# The Role of Emotion in Psychotherapy Supervision: A Contextual Behavioral Analysis

Victoria M. Follette, *University of Nevada, Reno*
Sonja V. Batten, *University of Nevada, Reno, and National Center for PTSD, Boston*

*While much has been written regarding the importance of emotional expression in psychotherapy, much less attention has been paid to the role of emotion in clinical supervision. Recently, several radical behavioral psychotherapies have been developed that may shed light on theoretical issues important to the expression of emotion in supervision. This paper describes the theoretical viewpoints of two such contextual therapies, Functional Analytic Psychotherapy (FAP) and Acceptance and Commitment Therapy (ACT), and applies the frameworks of these therapies to the process of clinical supervision.*

THE ROLE OF EMOTION in psychotherapy has long been a topic of importance in clinical psychology and has been subject to a great deal of research (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). However, the relevance of emotion to the supervision process has been much less frequently addressed, particularly in the behavioral therapies. While the experiential therapies have a longer tradition of interest in therapist variables associated with emotion, these therapies have focused more on the role of genuineness and accurate empathy on the part of the therapist with respect to client change rather than emotion expressed within supervision (Greenberg & Goldman, 1988). The focus of this paper (and this series) is on the expression of emotion in the supervision process, including a discussion of the conditions that might lead the therapist to be able to safely express core emotions. Additionally, we address the theoretical rationales for facilitating this expression of feelings and the caveats associated with such work.

## Contextual Behavioral Approaches

In recent years, new approaches to treatment have emerged that fit within the general paradigm of cognitive behavioral therapies. However, these interventions arise from radical behavioral foundations and call for a contextual analysis of clients and their problems. The origins of these treatments, as well as other novel and innovative approaches to complex problems, have led to an important shift in the field of behavior therapy. Notable among these therapies are Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), and Dialectical Behavior Therapy (DBT; Linehan, 1993). At their core, these therapies are concerned with acceptance, validation, and behavioral change. The role of emotions is central in these therapies, and the therapeutic relationship is often the context for the analysis of those emotions. These approaches, which are often used to address long-standing problems related to emotions and interpersonal functioning, continue to develop and evolve as clinical empirical research is conducted.

As these newer therapies mature, a parallel interest in the supervision process associated with them has also developed. Because these techniques are often used for clients with significant long-term clinical problems, the therapeutic relationship is frequently a complex one. Generally, the clients we treat are presenting with issues that have not responded to traditional technologies. Therefore, the duration of the therapy may be somewhat longer than conventional behavioral approaches and the interpersonal relationship is often more intense. Despite the difficulties associated with such therapeutic relationships, little has been said about the supervision of these types of psychotherapies. Additionally, given the importance of emotion in these therapies, it seems reasonable that the training process should also address the student therapist's development with regard to emotion in therapy. A recent study (Machado, Beutler, & Greenberg, 1999) has provided important data regarding the relevance of therapists' awareness of their own emotions. Using actual excerpts of therapy sessions as the stimuli, psychology undergraduates and experienced therapists rated a number of variables related to emotion. The participant's own emotional awareness was associated with higher levels of accuracy in labeling emotions. The authors go on to suggest that "the ability to focus on our

**Cognitive and Behavioral Practice 7, 306–312, 2000**
1077-7229/00/306–312$1.00/0
Copyright © 2000 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.

**Continuing Education Quiz located on p. 372.**

own emotional process or to resonate to others' emotional experiences in interpersonal situations is likely to provide us with important information about others' emotional experiences, enhancing our ability to recognize emotions" (Machado et al., p. 55). These results are consistent with our own experiences and suggest that the supervision setting may be a very appropriate place for a focus on emotional processing in the service of enhancing the therapist's effectiveness. Using FAP and ACT as theoretical touchstones, we will discuss the critical role of emotion in supervision.

## FAP

As noted above, FAP has its foundation in a radical behavioral approach. However, it moves significantly beyond techniques that have traditionally been used in behavior therapy (Kohlenberg & Tsai, 1991). Specifically, FAP's focus is on creating intense relationships in therapy that are central to client improvement. As with traditional experiential therapies, emotion and affect are at the core of the therapeutic process in FAP. While the expression of emotion is a necessary component of treatment, it is not in itself sufficient for change. Some observers have suggested that FAP is simply a behavioral reformulation of psychodynamic approaches. However, the creators of FAP contend that while the therapy bears some resemblance to psychodynamic techniques, the two therapies are, in fact, significantly different from one another. Reinforcement is a central theme in FAP. Drawn from a behavior-analytic perspective, therapy is viewed as "shaping and strengthening more adaptive repertoires of behavior through reinforcement" (Kohlenberg & Tsai, p. 8). While a complete description of the treatment is beyond the scope of this paper, important concepts relevant to the role of emotion in supervision will be highlighted.

