4

From Emotion to Repair

The measure of a conversation is how much mutual recognition there is in it.

—DYLAN MORAN (TUOHY, 2011, PARA. 18)

In this chapter, we build on our consideration of emotion and rupture in Chapter 3 of this volume and concentrate on therapists' regulation of their own emotions as critical to rupture repair and to promoting the possibility of mutual recognition—how patients and therapists move from objectifying the other to seeing the subjectivity in the other. As a means toward regulation and recognition, we present the principle of metacommunication, which involves the simple but not easy process of putting words to one's experience in collaborative inquiry with the other. Fundamental to this process is the dialogic (or social constructionist) epistemology that truth can be understood only in dialogue with another. In the same vein, ruptures are not only *coconstructed* but also *coresolved*.

EMOTION: FROM COMMUNICATION TO METACOMMUNICATION

As suggested by its early reference as talk therapy or the "talking cure" (Freud & Breuer, 1895), psychotherapy is founded on communication between individuals (typically between a therapist and patient). As communication theorists have long distinguished (Littlejohn, 2002; K. Miller, 2005), it is important

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to recognize the difference between *content* (what is said) and *process* (how it is said) in any human communication. From what we have described so far, from the perspectives of interpersonal process, multiples selves, and intersubjectivity, an essential task for therapists is to continuously consider these three questions: What's going on around here? (E. A. Levenson, 2005), Who is speaking to whom? (Bromberg, 1998), and, What do we make of each other? (Pizer, 1998). This task is necessary especially in the context of alliance ruptures and is relevant to addressing emotion regulation for both patient and therapist.

How to do so in this regard—that is, what to do in practical terms—brings us to the technical principle of *metacommunication*. Kiesler (1996) first introduced this principle to the psychotherapy literature and defined it as communication about the communication process *in the interpersonal sense* (i.e., about the two participants in the psychotherapy situation). It is predicated on the idea that we are in constant communication, that all behavior in an interpersonal situation has message value and thus involves communication. This concept was originally discussed in the seminal work on human communication by Watzlawick, Bavelas, and Jackson (1967): "The ability to metacommunicate is not only the condition *sine qua non* of successful communication, but is intimately linked with the enormous problem of awareness of self and others" (p. 53). In previous publications (e.g., Muran & Safran, 2002; Muran, Safran, & Eubanks-Carter, 2010; Safran & Muran, 2000), we elaborated on Kiesler's application by including communication in the *intrapersonal sense*, that is, about the multiple selves within an individual self, specifically focusing on therapists' self-disclosures about their immediate emotional experience.

Metacommunication in general consists of an attempt to step outside of a patient–therapist interaction by treating it as the focus of *collaborative inquiry*.[1] It is best understood as a process, conversation, or dialogue rather than a circumscribed intervention such as a single question or observation. Metacommunication aims to decrease the degree of inference and is grounded in the patient's or therapist's immediate experience of a specific aspect of the therapeutic relationship. This is much like what Edgar Levenson (2005) advised in order "to resist being transformed" by the patient: Instead of offering explanations or conjectures as to the meaning of a current interaction (consistent with traditional applications of transference interpretations), therapists should simply report their own experience of their participation—how it feels to be involved with the patient. It can be likened to more recent considerations of *immediacy*—when therapists "disclose how they are feeling about the patient, themselves in relation to the patient, or about the therapeutic relationship" (Hill, 2004, p. 283).[2]

[1]In some respects, what we mean by collaborative inquiry can be likened to *collaborative empiricism* (see Overholser, 2011; Tee & Kazantzis, 2011), but one important distinction is that the former includes the therapist's experience as part of the exploration.
[2]One important distinction is that we are advocating for the specific use of metacommunication in the context of a rupture and in the pursuit of rupture repair.

It is a process that can begin with questions about patients' perceptions of their emotions ("What's happening for you right now?"), about the interpersonal field ("What going on here between us?"), or about their therapist's emotions ("I wonder if you have any thoughts about what's going on for me right now?"). When it comes to such questions, it is important to court surprise, to ask questions to which one does not know the answer: It is a "good" question when the answer comes as a surprise to both patient and therapist (D. B. Stern, 1997). Here, the "beginner's mind" (D. T. Suzuki, 1991) and the Socratic "not knowing" method (Carey & Mullan, 2004) can be helpful. Metacommunication can also include observations about patient emotions ("You seem angry to me right now. Am I reading you right?"), observations about the field ("It seems like we're engaged in a game of cat and mouse. Does that fit with your experience?"), or self-disclosures about one's own emotions ("I'm aware of feeling hesitant to say anything right now"). As just illustrated, it is often important to check if these observations make sense to the patient ("Does that seem fair from your point of view?").

It is important for these interventions to be made in the spirit of "collaborative inquiry." They should be presented with "skillful tentativeness"—with an emphasis on one's own subjectivity and a stance of genuine uncertainty. This is in recognition that therapists' understanding of themselves and their patients is always partial at best, always evolving, and always embedded in the complex interactive matrix within which they exist (Mitchell, 1993; D. B. Stern, 1997). If we become aware at all, it is always in reflection and from another point of view. Metacommunication is the effort to look back at a recently unfolded relational process from another vantage point. But "because we are always caught in the grip of the field, the upshot for clinical purposes is that we face the endless task of trying to see the field and climb out of it—and into another one, for there is nowhere else to go" (D. B. Stern, 1997, p. 158). In other words, process is continuous—endless, for that matter—and we should recognize that we are trying to observe while experiencing; we are trying to move along while still embedded.

Metacommunication is a technical strategy that can promote emotion regulation. It can be understood as a form of "mindfulness in interaction," an attempt to bring immediate awareness to bear on the interactive process as it unfolds, to facilitate distance and acceptance of an emotional experience fraught with negativity and as a result often dissociated or unformulated (Safran & Muran, 2000). Recall the discussion of expanding awareness of patient and therapist self states in Chapter 3 of this volume. Metacommunication aims to engage both patient and therapist to label or put words to their respective (often unformulated) emotions and thus add granularity (as Barrett, 2017, would put it) to their experience. In a sense, the aim is to expand conscious awareness in patients (as well as therapists) with respect to the details of their experience. By invoking mindfulness, we mean to suggest a state of psychological freedom, the curiosity of "a beginner's mind"—a disciplined self-observation that involves a bare attention to our experience of mind and body at successive moments of perception, without attachment to

any particular point of view and without becoming stuck in unconscious prejudices (M. Epstein, 1995; Kabat-Zinn, 1991/2013). In this regard, the aim takes on the form of a contextualized exploration in the sense of what cultural anthropologist Clifford Geertz (1973, 1983; see also Ryle, 1949/1980) referred to as a "thick description." Accordingly, therapy involves an intimate process of detailing the complex specifics of patient and therapist experience—an intimate and infinite process of descending "into detail, past misleading tags, past the metaphysical types, past the empty similarities to grasp firmly the essential character of" individuals (Geertz, 1973, p. 53).

Although most clinicians from most orientations would agree with the importance of this approach, in practice this seems to be lost for a variety of reasons. In some instances, therapists fail to appreciate what this really means; in others, therapists' anxieties lead them to assume they are a lot closer "to the things" (Husserl, 1931) and "to the particular" (E. A. Levenson, 1991) than they really are. Simply put, therapists' efforts should be directed toward inviting and orienting patients to look at their immediate experience and especially calling their attention to the transition points of their experience as it emerges in the here and now. It is therapeutic, therefore, to increase not only the patient's retrospective awareness of the intrapersonal or interpersonal patterns, which is increasing awareness of the self-as-object, but also the patient's immediate awareness of how the patient engages in such patterns, which involves increasing awareness of the self-as-subject in relation to self-as-object. This process involves increasing one's immediate awareness of the self as the agent of one's own experience and behavior, of the subjective processes that mediate the objective patterns.

The notion of *experiencing* (and *focusing*) from Eugene Gendlin (1962, 1982) is also useful to consider here. Experiencing was originally coined by Carl Rogers (1951) to describe the patient's sense of exploring their perceptual field. This idea was later described by Gendlin as the basic felt sense of inwardly focused attention, and operationalized further with Marjorie Klein and colleagues (Klein, Mathieu, Gendlin, & Kiesler, 1969) in an observer-based measure, the Experiencing Scale. The Experiencing Scale measures emotional involvement and the progression of differentiating and signifying (through language) emotional experience in vivid representation as it immediately emerges in the here and now and is deeply felt by the individual. The progression toward higher experiencing is a movement toward greater granularity. A spate of research over the past 30 years has demonstrated emotional experiencing as an important change process in psychotherapy across various models (see Auszra, Greenberg, & Herrmann, 2013; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Pascual-Leone & Yeryomenko, 2017; Pos, Greenberg, Goldman, & Korman, 2003; Whelton, 2004). Metacommunication should facilitate experiencing for both patient and therapist.

