throat that was found distracting. One was too passive; another too active. Clients seem to know what they are looking for, and perhaps what is surprising is how many times the first encounter with a therapist turns out to be a beautiful match. This is a tribute to the effective therapist's adaptability — that is, his or her ability to reach so many different people with diverse backgrounds.

Still, some clients do not come back. And probably for valid reasons. Effective therapists accept this, acknowledging their inability to work with everyone all of the time and processing the feedback to help them become

even more skilled in the future. They also recognize the importance of a good match. Therapists unconsciously discourage those clients they do not wish to work with — those they perceive as boring, who they do not believe they can help, or who present issues that are experienced as too personally threatening.

I am uncomfortable admitting that some clients get more from me than others, but I work harder if I feel more engaged. I am more accommodating in my scheduling and payment of fees. I am probably more understanding and patient. I know that some clients get to me more easily than others; I sometimes punish them by being withholding or being more confrontational than I need to be. So, naturally, I am less effective with them than I could be. Sometimes they might cancel an appointment and I am ashamed to admit that I feel relieved. I do not follow up with a phone call as quickly as I might with another client. All in all, I tell myself that these thankfully rare mismatches with me deserve someone who can be more compassionate than I can. They eventually leave dissatisfied unless we can work things through more honestly in sessions as to what is getting in the way for us.

If this is the worst part of me — that which feels most unprofessional— then one of the best parts of my work is when the client and I can deal with each other in an open manner and come to realize that someone else might be better for him or her. One case I can recall feeling especially good about

involved a client who had the remarkable courage to confront me after a second session and tell me that she did not feel things were clicking between us. She did not think that I was "her kind of person." I was surprised at how nondefensive I felt, because usually I feel *very* threatened by this type of feedback, which I perceive as rejection. I shared with her how much I appreciated her honesty and openness. We were then able to put our heads together in the process of selecting another therapist who would be a better match for her. When she left, we both felt good about the interchange.

Rarely is this selection process so overt and direct. But the result is the same: we pick those clients we believe we can help, al owing the few others to drift away. Clients stay with therapists they believe can help them, and leave those who they perceive will not be helpful.

There are many other factors that play a part in each individual therapist's selection process. The effective psychoanalytic therapist is not going to agree to work with someone who wants only symptom relief but could care less about self-understanding. The cognitive therapist will stay with those clients who want to think more rationally. The existential therapist selects candidates who have the capacity and motivation to discover personal meaning in their lives in addition to having a high tolerance for ambiguity and suffering. The strategic therapist works best with clients who want quick symptomatic relief, without any interest in self-discovery. The gestalt

therapist wants clients who are not so literal-minded, who will cooperate with spontaneous encounters. This is not to say that these or other specific treatment modalities cannot work with almost everyone. However, effective therapists know what they can do well and with what kind of clients. And they are good at screening out those who are likely to be poor risks.

Role Induction

The client walks in confused. He is uncomfortable with the lack of structure and the therapist's ambiguous role. There are a host of conflicting feelings and desires — to make a good impression, to present an accurate portrait of what has been going on, to defend himself against more pain, to be a "good client." And he experiences tremendous anxiety because of muddled expectations:

Where should I sit? What am I doing here? Where should I begin? What does she want from me? Is it okay to take my shoes off? Am I supposed to pay now or later? What is she going to do? What is she waiting for? Am I supposed to start?

Hello, my name is Dr. ____. What can I do for you?"

"Um. Uh. Well, it . . . uh. I'm not sure." *What does she want to know? Should I just talk, or will she ask me questions? Should I give her brief answers*

or long ones? Should I even tell her the truth? I hardly know her.

It is truly amazing that despite such humble beginnings, in a matter of minutes this client will pick up what is expected of him: to be as open and honest as possible and to be patient with whatever unfolds. He will learn the rules of engagement — that while the therapist *says* it does not matter what you talk about, there are certain topics that seem more appropriate and certain ways of talking about them that are most helpful. Before this first session is over, the client will have a pretty good idea of what to expect next time.

Clients stay in therapy longer and get more out of the experience when the roles of both client and therapist are clearly delineated (Frank and others, 1978; Garfield, 1978; Richert, 1983). While the roles of the therapist are everchanging—from consultant to compassionate listener to supportive friend to authoritative expert to idealized parent — clients are helped to take on the role of a cooperative, open, trusting participant. In short, we are teaching clients to function optimally so that they may get the most out of treatment and we might feel most comfortable (Chessick, 1982; Beitman, 1987).

Most of the ingredients of successful therapy are introduced as the treatment first begins. Unless the therapist can recruit the client's help, set up

favorable expectations, establish realistic goals, structure a sound treatment plan, and initiate a productive working alliance, any further efforts will be doomed. Effective therapists are thus quite skilled at preparing the client for what will follow in a way that maximizes receptivity and active participation.

Inducting the neophyte into the role of a client involves several important steps that are part of most intake procedures. If there has ever been one area of consensus among practitioners of different theoretical allegiances, it is that initial interviews should have certain characteristics and goals beyond that of collecting needed background information. Some of these components of successful role induction have been proposed by Orne and Wender (1968), Got man and Lieblum (1974), Dyer and Vriend (1977), and Beutler (1983); they include the following:

Providing a General Introduction to Psychotherapy. The client is usually given a general overview of the process — what it can and cannot do and what is likely to occur. Often this includes a discussion of ground rules related to fees, scheduling, and confidentiality.

Assessing the Client's Expectations. The client is questioned about what he or she believes will happen and is asked for perceptions of what the therapist will do. Through patience and probing, we eventually learn what the client really thinks about being in our of ice:

- "This feels awkward and humiliating and terribly uncomfortable."
- "I am probably crazy, and I am about to learn that my therapist will put me away forever."
- "There is no hope for the incurable condition I have contracted."
- "Talking to a complete stranger about my problems is ludicrous and a definite sign of weakness."
- "This is a sham and a rip-off, paying so much money for so little."
- "This probably won't work, and even if it did, it's too late."
- "After about two more sessions I'll be fixed for good, and I won't have to do much to make that happen."

Stating the Therapist's Expectations. With diplomacy and sensitivity, the therapist systematically eliminates each of the client's misperceptions about what therapy can do. The clinician provides an alternative reframing of therapy that is consistent with what he or she can actually deliver. For example, "I have no magic wand, but I do have some degree of expertise that will al ow us together to explore what is going on and to help you find a way out."

The therapist also introduces the client to the behaviors expected of him or her. These might include some of the following:

- " . . . that you at end sessions regularly and promptly"
- " . . . that you give sufficient notice before canceling a session"
- " . . . that you agree to abide by office policies and pay bills according to our agreed-on schedule"
- " . . . that you not call my home number unless it is an absolute emergency"
- " . . . that you abstain from all alcohol and drug use while you are in treatment"
- " . . . that you accept primary responsibility for the content and direction our sessions take"
- " . . . that you try to be as open and honest with me as you can"
- " . . . that if things aren't going the way you like, you will take responsibility for making changes and letting me know what you need me to do differently"
- " . . . that you will give at least two weeks' notice before ending treatment so that we may work through unfinished issues between us"

Previewing Coming Attractions. The client is warned about, and prepared for, certain predictable occurrences that he or she may find uncomfortable. For example, the client is advised that he or she may feel some degree of discomfort throughout the experience, that at several junctures

there may be a temptation to run away, and that these resistances are normal and even useful to moving forward. This is an especially important phase of the role induction process since it builds a certain amount of patience and indulgence into the client's expectations and gives the therapist latitude in helping the client process periods of discouragement and disillusionment.