Of primary importance are the concepts of clinically relevant behaviors (CRBs) and therapeutic rules related to those behaviors. Kohlenberg and Tsai (1991) have identified three distinct classes of clinically relevant behavior. CRB1s are examples of the client's presenting problems that occur in session. In contrast to more traditional conceptualizations of a presenting complaint, CRB1s do not represent verbal reports of the problem, but rather the client actually engaging in the behavior that is functionally associated with the problem. For example, in our work with clients who present with histories of trauma, it is not simply the trauma experience per se that is the issue but also the observation that the client cannot express emotions. The CRB1 would be the client's report of her trauma history with no observable affect and report of no feelings associated with telling her story. Improvements that occur during session are labeled CRB2s. For the client referred to above, expression of appropriate affect during exposure exercises would be conceptualized as a CRB2. Finally, CRB3s are identified as client interpretations of her own behavior and recognition of functional connections between antecedent stimuli and her behavior. In this case, the client may report that when the therapist created a safe and caring environment, she felt more able to experience and share her emotional reactions to her abuse.

> Given that many clients present with difficulties related to emotional responding, it is essential that the therapist have within her own repertoire the requisite skills for observing, expressing, and evoking emotions.

While Kohlenberg and Tsai (1991) describe five rules central to their therapeutic technique, two are particularly salient to the goals of the current paper. Of primary importance is the exhortation that the therapist remain watchful for CRBs. The second rule of relevance is that the therapist find ways to evoke CRBs during the course of therapy. These concepts are important not only to the process of therapy, but are also essential to the context of supervision. This fact cannot be overemphasized.

As Kohlenberg and Tsai (1991) have stated, the supervision process has many parallels to therapy. We hypothesize that therapists will not be as effective at the implementation of FAP with clients whose presenting complaints are in areas in which the therapist also has skills deficits. Given that many clients present with difficulties related to emotional responding, it is essential that the therapist have within her own repertoire the requisite skills for observing, expressing, and evoking emotions. Thus, the effective FAP supervisor conceptualizes not only CRBs for the client, but also for the therapist.

While it is generally expected that individuals entering fields involving psychotherapy delivery have some skill in areas related to emotion, there is often room for growth in this area. As noted by Machado et al. (1999), there is variability in the ability of students and therapists to accurately label emotions in others. Dealing with emotions and the processes related to them is not a trait we are born with, but rather a behavior that is acquired and is therefore also subject to confusion and errors in learning. Just as learning effective emotional responding is often a part of therapy, these skills can also be developed and shaped in the therapist through the supervision process. The type of learning that is shaped by natural contingencies in supervision can increase the therapist's re-

sponsiveness to environmental contingencies in the therapy (W. C. Follette & Callaghan, 1995). However, because the relationship between the student and supervisor involves more mutuality than the therapist-client relationship, there is the opportunity for a type of disclosure that is beyond what would usually occur in the context of therapy. In our supervision, the second author worked very closely with a young client whose mother died in an unexpected and tragic manner. The therapist had experienced a similar loss in the death of her father while she was still a teenager, and the work of therapy rekindled the therapist's own grief. Supervision provided a safe place to experience that pain and sadness. This processing allowed the therapist to work effectively with the client without having to avoid areas of great pain in the service of protecting herself. This example also demonstrates the issue of balancing client/therapist needs. The supervisor did not see this emotional expression as problematic in any way. While the therapist had already appropriately dealt with her grief, it was only natural that the intensity of the clinical work would put her again into contact with her own history. In the therapy setting, there is the demand that the client's needs supercede those of the therapist, while in supervision there is more leeway to focus on the therapist's issues (of course, this is always to be in the service of enhancing the quality of the therapy itself). In our view, effective therapists will always remain in close contact with their own emotional experiences, and this ability represents both a strength and a vulnerability. Therefore, the supervisor can use the supervision as an opportunity to evoke the supervisee's emotional responses to clinical material and use those responses to facilitate development of the therapist's emotional repertoire.

Effective therapists will always remain in close contact with their own emotional experiences, and this ability represents both a strength and a vulnerability.