Mentalized affectivity (Fonagy, Gergely, Jurist, & Target, 2002; Jurist, 2018), a notion derived from "mentalization" in the attachment literature (i.e., the capacity to understand the mental states of self and others), provides another

useful lens. It is defined as "the process of making sense of emotions in light of one's autobiographical memory . . . [that] includes identifying, modulating, and expressing emotions" (Jurist, 2018, p. 83). Similar to experiencing, mentalized affectivity probably differs most significantly in its interpersonal referent (its orientation in relation to another). In psychotherapy, it is considered an important change process for the therapist to mentalize and thus stimulate mentalization in the patient. This includes mutual mentalization, when therapist and patient mentalize collaboratively, sharing their respective thinking processes in listening and reacting to each other. Here, judicious self-disclosure by the therapist is advocated (Bateman & Fonagy, 2006). Elliott Jurist (2018) described mentalizing about emotions "as the path to knowing what one feels and to action. . . . It adds fine tuning, or . . . granularity to our experience . . . [and promotes] seeing things in focus, in detail" (pp. 130–131). Research on mentalization in psychotherapy is still in its infancy (see Talia, Muzi, Lingiardi, & Taubner, 2018). Metacommunication should increase mentalized affectivity for both patient and therapist.

Metacommunication can also be understood as a technical strategy that can bring intersubjective negotiation into relief: the respective subjectivities of patient and therapist (their mentalized affectivity) and their underlying (unformulated or unspoken) desires and needs. As a result, it can make mutual recognition (mentalization of the other) more possible. As Donnel Stern (1997) suggested in his application of Gadamer's model, metacommunication can be understood as an effort to make visible "the very tailored prejudices" that two people bring to their encounter and develop between them (p. 216)—or put another way, to make explicit implicit biases. This characterization is comparable with Darlene Ehrenberg's (1992) notion of working at the "intimate edge" of the ever-shifting interface between patient and therapist—which for her refers to both the boundary between self and other and the boundary of self-awareness—"a point of expanding self-discovery, at which one can become more 'intimate' with one's own experience through the evolving relationship with the other, and then more intimate with the other as one becomes more attuned to oneself" (p. 34).

Metacommunication can reveal various selves or self states in communication between patient and therapist (Bromberg, 1998), including the power plays, accommodations, and refusals to accommodate inherent in patient–therapist interactions (J. Benjamin, 1995). As Pizer (1998) suggested, patient and therapist ongoingly negotiate what to make of each other. Metacommunication can make these subjective states plain, and thus it can promote the potential for mutual recognition—or what has been described as "an I–Thou relation" (Buber, 1923/1958), "a meeting of minds" (Aron, 1996), "a moment of meeting" (Boston Change Process Study Group, 2010), and "a genuine conversation" (D. B. Stern, 1997). This strategy can also make the dialectical tensions of agency/communion and objectification/subjectification more apparent, and thus more likely resolvable (see Muran, 2007b, 2007c, 2019; Safran & Muran, 2000).

How we describe metacommunication has technical implications, but we are not promoting a technical prescription. Rather, we are suggesting a sensibility to guide and organize intervention. In this regard, we previously outlined a number of general and specific principles of metacommunication (see Safran & Muran, 2000, for a comprehensive list). Here we present some basic ones.[3]

Invite Collaboration and Establish a Climate of Shared Dilemma

Patients can often feel alone and demoralized during a rupture, with the therapist becoming one of a string of figures who are unable to join with the patient in their struggle. The therapist is yet another foe rather than an ally. To counteract this expectation, the implicit message should be an invitation for the patient to join the therapist in an attempt to understand their shared dilemma—maintain a sense of "we-ness." Therapists should establish a climate that emphasizes the subjectivity of the therapist's and patient's perceptions. No perspective should be treated as absolute. Therapists should encourage a collaborative effort to clarify the factors influencing the emergence and maintenance of a rupture. Framing the impasse as a shared experience can transform the experience from one of isolation and demoralization for the patient to one of openness and honesty, where the patient feels safe speaking directly to the therapist about his or her feelings or overall treatment experience. This framework begins the process of transforming the struggle by diffusing the patient's defensiveness against the therapist and acknowledging that the therapist and the patient are stuck together.

Focus on the Immediate Details of Experience and Behavior

The process of metacommunication is formed around the examination of the immediate experience within a session rather than on events that have taken place in the past, such as previous sessions or at different points in the same session. Remember that what happened just a moment ago can be ancient history. Focusing on the concrete and specific details of the here and now of a therapeutic interaction promotes an experiential awareness. It lays down the groundwork for exploring a patient's actions and the internal experiences associated with those actions. Often when a therapist or patient feels anxious about a particular topic, they tend to pull the focus away from the source of conflict by deviating from the present feelings or by falling back on abstract, intellectualized speculation. Even talking about the therapeutic relationship can be done in a removed fashion, disconnected from the present. Refocusing

[3]Many principles are adapted from "Power Plays, Negotiation, & Mutual Recognition in the Therapeutic Alliance," by J. C. Muran and C. Hungr, in *Transforming Negative Reactions to Clients: From Frustration to Compassion* (pp. 32–38), edited by A. W. Wolf, M. R. Goldfried, and J. C. Muran, 2013, Washington, DC: American Psychological Association. Copyright 2013 by the American Psychological Association.

and opening up to exploring the present moment in concrete and specific terms can prevent this defensive deviation. Explorations of the present moment can also guide patients in becoming observers of their own behavior, promoting the type of mindfulness that fosters change.

Maintaining a focus on the here and now also encourages a respect for the uniqueness of each encounter. Each interaction between the patient and therapist is an individual moment influenced by both players. As the therapist is a key player in the dynamic, drawing premature parallels between the therapeutic relationship and the patient's other relationships can isolate the therapist's contribution and be seen by the patient as blaming. Therefore, attempts at identifying how patterns in the therapeutic relationship generalize to other relationships should be kept as an open question and should generally be left to the patient to draw. In general, such observations and explorations should be made in a tentative fashion from a stance of genuine uncertainty. In addition, therapists should try to convey the message to resist the urge to just make things different or better. They should privilege awareness over change. They should also remember that the aim is to use the therapeutic relationship to facilitate *awareness in relation*, which can then be brought to other relationships. Change (any new or different experience) instead should be understood as born in awareness, or as a by-product of awareness.

Explore One's Own Subjectivity and Contribution

Therapists' formulations should be grounded in an awareness of their own emotional experience. Therapists must work toward identifying feelings and responses that the patient evokes in them. Always try to start from where you are. This involves a careful awareness of the nuanced changes experienced by the therapist. These shifts may sometimes be difficult to articulate, but the process of attempting to articulate—both to oneself or directly to the patient—can help clarify the experience. The process of acknowledging one's contributions to the patient can also play a critical role in beginning to clarify the nature of the cycle that is being enacted. For example, a therapist could say, "As I listen to myself talk, I hear a kind of stilted quality to what I'm saying, and I think I've probably been acting in a pretty formal and distant fashion with you. Does that fit with your experience?" If the patient is receptive, this type of disclosure can lead in the direction of either clarifying factors influencing the therapist's actions or exploring the patient's feelings about the therapist's actions.

Encouraging a sense of "we-ness" involves being open to exploring the therapist's own contribution to and experience of the interaction. This process requires accepting responsibility for one's own influence in the development of a rupture with the patient. We all have a hand in an interpersonal process. When therapists disclose their own experience, they invite the patient to include their therapist as an active factor in their self-exploration. A therapist's self-disclosure may include simply asking patients if they have any ideas

about what may be going on within the therapist. The therapist may also suggest possibilities for what is occurring between them and check in with the patient. For instance, the therapist could state, "I have a sense of being defensive and critical. Are you sensing this from your side?" This form of self-disclosure can help patients become aware of inchoate feelings that they are not comfortable facing, such as feeling criticized by the therapist, and can validate patients' experience of their therapist. These self-disclosures should always be presented judiciously and tentatively, again with the recognition that all perceptions are subjective and nothing is objectively absolute. Such an emphasis will invite more from the patient.