Giving a Favorable Prognosis. The client wants and needs to hear that devoting this time, energy, and money is going to result in something tangible. While no guarantees can reasonably be offered, the therapist assures the client that what is ailing him or her is indeed workable, that it may take a while, but with sufficient motivation and hard work, the client will indeed experience significant improvement.

O'Hanlon and Weiner-Davis (1989) even recommend ending the first session by capitalizing on the client's positive expectations. They believe that rather than focusing exclusively on what is wrong with people — exploring and diagnosing their psychopathology — progress would be better served by asking clients to reflect on what is working for them. Thus they suggest asking clients to pay attention to all the positive or desirable things that occur during the week. For example, rather than spending time thinking about how often they argue, a couple can be directed to monitor everything about their relationship that they would like to nourish. A positive rather than a negative prognosis is therefore fostered.

Orienting the Client to New Behaviors. There are certain client behaviors that are essential for therapy to work. People who are used to externalizing their problems and blaming others for their suffering must give up these defenses in favor of alternative strategies that are consistent with the goals of therapy. Clients are taught to be more psychologically sophisticated, to be more introspective and analytic, and to begin looking at *their* role in creating difficulties for themselves.

There is usually a certain language and phraseology the therapist prefers the client to use that is representative of these new concepts. Thus the first or second time the client says "I need . . . " he or she may be asked to substitute "I want . . . ," or he or she may be encouraged to exchange "I won't" for "I can't." This sensitivity to language becomes one of the first signals for the new client that the rules of expression in therapy sessions are considerably different from conventional modes of thinking and talking.

Helping the Client Increase Tolerances. The client is helped to increase tolerances for certain experiences that will prove useful for the duration of the sessions. These will probably include expanding the client's range of vision — that is, increasing his or her willingness to consider new choices and possibilities. It also means increasing client tolerance for short-term suffering while rendering the prospect of long-term discomfort unacceptable. In other words, the client will have to tolerate the pain of the present symptomatology

as well as disquieting confrontations with himself or herself until things can be worked through, but will no longer be forced to confront a mediocre future.

Tolerances for other states are also increased to make therapeutic work possible — so that the client can temporarily live with uncertainty, ambiguity, frustration, and other likely experiences that usually accompany this personal journey. This orientation to "nowhere land" starts the first time the client asks a direct question and is told "It's up to you," or when the session is ended with things left hanging in the air. Essentially, the client is quickly taught to increase his or her capacities for tolerating the unknown and the uncomfortable.

Obtaining a Commitment. When all else is said and done, the final and most important component of the role induction process is securing a commitment from the client that he or she will agree to the conditions of the contractual arrangement and work hard in the sessions. Without such a promise, the client will feel little investment in the therapy and little inclination to stay with the process when the going gets rough.

Kanfer and Schefft (1988) have argued that one of the most common reasons therapy fails is that the client is not sufficiently motivated; helping him or her develop a commitment to change is the central task of the

clinician. They propose a variety of clinical skills and interventions that are often useful in (1) reducing the client's feelings of demoralization, (2) developing incentives for change in the clients, (3) obtaining a commitment from the client to participate in therapy, and (4) motivating the client to stay with treatment when the going gets rough.

It probably makes little difference exactly which techniques are used to accomplish these goals — whether the clinician prefers instituting positive imagery, recording progress in ways that make it easy to see changes, setting small but easily managed tasks, or using encouragement within the therapeutic alliance. Whatever particular style or approach is employed, the therapist must be successful in securing the client's commitment to follow through with the therapy process.

Relationship Building

Perhaps what makes therapists most effective is their ability to create trusting relationships with their clients. In the context of an alliance that consists of mutual affection, respect, openness, and excellent communication, there is much freedom for both participants. There is freedom for the client to explore unconscious motives, repressed experiences, and unexpressed feelings, and to experiment with new behaviors. But there is also freedom for the therapist to feel at ease and to make mistakes without jeopardizing future

progress.

In a trusting relationship in which we have earned the client's confidence, we are not as pressured to perform perfectly. The most effective therapists are not those who know exactly what to do in every situation; rather they are those who have secured sufficient time and patience on the client's part to experiment until the most helpful combination of interventions is discovered.

It is not necessary to be right in every interpretation, to be on target with every confrontation, or to be successful with every therapeutic strategy, as long as we have the client's trust and indulgence. If he or she believes in our integrity and competence, then we have all the time we need to eliminate those approaches that do not work and select (or stumble on) those that will.

One practitioner—a counselor educator and therapist for over twenty years — believes that the essence of everything she does with her clients boils down to her skill and expertise in building productive relationships: "I suspect that those clients with whom I am most effective feel deeply heard and valued by me. If asked, I hope they would say I understand them on all levels and to the depth of their beings. When we are together, I 'fit' tightly around them. I work closely with them, picking up nuances and subtleties of thought and emotion. I catch their smallest feelings and ideas as they arise in

the moment and stay present as these shift. I reflect the reality of their inner experience, thus giving them permission to move to deeper and deeper levels of awareness."

This counselor educator further describes what she considers to be the ultimate clinical skill as establishing a working relationship in a relatively short period of time. To do this the professional must exude a certain amount of charm, class, sincerity, tranquility, magnetism, kindness, empathy, wisdom, and other characteristics that make someone attractive to others. The effective therapist is seen as nurturing and safe, as someone who can truly be trusted with one's secrets, problems, and well-being.

These qualities are communicated in the very being of the therapist, in her energy and style, and also in her behavior. For the effective therapist acts in ways that are designed to win confidence and instil a sense of trust. This is done by demonstrating one's skill as an attentive listener, without judgment or criticism. It is done in all the innumerable ways in which we show our concern and caring.

Whereas Rogers (1957) was the primary spokesperson for the healing benefits of communicating caring and positive regard to the client, this skill(if it *is* a skill rather than a quality or even more diffuse "way of being") is certainly part of the repertoire of every practitioner. Decker (1988) points

out that most, if not all, therapists act as caregivers of parental love. Even though we accept financial remuneration in exchange for our attention, clients feel a sense of genuine caring from us — or they would not come back. (The notable exception to this point are those clients who are so used to being in nonreciprocal, withholding relationships that they will tolerate aloofness, rejection, and even disdain from their therapists because it is all they feel they deserve.) Since, however, this discussion is concentrating on the skills of the most effective therapists, we are justified in saying that at least some degree of caring is evident in therapeutic relationships.

It is not enough to care about our clients; most potent therapeutic effects result from the communication of this attitude in such a way that the client can accept these positive feelings. Indeed, perhaps the greatest skill is in communicating the positive regard in such a way that it is felt by the client, but is neither misinterpreted as seductive nor seen as inauthentic. We are giving of ourselves — our loyalty, our undivided attention, our focused concentration. We hear, see, think, feel, and share what we observe and sense.

