

The Therapist's Feelings.

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The present article discusses possible uses of the therapist's feelings to enhance treatment following Kohlenberg and Tsai's conceptualization of the therapist-client relationship. Four vignettes from a case study involving a couple are used as illustrative material. It is argued that the therapist's feelings can serve as clues for identifying functional similarities between the therapist-client relationship and the clients' daily life situation. They can highlight how the client affects other people and which behaviors are involved in causing these effects. Furthermore, they can prompt the detection by the therapist of in-session experiences that can be turned into in-vivo learning opportunities for clients. Practical suggestions for the use of the therapist's feelings are extracted from the discussion of the vignettes.

Emotions are complex whole-person responses that involve behavioral dimensions as diverse as muscular activity, subjective experience, attention and thinking, and not infrequently (but not necessarily) have a rapid onset outside awareness (Lang, 1970; 1988; Leventhal, 1984; Mauss, Levenson, McCarter, Wilhelm & Gross, 2005). Their seemingly imperative quality and the fact that we feel them come from within may sometimes distract us from seeing they are signals that tell about our contact with the outside world. However, that is exactly where their value lies. The contribution emotions can have to our wellbeing is directly related to the way they influence our interaction with our environment.

Emotions often involve salient bodily sensations and appraisals related to what is going on at the moment between us and our environment and to what action we are prepared to take. They also involve focusing our attention to identify specific data that make particular sense in the context of the ongoing emotion. These include, for instance, options for creative activity in the context of positive emotions (Frederickson & Branigan, 2005) or potential threats and options for avoidance in the context of anxiety (Leventhal, 1984; Lang, 1988).

The effects of positive emotions are much less specific than those of negative ones. For example, positive emotions most often do not focus attention on specific objects, nor do they generally promote a particular action tendency. Instead, they enhance new initiatives and openness to experience, including openness to negative feedback about our behavior and they broaden the variety of options for action (Frederickson & Branigan, 2005).

Feelings in therapy

Client feelings are the primary target for change in classical behavior therapy, which has historically taken a strong interest in the functions and process

of anxiety (Lang, 1970; Rachman, 1980). The most important role of emotion in cognitive therapy, on the other hand, is its use in identifying cognitive targets for change. Inappropriate or excessive emotional reactions provide good clues to related dysfunctional cognition (Beck, Rush, Shaw & Emery, 1979).

In psychodynamic therapy, working through transference feelings is a traditional focus. What the client feels toward the therapist is not actually related to the present experience, but to other, past, relationships. Transference feelings are typically understood in terms of neurotic conflicts. Similarly, the feelings of the therapist toward the client are often described as counter-transference. While counter-transference feelings are at times used as clues for diagnosis or for fine-tuned understanding of clinical processes, they are a function of the analyst's psyche and would hinder progress in analysis when the clinician acts on them (Freud, 1958/1910; Kernberg, Selzer & Koenigsberg, 1989).

In the literature on marriage and marital therapy, feelings play many roles. Negative feelings toward the partner, toward particular attitudes or toward the relationship in itself can be the very problem clients seek treatment for. When there are other goals for treatment, negative feelings may still need to be addressed because they hinder progress toward effective communication and problem-solving (Gottman, 1994; Jacobson & Christensen, 1996). Emotions can also be used as therapeutic aids to produce change in couples (Greenberg & Johnson, 1986). Furthermore, teaching the couple healthy ways of dealing with feelings is an important topic in its own right (Greenberg & Goldman, 2008; Fruzzetti, 2006). Various brands of therapy agree that emotions provide information and help process experiences (e.g. Rachman, 1980; Linehan, 1993; Greenberg, 2002). In order to take full advantage of this aid, it is often suggested that one must be aware of the

difference between what one feels and who one is. This implies an observer perspective that can be described as looking at the emotions in their context rather than looking at the context from the perspective of the emotion (Linehan, 1993; Teasdale, 1999; Hayes & Wilson, 2003). This change of perspective makes the whole difference, because, although emotions do not come into awareness in the form of declarative information, looking at emotions in their context, transforms them into clues that can be interpreted and are amenable to rational analysis.

