12-2-2016

Why Therapists Bite Their Tongue in Therapy and What to Do About It

Ingibjorg Thors

WHY THERAPISTS BITE THEIR TONGUE IN THERAPY AND WHAT TO DO ABOUT IT

A DOCTORAL PAPER

PRESENTED TO THE FACULTY OF THE

GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY

OFFICE OF GRADUATE STUDIES

UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE

DOCTOR OF PSYCHOLOGY

BY

INGIBJÖRG THORS, M.A.

DATE: 12.02, 2016

APPROVED: _____

Michael Karson, Ph.D., Chair

_____

Fernand Lubuguin, Ph.D.

_____

Kimberly Mathewson, Psy.D.

Abstract

Most therapists agree that therapy should be a place where the unspeakable is speakable, and the role of the therapist should be to help the client find a way to change by exploring the patterns of behavior that are no longer working for the client. Being blunt in therapy seems to be one of the key factors needed to promote immediacy, to challenge habitual ways of thinking that are not productive for our clients, and to create a relationship that is different from social and professional relationships. However, many therapists have distorted beliefs about using bluntness in therapy to stimulate curiosity and productivity, because of their own schemas/beliefs about what therapy is or about speaking one's mind. This paper will explore why clinical trainees bite their tongues in therapy, and what to do about it through the lens of Cognitive Behavior Therapy (CBT). To explore distorted beliefs that some therapists have about being blunt in therapy, I consulted with fellow students and myself, asking what it would be like to be blunt and say what we are thinking in therapy and, if they felt reluctant to do so, what would be the worst thing that could happen if they would speak out. I have categorized these personal communications down to six beliefs that my fellow student-therapists and I have about ourselves and our clients, that keep us from being blunt in therapy.

Keywords: Bluntness, immediacy, countertransference, distorted beliefs/schemas

Introduction

Perhaps my status as a non-traditional (older) clinical trainee, or my status as a foreigner (Icelandic), or my status as a parent (with other responsibilities) affected my perspective on clinical training. For whatever reason, I was struck by the general reluctance of my fellow trainees to speak their minds when doing therapy. This was true even of trainees who were assertive or unguarded in social situations. This paper examines the tendency of clinical trainees to bite their tongues with clients through the lens of Cognitive Behavior Therapy (CBT). Various schemas are identified that produce verbal constraint, and suggestions are made for clinical training to address them.

Being Blunt in Therapy

Immediacy

One advantage of bluntness in therapy is that it promotes immediacy. Immediacy is an important, but also complex, interpersonal skill crucial for the therapeutic relationship. It is a complex skill because it involves departing from the structure of problem-solving to the processing of the relationship between the client and the therapist (Turock, 1980). Many have written about immediacy, and it appears to be the artful use of several layered skills focused on sensing unspoken underlying messages by sharing perceptions and feelings in the present moment (Wheeler & D'Andrea, 2004). In that way it can be used to help both the client and the therapist to understand their therapeutic relationship. Immediacy can remove potential roadblocks by focusing on discrepancies between what a client communicates verbally and what is otherwise perceived (Gunzberg, 2011).

Immediacy in therapy can be defined as three layers of skills: 1) *Relationship immediacy* or the ability to discuss with the client where the two of you stand in your overall relationship. 2) *Event-focused immediacy* that emphasizes the here-and-now and being able to discuss the immediate interactions between you and your client as they occur. 3) *Self-involving statements* that are generally challenging in nature and focus on your feeling toward the client, or the Immediacy that fosters the Acceptance and Commitment Therapy (ACT) focus on living in the present moment (Hayes et al, 2012). This final layer takes advantage of the central behavioral idea that the variables that control behavior in the clinic are likely the ones that control behavior elsewhere (Skinner, 1953).

Challenging the Master Narrative

Another advantage of bluntness in therapy is to be able to challenge the *master narrative*, or habitual way of thinking, that is not productive for our clients. The clients' master narratives almost by definition are not working for them. Like all narratives, they account for data available to the client, and only new data can challenge them. Blunt therapists point out immediate moments that contradict clients' constructions of the situation, and they even create such contradictions by demonstrating how therapists depart from clients' constructed narratives about *them*.

Our clients repeat their well-practiced stories when they feel uncomfortable or vulnerable, and the therapist can disrupt that communication pattern by offering interpretations of the unspoken message (Turock, 1980). Our psychological barriers are often rooted in factors outside of our awareness, or as automatic thoughts according to CBT, and we find ourselves behaving in ways that we do not fully understand. The less aware we are of these automatic

thoughts, the more they control us and the more we stay stuck in unproductive patterns of thinking, feeling, and behaving (Wright, etc., 2006). It is important to allow the therapeutic relationship to serve as a model for the client's interpersonal interactions (Gunzberg, 2011). Every story that the client tells the therapist is embedded in a master narrative about who you are and how the world works. If the therapist is not willing to challenge that master narrative that is not working that well for the client, the client cannot change (Karson, 2008). We all have these psychological blind spots, and the role of the therapist is to be aware of their own and help the client to come into greater contact with theirs (Bader, 2015). The most powerful way to contradict one's master narrative is to experience emotionally impactful counter-examples first hand (Karson, 2008). The client´s tendency to "mess up" the therapeutic relationship in the same way they "mess up" other relationships (Karson, 2015) gives the therapist an opportunity to unpack what just happened by noticing our personal reactions as therapists and distinguish them from our clients' in order to help our clients with theirs. Tracking the "mess-ups" in the therapeutic relationship is a way to bring the client's habitual way of thinking into therapy, to understand how it developed and to make the dysfunctional pattern explicit. Noticing what gets acted out in the therapeutic relationship and helping the client to "think about their thinking" reveals these old patterns and frees the client to make healthier and more productive choices (Gunzberg, 2011).

Keying a Therapeutic Relationship

Therapy creates a relationship that is different from social and professional relationships (Karson & Fox, 2010). One purpose of this special form of relating is to remove the possibility of stigma, the sense of spoiled identity that keeps people from participating in their roles. Stigma

is largely avoided—but not reduced—in social relating by the deployment of tact or politeness (Goffman, 1963). A polite and tactful therapist inadvertently keys a social form of relating that makes it riskier for clients to remove their social masks.