The skills that are involved in this endeavor are initially taught in graduate school: how to reflect feelings, offer support, and demonstrate deep levels of empathy and understanding. Yet the best therapists have integrated these interventions into their natural style of relating to others. They radiate a warm smile, soft eyes, and a presence that invites people to confide their

deepest thoughts and feelings.

Effective therapists are also good at making adjustments when they sense that things are not going as well as they could. When they feel a client slipping away, they are able to quickly diagnose what they may be doing that is creating distance and what they might do to facilitate greater intimacy. They are able to adapt their style to the needs and requirements of each client, calculating when appropriate levels of familiarity or formality are needed.

Many clients report dissatisfaction with therapists they have seen because they were perceived as being either too loose or too rigid. A client confided his frustration with a therapist who was repeatedly asked for feedback and input on what had not been disclosed over a period of a dozen sessions, but instead encountered continued silence and passivity. The therapist refused to alter his style. Another client felt extremely uncomfortable with her therapist's informality and loose boundaries. She wanted more structure to feel safe and even expressed this to her therapist. But he, too, was unable or unwilling to change his style.

Some clients need more structure, others less. Some appreciate formality; others feel most comfortable in an informal setting. While generally we tend to keep those clients who are most like us in their basic interests and

values, those therapists who are able to reach a broader population are those who are good at diagnosing just what a client needs to feel comfortable opening up — and then to deliver it.

Interviewing

There is both an art and a science to a therapeutic interview. Even the most nondirective of therapists finds it important to gather background information, relevant family and medical history, and other material that may prove helpful in understanding the context of the present situation. While the degree of structure used in initial interviews may vary from the most regimented of mental status examinations to a more open-ended discussion about what brought the client to the office, conducting such an exploration is a prerequisite for any treatment that would follow.

The best interviews are those that appear to be the most natural encounters, where the therapist is able to elicit volumes of information without resorting to an interrogative style. It is this low-key, nonthreatening approach that separates the veteran from the beginner. The effective therapist is able to encourage sharing, openness, and helpfulness on the part of the client through a host of ancillary skills such as open-ended questions, reflections of feeling, probes, and demonstrations of general interest. Like any great detective, the therapist is good at getting people to *want* to tell their

story, complete with all the rich details that give it life and meaning.

There is probably remarkable consensus among practitioners of all theoretical orientations as to what information should be gathered during initial interviews. Such a list would include: a description of complaints and symptoms, the exact onset of problems and precipitating factors, previous history of emotional difficulties, a list of what has worked so far in coping with the problems, previous history of working with professional helpers, medical history including any medications being taken, previous or current illicit drug use, family constellations and history, current living situation, occupational and avocational activities, feelings about being in therapy, and reflections on how things are going so far. Marmor (1986) summarizes these various components; he suggests that careful history taking is intended to

1. Determine the onset of the symptoms (acute, chronic, precipitating factors)

2. Assess strengths the client brings to the sessions (intelligence, education, experience, support system)

3. Explore stresses in the client's life and capacities for dealing with them

4. Evaluate resources that are available in the client's world (quality of relationships, vocational and interpersonal skills, financial resources)

Rarely would this information be collected through rapid-fire "interrogation," although questionnaires are often provided to clients as part of an intake procedure. The skilled therapist is able to find out what has happened and what is currently going on in the client's life through the same process that is part of al good therapy — by being an attentive listener, by tracking themes and issues, by noting what is said and what is omit ed, by providing a safe, secure environment conducive to sharing and exploration, and by clarifying things through questioning content and reflecting on underlying thoughts and feelings.

Linguistic Coaching

Since therapy is an act of communication, much of what takes place is centered around the content and structure of linguistic processes. In a sense, therapists function as language coaches who listen carefully to what is communicated and how it is expressed. Much of the time, the messages contain distortions, exaggerations, overgeneralizations, erroneous assumptions, and inconsistencies that can be altered to represent more accurate aspects of reality or healthfulness.

Whereas it is obvious the way linguistic philosophers such as Ludwig Witgenstein would devote considerable attention to the differential meaning of expressive language, there is also a rich heritage of these methods evident

in much of therapeutic work. With the growing popularity of cognitive-based therapy and neurolinguistic programming, most practitioners have become quite adept at monitoring and shaping client language patterns.

The rational-emotive therapist believes that by learning to talk to yourself differently, you will subsequently think and feel differently. The neurolinguistic therapist is also concerned with correcting distortions of reality implied in verbal communication. The gestalt therapist finds it helpful to encourage clients to adopt the language of self-responsibility. And since it is the primary tool with which to influence the client, all practitioners are concerned with the precise and constructive application of language.

There are, for example, a number of ways in which therapists apply linguistic coaching skills in their work:

1. *Correcting distortions or exaggerations of reality.* "When you say you have *never* been successful in *anything* you have ever tried, I presume you are speaking only about your most recent attempt to find a date."

2. *Pointing out errors in logic.* "Perhaps I'm missing something here, but you said that *your* suffering is caused by what *others* have said to you?"

3. *Clarifying ambiguous referents.* "When you speak of people who should be more sensitive to others' feelings, what you mean is that your husband could be more attuned to *your* feelings."

4. *Helping clients to express more completely and fully the exact nature of their internal experiences.* "What is it like for you to feel out of control?"

5. *Teaching clients to avoid the use of certain words, phrases, and expressions that can be considered counterproductive.* "I wonder if you wouldn't mind repeating what you just said, but this time substitute *I want* for *I need, I won't* for *I can't,* and *I prefer* for *I must."*

6. *Encouraging clients to use the language of self-responsibility.* "You have been talking at length about how everyone feels in this group. You might try using the pronoun / to speak only for yourself."

7. *Pinning down responses that are evasive.* "You keep saying *maybe, probably,* and *I don't know.* Take a wild guess and tell me what you think might happen."

8. *Confronting sexism, racism, class prejudice, and other forms of bias to facilitate a deeper understanding of their impact on others.* "I notice you use derogatory terms whenever you refer to women — expressions like *bitch, my old lady,* and *weaker sex.* Let's look at what effects that might be having on some of your relationships."

As therapists, we must be sensitive to our clients' use of language. But we not only need to be skilled at logical analyses of words and their meanings; we should be experts at our own use of language. Since it is our job

to offer a reality that, if not more objective, is at least healthier than our clients', words and gestures are the principal means available to us in our efforts to clarify what we hear and offer interpretations regarding possible meanings.

Interpreting

Interpretation is the basis for much of our therapeutic work, since it is our job to draw together client material into statements of possible significance. It is an attempt to represent reality accurately in language that may be understood. As such, it is an aesthetic venture rather than an assertion of a truth or falsehood that cannot be verified (Spence, 1982). Like any work of art, it must be beautifully conveyed, arrest attention, and be a stimulus for discovering personal meaning. It is proposed as a hypothesis, a possibility of what may be, subject to the ways it is internalized by the listener.