Along these lines, various authors also build on the notion that feelings provide valuable information, but no reliable conclusions (e. g. Greenberg & Goldman, 2008; Linehan, 1993). Negative feelings on the part of the therapist, for instance, may signal an alliance rupture, which he or she then needs to identify, explore and work through from the client's perspective (Safran & Muran, 2000). Strong negative feelings may also occur when the therapist makes a mistake. To be able to take appropriate action, he or she must then find out what went wrong and identify in which manner this affected the therapeutic process (Banaco, 1993). When the therapist avoids contact with such negative feelings, or discards them, he or she unwittingly ignores clues that may indicate that something important is going wrong in the treatment process. Therefore, Pope, Sonne and Greene (2006) recommend systematic efforts to detect and explore therapist feelings related to taboos and issues that are hard to admit and deal with.

In R. J. Kohlenberg and Tsai's (1991) account of the therapist-client relationship, the therapist's emotional reactions to the client's behavior take on at least two other meanings. In the first place, therapists are part of their client's immediate environment. Their reactions are often direct consequences of client behavior, and this makes these reactions liable to shape the client behavior that evoked them. This process is curative when it helps develop daily life repertoires that permit the client to interact in healthier ways with the social environments related to his or her clinical problems. In the second place, the client is also part of the therapist's environment and thus affects the latter's behavior. Asking questions like: "How does what I feel now relate to what the client is doing to me?" will help the therapist understand how the client may also be affecting the behavior of other people in his or her daily life. "Am I abandoning my goals

for the session because the client punishes my clinical strategies?" or "Am I feeling angry because he or she is rejecting my interpretations?" can cue questions like: "Does this client punish helping behavior by others in her daily life? And does this explain why so many important others abandoned her?" or "How can I shape repertoires that will allow for productive interaction, instead of evoking anger in me and in others?" Thus, the therapist's emotional reactions can be valuable clues for identifying clinically relevant behavior.

However, the therapist's own history may compete with these two important functions of his or her reactions. Attraction to, admiration for, or boredom and irritation with a client may be related to personal experiences, sensitivities or preferences that are not relevant to the client's problems. Strong feelings may reveal problems or topics the therapist is trying to avoid or obtain in his or her daily life. Also, the therapist may feel that ethical or religious commitments are threatened by the turn therapy is taking. It is important that the therapist be alert to such confounding factors because they are hazardous to his or her capacity to help the client (Banaco, 1993). Thus, doing a careful functional analysis of her own negative feelings will help the therapist react in ways that will help the client, rather than providing relief for the therapist (B. S. Kohlenberg, 1999).

When a couple is in treatment, each of its members will need to relate to the therapist, communicate with him or her and deal with conflicts and closeness, among other challenges. In their relationship with the therapist, clients may feel loved, accepted, betrayed, rejected, cared for, used, etc. If these feelings are similar to what the client feels in his or her relationship with the spouse, they can be explored in the therapist-client relationship. Once functional similarities between the two relationships are identified, this will support the use of natural reinforcement as a therapeutic tool in-session, in the way described by R. J. Kohlenberg and Tsai (1991) for individual therapy.

The intention of this paper is to discuss, with the help of a case study, a number of uses of the therapist's feelings to promote therapeutic progress.

Method

The couple

Mary was 24 years old and John was 28. Mary and John sought help to improve their relationship in order to take better care of their son Bob, who lived with Mary. John lived on his own, but was responsible for Mary and Bob's daily transportation. This gave him the power to decide such as when Bob would be allowed to skip a school day or to which physician Mary or Bob would go, for example.