Evidence-Based Treatment

Generally speaking, all psychologists agree that therapy is to be of the highest quality and standard, and more effective than a placebo. Throughout the years, psychologists have conducted studies to determine the most effective treatments for clients in an effort to hold themselves accountable. Although research shows otherwise, many psychologists thought and still think that Cognitive-Behavioral Therapy (CBT) is the only therapeutic approach being researched, and the only one with empirical support (Shedler, 2015). If you were to practice something other than CBT, according to the conventional wisdom, it would be unscientific.

Psychologists are expected to conduct evidence-based treatment (APA, 2013). CBT lends itself very well to empirical research because it can be made into a manualized therapy, in which you can follow a manual for how to apply therapy and therefore ensure that every client gets the same treatment. This makes it easier for researchers to conduct Randomized Controlled Trials (RCTs), the gold standard in medical research (Dobson & Dobson, 2009). The unfortunate effect of focusing mainly on manualized therapy is that therapists ignore the non-specific factors by treating their clients according to their diagnostic labels, rather than focusing on their unique histories and specific life circumstances (Shedler, 2015). People and their problems are unique, and the "one size fits all" perspective may not be useful in producing lasting change. To match techniques to clients on the basis of their diagnoses ignores the particularity in each case. Departing from the manual is sometimes helpful (Ablon & Jones,

1998), and studies show when CBT is effective it includes focusing on the therapeutic relationship and drawing connections between the therapy relationship and other relationships. In other words, therapists adapt their approaches to the needs of the client and what is helpful for that client, using methods that are more fundamentally psychodynamic or at least relational (Ablon & Jones, 1998). The problem with manualized therapy is that it can often obscure what the client needs rather than clarify it (Shedler, 2010).

Theories of psychology that are held too strongly can create blind spots (Bader, 2015). Evidence from multiple sources show that there isn't much that distinguishes one form of psychotherapy from another (APA, 2013). The fact is that the therapeutic process is critical to success. Instead of keeping clinical wisdom out of manualized evidence-based therapy and casting out all good ideas until we can research them, we should preserve clinical wisdom, or the non-specific factors, that focuses on enhancing self-knowledge in the context of a deeply personal relationship between therapist and the client. The human element is essential for therapy, but it is hard to measure. As therapists, we must not forget that there are always exceptions to our rules because of the infinite differences among people. If we want more interesting results, we have to be willing to take the time to measure more than what is easy to measure and allow for maximum flexibility. Thus, I am using the lens of CBT in this paper partly because it claims to be the most empirically-supported approach, so it provides a potential legitimization for bluntness, which has not been empirically-supported. That statement is true even though one of the co-originators of CBT, Albert Ellis (who called his approach Rational Emotive Behavior Therapy), is generally regarded as the bluntest therapist of all.

Cognitive-Behavioral Therapy

CBT is based on two principles: 1) Our cognitions have a controlling influence on our emotions and behavior, and 2) how we act or behave can strongly affect our thought patterns and emotions (Wright, et al., 2006). CBT helps the therapist build a case formulation by focusing on the relationships among thoughts, emotions, and behaviors when working with problematic behaviors. During therapy, each question or intervention should be guided by the case conceptualization (Wright, et al., 2006). CBT hypothesizes that people's emotions and behaviors are influenced by their perception of events, and that their emotional responses or beliefs affect their perception of the situation, not the situation itself. It is therefore important that therapists develop a cognitive conceptualization from their first contact with the client, an evolving formulation that helps clients plan for effective therapy (Beck, 1995). CBT therapists encourage clients to think about their thinking to help detect and change their distorted automatic thoughts that are generating painful emotional reactions and dysfunctional behavior. Schemas are beliefs or cognitive maps that act as underlying rules for the autonomous distorted information processing (*I can´t do anything right*), functioning as a filter or a code to assign meaning to information from the environment.

The goal of CBT is to help the client develop an accurate and rational means of information processing by identifying and building healthy (realistic) schemas (*some people could love me*), while attempting to reduce the influence of the unhealthy schemas (*without a partner I am nothing*). According to CBT, the working alliance is a collaborative empiricism in action that is geared toward promoting cognitive and behavioral modification. The client and therapist work together to develop a shared psychological understanding why the client has not reached his goal by generating hypotheses about the accuracy or coping value of a variety of

cognitions and behaviors. Then they collaborate on developing healthier ways of thinking, building coping skills, and reversing unproductive patterns of behavior (Wright, et al., 2006). In Ellis's version (Ellis & Harper, 1961), dysfunctional schemas are not mutually assessed so much as they are subjected to disputation by the therapist.

The concepts of transference and countertransference derive from psychodynamic psychotherapy (both Beck and Ellis were psychoanalysts first). The client and therapist come together with a wide variety of expectations, life experiences, symptoms, and personality traits that create continual flow of mutual influences (Reidbord, 2010). In my effort to redeem concepts from relational therapy such as the working alliance that are not included in manualized evidence-based therapy, I use CBT language to work around it. Incorrect thoughts and unrealistic feelings that clients develop toward their therapists are what is referred to as transference. Psychodynamic psychotherapy uses the relationship that develops between the client and the therapist as a means of learning about how a client relates to others, and therefore provides important clues to the client´s thoughts and feelings that may be outside of their awareness (Spencer, 2010).

Instead of focusing on the unconscious components of transference, in CBT the focus is on habitual ways of thinking and acting that are recapitulated in the treatment setting. If there is evidence that a core belief is influencing the therapist-client relationship, the therapist watches for schemas and associated behavioral patterns that are likely to have been developed within the context of significant past relationships. By being reflectively aware of transference responses from the client, the therapist can use the knowledge to promote insight, improve the therapeutic relationship, and modify dysfunctional thought patterns. At the same time, the therapist has to be aware of possible countertransference reactions that could be affecting the therapist-client

relationship. These involve incorrect thoughts and unrealistic feelings the therapist has about the client.

Common indicators that the relationship with the client are activating automatic thoughts and schemas in the therapist are anger, frustration, becoming bored in therapy, being relieved when the client is late or cancels, or the therapist finding herself attracted or drawn to the client. To better understand and manage the reaction, it is important for therapists to be aware what they are bringing into the room by identifying their automatic schemas and how those are contributing to the collaborative-empirical treatment alliance that should be focusing on a joint effort to define problems and search for solutions. Transference and countertransference are powerful tools to learn about the client and oneself as a therapist. What is unique about therapy is that the therapist and the client can attempt to pay attention to transference and countertransference, and work with these schemas with the aim of helping clients discover aspect of themselves that may be operating outside of their awareness, as automatic thoughts, and causing difficulties (Wright, et al., 2006).