Monitor Relatedness and Responsiveness

Therapists should continually track how the patient responds to what is being said within a session. In this regard, therapists should pay close attention to their emotional experience as an important source of understanding the quality of relatedness with patients in a given moment. How connected or engaged does one feel? How compassionate? How uncomfortable? A therapist's intuitive sense of the relational atmosphere can inform them whether patients are getting closer to or distancing themselves from the therapist. The therapist may examine factors such as whether a particular interaction is facilitating or hindering the strength of the relationship, whether the discussion of an experience is elaborative or foreclosing, or whether the patient is expressive of their subjective experience or simply compliant to the therapist's view.

It is important to be aware that a patient may have difficulty acknowledging feeling hurt or criticized by the therapist or feeling angry at the therapist. Admitting such feelings may be threatening to the patient's self-esteem and in their mind may risk offending or alienating the therapist. Therefore, if an intervention fails to deepen exploration or further inhibits it, or if the therapist senses something peculiar in the patient's response, an investigation of the way in which the patient experienced it is critical. Over time this type of exploration can help to articulate the nature of the enactment taking place and assist in fleshing out an interactive matrix being enacted by the therapist and patient. It can also lead to a progressive refinement in the therapist's understanding of their own contribution to the interaction by encouraging a retrospective awareness of their own actions.

Recognize That the Situation Is Constantly Changing

The process of metacommunication is just that, a *process.* We should always try to use whatever is emerging in the moment as a point of departure for further metacommunication. Bear in mind that the therapeutic situation is constantly changing. This is a return to the concept of appreciating each experience with a patient as a unique configuration of the current encounter, with each instance leading to a further configuration. The need to recognize the fluidity of experience, where what was true about the therapeutic relationship

a moment ago may not be true now, is highlighted here. From this stance, all situations are workable provided that one fully acknowledges and accepts the situation. The critical idea here is the importance of the inner act of acceptance of the changing experience. This inner act facilitates a type of "letting go" and an increased attunement to the unique configuration of the moment.

Even the position of "being stuck" is workable once one ceases to fight against it and accepts it. Metacommunication emerges from the inspiration of the moment, whether or not the moment is familiar or clearly understood by the therapist. Acknowledging and accepting the situation as it is can be an emotionally freeing experience that makes room for new possibilities and interpretations for what is occurring—what Neville Symington (1983) referred to as an "act of freedom." For example, therapists who say "I feel stuck" to the patient may in the process free themselves up sufficiently to see what had eluded them before, such as an aspect of the patient's behavior or an angle of their own bias. A disclosure of this type may contribute to a shift in the interactional dynamic, reframing the situation in a way that might uncover a new jumping-off point for exploration.

Expect Initial Attempts to Lead to More Ruptures and Expect to Revisit Ruptures

The therapist should be aware that initial attempts to uncover relational patterns in a therapeutic rupture can lead to further ruptures and will likely need to be revisited. The overarching aim of the resolution process is to stimulate curiosity about the patient's internal experience: Court surprise. This process involves working toward awareness of the feelings and behaviors associated with the style of relating, rather than trying to force things to be different. Awareness of one's self-experience and self-structure is a challenging process that can take time and repetition of certain interventions. In this process, there is always a risk that in working with alliance ruptures, a moment of metacommunication with a patient can further aggravate the rupture. The paradoxical truth remains that we are always embedded *in relation* to another while we try to become mindful and thus disembed from some relational matrix. Perpetuating one versus entering another remains a challenging question.

Regardless of how skillful the therapist may be in framing their comments in a nonblaming, nonjudgmental way, metacommunication may be implicitly suggesting that patients should be saying or doing something other than what they are currently saying or doing. For example, the observation "I experience you as withdrawing right now" may carry with it the implication that it would be better not to withdraw. In light of this risk, the therapist should remember that facing one rupture is the beginning of a resolution process that may involve further ruptures. In other words, the experience of working through a single rupture may not stand alone as an ultimate intervention but should be viewed as one step in building awareness of the internal experience and consequent maladaptive relational matrix or pattern.

There is nothing magical about the process of metacommunication. It is designed to explore at a level near experience to avoid the potential negative trappings that have been shown to be more likely with cognitive challenges or transference interpretations (see Chapter 2, this volume), but there is no guarantee. Interventions aimed at metacommunication do not always follow the notion of mindfulness with nonjudgmental thinking and emotional neutrality; they can also arise defensively. Regardless of the tension from which metacommunication arises, it should be understood that it is a single moment within a string of learning experiences between the patient and therapist. One must accept the inevitability of revisiting ruptures that have not yet been fully processed or internalized while appreciating that each repetition of a parallel rupture holds a unique configuration within the ultimate process. Along similar lines, it is also important to remember that hope will wane in certain moments within the therapeutic relationship. During periods of a prolonged rupture or an impasse, the therapist can easily lose hope in the possibility of moving forward. Such periods of hopelessness and demoralization are part of the process, just as working through impasses is the work of therapy rather than an obstacle to therapy.

Beware of Overemphasizing the Explicit and Disrespecting the Private

One of our favorite principles in the assertion literature is "Being assertive all the time is nonassertive"—and actually annoying (Jakubowski & Lange, 1978). In a similar sense, the emphasis in metacommunication is on the explicit (i.e., make the implicit explicit), and this can be overemphasized and become intrusive. It remains important to respect privacy—both the patient's and the therapist's—to allow each participant the space to self-reflect, to be alone with themselves (see Ogden, 1997). The challenge is to balance the public with the private, to protect the boundary. Here, as with self-disclosure, we are recommending a measured or judicious approach, or respect for the natural flow of approach and avoidance in human encounters, especially intimate ones. There is the apropos notion of "titration of the intimacy" (E. A. Levenson, 1991; Sullivan, 1953) and the recognition that there are times when it is prudent to refrain. The aforementioned principle regarding relatedness and responsiveness is relevant to knowing when in this regard.

EMOTION: FROM PATIENT TO THERAPIST

Basic Negative Emotions

In this section, we review basic negative emotions that are common challenges for therapists (intrapersonal rupture markers) and present some vignettes based on my [JCM] clinical experiences that illustrate metacommunication as a

process toward rupture repair—emotional regulation and mutual recognition. In most of these vignettes, we are introducing beginnings to conversations that involve a more complicated process. It is important to remember, as previously suggested, that emotional experience is complex and idiosyncratic. How therapists experience and negotiate any of the challenges that we describe is highly variable and dependent on a number of factors. Therefore, these are not presented as prescriptive but as possible pathways—as regulation—and recognition-in-action.

Anxiety and Panic

Anxiety is an unpleasant state of uneasiness, worry, or dread in response to a potentially negative event characterized by uncertainty about its predictability as well as one's ability to effectively respond to it. Anxiety typically triggers defensive, avoidant, or security operations. It differs from *fear* primarily in that it is in response to a threat that is more diffuse and is future oriented. The most common negative emotion, anxiety is arguably the most challenging experience for therapists to navigate. In response to states of vulnerability and confusion, and emotions of anger and sadness, therapists often experience anxiety, which can sometimes lead to panic. The experience of anxiety can be unwitting and insidious in its effect on therapists, their attention, and experience of other emotions that may be primary (as exemplified previously).

On being personal: "Tell me something personal." "Tell me something about yourself, something personal," Tom asked me not too long into our work together. He was an imposing figure in his early 60s, considerably older than I at the time. He was a union employee who had worked almost 30 years for an airline that had recently closed its operations, so he was forced into retirement. He was alone in the world, never married and with no significant relationships when I met him, and he was looking for a new direction. I was immediately made uncomfortable by his request, very aware of my anxiety peaking. I remember responding, "I'm not sure what you mean, but I have to confess feeling wary about doing something like that and I'm not sure why." He turned silent, and after a while a smile came across his face. When I asked about the smile, he went on to say that he was just trying to set me up. When I asked what he meant by that, he explained he was looking for something "personal" to criticize me about—to knock me down from my "pedestal" in a sense. It was a startling revelation. I was impressed that he disclosed this so readily, that he was so candid. We then went on to explore why that was important to him, his regard to authority figures, especially to "false" figures. A year later, we were discussing something in session, and he asked me something rather personal. This time I didn't hesitate to reveal and responded directly, but shortly thereafter I was struck by the difference in our exchange. I brought this to his attention, and we were able to discuss the difference and how far we had come.