In daily life, John was highly involved in helping Mary, explaining practical issues to her and influencing her actions and choices. But he did not let her in on the motives of his decisions. He also came to sessions ready to give the therapist suggestions and to offer practical help. However, he remained emotionally uninvolved in either relationship and generally did not act on instructions or suggestions that were given to him. The goals that were chosen for treatment were increasing Mary's autonomy and improving John's reciprocal communication skills.

Procedures

The therapist (first author) selected four fragments of therapy interaction from her session notes in which she had felt intense emotional reactions. The discussions of the case material in supervision with the second author furnished the subsequent interpretation of the material.

The therapist's feelings

Example 1: As the therapist was explaining a homework assignment for the couple, John laughed heartily. The therapist asked him if he found the assignment funny. The therapist told him his reaction gave her a feeling of not being taken seriously. But when she opened discussion on the issue, John insisted that his laughter only reflected his genial nature. The therapist felt invalidated by John's laughter. She thought: "He may find my assignment silly, but I will defend it because I think it will be helpful".

John's laughter and the effect it had on the therapist were clinically relevant as in the couple's daily life John also laughed when Mary announced initiatives or shared her plans. Typically, Mary would then withdraw what she had said, and let John decide for her and handle things the way he chose. The therapist's goal in opening the

discussion about the incident was to weaken John's strategy of gaining power by disqualifying the other's initiatives. He successfully avoided the therapist's new initiative of discussing his strategy, but accepted the homework assignment.

Example 2: Mary shared her need for John to let her participate in his life. She asked questions about his routine, his work and the people he knew. John answered that he didn't trust Mary and thought she could use personal information against him in moments of conflict. Mary said that she had never done what he suspected her of when she had had the opportunity to do so in the past. She cried copiously. John defended his opinion.

The therapist felt sympathy for Mary's initiative of promoting the goals of therapy in such a direct way and felt sorry that this effort was being punished. She wanted to take therapeutic advantage of the moment but did not see how. She then stopped John and argued that his accusation was unfair.

Example 3: John wanted to dedicate the whole session to Mary's affective instability and repeatedly rejected proposals made by the therapist to include more items on the agenda. He dominated the entire session, mainly criticizing Mary, who did not react. At the end of the session, the therapist felt she had been used by John to increase his control over Mary and thought: "I'm not going to be part of this". She announced that his behavior would be the only point on the agenda for the next session.

Example 4: In the following session, the therapist started out by explaining how she felt in the previous session when John ignored her arguments for a balanced agenda, when he punished her subsequent efforts to contribute to the topic under discussion and when he undercut her efforts to involve Mary in the discussion. When John expressed concern about his effect on the therapist, she, who had left most sessions until then feeling gloomy, felt a deep sense of relief and led the discussion in the direction of how her disclosure and his reaction to it could be helpful in improving the couple's relationship in daily life. This session was a turning point for John, in that, from then on, he involved himself in treatment and opened up for change.

Discussion

In her interaction with the therapist, Mary developed behaviors including expressing her needs, only selectively accepting the therapist's interpretations and instructions, and openly disagreeing from and negotiating with the therapist in conflict situations. All of these new behaviors promoted the goal that was set for Mary. However, the therapist's most intense feelings were related to John's behavior. This may have been due to the more aggressive and incoherent nature of the interpersonal strategies John used. Until the example 4 occurrence, these strategies were also more often in-vivo problem behaviors than behaviors targeted for development.

John's hearty laughter (in example 1) was part of a class of behavior that threatened the quality of the couple relationship and that kept Mary's autonomy weak. When the therapist shared the feelings this behavior evoked in her, she brought John into contact with a class of effects he had on others (and probably also on Mary). In daily life situations, Mary had generally reinforced this behavior by withdrawing her initiatives and did not share the adverse effect it had on her. Making contact with the feelings John had evoked in the therapist was an opportunity for him to try out new strategies that could enhance the therapist-client relationship, such as openly stating his views and appraisals. Although John's rejection of Mary's requests (as in example 2) was a frequent problem for the couple, the candid sharing of his concern was highly unusual for him. Letting the therapist in on his fear of vulnerability was an in-vivo improvement. At that moment, the therapist's most urgent needs related to the couple were for John to start collaborating in an open, bi-directional way with her and for Mary to risk more autonomous behavior. The urge to interrupt the interaction was a clue to identifying important contingencies. However, it directly cued action related to the therapist's daily life experiences which had included saving apparently helpless people from unfair treatment. Stopping John from talking relieved the therapist's negative emotions, but left John's in-vivo improvement unreinforced and also cut short Mary's opportunity of learning to deal with conflict or giving effective feedback.