The role of the therapist – what are clients paying you for?

Clients come in for therapy because they are doing something that they wished they were not doing, or not doing what they wished they were doing (Karson, 2008). The therapist's job should be to help the client find a way to change by exploring the patterns of behavior that are no longer working for the client. The process of self-discovery of one's thoughts, feelings, options, fears, worries, joys, pain, concerns, and desires means confronting oneself and who one was, is, and wants to be (Ruskin, 2013). The general theme that came first to mind, when I asked some of my fellow graduate students in clinical psychology that same question, was to help people of

any age to go from being stuck to unstuck, offering therapeutic guidance, exploration, insight, strategies, and open and honest dialogue. I also noticed that most of them, as psychology trainees, have ideas about their clients that they do not tell them even if we all agree that therapy should be a place where the unspeakable is speakable.

According to CBT, the therapeutic relationship is characterized by openness in communication and team-oriented approach to manage problems. The style of questioning used in CBT focuses mainly on stimulating curiosity and to productively explore important topics that help achieve treatment goals, where the goal of this collaborative empirical relationship is to help the client recognize and change maladaptive thinking (Wright, et al., 2006). Even though that is the case, it seems like therapists have distorted beliefs about using bluntness in therapy to stimulate curiosity and productivity, because of their own schemas/beliefs about what therapy is. Thus, another reason for using a CBT lens in this paper is that its singularly cognitive explanation of disadvantageous behavior (such as excessive verbal constraint by the therapist) lends itself to cognitive self-reflection and cognitive intervention, both of which comport with training and education. Its use ensures that my findings and recommendations will be educational or supervisory and not therapeutic—telling trainees their thinking is incorrect comports with their role.

Distorted Beliefs and Schemas About Being Blunt in Therapy

To explore distorted beliefs that some therapists have about being blunt in therapy, I consulted with fellow students in a training program where articulating one's reasons for doing things in therapy is commonplace. I asked fellow students and myself what it would be like to be blunt and say what we are thinking in therapy and, if they felt reluctant to do so, what would

be the worst thing that could happen if they would speak out. As peer-consultants, I met with several of my colleagues individually to discuss our thoughts about this practice issue. Since not all venues are fully open to the idea that all therapists struggle with outdated maps and disadvantageous cognitions, my peer-consultants will not be identified. Some of their responses have been edited for clarification or to highlight the main theme of their thinking. I have categorized these personal communications into six beliefs that my fellow student-therapists and I have about ourselves and our clients, all of which ultimately keeps us from being blunt in therapy.

1. I am a gentle person and my clients are fragile.

One of my fellow student therapists (I will call him Andy) stated that he was reluctant to tell some of his clients what he was thinking in therapy because he is a gentle person and his clients are fragile. For Andy, being a caring person means being gentle. According to him, being gentle means that you must be careful and thoughtful with the client. Andy noted that he wants to make sure that he is not doing the client any harm in therapy, and to be fully aware of the hierarchical relationship between him and his clients.

His own psychology. Andy's mother is according to him a successful physician who takes great care of her patients. Andy fully admits that his mother is a role model and the reason why he decided to practice psychology. When asked, he also admits that there is and has always been a power difference between him and his mother, wherein she is the all-powerful doctor and parent, and he is expected to listen to her without questioning her opinion.

Beliefs. His belief is that he has, as a therapist, tremendous power to heal or harm the client who is suffering. He also believes that these power dynamics often result in his clients tending to

idealize him as a therapist (in the same way people often idealize medical doctors), and allow his opinion as a therapist either to lift his client's spirit or to crush it.

What schemas are operating. All clients are fragile because they are sick or helpless and the therapist is more powerful than the person in therapy seeking change. If you are blunt about your thoughts in therapy, it can harm your clients instead of heal them.

CBT Conceptualization. As a student therapist, Andy sometimes uses irrational beliefs or schemas for negotiating certain kinds of situations in therapy. For example, in situations that are challenging for his clients, he sometimes makes sense of them by thinking of them as functions of his own incompetence (*I am a gentle person with the power of harming my clients*), as if a more competent version of Andy (*I am a gentle person able to be blunt in therapy and still help the client to change*) should not have these things happen to him. These problematic schemas generally lead to problematic behaviors. The schemas "I am a gentle person with the power of harming my clients," and "my clients are fragile" helps him explain why he cannot be blunt in therapy, but leaves him poorly situated to help the client change and be open to the possibility that he can guide his clients towards being more productive in their lives by asking the right questions. Further, there may be unexamined beliefs about how gentle he really is; he may see himself as a ministering angel, for example, rather than as a human being.

What to do. In the same way as we want to work with our clients productively, Andy needs to be supervised through his own complexes. He has to set his own agenda aside of wanting to help and heal. In order to achieve that, supervision should focus on helping evaluate whether these schemas are true, and teaching him or help him to challenge the unhelpful beliefs connected to them and establishing competing behaviors. Andy needs to collaboratively investigate with his supervisor what he actually believes when he is reluctant to be blunt in therapy by exploring

what in this relationship with his client feels familiar to him and what is going through his head when he decides to bite his tongue. It is important for Andy to own his own psychology and notice that his beliefs are getting in the way of being blunt in therapy. Some writers believe that effective therapy helps clients find their power, because the locus of power is truly with the person in therapy (Rubinstein, 2014). Others hold that renouncing one's power as a therapist just makes therapy less effective, that the restorative agenda for misused power is to use power wisely, not to renounce it (Karson, 2008).

The idea of fragility has become an overarching theme in our society (Essig, 2014). Students in general fear learning the lessons that failure offers. Teachers and professors, in general, complain about the societal pressure to give every student an "A" and, to avoid conflict, teachers are giving a majority of their students high grades, even if the teachers do not think that the student deserves it. At the same time, students feel pressured to get high grades and are more likely to blame their teachers if they are not getting the high grades (Gray, 2015). When we focus on this social problem, it makes sense why clinical psychology trainees experience their clients as fragile, as the clinical psychology graduate programs treat their students as if *they* are fragile and their supervisors feel the pressure to be gentle.

