ABCT

ISSN 0278-8403
VOLUME 29, NO. 3 • MARCH 2006

the Behavior Therapist

Contents

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Photo ID (p. 67)

Clinical Dialogues

Client Curiosity About the Therapist's Private Life: Hindrance or Therapeutic Aid?

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Cognitive behavior therapists have a tradition of fostering collaborative relationships and being alert for client diversions that might block productive work. However, even when sessions are structured according to a standardized protocol and an explicit agenda, "the course of therapy, like true love, is not always smooth" (Beck, Rush, Shaw, & Emery, 1979, p. 295). The present paper is intended to draw attention to a particular client diversion that has a distinctive disruptive potential—asking the therapist questions about her or his private life. With an emphasis on how therapeutic progress can be hindered or accelerated, we will discuss how cognitive behavioral therapists can view these questions. We will conclude our discussion with an analysis of client questions from the standpoint of functional analytic psychotherapy (Kohlenberg & Tsai, 1991).

Intrusive questions can be viewed as a technical problem (Beck et al., 1979) that obstructs therapeutic progress and causes difficulties for the therapist. Freud (1961/1915) acknowledged the problem when he said that such questions are intended by the client to "... deflect all her interest from the work and to put the analyst in an awkward position" (p. 163). During cognitive behavior therapy (CBT), the ways such questions interfere with progress include subverting the agenda as well as diverting the therapist's attention and shifting the focus to low-priority items.

Further, some clients' questions might be personally evocative and the therapist may be conflicted about what to do. For example, the client might ask, "What is your sexual preference?" or "Have you ever been married/divorced?" and if so, "What conflicts led to you getting divorced?" Client questions that affect the therapist on a personal level in this way have great potential to cause the therapeutic interaction to stray from its most productive course. From this technical problem perspective, CBT protocol often calls for the therapist to refocus the client as these "diversions" take away from the time needed to cover the planned work (Beck et al., 1979; Freeman, Pretzer, Fleming, & Simon, 1990). Accordingly, suggestions are offered that the therapist can use to bring the client back on track. Consistent with this view, it would also make sense for the therapist to structure treatment in such a way that these questions will never come up (although, as discussed later, we think this is a mistake). For example, early on in the treatment process, the therapist might let the client know that personal questions will generally not be answered.

On the other hand, it is also possible to view client questions about the therapist's personal life as providing opportunities for beneficial therapeutic interventions. Answering a client's questions is a form of self-disclosure. Walen, DiGiuseppe, and Dryden (1992) encourage the use of self-disclosure to provide clients with models of appropriate thinking and acting in relation to problems therapists have successfully grappled with in the past. Others have proposed even broader therapeutic utility of self-disclosure (e.g., Goldfried, Burckell, & Eubanks-Carter, 2003; Hill & Knox, 2002).

Based on their review of self-disclosure research, Hill and Knox (2002) recommended selective and generally infrequent self-disclosure that includes, for example, professional background but excludes highly intimate topics such as sexual orientation. They suggest that self-disclosure can help build trust, validate reality, strengthen the alliance, and offer alternative ways to think or act. If the self-disclosure mirrors the client's concerns, it can help clients to feel normal and reassured. Accordingly, therapists should note how a client responds to the disclosures and use that information constructively. Along the same lines, Goldfried et al. (2003) recommend that cognitive behavior therapists self-disclose in order to enhance positive expectations and motivation, to strengthen the therapeutic bond, to normalize the client's reaction or reduce fears, and to provide feedback concerning the interpersonal impact made by the client.

Returning to the inner conflict a therapist might have about whether or not to disclose, the client's questions can have another effect. They can personally threaten the therapist in ways that not only interfere with her or his ability to focus on the CBT protocol, but also provoke tensions or relational problems between therapist and client. In other words, they can precipitate a rupture in the therapeutic alliance. Because therapeutic alliance has reliably been related to outcome (Horvath & Symonds, 1991; Orlinsky & Howard, 1975, 1986; Strupp, 1996), a breakdown in the alliance, if not addressed, may lead to poor outcome. As discussed below, however, if taken advantage of, this breakdown can be used to improve outcome (Safran & Muran, 1996).

Client Personal Questions From the Perspective of Functional Analytic Psychotherapy

Both therapist self-disclosure and addressing alliance ruptures are topics at the heart of functional analytic psychotherapy (FAP), a behavioral approach to therapy proposed by Kohlenberg and Tsai (1987, 1991; Kohlenberg et al., 2004). According to Kohlenberg, Tsai, and colleagues, what happens between therapist and client during a session can be analyzed in terms of its similarities to the client's daily interpersonal situations and problems. FAP posits that the outcome of CBT is greatly enhanced if the therapist becomes aware of naturally occurring instances of the client's actions and thinking during the session as either an in-vivo occurrence of the same daily life problem that brought them into treatment or, conversely, an improvement in the same (for empirical support see Kanter, Schildcrout, & Kohlenberg, 2005; and Kohlenberg et al., 2002). In FAP terminology, these in-session occurrences of the client's daily life problems (or improvements) are referred to as *clinically relevant behaviors* (CRBs). Further, CRBs are either rewarded or punished by the reactions of the therapist—regardless of the therapist's awareness. Based on the well-established principle that maximum change occurs when reinforcement is immediate, these rewards and punishments are seen to have particularly powerful effects on the outcome of treatment. The strengthening of new behavior during the session is, in turn, hypothesized to influence future occurrences of improved thinking and interpersonal relating in the client's daily life. Correspondingly, a therapist's inadvertent punishment of in-vivo improvements has particularly strong countertherapeutic effects.