On being ignorant: "Why didn't you know?! Why didn't you tell me?"[4] Richard's accusatory words struck me hard. He expressed these upon discovering that his partner was cheating on him. His expression alternated between heart-wrenching sorrow and rage at me for not having known in advance. I was very aware of his pain: I could see his tears pour effusively; I could hear his chest heave palpably. And at the same time I felt anxious about approaching him. At first, I felt jerked back and forth, pulled in and then pushed away. After a while, it became harder to approach him even when he cried. When I finally found the courage to describe this experience—"I want to help you right now. I'm feeling pulled to but also pushed back, so I'm finding it hard to approach you"—it gave him pause. Eventually, he began to muse about what he was making of me. He moved from "You don't understand!" to "You can't understand!" which then led to an exploration of his fears and expectations regarding me, as well as my own regarding him. It brought into greater relief his struggles with independence and dependence that we had touched on before. Richard was a middle-aged, biracial gay man who came to me because he was struggling in his relationship with a partner of 1 year. He had two unfortunate experiences with gay therapists, so on one hand he was relieved I was straight. On the other, he was wary about whether I could fully understand his situation. He had a history of relationships in which he was ultimately betrayed by a lover. He was also physically and verbally abused as a child by his mother. As a result, he felt doomed to be forever untrusting and hypervigilant. He was also convinced that fidelity was an anomaly in the gay community. This latter conviction was something he believed I could not appreciate. Our accusatory encounter allowed us to explore his wish to trust me and his fear that he could not because of his history and the way he was objectifying me as a straight White male. This allowed me to become more than that for him.

On being careless: "You revealed your true colors!"[5] Bea started our session with this pronouncement of disappointment in me. Our previous ended with her conveying dismay over Martha Stewart's recent conviction. She had asked my opinion, and I responded rather casually, saying something about Greek tragedy and the downfall of another larger-than-life figure. She declared her dismay by my assessment of Martha, and I was taken aback, as I had not given much thought to a comment I made in passing. When I asked what she meant, she said that she found my judgment harsh and that it revealed a

[4]Adapted from a vignette previously presented in "A Relational Turn on Thick Description," by J. C. Muran, in *Dialogues on Difference: Studies of Diversity in the Therapeutic Relationship* (pp. 270–271), edited by J. C. Muran, 2007, Washington, DC: American Psychological Association. Copyright 2007 by the American Psychological Association.

[5]Adapted from a vignette previously presented in "A Relational Turn on Thick Description," by J. C. Muran, in *Dialogues on Difference: Studies of Diversity in the Therapeutic Relationship* (pp. 267–268), edited by J. C. Muran, 2007, Washington, DC: American Psychological Association. Copyright 2007 by the American Psychological Association.

surprising lack of compassion, "especially given my profession." At first, I was defensive, explaining that I wasn't really following Martha's situation: Admittedly, Martha Stewart was more of a cartoon figure to me. Bea was quick to cut me off—"No," and repeated, "Your colors are revealed!" Seconds of silence passed, and then I anxiously ventured, "I'm afraid to say anything right now." She appeared to soften a bit in response; her eyes turned downward, and her hands trembled. I took the opportunity here to ask what was going on for her. After some pause, she replied, "It makes me wonder what you must think of me." When I gently asked for more, she reflected on all her confessions to me, all her transgressions over the course of her life: all the lies and manipulations she described. She was 30 years older than I was at the time, a 72-year-old woman who at the age of 17 took over running her family business when her father tragically died. She developed quite an armor over the years, wary of all humanity—and especially a male therapist considerably younger. She went on to defend Martha, her strength and independence, her industriousness and fearlessness. With each word, she became increasingly emotional and was moved to tears. Eventually, she looked to me. "Why am I crying?" I suggested that maybe she was defending not only Martha but also herself. She paused and then replied, "You know, when I was running the family business, I always thought, 'I made it in a man's world!'" This moment made Bea less of a cartoon character, more of a person of greater complexity to me, and allowed her to consider that I might be able to understand despite all our differences and my inevitable misunderstandings.

On being too nice: "We're so f'kin' polite to each other!" At the start of a session, Valerie plopped herself down in her chair and blurted out this observation with a laugh: "We're kinda like Heckle and Jeckle." She went on to mimic a routine of the talking magpies. "No, after you . . ." "No, no, after you," as the birds would so pleasantly say to each other with a slight bow. When patients colorfully make you think twice about your relationship and what you might unwittingly be doing or feeling, it should be appreciated. With my request for meaning, she went on to describe how she saw us both painstakingly treating each other with "kid gloves." She appreciated my gentle manner: It often suggested care and consideration, but sometimes it felt to her as if I were treating her like a "china doll"—"fragile and maybe even cracked"—as if I were afraid of her. This revelation brought to my attention my anxieties when I was with her, which in turn allowed her to put words to her own and allowed us to address various disowned impulses. For her, she was better able to experience and express her frustrations and desperations with me as a result (see the upcoming and more elaborate illustration with Valerie on hopelessness). For me, it brought to light the subtle ways I avoided and aggressed against her at times.

Anger and Hate

Anger is a powerful and intense emotional state experienced in response to an attack or intrusion, some form of violation or abuse. It typically triggers

adaptive actions with regard to assertion and control. Important distinctions have been made with anger (see Harmon-Jones & Harmon-Jones, 2016): There is *passive* anger—that is, anger kept in, including suppression and passive aggression, or anger turned toward self, such as self-blame; there is *aggressive* anger—that is, anger turned toward or against another, attacking behavior; and there is *assertive* anger—that is, standing up for or protecting oneself. *Hate* has been defined as an extremely intense version of anger or as extreme dislike or disgust regarding the other. Some have distinguished it as a rooted belief rather than a passing emotion like anger, but extreme or sustained anger and frustration can lead to hate; here we address it as an emotional state. For therapists, the challenge is to not disown their anger or aggressive impulses by acting on them without awareness. Awareness is key in this regard, and anxiety about anger, especially its expression, is a major obstacle. As has been long noted (e.g., Spielberger, Krasner, & Solomon, 1988), there is a difference between the experience and expression of anger. In the face of patients' sometimes ruthless attacks or intrusions, it is understandable to experience anger and counterhostility. As some theorists have noted, the therapeutic aim in this regard is to survive these aggressions, and in many instances this includes more than just tolerance. The aim can also include therapists making controlled expressions of anger that demonstrate strength and resilience (L. Epstein, 1984; Slochower, 1996): Defending oneself with firm limits and playful repartee are examples. It is also not unusual for therapists to move from not liking a patient at first (hate is probably too strong here) to a position of compassion and love as the patient reveals other, more vulnerable aspects of themselves.

On being nonassertive: "It's a little too late to be angry!" These were the final words I heard from my patient Rachel before she fired me. They still cut to the quick to this day. I was a newly minted PhD who was still trying to figure out my boundaries and limitations. Rachel presented with panic disorder as her chief complaint when we started to work together. I provided her with the current cognitive-behavioral technology at my disposal, relying heavily on Barlow's (1988) empirically supported contributions (e.g., psychoeducation, breathing retraining, cognitive reappraisal). In addition to our once-weekly sessions, I made myself available for phone consults when she was in a panic or at risk for panic. I even made myself available to be present at a dental appointment that was extremely anxiety provoking. I worked very hard at teaching her how to manage her breathing and thinking in the face of her fears. At first my efforts appeared to be appreciated by Rachel, but soon they were not enough. Our sessions became filled with complaints about the limitations of these techniques and my availability plus ability to help. My experience in our sessions became fraught with my own anxiety. I remember even saying a little prayer and pointing to the sky as I waited for her to come in and start a session—much like a baseball player before stepping into the batter's box. At some point, I became aware of feeling anger: This awareness first came to me between sessions when my anxieties receded. I took what

felt like a big risk of disclosing it in our next session. "You know, after our last session, I became aware of feeling angry toward you." I was not sure how she would respond, but to my relief she was curious. She became open to exploring her fears in what felt like a more in-depth way: She talked about her experience of isolation and vulnerability in the world. She seemed to appreciate the impact of her anxieties and consequential criticisms on me (and maybe others). This exploration, in turn, brought another dimension to our work on her anxieties and really helped me to reapproach her in a more compassionate way. This process brought new fuel to our collaboration, or put more precisely, to my commitment to her. For a while this seemed to work. In time, though, the demands on my availability took its toll. Calls came at all hours, and I became very anxious when checking my voice mail and at seeing my phone flashing. Then came the criticisms of my ability again. At last, on our final call, I anxiously tried to talk about being angry again, to which she responded, "It's a little too late to be angry!" and hung up. To be fair, I was more anxious than angry. In retrospect, I realized I did not mind my anger sooner: I did not respect my limitations and recognize when I was being exploited and abused earlier in our work. How she would have responded remains an open question, but this was the lesson learned.