John was successful in overriding the therapist's control strategies during an entire session (in example 3). This allowed the therapist to sample the effects that functionally similar behavior by John had on Mary. Attending to the feedback the therapist gave John (in example 4) was an in-vivo

improvement for him. The therapist's feeling of relief was a clue about how a similar change in John's relationship with Mary would affect the latter.

The actions that the therapist took in the context of these emotions included stopping John's talk (examples 1 and 2), announcing that John's behavior would be the focus of the next session (example 3) and taking a new initiative similar to the initiatives she hoped Mary would take (in example 4). In example 2, the action tendency did not coincide with the task the therapist had set for herself based on the case conceptualization. But even so, it drew her attention to contingencies that needed to be taken into account.

In the other examples, feelings helped the therapist to directly identify in-vivo learning opportunities, as when she felt that she was not being taken seriously (in example 1), that she was being used (in example 3) and that she was being validated (in example 4). In all these examples, her feelings provided clues about what John's clinically relevant behavior did to the other person in the relationship and how this behavior could be influenced.

Conclusion

The therapist's feelings signal contingencies the therapist can act upon. That is why they deserve to be reflected on by the clinician herself and to be given serious attention in supervision. One interesting point is that emotions can take the person who produces them by surprise. Puzzling feelings often indicate contingencies the therapist has not yet identified. They also may signal high-strength behaviors in the therapist repertoire that ought or ought not to be emitted, depending on the case conceptualization and the goals for the session. As we showed above, information about both the in-session contingencies and the therapist's personal history is useful for making choices in-session. The therapist who knows more about his or her feelings, and is diligent in analyzing their origins and their effects on the relationship will be able to use the information thus obtained in treatment.

Mindfulness is a concept used in the literature for feeling or perceiving directly (without mediation of conventional evaluations) or for acting in contact with direct experience (Kabat-Zinn, 2005). It is also defined by openness to novelty, continuous creation of new categories and sensitivity to

context (Langer, 1989). We suggest that the therapist who detects an emotion related to the client or to the session must pay attention, to the bodily aspects of the emotion, to what appraisals occur about the object of the emotion and what action tendencies come to awareness. All these should be non-judgmentally accepted and examined. The therapist should try to relate them to the situation in which they emerged. This makes it possible to identify what the emotion means in the context of the present interaction in-session and in relation to treatment goals.

In using therapist emotions as our guides, an important caveat must be considered. A focus on the content of the emotional response can be more mystifying than clarifying. One can be caught up in emotion intellectually elaborating on its content or one can mindlessly surrender to the action tendency involved in this emotion. Neither is productive. Allowing this to happen would imply seeing the situation from the perspective of the emotion instead of seeing the emotion function in the situation. Looking at the interaction with the client from the point of view of the therapist's emotion would make it difficult to examine the emotion as a source of data that could help to explain the situation. This use of emotion as a lens may distort and even unduly filter out relevant information. It makes it difficult for the therapist to detect what the feeling means in the moment and how it is related to the flow of interactions in-session.

Instead of concentrating the analysis on the emotion's content, the therapist can find out what the emotion is a response to and what it means in context. This amounts to a focus on what exactly is being felt or, in other words, on what the therapist is sensing and not on the sensation in itself. The present paper suggests that putting feelings in perspective and observing them in a mindful way can aid in understanding better what happens in the session and what must be done.

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