Thus, the occurrence of a *CRB* provides the opportunity for significant behavior change via the here-and-now reactions of the therapist. One central tenet in FAP is that the therapist should avoid reacting in planned, technique-guided ways and instead use natural reinforcement of in-vivo improvements. This is intended to help with generalization of the gains in therapy to daily life—natural reinforcement is available in the outside world and contrived reinforcement is restricted to the therapy session. Let's say, for example, a particular client's problem is that he does not ask others directly for what he wants or needs. If this client then directly asks the therapist for something he wants, the natural reinforcement is to get what he asked for—not, for instance, the all-too-prevalent contrived therapist response of being praised or congratulated for "sharing that with me."

Therapist self-disclosure can act as natural reinforcement for a variety of improvements the client may emit for the first time during therapy, such as "trying to get to know the person to whom one is relating" or "trying to learn from the other." Alternatively, self-disclosure can be a tactic used by the therapist to intensify the relationship and thus be more apt to evoke CRBs (including thoughts and beliefs) that are related to the client's daily life problems with intense (intimate) relationships. Therapist self-disclosure can also take the form of sharing with the client the effect the client has on the therapist as a person, allowing for the natural consequences of the client's behavior to do their job as reinforcers. This type of sharing on the part of the therapist is seen as making visible or apparent the feelings or thoughts others have in reaction to the client's behavior, but which in daily life situations remain covert and thus invisible to the client.

Alliance ruptures provide in-session, here-and-now opportunities to observe how the client's thinking and behavior contributed to the rupture. Further, ruptures provide an opportunity to observe how the client deals with the event and whether or not this constitutes a concrete case of problem behavior or an in-vivo improvement. Finding out whether the client is showing an improvement or not depends on a comparison between what just happened and the ways the client has responded in the

past and in other important interpersonal relationships.

Case Illustration

Mr. A was a middle-aged man who sought therapy shortly after a schizophrenic episode. He was anxious and depressed about his lack of economic success and about the consequences of earlier episodes that had shattered his plans to go to college or grow professionally. In the recent past, he frequently started and abandoned university courses and grandiose personal or professional projects. He had deficits in social abilities and lived in relative social isolation, feeling angry with his wife, his father, and others whom he held responsible for his lack of success.

Typical questions he asked his therapist were: Are you married? Do you have children? What does your husband do for a living? In what neighborhood do you live? How much do you earn in a month? What do you think about life? Are you afraid of the future? Are you able to apply what you studied [about psychology] to your own life? How do you go about doing that? Does your husband smoke? Why don't you help him quit?

These questions made the therapist falter. She often felt threatened or ashamed and unsuccessfully tried to avoid and discourage the questions. Still, she answered what she considered to be the strict minimum to maintain a collaborative relationship. The continuing interference with her capacity to focus compelled her to reconsider what was going on between her and Mr. A. That the therapist looked young, inexperienced, and professionally (thus presumably financially) not yet firmly established may have set the stage for these questions as well as the fact that these same issues related to the client's problems.

Not only was Mr. A distressed about his financial condition and future, he defined himself as a victim and a failure, and begrudged others their successes. Mr. A understood the adversities of his life as extraordinary events that only could happen to him. The ways in which people reacted to him, according to his reports, indicated that they felt unwelcome and devalued by him. People who had initially offered their support were soon punished and left him to himself. Mr. A's questions had similar effects on the therapist. She viewed them as intrusive and inappropriate. They interfered with her capacity to help him effectively and promoted unproductive escape behavior.

Once the therapist became aware that Mr. A's questions indicated improvement, a major breakthrough occurred. Mr. A was trying, for the first time, to explicitly evaluate his assumptions about others (e.g., the therapist might struggle with personal difficulties). The therapist began to view the questions as evidence that Mr. A had adopted a more functional attitude and had started to test his hypotheses about the world. While the therapist once viewed his questions as intrusive, she now considered Mr. A.'s inquiries as attempts to gain an understanding of how to deal with and view his own problems. While initially the questions ran the risk of being punished, it was after the therapist started addressing them as legitimate attempts by Mr. A to learn from her that they allowed for therapy to take a more effective course.