Interpretation is the act of assigning meaning or causality to behavior or experience (Beitman, 1987). When we increase clients' awareness of patterns in their lives, they can no longer get away with acting in self-defeating ways without realizing what they are doing and why. A case in point is demonstrated by Nina and Nicholas, a couple who are especially wrathful in their conflicts with one another. The marital therapy that takes place consists

of the clinician playing referee to stop them from doing irreparable damage to one another in their reciprocal attacks. The therapist interpreted a pattern she had observed again and again in which each partner would take turns sparking an argument during times of relative tranquility. The other spouse would then take on the role of abused victim and milk the part to the hilt—until it became tiresome, when according to some unspoken agreement, they would switch roles of antagonist and defender. This carefully choreographed production was, of course, reminiscent of the behavior they had each seen modeled by their own parents at home. They had each auditioned candidates for the role of spouse over a long period of time until they found a suitable match.

It never became necessary to resort to an intrusive, strategic intervention — paradoxical, directive, or otherwise. The awareness of their pattern became embarrassing enough that they could no longer engage in ridiculous behavior without one of them realizing what they were doing and refusing to continue playing out the same script.

Family therapists — especially those who practice brief therapy, such as Fisch, Weakland, and Segal (1982), Budman and Gurman (1988), and Haley (1990) — see their essential mission of affecting cures within a half-dozen sessions as altering the client's perception of his or her presenting complaint. This reframing is accomplished mostly through the presentation of an

alternative interpretation of the problem in such a way that it may be more easily solved. Thus Weiner-Davis (1990) describes the case of a discouraged and demoralized single woman who had all but given up male companionship because of an image of herself as a loser. The therapist reinterpreted the issue in terms that were not only easier to work with, but in a way that reduced the client's sense of hopelessness — that the client needed to construct a more effective "self-marketing" strategy.

These sorts of interpretations, while the antithesis of traditional psychoanalytic interventions, nevertheless demonstrate the clinician's potential to suggest alternative realities that the client may find helpful. Bernstein (1965) summarized other uses of interpretation as a means to: facilitate insight, provide solutions, alleviate anxiety, inhibit acting out, improve communication, handle resistance, offer support, increase awareness, and infer causes of action. In each of these cases, the therapist seeks to label or explain phenomena in order to make them both understood and manageable (Dollard and Auld, 1959).

It does not really matter what type of interpretation is offered to the client — be it an existential, psychoanalytic, or cognitive-behavioral formulation. As long as it is a convincing, relatively comprehensible explanation of the source of conflicts, the client will find the therapist to be both reassuring and helpful (Garfield, 1980).

So we are dealing with style here rather than content. The client comes in and presents himself as agitated and anxious. He does not sleep well, waking up almost every hour of the night. In addition, he reports he has no goals in life, or anything in particular to look forward to. He is looking, desperately seeking, some explanation for this disturbing state of affairs. He does not care where it comes from — only that it reassures him that he is going to be alright, that he is not in fact falling apart.

One interpretation of his situation that could easily be proposed is that the meaninglessness he is experiencing in his life, the lack of purpose and direction, is keeping him up all night. The symptoms are creating the necessary discomfort to motivate action. They are his body's way of getting and keeping his attention until he takes care of unfinished business. If the therapist presents it with authority and eloquence, this interpretation may offer some comfort and understanding. The client would probably feel less anxious immediately, just from learning that this is a natural and even a necessary situation for him to live through. This interpretation would be effective because it makes sense to him. It is not so important to him *what* the explanation is as much as that there *is* an explanation for what is bothering him.

Effective therapists of all theoretical persuasions would make use of similar interpretive procedures — that is, giving meaning, even if it is only a

working hypothesis, to a situation that seems frightening and hopeless. With the preceding client, I offered just such an interpretation of his plight, quite proud of myself all the while — thinking I had (1) tied together most of the threads of his story, (2) proposed an idea that seemed logical and intellectually sound, and (3) explained the theory in a highly impassioned and convincing manner designed to recruit his support. He would, however, have no part of it. Although, he admit ed, the idea did have some merit, it did not "feel right" to him. He was quick to reassure me that he could see how I might think that, and perhaps it was true — but it did not seem to help him much.

I responded by offering another interpretation that I thought he would accept until he was ready or able to face some other issues. I recalled that the frequent waking problems had started gradually when he turned thirty, and they had been getting steadily worse. My interpretation of his situation was rather simple: I told him that most men over thirty begin to experience decreasing bladder capacity, which leads to the necessity of more frequent urination in the middle of the night. Now whether this is really what is going on with him or not is beside the point. The point is that this explanation made perfect sense to him (much to *my* surprise). He felt more relaxed, more hopeful, and relieved enough to begin to explore the other issues in his life.

This case illustrates how interpretations can be used to reduce client anxiety. However, the primary purpose of this intervention is to promote

insight and self-awareness, a process that often involves a certain amount of discomfort. Pope (1977) has observed that interpretation is an especially difficult skill to master since it is not only helpful; it can also be quite dangerous.

The client will not accept interpretations that are too deep, and those that are especially threatening will provoke greater resistance and defensiveness. Superficial and shallow interpretations, on the other hand, can be perceived at best as a waste of time, and at worst can be seen as evidence the therapist does not really understand what the client is communicating.

The worst kind of interpretations are those that appear pejorative, denigrating, or accusatory. Strupp (1989) believes that often a client's negative reactions are not due to resistance or pathology, but the natural defensiveness to perceived attacks: the client feels hurt and rejected. Here are a few examples of how interpretations can be framed negatively or positively. One alternative would be to say, "You seem to be acting out toward your wife just as you did toward your m other." But consider this version: "There seem to be some similarities between your relationships with your wife and mother." Or, for another example, "You feel helpless and trapped, but don't seem to want to do anything to change." The following version would have a much more positive effect: "There's a part of you that really wants to get better, and yet another part of you that likes things the way they are."

The principal task, then, for therapists is to offer opinions that are plausible to the client as well as insightful, without creating further resistance. Strupp advises that interpretations are most helpful when the therapist shows empathy, metacommunicates about the process without being specifically critical, and frames interventions carefully, diplomatically, and positively.

Confronting

While it is indeed counterproductive to create undue stress through the use of misguided interventions, there is an appropriate time and place for exacerbating the client's dissonance. Beutler (1986) believes this to be the hallmark of all effective therapy.

The purpose of confrontation is to help the client face discrepancies between aspects of his or her behavior and espoused attitudes, values, and goals (Dyer and Vriend, 1975). This may include pointing out differences between:

1. *What was said earlier and what is being said now.* "Earlier you mentioned that growing up in your home was so calm and pleasant, yet you are relating one instance after another in which things actually sound quite conflicted and stressful."

2. *What was verbalized versus what was actually done.* "You said

finding a new job is so important to you, yet you have been so reluctant to go out on any interviews."

3. *What is implied in one aspect of communication (nonverbal communication, expressions of feeling, intellectual responses, and so on) but contradicted in another.* "You report feeling comfortable right now and free of any concerns, yet you appear rigid, tense, and controlled. Your speech is tight, your knuckles are white, and you are unable to meet my eyes."

In each of these examples, or any confrontation, the therapist seeks to induce higher levels of dissonance in the client by forcing him or her to examine inconsistencies. When discomfort has been increased to uncomfortable but manageable limits, several things begin to happen: the client lets go of previous strategies that are clearly not working, the disequilibrium motivates a search for something else that will reduce discomfort, and the disorientation leads to a degree of experimentation with other alternatives that were previously unacceptable.