On being repulsed: "To know me is to hate me!" Bea came to me to address her interpersonal difficulties, her conflicts, and her isolation. In our first meeting, which was explicitly set up as a consultation to explore the possibility of working together, she began by informing me of a problem with my voice mail system. This issue would be a forerunner of her knack for finding wrinkles in my practice. She then asked about my phone policy, to which I asked what she meant. "Do you return calls?" I responded, "Yes." "How about after hours?" Again, I asked what she meant. She referred to calls late at night and during the weekend. I told her about my general policy of returning calls within a reasonable time frame, but I added that much is dictated by the nature of the specific case. She was not impressed. It seemed to her I had set up a practice primarily for my own convenience. During the course of the session, she expressed skepticism about therapy and her ability to change. She had a long history of being in therapy with some bad experiences. She also expressed some concern with my age and ethnicity, wondering aloud whether I could truly understand her. When she finally asked if I would be willing to work with her, I confessed I was not sure. I said I was intrigued by her situation. But I didn't say that I was drawn in by her apparent difficultness. I thought, "If you really want to study negative process, this is the patient for you!" I also told her that, given her expressed concerns about me, I was wary that I might never, in a sense, be good enough. But I didn't say that she reminded me of Rachel. So I was wary and very measured.

Bea was taken aback by my disclosure. She seemed to soften her position when she realized that our working together was not just up to her. She went on to say she wanted to work with me. She thought I was sharp and liked my ability to smile. When I asked how she felt about my disclosure, she said she

didn't like dealing with the "person" behind the "professional"—her words. She went on to describe all her difficulties dealing with and relating to others. With our time up, I suggested that we meet again, and as she walked out of my office, she stopped with a smile and said to me, "You know, I've always thought, 'To know me is to hate me!'" It was a startling declaration and introduction.

As we worked together after this, Bea would occasionally poke a criticism at my various policies, attack me about something I said that she considered insensitive, and test the limits of my frustration and anger. To some extent, being upfront and mostly nondefensive about what I could and could not do for her and knowing and accepting my limitations helped me to tolerate her movements against me and to recognize my resulting anger in an immediate sense. We were able to have a number of candid conversations about our mutual frustrations, which allowed us to come to a greater appreciation of our respective personhoods. To some extent, I learned a lot from my experience failing Rachel.

Sadness and Despair

Sadness is an emotional experience of pain that emerges in response to a misfortune, separation, or loss. It initially results in a turning into oneself to mourn; it can be experienced as a deeply painful emotion, but it can ultimately mobilize the individual to recover or replace what was lost. Sadness can also result in a reevaluation of life goals and in aid and comfort from others. Thus, the sad person is at once pained and hopeful. In contrast, depression involves sadness about everything (in a global sense) and is often characterized by blunted or restricted emotional expression and by the experience of self-preoccupation or rumination and disconnection or isolation from others; it is founded on hopelessness or despair, such that the depressed person has given up (A. T. Beck, 1967). Therapists typically experience compassion in the face of a patient's sadness and are drawn toward the patient. In the face of a patient's depression, therapists can feel disconnection and, especially with regard to despair, futility, which mirrors the patient's experience. Typically, therapists champion hope and resist and avoid the patient's despair.

On being hopeful: "I'm just confused all the time!"[6] Valerie entered treatment in a severe depression that had debilitated her both mentally (she had great difficulty concentrating) and physically (she had great difficulty maintaining a working schedule). In the early stages of therapy, she described herself as in a perpetual state of confusion. She would often begin sessions in a half-humorous and half-poignant manner, which would confuse me and which became a marker that something was amiss. For example, she once

[6]Adapted from "Meditations on Both/And," by J. C. Muran, in *Self-Relations in the Psychotherapy Process* (pp. 357–360), edited by J. C. Muran, 2001, Washington, DC: American Psychological Association. Copyright 2001 by the American Psychological Association.

settled herself in her chair, turned to me with a smile on her face, and laughingly said, "Oh, sure, just look at me. I don't get it. I'm just confused all the time. I don't get it." I responded, "Well, let's start with the 'Oh sure, just look at me.' What's that all about?" Valerie responded, "Like you're all focused to start, and I don't even know what planet I'm on." When I asked her to elaborate, she went on to describe how she gets confused by some of her reactions and to wonder why (specifically) she had an "outburst" at the end of the last session ("It was probably one of those things that went over your head, but in my mind it was a big outburst"). I had not remembered any outburst and so asked for more detail. Valerie then went on to describe the end of the previous session, which I had punctuated with "To be continued." The expression sent her into a panic, as she experienced it as "Here, now take your problems and go away, go work on them on your own." She had jokingly blurted out halfway out the door, "Yeah, right, like you really want to." This was her so-called outburst.

Prior to this encounter, Valerie had been discussing the experience of feeling ignored by one of her brothers. She had also had a dream in which I was portrayed as impatiently waiting for her to leave me alone. When I had previously asked her if she experienced me as ignoring her or as impatient with her, she could not link the experience to anything particular that I had done. In this instance, when I raised it again and wondered aloud about what I did specifically to provoke this experience, she responded, "Well, it's based on something, but you didn't do anything terrible. . . ." I chose to focus Valerie on the "something" that she was picking up rather than focus on her characteristic tendency to dismiss, forgive, and attribute the blame to herself, which we had explored before in some detail.

In the ensuing exploration, I invited Valerie to explore my subjectivity, to speculate on what might have been going on for me when I ended the previous session ("So what do you imagine was going on for me?"). In response, Valerie elaborated on her sense that I was feeling a bit overwhelmed by her dependency and experiencing her as "too much" to handle and tolerate. She then disclosed her fear of being too dependent on me and her fundamental fear of being abandoned by me. As a result of these fears, she was exquisitely sensitive to my movements toward and away from her. She revealed that sometimes she experienced my "careful" approach to her as gentle and caring and other times as cautious and fearful of her. This revelation stirred me to explore my experience further and to begin to identify my subtle reactions to and anxieties about Valerie and what she needed from me. It helped me become more aware of how much she scared me at times, how much I felt wary of her dependency needs.

Subsequently I disclosed moments in sessions with her in which I felt anxious and guarded toward her as junctures to begin to explore what was going on between us and to discern our respective subjectivities. These disclosures helped orient our focus to the concrete and specific of the here and now and ground our awareness of our actions and self states, facilitating the experience of mindfulness in a sense for both of us. Earlier in treatment, Valerie responded

to my transgressions with extended periods (sometimes days) of confusion and despair. These disclosures helped her to become more aware and vocal about her discontents with me, quicker and clearer in recognizing what she did not want from me and ultimately what she did. Of course, this process included my being mindful of my own desires with respect to her needs.

For example, when she would enter one of her self states of confusion and despair, she would frequently contact me by telephone (sometimes at the most inopportune times) but then would not be able to articulate what she wanted. The challenge I faced in these instances was to somehow try to create an optimal space for exploration and expression in an abbreviated time and without visual cues. In this regard, as I learned by my mistakes, it was important for me (and for her) to attend to what extent I resented the intrusion and to what extent I could hear her in the given moment. Sometimes this led to my asking her to call at another, appointed time or to wait until our next session. Simple, but not easy. Valerie appreciated knowing where I stood. It helped her recognize and express her own needs. It helped her move from a diffuse state of confusion and upset marked by occasional "outbursts" to a more differentiated state in which she could more readily discern her desires in contrast to mine. So it became an important, never-ending task to try to figure out where I stood. It was impossible to always or absolutely know, but it was a process—an ongoing negotiation between us.

Typically, Valerie would slip from a hypervigilant state, in which she paid exquisite attention to my position vis-à-vis her, into a dissociative self state of confusion and futility when I would be neglectful by an act of either commission (e.g., asking the "wrong" question) or omission (e.g., being nonresponsive). When faced with her futility, I often found myself feeling ineffectual and hopeless. In response, sometimes I would anxiously or angrily move away from this state and would commit another neglectful act (e.g., by imposing a sense of hope, sometimes a disingenuous assurance). When I was able to become mindful of this hopeless state, I was more able to meet her where she was. As she described, in my efforts to face and stay with my despair, she felt there was room for her to hope and to begin to talk about her specific fears and expectations.