While we are focusing on experiential learning in this article, didactic learning is also an important part of the training of a FAP therapist. After the therapist and supervisor explore experiential aspects of the therapy situation, it is important that the supervisor then move to a more didactic role. Just as in the therapy, it is important that the supervisee develop the ability to accurately observe and describe her own behavior. The ability to describe functional relationships requires a great deal of practice, and the supervision setting allows the therapist to develop a verbal repertoire for this task.

## ACT

The second radical behavioral approach to psychotherapy upon which this model of supervision is based is that of Hayes's ACT (Hayes et al., 1999). The core goals of ACT have been described as (1) reducing experiential avoidance, (2) changing an excessively literal response to cognitive content, and (3) increasing the ability to make and keep commitments to behavior change (Hayes & Wilson, 1994). In this section, we will present each of these goals and describe the application of ACT principles to dealing with therapist emotional reactions to clients, both in and out of supervision.

At the heart of ACT is the goal of reducing experiential avoidance. Experiential avoidance has been defined as a process in which a person is unwilling to experience negatively evaluated private events, such as thoughts, feelings, or memories, and the person thus makes subsequent attempts to reduce, numb, or alleviate those experiences (Hayes et al., 1996). While avoidant coping strategies may appear useful in the short term, this theory suggests that what humans experience as psychological distress may often arise as a result of the struggle to avoid negatively evaluated private events (Hayes et al., 1999). Hayes and Gifford (1997) have suggested that experiential avoidance remains so pervasive, despite the long-term negative consequences, due to the derivation of bidirectional relations and rule-governance.

While we often use the theory of experiential avoidance to understand the problems of our clients, this process does not exist only in those who seek therapy or meet criteria for *DSM-IV* (American Psychiatric Association, 1994) diagnoses. We argue that the use of experientially avoidant strategies is a phenomenon that occurs frequently in Western culture, including in those individuals who provide psychotherapy. Thus, just as we would attempt to help our clients become more accepting and nonjudgmental of their own private events, we must also work to help therapists be accepting of whatever thoughts and feelings they may have during the course of therapy or supervision. Conversely, it should be added that at times some level of avoidance is not only natural, but also useful. That is, if one were fully in contact with all emotions at all times, effective functioning might well be somewhat limited. It is when this avoidance becomes a generalized mode of responding that it becomes problematic.

A necessary precursor to a therapist being able to accept his or her own negatively evaluated private events is being aware of what he or she is experiencing, both during therapy and supervision. In the service of this goal, we might start therapy or supervision with mindfulness exercises, in which all participants work to become aware of their private experiences, such as their senses, thoughts, feelings, or bodily sensations. Within such an exercise,

participants may also do the rudimentary work of acceptance—simply noticing what they are experiencing without trying to control or change it. Regular practice of mindfulness exercises can help to center both the processes of therapy and supervision.

After working on awareness of private experiences, a therapist practicing within this framework must learn to recognize that the private events that he or she encounters are not the enemy. That is, feelings of anger, dislike, or attraction toward a client are not seen as problems or as barriers to good therapy. Consistent with an acceptance perspective, it is not that these feelings lead to ineffective therapy; rather, it is the struggle with those feelings that is not useful. Feelings of anger or attraction do not have to change before a therapist can behave effectively. However, the way in which the therapist views or deals with such feelings may have to change, such that the therapist can stop trying to control what he or she is feeling and instead focus on the work of therapy.

Explicit control strategies, in which the therapist tries to change what he or she feels before being able to engage in effective therapeutic behavior and take the client's best interests into account, are not only difficult—they may be impossible. Data to support this are found in the literature on emotional and thought suppression, a process that has been described as attempts not to think about a specific thought or subject or feel a specific emotion (Wegner, 1988, 1994, 1997). Empirical studies have consistently found that, regardless of the reason for suppression, this process often has the same results—a subsequent rebound of the thought or feeling that was to be avoided. Attempts at mental control and thought suppression are seen as logical responses to psychological traumas and stressors (Wegner & Pennebaker, 1993). Thus, it follows that people who have experienced a less socially acceptable thought or feelings toward a client, such as anger or attraction, might be more likely to suppress those thoughts and feelings, leading to increased obsession and rumination about the negatively evaluated private event in the future (Wegner & Erber, 1993). If the frequency of this thought or feeling increases, it suggests that the control strategy has been unsuccessful. These private events may then interfere even more with the therapy than they had originally.