Dysfunctional behavior is, in many ways, the avoidance of issues and conflicts that will not go away by themselves. Clients develop defenses and adaptive mechanisms to protect them from dealing with painful material. Effective therapists use direct or indirect confrontation as the primary means of helping clients face the problems they have been avoiding. Garfield (1986, pp. 153-154) believes the common factor in all approaches "appears to be

that the client in some way is confronted with the negative situation and learns that he can face it without any catastrophic consequences."

Handling Resistance

One of the first paradoxes confronted by a beginning therapist is that whereas clients universally claim they wish to change, there is a part of them that would prefer that things stay just the way they are. We have learned that this phenomenon holds true for a number of reasons: fear of the unknown; reluctance to accept responsibility; repression, denial, or other defenses to keep the unconscious buried; reactions to perceived threat; anger or resentment toward the therapist for some perceived injustice; transference acting out; self-defeating personality style; sense of hopelessness; and so on. In fact, there are so many reasons why resistance occurs that it is a wonder anyone changes at all!

Nevertheless, effective therapists are highly skilled at dealing with client reluctance, respecting the messages it conveys, and using the conflict for the purposes of learning and growth. Imagine, for instance, how you would respond to a client you have been seeing for some time who does any of the following:

- consistently comes five to ten minutes late to every session

- cancels or reschedules sessions on a regular basis
- becomes unduly argumentative over apparently insignificant points
- remains silent for lengthy periods of time
- denies the existence of conflicts that appear evident
- agrees with almost everything you say
- reports not thinking about the content of therapy between sessions
- changes the subject whenever certain matters arise
- indulges in incessant chatter, filling the time with long-winded, rambling monologues
- maintains feelings of abject hopelessness in the face of any and all interventions
- expresses anger and hostility without provocation
- fervently denies the presence of *any* feelings toward you

Decker (1988) reminds us of the value that psychoanalytic thinking has brought to the understanding and management of the behaviors just listed. The analyst has taught us that opposition to treatment is not only to be expected in a therapeutic encounter, but is viewed as a healthy way of pacing progress until the ego is strong enough to deal with threatening material. As

such, resistance is respected as a legitimate, albeit indirect form of communication. Once recognized, in all its many guises, it can be brought to the client's attention. Its origins, meanings, and motives are further explored, including its functional values.

Effective therapists have adopted a nonadversarial attitude toward client resistance so as to minimize feelings of being personally attacked as well as being able to neutralize the negative energy. To borrow a metaphor from the martial arts such as T'ai Chi, sparring is not seen as a match between opponents but rather as an encounter between partners. The object of this exercise is to maintain one's own sense of balance in the presence of someone else who is trying to maintain his or her own balance in the same space that you are occupying. When we are attacked by an opponent who is pushing against us, the most advantageous way to counter it is *not* by pushing back; rather, it is to absorb the force, neutralizing it by not presenting any surface for him or her to push against. The act of T'ai Chi sparring, like that of resistance in therapy, consists of recognizing that one's partner is defending or attacking, and dissipating the force of aggressive energy by shifting one's position and thereby causing him or her to miss the target.

Some therapists are able to work through therapeutic resistance in such a way that they are able to minimize their own sense of frustration at the same time that they are able to help clients reach a point of futility where they

are willing and ready to abandon their self-defeating ploys. The literature is full of advice, techniques, and strategies for dealing with resistance, including everything from giving more of the self or less, to being more open or less revealing, to setting stricter boundaries or looser ones, to confronting the symptoms or exaggerating them. The most important variables seem to include: (1) staying calm internally; (2) being more inventive, creative, and flexible; (3) remaining patient; (4) respecting what the resistance is saying; (5) recognizing and avoiding traps that are intended to derail progress; (6) continuing to be caring and accepting toward the person while not tolerating unacceptable behavior; (7) interpreting what is occurring and helping the client to see his or her covert actions and underlying motives; (8) reassuring the client that this is a normal reaction, considering the circumstances; and (9) admitting your own role and responsibility in exacerbating the situation.

Many diverse writers, including Langs (1981), Goldfried, (1982a), Masterson (1983), and Ellis (1985), have felt that the greatest source of resistance in therapy comes not from the client but from the therapist. When unresolved issues are triggered in sessions, or when the clinician has a low frustration tolerance or a high need for approval, the most minor resistance can escalate into major impediments to progress. Effective therapists try hard to be aware of the source of process difficulties, whether they emanate from the client or from themselves. They are both committed to and expert at confronting their own resistance to looking at unresolved issues as these are

ignited by client struggles.

Focusing

One interesting attempt to synthesize the ingredients common to all effective therapies was undertaken by Fuhriman, Paul, and Burlingame (1986) in their efforts to operate a university counseling center more efficiently. Confronted with a hopelessly unwieldy waiting list of prospective clients, the authors sought to develop a time-limited eclectic model that would employ the best features of all therapies. They identified *focusing* as one of the major mechanisms of change that is promoted through therapist interventions.

Focusing consists of offering some degree of structure to the therapeutic endeavor—that is, helping a client who is confused, frustrated, and imprecise in articulating what is wrong to center on areas that are likely to be most helpful. Focusing can involve any of the following:

1. *The act of making elusive, abstract, and ambiguous verbalizations more specific and concrete.* "So when you say you are unhappy, what you mean is that your closest relationships feel impoverished and devoid of intimacy."

2. *Reframing the client's conception of the problem as a treatment hypothesis that can be more realistically attained.* "When you say you want me to make your wife understand your

position, what you really mean is that I should help you to become more effective in getting across your ideas in a way that your wife can hear them ."

3. *When the client rambles incessantly, the therapist keeps the progress and development of a session centered around a particular theme.* "I notice that you have been talking about everything other than what originally brought you here."

4. *When the client begins to externalize problems and fixate on others as the cause of his or her suffering, the therapist focuses attention back on the client.* "You keep relating the source of your problems as the fault of your parents, your boss, and plain bad luck. In what ways are *you* responsible for your present plight?"

There is considerable variation in the degree of importance that different therapists would place on the value of focusing. Some practitioners, especially those working under the pressures of a time-limited model, would see focusing interventions as imperative to keep therapy proceeding in an efficient manner. Yet even those who prefer to allow clients to structure and lead the sessions at their own pace have developed subtle means to focus progress in areas that are likely to be most fruitful. When the client-centered therapist reflects feelings, she makes a choice as to which client statement is most worthy of attention and which feeling seems most important. When the psychoanalytic therapist asks about a dream, he is focusing attention on what he considers to be the most productive path. All effective therapists similarly

take some degree of control in helping sessions flow smoothly and efficiently.

Questioning

Asking questions is the most direct way of eliciting information. Questioning is also helpful as a focusing tool, to provide a structure for sharing and exploration, in creating a transition to new subjects, and in identifying meaningful therapeutic content (Long, Paradise, and Long, 1981). And yet, when awkwardly worded, questioning cuts off communication, puts the client on the defensive, creates dependencies, and leads to the expectation that the therapist will continue to assume primary responsibility for session flow. It can also limit exploration in other areas and lead the client to feed answers the therapist wants to hear (Gazda and others, 1977).