On being stuck: "They'd be better off without me!" Jen had said something to this effect before, but this time she sat in front of me with a look of despondency I hadn't ever seen. She was in an especially dark place—devoid of any reason. We had discussed her suicidal impulses before, but the thought of leaving her two young daughters behind was always unthinkable. She was caught in a horrible, long-drawn-out divorce proceeding, and her husband by more than one account was a bastard (her medicating psychiatrist who also saw the husband said as much). Jen was involved in a long-standing extramarital affair with a colleague at a management consulting firm: He was also married with no intention of leaving his wife. On this day, Jen could not assure me she would not take her life. She had a plan and now was convinced that her daughters would be better off with their father. To hospitalize her

would probably increase the likelihood she would lose her children in the custody battle and provided no guarantee she would not try to kill herself after her release—especially if she were to lose custody. In a word, I was stuck—perhaps as she felt—and in stare down. All I could think of was I couldn't let her leave, and I told her so. Fortunately, I didn't have an appointment in the next hour, but I did call and cancel my subsequent appointment. I cleared some space (3 hours) for us to just talk, to articulate her feelings of despair—not to try to talk her out of it but rather to be there with it. (Certainly, my experience with Valerie helped here.) By doing so, Jen began to feel less isolated and alone. This required me to be aware of and tolerate my own anxieties regarding despair and provided her with the experience of being cared for and connected to another in her pain. Thus, I became a conduit for her to return from exile to being a member of the human community, a loving mother and a "doing" person.

Self-Conscious Emotions

Here we introduce so-called self-conscious emotions (see Lewis, 2016; Tangney, 1999) that develop with the emergence of consciousness and involve complex cognitive processes, including standards, rules, or goals shaped by family and culture.

Embarrassment and Shame

Embarrassment (or *shame* as a more intense version) is an anxious state that is based on the fear of another's negative evaluation and characterized by the phenomenological experience of wishing to hide or disappear and an action tendency toward inward withdrawal (Gilbert, 1998; Lewis, 2016; Tangney & Dearing, 2003). For therapists, this state is typically experienced in the face of explicit attacks by the patient on their professionalism or personhood. The challenge is not to succumb to the wish to withdraw.

On being wrong: "How could you?!" A silly joke on my part drew this sharp rebuke from Mathew. "That's not very professional," he went on to say. Mathew was a peer in many respects but always called me "Dr. Muran" even though I would often return his calls with "Hi, Mathew, this is Chris," thus indirectly inviting him to address me informally. When I asked him about his apparent resistance to take up my invitation, he first said I needed to be more direct, but then talked about the importance of formality to him. More to the point, he needed to see me just as a professional, not as a person. He declared this even though he would occasionally relate to me in more familiar terms: For example, he would ask how I handled disciplining my son (his was always a challenge for him) or how I dealt with my aging parents (his relationship to his own was fraught with anger and guilt in addition to love). So the pull for mutuality was strong at times for me, but as we explored, he acknowledged being wary of seeing me as a flawed person. The pull to be authoritative was equally strong. Making a silly joke was an unwitting attempt by me to relate

to him on mutual grounds: It undermined my authority in his eyes. It scared him and led to his rebuke—and a moment of embarrassment for me. I was not only unprofessional but also misread him badly. It was important here not to shrink away or to simply apologize: Here was an opportunity to explore his anxieties while they were palpable. Apologizing was beside the point and could have undermined the opportunity to explore his anxieties by defusing them. Here was an opportunity for Mathew to see me as both professional and person.

On having to succeed: "Too much on the line!" Early in my career, I was asked to see an elderly gentleman who was a major benefactor to the medical center where I worked. The directive came from upper administration. Needless to say, I was in a difficult situation with no easy answer (one ripe for embarrassment among other emotional challenges). One senior colleague advised without hesitation, "You can't take this case." At the time, I was in supervision in the New York University postdoctoral program, and I brought my dilemma to my then supervisor, a very senior analyst who had built a practice (maybe better put, a career) as "the analyst's analyst," which invariably involved negotiating complicated relationships. He replied, also without hesitation, "Well, do you want to learn how to do this now . . . or later?" I was curious and so proceeded to work with the gentleman. He presented with a severe case of covert compulsions that seemed to serve to redirect his attention away from his experience of anger or sadness. He was some 80 years old when we started our work. He had survived a betrayal by his wife, who had an affair with a friend, and the suicide of his son, who overdosed as a young adult. Maybe better put, he was trying to survive these experiences. In most respects, this case was as challenging as any other. In time, the pressure to perform seemed to recede as I believe he appreciated my earnest efforts. I also believe he became very fond of me and a father–son dynamic emerged: In some respect, I filled the void left by the death of his son. We never talked about our relationship in this way. The relationship was more uncomfortable and challenging for me when he discussed the money he bequeathed to the medical center, which he did without designating how it should be used. One time, he told me how a development officer had called him and asked if he wanted to assign his bequest to the psychiatry department. His response was that he could never associate his family name with psychiatry. Apart from a few clarifying questions, I didn't say much, though much was going on in my mind: I knew what other departments (including oncology, surgery, and urology) could and did do to solicit funding, and I knew it was different for our discipline, right or wrong. We never talked about how this impacted our relationship. To this day, I wonder about my silence on our parental dynamic, including its relation to his bequest. I think in the end I did not trust how the conflict of interest within me would play out if we engaged in a conversation about it. I feared that such an explicit communication would be an implicit form of coercion on my part. So I kept my silence on this matter and my focus on his experiential avoidance of painful feelings.

How this focus intersected with what we did not address and whether it would have been worth addressing remain intriguing questions for me—and are posed here for your consideration.

Guilt and Self-Doubt

Guilt is an anxious state based on negative self-evaluation or self-criticism and motivates an action tendency toward correction or reparation, toward atonement for wrongdoing (Baumeister, Stillwell, & Heatherton, 1994; Lewis, 2016; Tangney & Dearing, 2003). If no remedial action is available, guilt can result in paralysis and turn to shame (and depression). For therapists, self-doubt (especially as self-reflection) can serve to make critical changes or adjustments in their actions, but in the extreme, hyperreflexivity and self-castigation can lead to rigidity and isolation—difficulty in being responsive to the other.

On being inexperienced: "You just don't have the experience!" I was a predoctoral extern when I heard these words from Campbell. He was a middle-aged basic science researcher who was "all but dissertation." My first thought when I heard that was an angry, "Well, I bet I get my PhD before you!" Of course, this thought was founded on my own insecurity: I was new to practice and only in my mid-20s. He accentuated his point by raising his pinky finger and indicating that the extent of my experience was equal to this finger. I don't remember much of that session, except for this exchange and that it was our last session together. It would forever remain a formative experience—an important memory of a missed opportunity. Years after this experience, I supervised a predoctoral intern who was facing a similar challenge. A patient who was a recovering alcoholic entered an early session and proclaimed, "I don't think this is going to work!" This was no surprise, as in previous sessions the patient had communicated her doubts in several less direct ways and supervision had focused on the intern's own self-doubts that were especially stirred by the patient's. We spent significant time putting words to my student's feelings in this regard. "I don't think you have the experience to help me with my addiction." My student responded, "Can you say more about what you're concerned about?" The patient accepted this invitation and began articulating her concerns, elaborating on her fears, and my student just listened and invited more expression. It was not so much what she said in response but that she remained open and nondefensive. She did not let her own doubts, which remained present, loom so large that they interfered with her ability to approach and explore the patient's feelings. The result was that the patient continued to work with her.

On being rejecting: "You got married!" Doris stood at the threshold of my office door and immediately broke into tears. She could see my wedding band from 10 feet away. I did not tell her in advance and had been away for 2 weeks for my honeymoon. It all hit her at once. I knew she had a bit of a crush on me. It was something we had talked about before, something we had explored to some extent, and something that always made me feel uncomfortable in

our relationship. But in this tearful recognition, the depth and complexity of her feelings came crashing down upon me. Doris lived a reclusive life, alone and on disability, with her sister who also had long-standing psychiatric issues as her only close relationship. On the rare occasions Doris left her apartment, she would carry at least three bags full of stuff: She was a hoarder and remained one on the go. Her presenting concerns and goals were to redress her hoarding and to find part-time work—the latter to help also her re-engage with the world. Her tears made her wish to re-engage more profound. Her therapeutic relationship with me had become an important attachment, but one ripe with fantasy that precluded her from more realistic pursuits. I became a love object that she could count and settle on. When I saw her cry, I was first overcome with guilt: Should I have told her? Had I betrayed her? What had I become for her? And what had I missed? "Come in, Doris, and let's talk," I had the wherewithal to invite her to express and resist the trappings of guilt. With this watershed moment, we addressed these questions and then some. We reached a new depth of understanding of our relationship, including what she made of me and what I could be and do for her—namely, I couldn't care for her as a husband, but I could as her therapist.