Within this model, effective supervision would work to help the therapist become aware of the private events that he or she is experiencing in therapy, both positive and negative, and to notice how attempts to control or get rid of unwanted thoughts or feelings can actually get in the way of being an effective therapist, even if the reason for trying to avoid such private events was originally to improve the process or outcome of the therapy. It is thus the work of the supervisor to model for the therapist a nonjudgmental posture toward the therapist's private experiences, regardless of their social acceptability. Such a stance is essential to allowing the therapist to have all of his or her private experiences without judgment by self or supervisor. This acceptance also allows the therapist to continue to experience a number of thoughts or feelings in session without having to take any action to avoid or suppress the thoughts. Rather, the therapist can focus on engaging in therapeutic behaviors that are likely to be effective in helping the client to change and can stay present to contextual cues indicating the effectiveness of those interventions.

> We might start therapy or supervision with mindfulness exercises, in which all participants work to become aware of their private experiences, such as their senses, thoughts, feelings, or bodily sensations.

The second major goal of ACT is changing an excessively literal response to cognitive content. This process has been described as deliteralization or reducing cognitive fusion, and therapeutic techniques used for this purpose have been described extensively in other places (Hayes et al., 1999). What is important for the purpose of this paper is to understand the essence of this intervention, which is to help the client be able to see his thoughts as "just thoughts" and not have to take them literally. For example, we might teach an agoraphobic man that just because he has the thought, "I can't go outside," does not actually mean that he literally cannot go outside. Similarly, the therapist who thinks, "I can't stand to work with this client," will be able to see that he is a person having that thought *and* that having that thought does not actually make it true that he cannot work with the client. The first author had done a significant amount of therapy with victims of sexual abuse and domestic violence prior to her clinical internship. While on internship, there was an opportunity to co-lead a group for batterers. Reviewing initial thoughts and feelings in reaction to working with batterers seemed to suggest that doing such therapy would be impossible. However, acceptance of these private events and discussion of the issues with a supervisor led to a different outcome. The therapist was able to contact these feelings and use them to convey the terrible fear and sadness that victims of violence experience, while at the same time demonstrating strength and lack of acceptance of the violent behavior. Probably of most importance, the therapist was able to accept the clients, truly valuing them as people of worth, while also not accepting the violent behavior. This combination of experiences led to the delivery of the treatment in a firm and

yet compassionate manner. The group went well and, having had this training opportunity, enriched the therapist's experience.

Within the context of therapy and supervision, the third goal, making and keeping behavioral commitments, would consist of the therapist conceptualizing the case with accuracy and providing therapeutic interventions that are consistent with the case formulation. Clearly, the ACT therapist would do this regardless of the thoughts and feelings experienced by the therapist both in and out of the therapy room.

### Exposure-Based Therapy

Our emphasis on work with trauma survivors raises important considerations with relation to emotion in supervision. Most behavior therapists would agree that exposure is the sine qua non of effective trauma therapy (V. M. Follette, Ruzek, & Abueg, 1998). While many treatment protocols for trauma employ techniques intended to manage the client's affect during exposure work, relatively little has been said about the therapist's experience of this process. For example, therapists working with survivors of child sexual abuse may have painful emotional reactions when hearing the client tell her story. These responses may arise either because the client's history reminds the therapist of some aspect of her own history, or conversely because the therapist may never have been exposed to such abusive treatment of children. In either case, the pain experienced by the therapist is valid and often requires a venue for expression, for a number of reasons. First, the trauma survivor is often extremely vigilant with regard to very small variations in interpersonal responses (V. M. Follette, 1994). If the client detects some reluctance or discomfort on the part of the therapist in dealing with an aspect of the trauma history, she may well avoid the material in the service of attempting to protect both the therapist and herself. Second, the therapist's experiencing of her own emotional responses in the supervision setting allows the development of empathy and connection with the client that can enhance the therapeutic relationship. Third, the expression and discussion of emotion in supervision can facilitate the therapist's accurate labeling of her own experience, leading to more precision in labeling the client's response. Finally, therapists are human and generally have entered the field with a desire to help others. Unfortunately, repeated exposure to traumatic material with no appropriate outlet for expressing the feelings associated with that material can lead to a number of difficulties, including depression, substance abuse, and burnout (V. M. Follette, Polusny, & Milbeck, 1994).

> It is the work of the supervisor to model for the therapist a nonjudgmental posture toward the therapist's private experiences, regardless of their social acceptability.