Primary and secondary school teachers reported that they were struggling to hold students accountable for their lack of schoolwork because of the interference of parents and administrators. The parents want to help their children into college and administrators do not want to get bad ratings that could affect their budget (Gray 2015). With that kind of mindset, students fail to learn to take responsibility for their own work, how to deal with disappointment when they perform poorly, and to speak out. This dynamic encourages both the student and the teacher/supervisor to bite their tongue, or not to be blunt. It is difficult but vital for therapists to

unlearn what they have learned in school and training if one is to be truly responsive to the very different things that each client needs in therapy (Bader, 2015). As inexperienced therapists, we have to keep in mind the unpredictability of the here-and-now encounter in the therapeutic relationship which forces us as therapists to confront our beliefs and emotions in a way that no amount of training can fully prepares us for (Gunzberg, 2011).

2. I don't want to be wrong.

Another fellow student therapist (I will call her Lisa) stated that she was reluctant to tell some of her clients what she was thinking in therapy because she was afraid to be wrong. For Lisa, being wrong means being inadequate. According to her, being inadequate means that she doesn't know what she is doing and it will risk the progress of therapy that should look a certain way. Lisa noted that she uses only a specific technique to do therapy, and that she believes that is the right way to do therapy.

Her own psychology. Lisa stated that she comes from a lower-class family, and that her family was not able to afford college tuition without a scholarship. With that in mind, and being the first one getting a doctoral degree in her family, she early on associated ignorance with not getting an education at all and constantly monitors herself for being differentiated from her family. She noted that excellence and obedience are her baselines for having a chance to become a successful therapist. Lisa admits that she is very uncomfortable about not being right, and that she would do whatever was needed to make sure that she does not take the risk of being wrong in therapy.

Beliefs. Her belief is that the right way of doing therapy is to know, all the time, what she is doing in therapy and therefore she has to stick to the manual. Lisa also believes that you should not take risks because then you could be wrong about the client and that is unacceptable to her.

What schemas are operating. If you are wrong as a therapist in therapy, then you are failing to help your client and risking a departure from your manualized therapy. If you are blunt about your feelings in therapy, it increases the chance of you being wrong and therefore an imperfect or inadequate therapist. Being wrong makes her a member of a group that does not get an education.

CBT Conceptualization. As a student therapist, Lisa sometimes uses irrational beliefs or schemas for negotiating situations that are challenging for her clients. She sometimes makes sense of them by thinking of them as functions of her own incompetence (*I always have to be right to be an adequate therapist*), as if a more competent version of Lisa (*I am a good enough therapist able to take risks and be blunt in therapy and still help the client to change*) should not have these things happen to her. These problematic schemas helps her explain why she cannot be blunt in therapy, but leaves her poorly situated to help her clients to change.

What to do. Lisa has to set her own agenda aside of wanting to be perfect and right. In order to achieve that, supervision should focus on helping evaluate whether these schemas are true, and teaching her or helping her to challenge the unhelpful beliefs connected to them and establishing competing behaviors. Lisa needs to investigate with her supervisor what she actually believes when she is reluctant to be blunt in therapy by exploring whether her beliefs themselves are correct and how they define her as a therapist. Whatever a therapist's background, training, and beliefs, her style and technique should be highly specific to the person sitting in the room with her (Bader, 2015; Shedler, 2010). The unlearning process can be especially challenging for us as

therapists since we have to develop an understanding of human nature and how it applies to us personally, to our supervisor, and to the client. Lisa has to allow herself, with supervision, to experience failure in therapy, how to survive it, and then learn how to make use of these bumps in the road to explore and identify the schemas and associated behavioral patterns. A good place to start is an evaluation of the correctness of her beliefs about being correct. In other words, she needs to take responsibility for herself and her own psychology. In our educational system where a "B" grade is considered to be a failure and the main focus is about earning a high grade and obeying the rules, whether or not the student is actually learning anything, it is not surprising that students are terrified by the prospect of failure. This terror is depriving students of the freedom they need for real learning and to develop resilience (Gray, 2015). Instead of doing things that set the stage for lifelong improvement for the client, which includes being blunt in therapy, students cling to a way of doing things that makes their anxiety go away (Karson, 2008).

3. I don't want to intrude and make my client angry.

I personally have been reluctant to tell some of my clients what I was feeling in therapy because I don't want to intrude and make my clients angry. From my perspective, to intrude includes the risk of eliciting anger and frustration.

My own psychology. Going back to my extended family culture, irrational anger and frustration has gotten in the way of meaningful family relationships, so that the emotion of love has been buried beneath years and years of hostility and resentment. Therefore, I sometimes feel helpless when someone I am trying to build a meaningful relationship with becomes angry.

Beliefs. My belief is that if I am intruding or deliberately asking my clients blunt questions they may become angry, and therefore I am putting myself into a situation where I feel helpless and unable to have a meaningful connection with my clients.

What schemas are operating. If my clients become angry in therapy, I will struggle to have meaningful relationships with them and I will feel helpless as a therapist.

CBT Conceptualization. As a student therapist, I sometimes have irrational beliefs or schemas for negotiating certain kinds of situations in therapy. These problematic schemas generally lead to problematic behaviors. The schemas "If I intrude I will make my clients angry," and "if my clients become angry I will not have a meaningful relationship with them" help me explain why I cannot be blunt in therapy, but leaves me poorly situated to help the client change and open to the possibility that I can guide my clients towards being more productive in their lives by raising difficult or hidden topics.

What to do. In the same way as I want to work with my own clients productively, I have been supervised and need to continue to be supervised through my own complexes. In order to achieve that, supervision should focus on helping me evaluate whether theses schemas are true, and teaching me or helping me to challenge the unhelpful beliefs connected to them and establishing competing behaviors. I need to collaboratively investigate with my supervisor what I actually believe when I am reluctant to be blunt in therapy by exploring what feels familiar in the therapeutic relationship with my client, and why I feel like I am recreating patterns of anger in my relationship with my clients by asking blunt questions. A supervisor could point out when my clients are already angry at me to show me that their anger did not interfere with relatedness. A rupture between a therapist and a client helps the therapist notice the client's dysfunctional pattern. By noticing the frustration and what is happening in the room during a rupture, you

open up a discussion about the thoughts and the feelings that are coming up for both the therapist and the client. Being able to stay connected with your clients' anger or frustration allows you to acknowledge their anger, which helps clients express it and explore feelings about their anger towards you as their therapist.