Pride and Hubris

Pride involves personal satisfaction based on a positive evaluation of a successful action and associated with achievement motivation and constructs such as efficacy and mastery: Pride that turns to arrogance is *hubris* (Lewis, 2016; Tracy & Robins, 2014). For therapists, helping another, relieving suffering, seeing change in behavior can result in a tremendous amount of personal satisfaction. The challenge is to not get carried away with oneself and one's evaluation of self-efficacy. Slipping from pride to hubris on occasion is not as unusual as we would like to admit. "You're my last resort!" Patients make such expressions in many different ways. Sometimes explicitly: "You're the only one who really understands me!" Sometimes implicitly: "That's really helpful." These are expressions that can seduce us into feeling masterful. But as Dirty Harry pronounced on the death of the villain in *Magnum Force*, "Man's got to know his limitations" (yes, this would include women too; Daley & Post, 1973). Humility is essential: As the performance science literature cautions (Kahneman, 2011; Redelmeier, Ferris, Tu, Hux, & Schull, 2001), we should mind the trappings of overconfidence.

On being competitive: "Pride of the Yankees!" Oliver was about my age, highly educated, extremely smart, and very successful in the financial industry. He liked to show off—sometimes with regard to his financial success, but more often with regard to his intelligence. Often he liked to test mine and would reference something he read in the *Science Times*. There was a competitive edginess to our interactions. Sometimes there were repartees, some playful teasing. Touché, he liked that I could keep up with him. When we would explore this dynamic, he would acknowledge that he appreciated that he saw me as a worthy adversary. Oliver was also a rabid Boston Red Sox fan. And

he noted I was a devoted (alright, rabid) New York Yankees fan (a mood-dependent fanatic since I first saw Mickey Mantle in pinstripes): I did drink my coffee from a Yankees mug depicting all the championships and with the caption "Hard to be Humble!" Admittedly, I didn't feel any competition in this regard . . . at least at the time.

We started working together in the summer of 2004. Oliver presented with frustrations in finding meaningful relationships: He had many male friends but no one with whom he could share his fears and insecurities, and he seemed to move from one short-lived romantic relationship to another. He was aware I was married by my band and once asked how long I was married. When we explored why he wanted to know, he expressed he was curious about my personal experience with sustained intimate relationships. So apparently I had credibility—or some kind of status. Then came October 2004, the American League Championship series, and another showdown between *my* New York Yankees and *his* Boston Red Sox. It didn't take long for my boys to take a 3–0 series lead and for me to have my World Series tickets in hand and clipped in my daily planner calendar book. Yes, it was hard to be humble as a Yankees fan!

Then came the unthinkable: The hated Sawx, the self-proclaimed "idiots," started to come back. At first, no big deal, I couldn't take this rally seriously. I survived my Boston-based uncle's merciless teasing back in the 1978 when the Sawx led my boys by 14½ games, only to see the Yankees stage a historical comeback and beloved Bucky "F'kin'" Dent punctuate it with an improbable home run. And of course there was the most recent 2003 championship series when the Yankees were at the brink and staged another comeback, capped by Aaron "F'kin'" Boone's home run. So there was nothing to worry about as I sat down to watch the deciding seventh game on October 20, 2004. Well, I was wrong, and I stared in disbelief at the television as the final out was recorded. The Red Sox won! My first thought was to turn off the television: I couldn't bear to watch this celebration. My second thought was, "F . . ., I have a session with Oliver first thing tomorrow morning!" I went on, "This is going to be the hardest session!" It is hard to be humbled. I didn't really know what to expect from Oliver, but he was incredibly gracious . . . and very curious about my experience—and not in an intrusive or "conquering" way. Even though I wanted more time to lick my wound, to process *my* loss, it was time to get to work, and I remember recognizing that this would be a challenge for my competitive impulses. I remember reminding myself to "mind and mine" those feelings, and it really mattered how Oliver approached me. The result was an in-depth and intimate conversation—about competition, winning and losing, camaraderie and loneliness—about self-definition and relatedness.

On not being as good: "My old therapist would have assured me." Grant pointed this out, and not for the first time. He had described how he had just gone on a mental journey of illness and death on the heels of stomach cramps. His previous therapist would automatically and emphatically assure him whenever he would go "hypochondriacal—'That's not gonna happen!'" Then

she would explore. I was less generous with the assurances, I suppose because there were times such symptoms led to some kind of illness for Grant and I was trained to try to avoid arguments of probability with very anxious patients.

"So tell me more about your experience that I didn't respond as assuredly here." I focused on my most recent failing, trying to stay grounded on the immediate details (and not to drift to a more abstract discussion of patterns, which could obscure meaningful differences and emotional definition). It can be difficult for therapists to invite negativity or criticism—and I did *not* explore the first time Grant made such an expression, letting my anxieties move me to avoid—but ultimately I did. I have always been encouraged in this regard by the Chinese proverb "Go to the heart of danger, for there you'll find safety" (of course, this might strike some as counterphobic, and so one should strive as much as possible to do so in awareness). In response, Grant was able to explore in depth his sadness regarding the loss of a very important maternal figure in his life: His previous therapist died after a prolonged illness and, as he described, filled a very important void in his life, as he always found his mother lacking. In this context he was able to express his need for support and nurturance from me—his wish for assurance that I was there and that I cared.

Other Challenging Emotional States

In this section, we present other emotional states commonly experienced by therapists that can pose challenges.

Boredom and Neglect

Boredom is an unpleasant emotional state characterized by problems in engagement of attention, "a pervasive lack of *interest* and difficulty concentrating on the current activity" (Fisher, 1993, p. 396). Lack of stimulation and bouts of disinterest are not unusual experiences. Often we are not so aware of drifts to inattention. Whenever we are a bit bored, our minds naturally begin to wander. Much has been written about mind wandering: Research indicates we wander 47% of our waking hours (see Killingsworth & Gilbert, 2010). Also, increasing demands on our attention have resulted in large measure from excessive social stimulation and ever-expanding communication technologies that dominate our professional and personal lives (see Gergen, 1991, for an early discussion of this experience). Therapists are not above this. When sitting with a patient, a therapist can commonly find their mind wandering or trafficking in thoughts that concern matters apparently apart from the patient. Some authors have written in depth about this in the clinical setting (e.g., Ogden, 1997). When these wanderings become more pervasive, they are often meaningful markers of what's going on in the therapeutic relationship. Here are some illustrations of how such experiences can be negotiated in therapy.

On mind wandering: "Sorry, I was multitasking." In modern-day terms, mind wandering can take the form of "multitasking" whereby one can find oneself working on other tasks in addition to or sometimes instead of the

therapy task at hand with a particular patient. I suspect this is as common in psychotherapy as it is in everyday life. The questions are whether it is more than usual, whether it interferes with the psychotherapy process, and whether it bears some significance about the intersubjective negotiation between patient and therapist.

After several weeks of working with Peter, who presented with concerns about social anxiety and relating to others in an intimate way, I began to recognize my attention often wandering. I could and would return to engaging with his concerns. At first I just shrugged this experience off. Then I started noticing it happening again and again, and it seemed too often to not be meaningful. I tried to tie my wanderings to an interpersonal marker and thought it might have something to do with how he spoke about his worries, his various machinations in negotiating social situations. At some point I shared, "Peter, I find myself getting lost in all your worries and wondering what that means. Does that make any sense to you?" Peter initially smiled in response, but that quickly disappeared. He then confessed he felt at times that I wasn't present. When I asked about his experience of my absence, we were able to move to a place where we could explore his sense of isolation in the world and his profound sense of sadness regarding feeling disconnected. Here I could more meaningfully recognize and connect with him.

On being neglectful: "I rarely worry about you." One day before the start of a session with Emily, it occurred to me that she didn't occupy much of my attention between sessions. I began to wonder to what extent I took her too lightly. Emily was a high-achieving professional who came to see me after ending a 5-year relationship when she discovered that her boyfriend had no desire to marry and start a family. Our work together seemed to proceed smoothly—probably too smoothly. She seemed willing and able to grapple with her perfectionism and overdeveloped work ethic and to examine her recently failed relationship and why it took so long for her to discover that her boyfriend had different aspirations. My realization and growing unease regarding my apparent neglect led me to take a risk.

I decided to explore this feeling in session, first by grounding it in the specifics of how we interacted and then by metacommunicating: "You know, it recently dawned on me that I rarely worry about you between sessions. And I became concerned that I might be taking you for granted. Does that make any sense to you?" This stirred a tearful reaction in Emily, as she acknowledged feeling neglected by me. In the exploration that ensued, she associated to always feeling compelled to be self-reliant and began to identify the ways in which she tended to smooth things and communicate that all was fine when it wasn't. She described this as a profoundly lonely experience. It was important for me to acknowledge my participation or collusion in this process. In time, she was able to explore the way in which her fear of being too demanding and of driving the other person away led her to disown her own desires.