Decker (1988) has explained that many therapists use questioning so routinely that they never stop to consider that they may be acting out their own pathology rather than actually trying to help the client. This can include our voyeurism in wanting to know certain private facts for our own titillation, our narcissism in wanting to elevate ourselves by asking difficult questions that the client cannot answer, and our sadism in harassing the client with painful queries.

Effective therapists know when they should or should not question clients, and when they are only attempting to meet their own needs. There

are times when it is crucial to provide structure, elicit information, or facilitate exploration in a specific area. And there are times when the client is best left to flounder a bit and, with support, be allowed to work things out for himself or herself.

Like most interventions, the best questions are generally ambiguous and open-ended so that the way the client chooses to interpret them reveals as much as the answers that are supplied. Most clinicians avoid asking "why" questions since the client rarely knows why anything happens the way it does; instead they use inquiries to stimulate introspection or discussion. Common examples include:

- "What meaning does this have for you?"
- "What will you do with this insight?"
- "How are you feeling about what I just said?"
- "How are you going to proceed next?"
- "How does this seem familiar to you?"

In most cases, questioning is designed to help the client to clarify themes, synthesize issues, and explore areas that appear confusing. While extremely difficult to do without being intrusive or abusive, questioning is among the most direct means of eliciting important information in specific

areas.

Problem Solving

As uncomfortable as most of us are with being identified as problem solvers — preferring instead to replace *problem* with *concern,* which does not imply that there is a single solution — we do attempt to resolve situations that seen unresolvable. We do this mostly by teaching clients to be their own problem solvers, to become aware of feelings and factors, to reason through the consequences of certain actions, to take steps likely to reach their desired goals. But therapists are also highly skilled at seeing the obvious that others have missed and at distilling the essence of complex situations. Often this involves going through an internal dialogue — or even leading the client through such a process — in which we ask things like:

- "What *is* the actual problem?"
- "What is the desired goal?"
- "What options are available for realizing that goal?"
- "Which of these alternatives are likely to be most useful?"
- "What is a course of action that can be used to implement this plan?"
- "To what extent have the desired goals been met?"

Most of us learned to operate in a problem-solving framework in graduate school. Often with considerable resistance, we conformed to the prescribed standards of doing research, writing a paper or thesis, or completing all the paperwork at internship sites. Therapy, of course, does not proceed in an organized, predictable manner — despite what insurance companies seem to expect when they mandate treatment plans that specify the exact diagnosis and course of intervention to be followed.

Many of the strategic practitioners, such as Bandler and Grinder (1975), Fisch, Weakland, and Segal (1982), Madanes (1981), Haley (1984), and deShazer (1988), epitomize the effective use of problem-solving strategies in therapy. While some practitioners may have some difficulty embracing these brief therapists' assumptions that insight is irrelevant, or that there is no such thing as resistance, they do offer some marvelously inventive techniques that have great appeal. Some of these interventions, likened to a skeleton key or broad-based antibiotic, work with most clients most of the time. For example, deShazer (1985) and O'Hanlon and Weiner-Davis (1989) describe the "basic miracle question," in which the client is asked to go into the future to a time when his or her problems have been resolved. "What, then, did you do to fix them?", the client is next asked. The response, of course, provides the key to which path is likely to be most effective. Another popular problem-solving task is the "exception question" — clients are simply asked to describe those times when their problems do *not* occur. For instance, parents complaining of

a belligerent and surly adolescent are asked to focus on those times when he is cooperative and loving. With these examples, or with other strategic interventions such as “reframing,” “prescribing the symptoms,” or “forcing the spontaneous,” the clinician works as a problem solver who is trying to find satisfactory solutions.

While strategic and other action-oriented or directive practitioners use problem-solving skills in quite direct ways, those who work in a more indirect, insightful style also make use of such methodologies, albeit in a looser framework that nevertheless cuts through to the essence of a client’s difficulty. A psychiatrist who follows many of the tenets of structuralism and ego psychology describes what he considers to be the core of how he operates as a therapist. He supplies the following example as representative of what makes him most effective as a helper:

> A professional woman had remarried and was living at what had been her home in the country. She and her husband, who earned less than she did, had one car that he drove most of the time, leaving her stranded whenever he was gone evenings and weekends. She complained to me: “I can never go anywhere.” I immediately replied, “Why don’t you buy your own car?” She looked puzzled for a minute, wondering to herself before she answered me, “I don’t know.” Later that day she bought a new car.
>
> So what happened? I made a difference, but why, how, and what for? Maybe I missed the point; what she really wanted to deal with was her deep loneliness, her demands for nurturance from a mother, husband, therapist who were never “present.” Maybe she missed the point, running away once again from facing that pain. Maybe she needed my permission to do her own thing, to get out on her own and explore the world. Maybe

> she just wanted to please me, to show some improvement that would make me feel better. Maybe she was truly a stranger to her own autonomy.
>
> I think that understanding this interaction requires observation of what she did with the car and with isomorphs of the car. (We surely would not want a "flight or drive into health," one of those horrible transference cures, at this point. We never want to quit when we are on a roll, which has led one skeptic to write that a successful therapy is terminated at a point of mutual boredom.) These observations provide a context of meanings that cannot be derived from an analysis of this one chunk of behavior. Or so goes my myth!

This psychiatrist, as most of us would feel similarly, would bristle at the prospect of being called a problem solver, or even a derivative of that label such as a teacher of problem-solving skills. Yet our problem-solving abilities allow us to proceed in ways that are somewhat organized, sequential, and hierarchical. We help clients to slowly build on what they already know, understand, and can do. We do this by constantly assessing (even unconsciously and intuitively): Where have we been? Where are we now? Where are we headed?

Setting Limits

It is a paradox that within an atmosphere of maximum permissiveness there is also the enforcement of certain inviolate rules. Indeed the effective therapist must maintain a delicate balance between permitting experimentation and encouraging the acting out of spontaneous feelings and desires on the one hand and setting limits as to appropriate conduct within

the contractual relationship on the other.

An analytic therapist, who is comfortable deferring completely to the client with regard to the selection of content and direction in sessions, nevertheless feels that one of the most important skills she has mastered is the establishment of clearly defined limits in the therapeutic relationship: “I set firm boundaries with my clients and I believe this is crucial to helping them assume greater responsibility in their lives. They understand that if they work with me they have to make a commitment to come regularly and punctually. By setting parameters such as this, and confronting clients when there are attempts to be manipulative, I am helping them to develop coping skills within reasonable limits.”

This very point is illustrated in the case of a rather timid, passive, depressed woman with a long history of hurting herself when she felt out of control. Her therapist tolerated a great deal of flexibility in the way they spent their time together, sometimes sitting silently for a whole session, other times patiently repeating encouragement a dozen times until she could hear the words. However, it was not only the permissiveness and acceptance of the client that aided her recovery: “I believe the most important thing that I did for her was to let her know quite clearly what was okay and what was not. She would test me continuously. Cal s at home. Threats of self-mutilation. One game after another. It was when I intervened in a firm manner, telling her it

was not okay for her to act in dangerous and irresponsible ways, that she regained her control. I learned in my training many years ago that I should be unconditionally accepting, yet over the years I have since modified my view to accept conditionally certain behaviors that could be quite destructive."