To be able to be blunt in therapy, therapists have to be aware of their own beliefs or countertransference reactions towards their clients' behavior, and ensure that they are focusing on their clients' needs rather than their own needs (Kasper, etc., 2008). If the therapist is unable to set aside their own psychology or the reluctance of being blunt in therapy, they risk that the productive blunt conversations needed to help the client to change will not occur, and their relationship will hit an impasse that can instead create lack of trust and distance between the therapist and the client (Gunzberg, 2011).

Empathy is critical for the therapeutic relationship because it allows the therapist to meet their clients where they are. While empathy helps the client feel supported and understood, some writers think it does not necessarily promote change (Handelman, 2011); while some do (Buirski & Haglund, 2001). In some cases, empathy does not further our clients' self-understanding or change their master narrative, and it simply recycles the communication without changing the pattern (Turock, 1980).

As therapists, we have to be aware of the different parameters between a social versus therapeutic agenda. For example, conversations and small talk in the beginning or during therapy evokes social responding in the client, and that kind of social exchanges require people to polish their masks, while therapy should involve taking the mask off (Karson, 2008). It makes sense that clients feel uncomfortable talking about their reactions, thoughts, feelings, or

fantasies about therapy and their therapist because this is not how we generally operate with our friends, family, or partners.

Most clients come to therapy to help combat irrational beliefs and fears, and it makes sense that they have fears of being judged by the therapist as in the outside world. This feeds into their anxiety about revealing their feelings, impulses, and experiences that may have been traumatic or upsetting (Swift & Greenberg, 2012). It takes time and effort for clients that have hidden their shame and pain from others in their lives for years to talk about embarrassing things in their lives. We have to acknowledge that it is hard for clients to maintain their sense of self or a positive self-image when they have to confront the more embarrassing or painful aspects of their lives. If clients feel like they are unable to take their social masks off, it is likely that they will continue to construct desirable images for the therapist. In these cases, clients may stop being forthcoming with their own beliefs and feelings in order to keep the social agenda alive within the therapeutic relationship (Grohol, 2008). According to the social agenda, the client wants to get a gold star for being the perfect client and puts on a performance, and at the same time the therapist does the same thing because she wants to get a gold star for being the perfect therapist (Karson, 2008). Maintaining the therapeutic frame takes an effort, but it welcomes curiosity and creates a relationship that encourages clients to take off their social masks and reveal themselves to their therapist. The therapeutic frame helps the therapist to be blunt and to act in the best interest of the client, and at the same time it instills a sense of emotional safety so that the client can open up difficult feelings and then contain them (Seeman, 2013).

4. I want my client to come back to therapy.

Yet another fellow student therapist (I will call him Brian) stated that he was reluctant to tell some of his clients what he was thinking in therapy because he was afraid that his clients would not come back to therapy. For Brian, not seeing his clients again means abandonment and being unsuccessful. According to him, and our graduate school, being a successful therapist means that he needs to see his clients at least eight times. Brian noted that he feels that he needs to make sure that his clients come back to therapy to be able to show a specific desirable outcome.

His own psychology. Brian stated that his parents divorced when he was in elementary school and that it included a tough custody battle. As an only child, he explained how he had to play the mediator and make sure that both parents felt loved by him. According to Brian, standing up for himself and being honest about his own needs felt mean because it resulted in one of his parents being hurt and rejected by him. He noted that he still plays the mediator role in his family and constantly makes sure that he spends time with both of his parents so they do not feel abandoned by him.

Beliefs. His belief is that if his clients do not come back for therapy, he is an abandoned, unsuccessful therapist who is not getting the desired outcome needed.

What schemas are operating. If your clients do not come back to therapy, then you are not a successful therapist getting the desired outcome needed. If your clients do not come back to therapy, you are being mean and abandoning your clients or being abandoned by them. If you are blunt about your thoughts in therapy, it increases the risk of being mean or it increases the risk that the client will realize that you also have an agenda, and your clients might not come back to therapy, and therefore you will not be a successful therapist.

CBT Conceptualization. As a student therapist, Brian sometimes has irrational beliefs or schemas for negotiating certain kinds of situations in therapy, and helps him explain why he cannot be blunt in therapy. For example, in situations that are challenging for his clients, he sometimes makes sense of them by thinking of them as functions of his own incompetence (*if my clients do not come back to therapy I am mean and unsuccessful as a therapist*), as if a more competent (*I am a successful therapist able to be blunt in therapy whether or not my clients come back to therapy*) Brian should not have these things happen to him.

What to do. Brian has to set his own agenda aside of wanting clients to return to therapy whether or not it is helping them. In order to achieve that, supervision should focus on helping evaluate whether these schemas are true, and teaching him to challenge the unhelpful beliefs connected to him and establishing competing behaviors. Brian needs to collaboratively investigate with his supervisor what he actually believes when he is reluctant to be blunt in therapy by exploring whether his need to make sure that his clients come back to therapy, no matter whether they are working productively or not, is accurate. A good place to start would be in voluntary supervision, wherein the supervisor and Brian could monitor his varying interest in quitting. Brian has to explore with his supervisor how he can stand up for himself without losing other people, and look for other productive ways to define a successful therapist. Therapy, no matter the duration, is not a pass-or-fail experience, but rather an opportunity for positive and productive change.

Readiness for therapy provides the platform needed for clients to change. One in five clients will drop out of therapy before completing treatment (Swift & Greenberg, 2012); it is not known what percentage of clients stay in therapy without changing. Being blunt in therapy can alter the relationship dynamic between the therapist and the client, if the therapist chooses not to

feed into the master narrative. An important part of the therapeutic relationship is to make messes and clean them up. If we, as therapists avoid making a mess, even if that means that your client will leave, we are not engaging the problematic pattern (Karson, 2008). Instead of relieving your own anxiety by feeding into your clients' master narratives and not running the risk of client termination, your job is to accept what they are doing and accept where they are in their own personal journey (Meyers, 2014). By recognizing your own needs as a therapist you can avoid an unhealthy or stagnant relationship by being blunt in therapy (Turock, 1980).