Love and Seduction

Love is a positive feeling of strong attraction and emotional commitment that Robert Sternberg (1986) described in terms of three components: *intimacy* (shared confidences and personal details), *commitment* (expectation of a meaningful relationship), and *passion* (infatuation and sexual attraction). Love has also been defined as involving an intricate balance between recognizing the subjectivity of the other and objectifying the other (see J. Benjamin, 1988). Objectification can be what excites or tantalizes one about the other, but it can also lead to depersonalization, degradation, or dehumanization of the other (see Kant, 1797/1996). Martha Nussbaum (1995) and Rae Langton (2009) identified several features involved in objectification: treatment of the other as a tool, as a possession, as interchangeable with other objects, as lacking autonomy and agency, as lacking boundary-integrity, as without subjectivity, as silent, and as reduced to appearance and body. For therapists, the challenge is to resist becoming fully engaged in objectification as both perpetrator and sufferer.

On being seduced: "How about a hug?" These were James's words as he got up to leave our session. It was our first session in a number of years: We had worked together for a brief spell before he moved away from the New York area. James was gay, and though we were close in age, he was quite childlike. In fact, he did not work but was rather kept by his partner of many years. I had forgotten how flirtatious and provocative he could be. In the moment, I was caught off guard and let him hug me. It was brief and probably awkward, though I tried to appear cool with it. I reciprocated with a simple pat on his back.

In subsequent sessions, James would occasionally make an off-color remark that would make me feel uncomfortable. Increasingly I felt sexualized and objectified. At some point, I "screwed" up my courage to share my discomfort after another sexual comment. "At the risk of sounding prudish, I have to say that I do feel uncomfortable about what you just said." James went silent. It appeared I hurt him. When I asked him what was going on for him, he confirmed the hurt. I acknowledged that my disclosure was also a form of pushing back. James appeared to appreciate my candor and was able to articulate his fear that I would reject him. This in turn allowed us to explore our respective subjectivities and differences in a much richer way, including his feelings of alienation, his needs for nurturance—and more constructive ways to address these.

On being starstruck: "Look at me!" Paulo was an artist who created in various media, from painting to photography. He was well travelled, though his renown was based solely in South America, which was always a source of great disappointment to him. He was just 50 when came to see me. His presenting complaint was long-standing depression. Our sessions typically concerned his latest creations and frustrations with finding a New York gallery to

exhibit them. He often brought in a sample of his work—a form of show-and-tell. And I was enthralled not only by what I saw but also by what I heard of his creative process. I became starstruck as our sessions became exhibitions, which he seemed to really enjoy. He was so animated that I could hardly tell he was depressed.

At some point, though, I was also struck by the unusual nature of our encounters, so I explored. "I'm so impressed by this photo of yours. Can I ask what it means to you that I am?" Paulo acknowledged how much he appreciated my appreciation but also his wanting for more recognition. This allowed us to explore his ambitions and failings in more depth. This also allowed us to better understand his desires and frustrations regarding others. He was able to give definition to how he was approaching me, how hard he was working to impress me, and how much he feared further rejection.

Misempathy and Overidentification

Empathy is the ability to understand another individual's emotional experience or internal state, to feel from within another's frame of reference, to make less distinct the differences between the self and the other, having the separateness of defining oneself and another blur (Zaki & Ochsner, 2016)—to put oneself in another's skin and walk around in it, to paraphrase Atticus Finch in *To Kill a Mockingbird* (H. Lee, 1960). *Compassion* and *sympathy* are other terms associated with empathy but are oriented more toward feelings of concern for another in need. Empathy has been operationally defined as comprising multiple abilities or tendencies, including (a) *experience sharing*, or to take on an emotional state of another; (b) *mentalizing*, or to explicitly theorize about the internal states of another; and (c) *prosocial motivation*, or to want to help another as a result (Zaki & Ochsner, 2016). Empathy has long been considered essential in psychotherapy (see Bohart & Greenberg, 1997; Elliott, Bohart, Watson, & Murphy, 2018). For therapists, the challenge is to recognize misempathy (the belief that one knows exactly how another person feels when in fact one doesn't) and overidentification (when one excessively identifies oneself with another to the detriment of individuality), both of which involve missing the difference between self and other.

On being overidentified: "Why do you care?"[7] Over the first few months in our work, Michael would often start our sessions by describing a problem—whether it had to do with moving to a new apartment, approaching a woman he was interested in, or resolving a conflict at work—and my efforts to try to clarify the situation or even provide advice were met with quick dismissals. When I would explore his reaction to my efforts, he would criticize them as

[7]Adapted from vignette previously presented in "A Relational Turn on Thick Description," by J. C. Muran, in *Dialogues on Difference: Studies of Diversity in the Therapeutic Relationship* (pp. 268–269), edited by J. C. Muran, 2007, Washington, DC: American Psychological Association. Copyright 2007 by the American Psychological Association.

"idealistic and ill-conceived." After some time, I became increasingly wary when confronted with this scenario. In one session when I finally revealed my wariness, he was able to acknowledge that he realized he was setting me up and testing me in a sense. He recognized that he wanted me to succeed *and* that he wanted me to fail: The former was his hope, the latter his expectation. Although this seemed an important exploration and revelation, it still seemed as if we continued to repeat this enactment of my trying to solve his problems and trying to save him.

In another effort to talk about what was going on between us, he stopped and asked, "Why do you care?"—a simple-enough question, but one that gave me great pause. Was it because I liked him? I knew I experienced him as a pain in the ass when he was being particularly enigmatic and impossible to help, and yet I did like him; and I was aware of a strong investment in him. I shared these thoughts with him, which led him to ask another significant question: "What is it that you want *for* me?" As I reached for an answer to this, it occurred to me that maybe I had designs for him that had more to do with my own aspirations than his, that maybe I saw him as a younger version of me. I was blind to a prejudice of mine and to a critical difference between us. When I considered this aloud, I realized how neglectful I had been of him. This seemed to open up some space for us to begin to define with greater resolution what he wanted for himself, what he needed from me, and his fears in both regards.

On being different: "Are we much more simply human than otherwise?" This question is based on a famous acknowledgment by Harry Stack Sullivan (1953) that was meant "in most general terms" (p. 35). The interpersonal tradition has also promoted the notion that each of us is highly idiosyncratic—"totally unique and singular as our fingerprints" (E. A. Levenson, 1991, p. 83). Both these truths stand in dialectical relation to each other. A. R. was an African American man in his mid-70s, some 30 years older than I, when he came to see me to discuss his adjustment to life in retirement. An academic, he was politically active throughout his life. Our differences (or at least some of them) were obvious, but over time I felt our mutual humanity prevailed. He was a man in existential crisis, trying to sort out what to do in the next chapter of his life. We had engaging conversations about his life in academia and his accomplishments and regrets, and I felt that we shared a lot in this regard. He also captivated me with an occasional anecdote about the civil rights movement back in the day, and he gave me great insights on a history I studied as a youth. In time, I grew in my empathy and affection for him. Then came Election Day, November 2008: We met for our regularly appointed session the day after. A. R. walked into my office and broke into tears. These were tears of joy and then some for the election of the first Black president of the United States. The depth of feeling woke me from my illusion of understanding the man. "I didn't really understand," I confessed, which allowed us to converse in an entirely different way. I learned another lesson on difference and its scale.

CODA

Ruptures as Emotional Challenges

Alliance ruptures represent opportunities to explore core relational themes for both participants in the therapeutic relationship. For therapists, they invariably involve emotional challenges marked by various basic and complex emotions, but these can provide guidance: Therapist internal experience can serve as an internal compass to what is going on *within* the patient and *between* the patient and therapist.

Rupture Repair as a Change Event

Therapist emotions can be used to build bridges to dissociated states, to repair misattunements, to resist interpersonal pulls, to disembed from relational matrices or unhook from vicious circles, and to bring an intersubjective negotiation between patient and therapist beliefs and identities into relief. Their definition can provide regulation for the therapist and coregulation within the therapeutic relationship.

Metacommunication as a Technical Principle

Metacommunication, or communication about the communication process, is a technical principle founded on collaborative inquiry that can facilitate rupture resolution, promote emotional regulation for both patient and therapist, and increase the likelihood of mutual recognition by patient and therapist of their respective subjectivities—a moment of I–Thou meeting or meeting of the minds.