Kroll (1988) has pointed out in his work with borderline clients that the consummate therapist skill necessary to promote growth is mastering the art of engagement. This would in fact be true of work with any person. We attempt to maintain an optimal distance that allows us to get close, but not too close: "I am reminded of a passage in Hemingway's *The Sun Also Rises* in which a duel between the matador and bull is described. There is a proper distance between the protagonists within which the interaction most meaningfully occurs. If the matador is too concerned with his own safety, he maintains too great a distance between himself and the bull, so that little engagement occurs. If the matador works too closely to the bull and is too reckless, either because of concern for his own image or because of ignorance of the risks involved, then he is likely to be gored." (Kroll, 1988, p. 101).

With the flair of a bullfighter (although we are hardly encountering an adversary), a therapist works hard to maintain boundaries and limits that are both safe and yet within effective range to make contact. These parameters are established with regard to roles, expected behaviors, and limits to protect both participants. The tremendous skill involved in creating and maintaining

these boundaries allows the therapist to become intensely intimate with a person, but without jeopardizing his or her own welfare or that of the vulnerable client.

With clients who are manipulative, narcissistic, or exploitative, or who show borderline or hysterical features, the therapist must work extra carefully to set limits without creating feelings of alienation. The problem is, then, to be careful without being withholding, to be warm without being seductive, to be supportive without fostering dependencies, to be firm without being punitive, to be compassionate without getting sucked into the client's destructive patterns.

There is a moment forever frozen in my mind when I stood poised with my hand on the phone and a client was deciding whether to walk out of the office or not. She was an adolescent who had just threatened suicide, after which I asked her to promise she would not hurt herself before our next session. She refused. I told her that she then left me little choice but to call her parents and inform them of her precarious state. She became enraged: "How dare you call my parents without my permission! What about the promise you made to keep our talks confidential?"

"You are correct. I would be breaking confidentiality. But if you walk out the door without being able to make a promise you won't hurt yourself, you

are telling me by your behavior to call your parents because you are so out of control."

She looked at me, one foot out the open door, and she *knew* I would do it. We had agreed long ago there were boundaries that had to be maintained. And if she crossed the line of responsible conduct, then I would have to cross another line to safeguard her welfare. This is, of course, standard operating procedure. Yet, it takes a great deal of skill to set limits without jeopardizing the trust in the alliance.

The effective therapist has discovered a way that he or she can become truly engaged with even the most destructive of clients, but without collapsing those barriers that help provide structure and limits when they are needed. By way of contrast, there are those relatively inexperienced and unwary clinicians who proceed blithely, allowing themselves to be manipulated or seduced wherever the client's pathology may lead. Or there are those who are so fearful of even the controlled closeness of a rigidly structured therapy process that they become completely detached and disengaged from any authentic connection with the client whatsoever. Balance, of course, is the key to be mastered—being permissive enough to encourage free and spontaneous expression but also sufficiently restrictive of those behaviors and ploys that are ultimately self-defeating.

These include:

1. Playing mind games to discredit or devalue the therapist

2. Testing limits of tolerance surrounding missed or late appointments, frantic calls at home, delinquent payments

3. Hostile, angry, or dramatic outbursts intended to elicit some response

4. Threats of suicide, self-mutilation, or self-destructive acts

5. Coming to sessions under the influence of some mind- altering substance

6. Attempts at emotional or sexual seduction to knock the therapist off a pedestal

There is indeed tremendous skill required to manage each of these relatively common manifestations of disturbed behavior. This involves not only what is said and done with the client to neutralize the unacceptable behavior, but also what we tell ourselves in order to stay relatively clear and calm inside.

Self-Disclosure

There is no doubt that self-disclosure is probably the single most difficult therapist skill to use appropriately and judiciously. The therapist's

revealing of self during sessions can be tremendously useful as a way to encourage a strong identification and mutual bond with the client. It is a way to model effective behaviors, to share instructive anecdotes, and to close the perceived distance between client and therapist, thereby facilitating greater trust and openness. Therapist self-disclosure begets client self-disclosure.

One resistant adolescent was even more surly than I am accustomed to — even for a withdrawn, angry boy referred by his parents against his will. Since his mother insisted that he come for a few months because she was tired of seeing him mope around the house in a deep funk, we each felt stuck with one another. All my usual ways of attempting to engage him proved futile; each well-intended reflection of his feelings or well-meaning question about things I knew he was interested in were met only with scornful grunts.

After the first month, about all I got out of him was that he was angry and depressed because his girlfriend had ended their relationship six months earlier and she refused to consider a reconciliation. He just wished to be left alone by everybody — by his teachers, his sisters, his parents, and especially by me. We were reduced to spending our time playing gin rummy and poker, but it seemed like we were both biding our time, waiting for the two months to end so we could satisfy his parents.

It was stating that very synopsis of our mutual plight that finally got his

attention. I told him how silly I felt talking to myself with him as a critical audience. I shared my frustration and impotence in trying to reach him in any way. Without my quite being aware of it, other feelings began to pour out of me, especially about how I could feel his pain, not as *his,* but as my own. Just as if it had happened last week, I began to relate my own traumatic breakup with a girlfriend in college — one that left me broken and despondent for months and months. In fact, even now after twenty years, I can still feel the pain.

As my eyes started to mist up a bit, a great wracking sob from the young man interrupted my story. The words and tears that had been stored inside him for so long finally flowed out. We had made contact.

Therapists who are highly skilled at self-disclosure are able to reveal themselves freely yet sparingly. They are not afraid to show their humanness, but do so without taking the focus off the client for any great length of time. The key criterion in knowing when to use this skill seems to be to use it only when there is an obvious reason why another intervention (which keeps the focus on the client) cannot work just as well.

There are many practitioners who prefer not to reveal them selves with clients for any number of reasons, most notably that it can lead to self-indulgence. And indeed there are some therapists who are so narcissistic and

self-involved that they define their work primarily in terms of telling stories about themselves. This, hopefully, is the exception, not the rule. But so many of the mentors we consider to be most influential to our development are people who revealed themselves to us in a uniquely personal way — and we appreciated those gifts as much as we did their knowledge.

Whitaker (1986, p. 90) makes the very interesting point that the reason Freud created such strong prohibitions against therapists revealing themselves to their clients was not only because it can lead to unnecessary self-indulgence or confuse the transference, but because it makes the clinician more vulnerable. He or she can be seen as the patient. And of course the therapist's privacy is at stake; anything said in an interview is public information. Self-disclosure can also create a number of problems when it is employed at inopportune moments or when it is used excessively. There are, in fact, some practitioners who seemed to enter the field so they can have a captive audience to talk about themselves to. And even otherwise effective practitioners can see their well-intended self-disclosure backfire before their eyes.

During the same period in which I found that revealing my own story to the resistant boy worked wonders in cementing a bond between us, I decided to try a similar intervention with another case I felt stuck with. While I should have known that we tend to get into trouble whenever we attempt to impose

a structure on a client, rather than allowing the exact situation to dictate the best match of strategy, I was riding high on my previous success. “Why,” I reasoned, “shouldn’t revealing myself more often help in other cases as well ?”