5. I don't want to disrespect the client´s performance of self.

A fellow student therapist (I will call her Renee) stated that she was reluctant to tell her clients what she was feeling in therapy because she wants to be seen as a diplomatic and likable therapist, not as a disrespectful person. For Renee, being diplomatic means that you have the skill to avoid offending others or hurting their feelings. According to her, honesty (or speaking out as a therapist) can be disrespectful towards your clients and other people, especially if you are a woman and the other person is older than you.

Her psychology. Renee's culture focuses on a collectivism that values community and respect for the elders. Her family expects her to study hard and to become a respectful educated woman. According to her values and beliefs, a respectful woman is quiet, likable, and does not express her opinions. She noted that she feels guilty and ashamed if she does not fulfill those roles as a therapist. For her, assertiveness and bluntness is the opposite of interpersonal harmony.

Beliefs. Her belief is that, as a therapist, in order to honor her cultural values and family, she has to be respectful and diplomatic towards her clients and her colleagues. She also believes if she is too honest as a therapist, her reputation as a respectful person will suffer.

What schemas are operating. If someone says trenchant or observant things about her as a therapist, her reputation as a therapist will suffer and she will bring shame on her whole family. If you are blunt about your feelings in therapy, you are not perceived as diplomatic and respectful person. Speaking the unspeakable can only lead to harm; people need to be even more tactful and polite, even if that stigmatizes authenticity and intimacy.

CBT Conceptualization. As a student therapist, Renee sometimes has irrational beliefs or schemas for negotiating certain kinds of situations in therapy. For example, in situations that are challenging for her clients, she sometimes makes sense of them by thinking of them as functions of her own incompetence (*I am a respectful woman therapist that needs to be diplomatic and likable in therapy*), as if a more competent (*I am a respectful woman therapist able to be blunt in therapy to help my clients, and honor my family at the same time*) Renee should not have these behaviors. The schemas "I am a respectful woman that needs to be diplomatic and likable," and "I need to honor my family by being respectful" helps her explain why she cannot be blunt in therapy, but leaves her poorly situated to help the client change or to be open to the possibility that she can guide her clients towards being more productive in their lives by discussing what is conflicted or hidden.

What to do. Renee needs to be supervised through her own agenda of being diplomatic and polite. In order to achieve that, supervision should focus on helping evaluate whether these schemas are true, and teaching her or helping her to challenge the unhelpful beliefs connected to them and establishing competing behaviors. Renee needs to collaboratively investigate what cultural values and beliefs she is bringing into the therapeutic relationship and how it is getting in the way of being blunt in therapy.

In general, it seems to pays off in many cases to be diplomatic because in many cases diplomacy can function as a self-protection. For example, it helps you to win over people, keeps the stigmatized at bay, avoids (without resolving) disputes, and makes offense less likely. In other words, it includes a lot of "sweet talk." On the other hand, you may not come across as a genuine person, which results in other people behaving cautiously towards you (Malik, 2015). As a therapist, diplomacy does not always work well with being honest and willing to speak out to help the client to change. There is a thin line between being honest/blunt and being diplomatic, and we have to be careful to choose between the two. Here, it might be helpful to remind the therapist that therapy is also a professional relationship, as is supervision; you would not pay an attorney to tell you that you already know how to evaluate a case and you would not pay a supervisor to tell you that you already know how to do therapy. In relationships, both personal and in therapy, we need honesty to gain trust, and at the same time it means that we have to be willing to confront the truth. Some say that an honest person will feel frustrated when forced to be diplomatic, while a diplomatic person will get highly stressed at the thought of speaking the truth (Vaidyanathani, 2012).

It all boils down to fear, fear of how others will perceive us and think of us. Assertiveness is one of the most important tools to express the essence of who we are, without being destructive to others. Assertiveness and bluntness in therapy are methods of communication that clearly communicate needs, desires, ideas, and feelings (Firstein, 2010). It is interesting how women often have a smaller range of acceptable behavior as professionals. They are said to be "bitches" or "trying to act like men" if they are too assertive. On the other hand, if they are too weak or nice, they are seen as weak or manipulative (Reynolds, 2010). Again, it has to do with personal beliefs and associated behavioral patterns that our society

reinforces. Learning assertiveness takes an effort because it is not easy to change a habitual way of communication. It takes courage for the therapist to model how to communicate vulnerability and honesty about what you need, want, or feel. You have to be willing to risk a conflict in order to set the stage for more authentic, intimate, and satisfying connection (Firstein, 2010).

6. I want to be an objective and non-judgmental therapist.

During my last peer-conversation, my fellow student therapist (I will call him Mark) stated that he was reluctant to tell his client what he was thinking in therapy because he wanted to make sure that he was perceived as being an objective and non-judgmental therapist. For Mark, being a judgmental therapist includes being blunt about his thoughts in therapy, even his thoughts about what the client is doing or not doing to the client's disadvantage. Mark seems to conflate the kind of judgment that says, "That works" or "That doesn't work" with the kind of judgment that says, "I approve" or "I disapprove." According to him, his judgments carry much influence in the therapeutic relationship and the potential impact of his judgment can harm his clients. He also noted that being an objective therapist includes being an outside listener where his clients can share all their thoughts and feelings without the fear of being judged.

His own psychology. Religion is important to Mark and his family, and in many cases his moral or religious beliefs conflict with his clients' lifestyles. Through his religious upbringing, Mark was taught not to affirm lifestyles that are not acceptable in his religion. Mark holds strong opinions about what is morally right and wrong according to his beliefs, and sometimes struggles with that in therapy.

Beliefs. His belief is that he has, as a therapist, to be objective in therapy and to be non-judgmental, and the best way to accomplish this is to squelch his reactions. He also believes that he needs to affirm his clients' beliefs if he allows himself to be blunt in therapy.

What schemas are operating. All therapists are supposed to be objective and non-judgmental so they will not harm their clients. If you are blunt about your feelings in therapy you have to affirm your clients' beliefs even though you think they is morally wrong. He also acts as if all discrimination is moral.

Conceptualization. As a student therapist, Mark sometimes has problematic schemas such as "I am an objective and non-judgmental person even though I know what is morally right and wrong," and "if I am not objective I have to affirm my clients beliefs." These schemas help him explain why he cannot be blunt in therapy, but leaves him poorly situated to help the client change and open to the possibility that he can guide his clients towards being more productive in their lives.