Asking the therapist about her opinions, her difficulties, and her coping resources also inaugurated an empathic attitude that would help Mr. A improve his interpersonal relations in daily life situations. Furthermore, taking others' struggles seriously also validated them as possible sources of help. Several changes in the client's daily life occurred shortly after the therapist shifted her understanding of Mr. A's questions: he started to analyze the pros and cons of new projects before acting; he began testing his assumptions and beliefs; he discussed his professional plans with his wife and began accepting her advice; and he talked to persons he would previously have despised concerning topics on which they were well informed.

These proximal changes may have been the first steps in a more general process of change that came about gradually. Mr. A started seeking more social interchange and was more successful in relating to others as he stopped rejecting and blaming them. One year later, when he opted out of therapy, his professional initiatives were more realistic and succeeded better than ever before, and the anxiety and depression that had brought him to seek therapy had declined significantly.

Discussion

How can therapist reactions to intrusive questions be curative? Educating the client about keeping an adequate focus in the client-therapist dialogue can be necessary, and can even provide a powerful in-session therapeutic opportunity when the client's daily life problems are related to difficulties in maintaining focus and asking irrelevant questions as a way of avoiding dealing with more relevant issues. But in the worst case, it may result in discouraging precious in-vivo improvement as when the client's problems are related to his or her overrespectful submissiveness or rigid conscientiousness.

When a client "goes off on tangents," asking questions that deflect from the focus of therapy, the clinical relevance may not be in what the client asks, but in what effects the question has on the person of the therapist. Invasive questions by clients can evoke emotional reactions and thoughts of different sorts, including insecurity, fear, and distrust. The therapist can also feel important, honored, or seduced by the client's curiosity. Acknowledging that the therapist's reactions to a client are subject to the same regularities as those of other people interacting in daily life settings, the therapist's reactions may include clues about how a certain behavior affects people outside the session and thus either contributes to daily life problems or to their solutions.

After a therapist considers the possibility that the client evokes similar reactions in others besides the therapist and that these are related to the client's daily life problems, the client's questions might now be seen as providing special therapeutic opportunities. Our position is that self-disclosure makes sense as natural reinforcement if asking those questions is an improvement. In the case of Mr. A the function of the behavior was at first ambiguous. The questions made the therapist feel threatened and disqualified as a source of help. As long as she reacted with escape behavior, she strengthened the client's dysfunctional thinking and behavior and made it more likely he would keep others at a distance and not check out hypotheses during his daily life. But by providing directly or indirectly helpful information in reaction to the questions, she strengthened an entirely different function of that same behavior, and shaped Mr. A's repertoire of obtaining opinions and reports of experiences, listening and discussing.

In other cases, disclosing feelings about intrusive questions may be curative in a variety of conditions. A therapist can try to weaken in-vivo problem behavior by revealing the negative effect the behavior has on him or her. This may be the case, for instance, when a client's intrusive ways make people in his or her natural environment feel invaded or disqualified, when these behaviors keep potentially constructive contacts at a distance or destroy chances to improve interpersonal relations. Alternatively, the therapist may reveal that the questions made her or him feel closer to the

client, or made her or him feel valued as a person. This may happen when the questions indicate an improvement in the repertoire of a client who has problems maintaining personal relationships, who rarely shows interest in others, or is seen by others as egocentric or uncaring.

Of course there are caveats. Therapists, feeling vulnerable, may refrain from disclosing (Hill et al., 1988). Actually, when answering an intrusive question, therapists do run risks. Acknowledging the client's curiosity as a CRB can conflict with the need for managing the relationship. Furthermore, disclosure gives the client an opportunity to punish the therapist's honesty and openness. However, running the risk may have therapeutic advantages. What Cordova and Scott (2001) call an intimate episode occurs when someone reinforces behavior of another that generally is vulnerable to interpersonal punishment. The curative potential of a relationship characterized by such episodes is suggested by the philosophy of FAP. Only when the therapist allows him- or herself to be personally affected by the behavior of the client will his or her reactions to that behavior be natural consequences of that behavior. When the therapist does not allow for this to happen, the reactions she or he will offer may turn out to be rationally justifiable but profoundly alienated from what is really happening that moment between the two people in the therapy room.

On the other hand, it must be clear that in a therapeutic relationship, not all that reinforces a specific in-vivo improvement or weakens a certain in-vivo instance of problem behavior would be adequate. A particular self-disclosure could be effective as a response to a particular CRB but could jeopardize the future potential of the client-therapist relationship. This may be the case when, as Goldfried et al. (2003) point out, appropriate boundaries are trespassed.

Summary and Conclusion

Instead of hindering progress, client intrusiveness can provide opportunities to improve outcome. It can be in-vivo improvement that should be reinforced or problem behavior that should be weakened. Avoiding problems may impoverish the relationship as a space for learning about daily life problems. Thus, as seen through the lens of FAP, avoiding disruptive client behavior should not be a priority. This means that therapists may drop much of the control they could have over the therapy process and be vulnerable to client reactions in order to allow for intimate and intense relationships that may offer greater curative therapeutic opportunities.

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