Indeed, on the surface things appeared to be similar to the other situation, since the case involved a young woman who was mostly mute in sessions and refused to reveal real feelings about her life. When I pressed her to share feelings she may have toward me after spending a dozen hours together, she replied smugly that she did not think about me one way or the other. To her, I was just part of the furniture.

It was *because* I lost sight of my objective — to help her open up at her own pace, not my own — that I let my own needs get in the way. In anger and exasperation I used self-disclosure as a weapon (although at the time I reasoned that I was trying to push her to respond in some way, *any* way). I shared with her my own feelings that I felt abused and manipulated, that I thought she was playing games with me — and herself.

To my initial satisfaction, my remarks struck home. She *did* react! But in a way I hardly expected: “It takes me a long time to trust someone. I have been hurt so many times before. Where do you get off telling me that I’m not okay because I don’t respond the way you want me to? You have just proven

to me that I can't even *pay* someone to be cordial to me. While I do accept some responsibility for this mess, you are way out of line. I think it's best if I find someone else who can be a little more understanding."

After we both licked our wounds and tried to begin anew, I reflected on how I had violated almost every rule for using self-disclosure appropriately. I ignored what she needed in order to do what I needed at the time. I misinterpreted the cues as to how she was reacting to my disclosure and blundered on obliviously. I had become more forceful than was called for. And I took the lazy way out by using an intervention that was convenient for me rather than appropriate for her.

Of course, with hindsight, it is always easier to analyze what we should have tried or should not have done. The fact is that *because* self-disclosure can have such a powerful effect, it is best used cautiously, in moderation, and only when we are certain that it is in the client's best interests.

Dealing with Endings

I remember that in all the texts I used as a graduate student, the books I read subsequently, the workshops I at ended, and the supervision I received, I was told repeatedly about the importance of *termination.* Although that very word struck terror in my mind (conjuring up images of turning off someone's life support system), I came to appreciate the importance of ending the

therapy relationship on a productive note so that the previous work would not be undone. I always felt that this was, among all the other therapeutic tasks, the most difficult — not only for the client but for me. When clients leave treatment, I sometimes feel abandoned, sometimes elated and relieved, sometimes sad, but always I feel *something.* Clients, of course, also carry around a lot of unexpressed as well as overt feelings about us, about the therapy, and about things coming to a close.

I learned that termination is something that should be prepared for weeks and sometimes months in advance. I was taught that clients should give plenty of notice before they stop treatment so there is enough time to work through all their unresolved issues (yes, like most graduate students, I thought it was possible, someday, to be finished, once and for all, with one's issues). I was exposed to a series of steps one should go through when ending therapy, much like a pilot preparing for a landing. These included things like: mutually agree that the time is appropriate to draw things to a close, slowly wind down the frequency and intensity of sessions, summarize the work that has been done, identify areas the client may wish to continue to work on independently, offer support and encouragement, work through resistances and ambivalence to ending, and schedule a follow-up visit sometime in the future.

You can therefore imagine my surprise when I discovered that in the

real world of daily practice this neat progression hardly ever occurred. Most often clients would end therapy by simply canceling an appointment and never again rescheduling another. Sometimes they might do this because of trouble with intimacy or letting go; other times, therapy ends this way because it is expedient for both partners who want to say goodbye but feel awkward about it.

Effective therapists are skilled at trying to help their clients end in a way, *any* way, that allows them to feel good about their work and continue to be their own therapist in the future (Kupers, 1988; Kramer, 1990). Indeed, the transition from being in therapy to not being in therapy is a difficult transition to manage — for both participants. It is likely that some dependence has developed. The client has come to look forward to the regular talks, the intimacy, the accountability to a concerned and wise mentor who gives such wonderful input. The client remembers all too well what things were like before treatment began, and although the client is now quite a different person, he or she cannot help but wonder whether, once the sessions cease, the old problems will recur.

For many weeks, months, perhaps years, the client has participated in a structure that has produced wondrous results. What will happen when it stops? Will he or she be able to continue growth without benefit of the expert's help?

The answers to these questions depend, to a great extent, on the therapist's skill in ending the therapeutic encounter. And there are several distinct skills involved.

Recognizing That the Time Is Right. If done appropriately, this is most often a mutual decision, especially when the client has been helped all along to assess where he or she is in relation to desired goals. Sometimes the cues signaling that the client is ready to go it alone are more subtle: (1) evidence of disengagement or slowed pace in sessions, (2) a number of missed or canceled appointments, (3) difficulty finding new areas to work on, and (4) a lack of compliance with therapeutic tasks.

The hard part is determining when resistance is a sign that there is a lot more work to do once blocks are removed, versus a signal that it is time for things to end. I have always thought it interesting that this decision is so often influenced by the setting in which therapy is practiced. In agencies where there is a waiting list of prospective clients, hesitation, reluctance, and slowed pace are more often interpreted as signals that the client is ready to end sessions, whereas in private practice where the clinician's livelihood depends on the ability to hold onto clients, quite a different interpretation may be made. Whatever criteria are used, or whatever the setting in which therapy is practiced, there are opportune times to begin closing.

Preparing the Client for Ending Therapy. Transitions are always difficult, and especially so if they have not been anticipated. Effective therapists continue to reinforce these messages to their clients: "I appreciate your gratitude, but you are the one who has done most of the work. *You* are the one who has worked so hard on yourself, who has taken such risks, who has changed the way you think and feel and behave so dramatically. And because *you* have done these things here, you can continue this growth on your own."

The client is helped to realize that:

- Therapy is not magic; it is the result of a systematically applied way of thinking and problem solving that has already been internalized.

- It is indeed an appropriate time to move on. Evidence is reviewed of all the progress that has been made, what was done, and how it was done.

- When inevitable setbacks occur, there are many things the client knows how to do that have proven useful previously.

- Although the therapist may no longer be physically present in the client's life, the therapist will always be a part of him or her in spirit. The therapist's voice has become the client's voice, at least in part.

Structuring a Gradual Transition. The trauma of ending therapy can be

minimized when the client is gradually weaned of dependency issues and the need for regular checkups. Not al clients require such deliberate programs; some simply announce one week they feel ready to try things on their own for a while. Other clients need weeks, perhaps months of discussion and practice in order to work toward ending.

The universal skill in all therapies is helping clients to maintain their continued growth once the sessions have ended. This is accomplished by working through unfinished business and parting on the best of terms. It also involves providing a structure and support after things have ended, as well as leaving the door open for follow-up work as needed. Some people believe that therapy never ceases, that clients continue their dialogues with us (as they do with deceased parents) for the rest of their lives.

In Summary

"Compleat" therapists have much in common in terms of their technical proficiency. Apart from any specific philosophies and theoretical positions they may hold, good clinicians have mastered a set of universal, core skills. These are adapted to the unique personality and situation of each practitioner. They are easily recognizable in the behavior of most effective therapists, who can readily demonstrate their ability to be empathic or confrontational or insightful, depending on what is required.

Being an effective therapist involves much more than applying a set of technical skills and interventions when they are called for. There is a distinctly passionate, human quality to the performance of a virtuoso in any field. We do not use skills as a plumber or electrician would employ tools; rather, through training, practice, and dedication, we have made therapeutic skills part of our very being — like breathing. The most accomplished therapists do not just *act* like compassionate and skilled helpers; they *are* effective precisely because they do not have to act.

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