What to do. He has to explore through supervision what is the role of the therapist in therapy. Is it to affirm his clients' beliefs, or to offer support and guidance to help the client achieve mutually agreed-upon goals? In order to achieve that, supervision should focus on helping evaluate whether these schemas are true, and teaching him or help him challenge the unhelpful beliefs connected to them and establishing competing behaviors. A supervisor might help Mark distinguish bad behavior in a therapist that is clinically wrong from bad behavior that is ethically or professionally wrong. The supervisor could model discriminations that are judgmental in the sense of useful versus not useful, but not judgmental in the sense of good or evil.

One of the first things we learn as psychology students is that psychotherapy is supposed to provide a non-punitive environment that allows the client to talk to a therapist who is

objective, neutral, and non-judgmental. It would be unrealistic to suggest that we, as therapists, are unbiased. Therapists are human beings with their own moral convictions, beliefs, flaws, and failings. Even if therapists say nothing, clients will pick up clues about their beliefs in the silence (Barth, 2012). The therapist's objectivity can also be experienced as indifferent or even disapproving. Some writers think that many clients do best when they experience the therapist as explicitly partisan and an outspoken advocate (Bader, 2015). Defining goals in therapy is a crucial part of the therapeutic alliance (APA, 2013). It is important to set positive therapeutic goals that have specific concrete behavioral components so your clients feel motivated to achieve them. The journey through therapy must be a collaborative effort to be effective. If we want to help the client change, we have to allow ourselves to work in the present with what is happening and be emotionally fully engaged and connected with the client, take risks, and offer transparency. If we choose to hide behind our professional roles as experts and only talk about relationships outside therapy, we miss the opportunities to deepen our work together through scenarios that are acted out and worked within the transference and countertransference of the therapeutic relationship (Gunzberg, 2011).

Summary and Recommendations

As the examples show, we have to acknowledge our own psychology as therapists and the challenges that arise when we get caught in our own complexes or unrealistic beliefs. Just like our clients, each therapist has unique beliefs and associated behavioral patterns. As a therapist, you have to acknowledge what you bring into the therapeutic relationship by noticing your own feelings and not let them intrude on your technique. Clinical supervisors need to acknowledge their students' reluctance about being honest in therapy and model it for the student

in supervision. Even though there are risks in using bluntness in therapy, there are also risks in not using it in therapy.

We have to keep in mind that therapy is a relationship between two individuals into which clients bring their beliefs and dysfunctional patterns. As therapists, we enter the problematic relationship patterns of the client. The only way to help our clients rework and understand these patterns is to recognize our participation and experience of these patterns (Shedler, 2015). As therapists, we have to be able to decipher the covert messages from our clients and sense if there is a distance overshadowing the relationship, without imagining all kinds of damaging consequences that comes from our own psychology. The most productive way to recognize the meaning of the covert messages is to be able to disengage as listeners and focus on our own experience of that relationship and our own emotional responses (Turock, 1980). If you are able to sense what your clients are telling you without saying it directly, you can catch the client in the act, be blunt about your observations, and speak out. In that moment, you can help your clients notice how their own behavior creates and maintains the problem. If the therapist has the self-awareness, knowledge, and courage to see and speak out about what matters, the clients learn to tolerate and digest their internal world within the therapeutic relationship by integrating the disowned part of themselves and inhibit the dysfunctional reactive patterns that are getting in the way of reaching the clients' goals, thereby their connections with themselves and their world transform (Gunzberg, 2011).

There are many things in our society getting in the way of modeling honesty in the classroom. For example, teachers and faculty members are encouraged to cater to students' sensitivity and treat them like delicate flowers. On college campuses across the United States, a growing number of students are demanding trigger warnings on class content, wherein teachers

are advised to remove triggering material when it does not contribute directly to learning goals. Trigger warnings were originally presented as a gesture of empathy, but the irony is that if we bend the world to accommodate our personal frailties, it does not help us overcome them (Jarvie, 2014). Professors are not nannies! Instead of limiting ourselves to images of rainbows and unicorns, real education calls for us to speak out and face the true messiness of the world. We need to talk about it, think about it, write about it, analyze it, and learn to fully engage with all of it. The whole problem of education, wherein we have generations of pampered and sheltered students, needs to be addressed (Essig, 2014). A blunt discussion and exposure to new concepts and information is part of a successful education, in the same way it is important for successful therapy.

How can we structure a training program that helps student therapists acknowledge their own psychology (schemas), and be more blunt about their own experiences? One way to help clinical psychology students notice their own psychology is to ask students to present their own genogram. A genogram shows a multi-generational diagram of that person's family and social network. It allows the student and the supervisor to focus on relationship dynamics and patterns, and to explore developmental influences (Mote, 2016). It provides a broad framework for realizing how your own beliefs are shaped by lived experiences and family patterns of communication through a visual representation. Beliefs and values may thread through generations in powerful and sometimes subtle ways. By focusing on the quality of those relationships, students can explore patterns they may never have noticed, or at least be more aware of what they are bringing into the room. This opens up an honest discussion between the student and the supervisor, wherein they can collaboratively investigate what the student actually

believes when she is reluctant to be blunt in therapy by exploring what in this relationship with her client feels familiar to her, and what is going through her head when she bit her tongue.

Another way is to rehearse making interpretations in a low-stakes and safe environment about your own thoughts, emotions, and behaviors when working with a problematic belief. Many therapists' training provides opportunities for bluntness only in real therapy, wherein the stakes can be high. Welcoming comments about each other's psychologies can be a training tool that exposes students to interpretative bluntness without worrying about its effects on clients.

Feedback is a key component within a culture of learning and development. The skill of giving and receiving effective feedback is also central to effective clinical teaching and supervision, and to model honest conversations. To build a culture that handles honest feedback, and in which both students and professors hold themselves accountable, we must be courageous and provide blunt and specific feedback that articulates the desired expectation. Incorporating honest feedback in clinical learning helps student therapists approach conflict and have a dialogue about it, develop capacity to evaluate their own performance and others' performance, self-monitor, and move towards becoming a successful therapist (McKimm, 2009). To become a successful or effective therapist, the person needs to have an understanding of their impact on others and to what extent they are fulfilling their professional goals. If direct feedback is not a part of the surrounding culture, it will not be an efficient way to gather necessary information needed to become more effective professional. If feedback is something that only happens when something has gone wrong, it will never become an organic part of the culture. To give and receive honest feedback, the person must feel a sense of reliable connection and trust. The ability to discuss emotions and use specific examples are critical features for sharing effective feedback. Without feedback, the student will not be able to know what she is doing right – and

wrong. Honest feedback inevitably generates difficult feelings. When we can talk about our disappointments, anger and failures, the culture is sufficiently resilient to handle real feedback (Batista, 2013).

References

American Psychology Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist,* 57, 1060-1073.

American Psychological Association. (2013). Recognition of psychotherapy effectiveness. *Psychotherapy (Chicago, III.), 50*(1), 120-109. doi: 10 1037/a0030276

Ablon J.S. & Jones E.E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavioral therapy. *Psychotherapy Research, 8*(1), 71-83.

Bader, M (2015). *More than Bread and Butter: A Psychologist Speaks Progressives About What People Really Need In Order To Win and Change the World.* San Francisco, CA: Author.

Barth, F.D. (2012). Are Therapists Really Nonjudgmental? Retrieved from http://psychology today.com/blog/the-couch/

Batista, E. (2013). Building a Feedback-Rich Culture. Retrieved from http://hbr.org/2013/12/building-a-feedback-rich-culture/

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press.

Buirski, P., & Haglund, P. (2001). Acceptance and Commitment Therapy as a Unified Model of Behavior Change. *The Counseling Psychologist, 4*(7), 976-1002.

Dobson, D. & Dobson, K. (2009). *Evidence-based practice of cognitive-behavioral therapy.* New York, NY: Guilford.

Duncan, B.L., & American Psychological Association. (2010). *The heart & soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Ellis, A., & Harper, R.A. (1961). *A guide to rational living.* Englewood Cliffs, N.J: Prentice-Hall.

Essig, L. (2014). Trigger Warnings Trigger Me. Retrieved from http://chronicle.com/bogs/conversation/2014/03/10/trigger-warnings-trigger-me/

Firstein, I. (2010). Communication Modes: The Benefits of Being Assertive. Retrieved from http://goodtherapy.org/blog/communication-modes-and-benefits-of-being-assertive/

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identities.* Englewood Cliffs, NJ: Prentice hall.

Grohol, J. (2008). 10 Common Reasons to Lie to your Therapist. Retrieved from http://psychcentral.com/blog/

Gray, P. (2015). Causes of Students' Emotional Fragility: Five Perspectives. Retrieved from http://psychologytoday.com /blog/

Gunzberg, N. (2011). Working in the Here-and-Now of the Therapeutic Relationship. Retrieved from http:// psychotherapy.net/article/

Handelman, M. (2011). Empathy is Not Enough. Retrieved from http://psychotherapy-nyc.com/blog/2011/01/empathic-therapy/

Hayes, S., Pistorello, J., & Levin, M. (2012). Acceptance and Commitment Therapy as a Unified Model of Behavior Change. *The Counseling Psychologist, 4*(7), 976-1002.

Jarvie, J. (2014). Trigger Happy. Retrieved from http://newrepublic.com/article/116842/

Karson, M. (2008). *Deadly therapy: Lessons in liveliness from theater and performance theory.* Lanham, MD: Jason Aronson.

Karson, M. (2015). 4 Ways to Tell If a Therapist Is Competent. Retrieved from http://psychologytoday.com/blog/feeling-our-way/201508/4-ways-tell-if-therapist-is-competent/

Karson, M. & Fox, J. (2010). Some common skills that underlie the common factors of successful psychotherapy. *American Journal of Psychotherapy, 64*(3), 269-281.

Kasper, L.B., Hill, C.E., & Kivlighan, D.M. (2008). Therapist immediacy in brief psychotherapy: Case Study I. *Psychotherapy: Theory, Research, Practice, Training 45*(3). 281-297.

Malik, R.S. (2015). What is being diplomatic? Is it good or bad to be diplomatic? Retrieved from http://quora.com/What-is-being-diplomatic/

McKimm, J. (2009). Clinical Teaching Made Easy: Giving effective feedback. *British Journal of Hospital Medicine, 70*(3), 158-161.

Meyers, L. (2014). Connecting with clients. Retrieved from http://ct.counseling.org/ 2014/08/ connecting-with-clients/

Mote, T. (2016). What Is the Purpose of a Genogram? Retrieved from http://livestrong.com/ article/24801-purpose-genogram/

Reidbord, S.P. (2010, March 24). Countertransference, an overview: What is countertransference? Retrieved from http://psychologytoday.com/ blog/sacramento-street-psychiatry/

Reynolds, M. (2010). The Fine Art of Female Assertiveness. Retrieved from http:// psychologytoday.com/blog/wander-woman/

Rubinstein, Noah (2014). Myth: The Therapist Is More Powerful than the Person in Therapy. Retrieved from http://goodtherapy.org/blog/

Ruskin, K. (2013). Do Therapist Tell Clients What To Do? Retrieved from http:// drkarenruskin.com/

Seeman, G. (2013). Getting the Most Out of Psychotherapy. Retrieved from http:// drgaryseeman.com/getting-the-most-out-of-psychotherapy/

Shedler, J. (2015). Where is the Evidence for "Evidence-Based" Therapy. *The journal f Psychological Therapies in Primary Care*, *4*(1), 47-59.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 63*(2), 98-109.

Skinner, B.F. (1953). *Science and Human Behavior.* New York: The Free Press.

Spencer, R. (2010). CBT or Psychodynamic Therapy: An information Resource About CBT and Psychodynamic Therapy. Retrieved from http://cbtvspsychodynamic.com/

Swift, J.K., & Greenberg, R.P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80,* 547-599.

Turock, A. (1980). Immediacy in counseling: Recognizing clients' unspoken messages. *The Personnel and Guidance Journal, 59*(3), 168-172.

Vaidyanathani, P.V. (2012). Should we be honest or diplomatic? Retrieved from http://timesofindia.indiatimes.com/life-style/should-we-be-honest-or-diplomatic/

Wheeler, C.D., & D'Andrea, L.M. (2004). Teaching counseling students to understand and use immediacy. *The Journal of Humanistic Counseling, Education and Development, 43*(2), 117-128.

Wright, J. H., Basco, M. R., & Thase, M. E. (2006). *Learning cognitive-behavior therapy: An illustrated guide (1st ed.)*. Washington, DC: American Psychiatric Pub.