Another important role of the supervision team for trauma therapists is that of vicarious exposure to other therapists' case material. That is, it can be very useful for therapists to listen to each other talk about their clients' trauma experiences in supervision. Hearing about diverse types of trauma without having to conduct therapy with as many individuals allows for a healthy type of desensitization. Additionally, an experientially open member of the supervision team can provide valuable modeling for other supervisees, who can see that it is acceptable, and actually beneficial, to express emotion in supervision. Likewise, it is crucial that the supervisor also be willing to express her own private experiences and to tolerate those expressed by the supervisee. It is important to stress here that we are talking about a balance between being desensitized to hearing about a trauma such that the therapist can function effectively within the therapeutic context without being overwhelmed, while still remaining emotionally present to the client's individual story and pain. In fact, the radical behavioral therapies upon which this approach to supervision is based, ACT and FAP, emphasize the absolute need for the therapist to be experientially open to his or her own private experiences for the therapy to be successful.

### Problems and Issues

The role of the supervisor in evaluating students can be a difficult one with respect to the issues of encouraging the expression of emotion in the supervision setting. As noted by Vasquez (1992), it is part of the supervisor's responsibility to assess impairment on the part of the supervisee that could have a negative impact on the client. This part of the supervision process is uncomfortable for both the supervisor and the supervisee. Of course, it is the supervisee who is most at risk and feels more vulnerable with respect to negative evaluation. Nevertheless, it is a task that is often avoided by the supervisor, for a number of reasons. Specifically, we often fear confusing the role of supervisor and therapist, and in the service of a conservative approach to this issue, will avoid interpersonal issues. Also, there is little data on the impact of therapist problems on therapy outcomes, leading to an understandable caution in overinterpreting the role of personal difficulties. There is no clear answer to this dilemma and, as with many clinical issues, the supervisor must proceed with gentleness and respect in helping

trainees to address these issues. It is incumbent upon the supervisor to recognize the predicament for the student in being vulnerable and fearing negative evaluation regarding emotional impairment.

Pope and Vasquez (1998) outline some of the critical ethical issues surrounding the supervisory relationship. While the supervisor is responsible for the supervisee's training, the client's care is of primary importance. And while supervision is not therapy, it can share some common features with the therapy process. As with many clinical processes, dealing with these issues is a matter of balance. Rather than avoid such issues and engage in more structured, rule-governed approaches to supervision, we believe that the supervisor must be willing to take on these complex issues. While it is important for the supervisor to avoid emotional tyranny of the student (Kohlenberg & Tsai, 1991), she must also be willing to assist the student in dealing with her own emotional responses to clients.

The willingness of supervisors to practice what we preach is relevant to these concerns. That is, are we as supervisors willing to be emotionally present? In therapy, especially trauma therapy, the client may need to express feelings of extreme pain around historical events that we are unable to change. While we intellectually acknowledge the importance of one's history as essential to who one is now, we must also acknowledge that, at times, there is a part of us that wants very much to spare the client that pain or to change that part of her life. At the same time, we expose the client to pain, pain that we cannot obliterate, in the hope of finding a way to transcend that experience. This task exposes the therapist to her own pain and vulnerability as a healer, and this process may be mirrored in the supervision process. That is, supervisors may also feel vulnerability and uncertainty about directing the therapy process, particularly when there is so much pain involved for the client. As a supervisor, allowing oneself to be present to the pain that the student therapist experiences in recounting the history of the client can lead to feelings of sadness in the supervision setting. The supervisor's willingness to cry or express sadness can be a much more powerful influence on the student than lengthy, intellectualized discussions of the role of emotion in supervision. At the same time, the supervisor must manage her own fears and insecurities about the ability to help the client and student through the situation. That is, it is very important for the student to remain confident in the supervisor's ability to support both the student therapist and the client through the process. This dialectic is very much a mirror of the therapy process, where the therapist needs to exhibit both vulnerability and safety. It follows that there should also exist support for the supervisors, a place where they can discuss these issues. In academic settings, clinical training committees can serve this function.

## Summary

In closing, it is important to note the need for the empirical evaluation of various models of supervision. While we believe that the labeling and expression of emotion is a critical aspect of the therapist's repertoire, and that these are skills that can and should be shaped and developed within the context of supervision, there is a dearth of data addressing this issue. A productive approach to research in this area would involve development of theory-based process measures of the supervision experience within a specific orientation that are tied to therapy outcomes (Stoltenberg, McNeill, & Crethar, 1994). The inclusion of training around supervision and its evaluation has been a neglected part of many training programs. Given the expected roles of psychologists as trainers and supervisors in the next millennium, we believe that it is particularly important for clinical psychology programs to incorporate training in effective supervision into their curricula. These supervision strategies are not inconsistent with behavioral or cognitive-behavioral therapies and can even be important adjuncts to standardized therapy protocols.

The supervisor's willingness to cry or express sadness can be a much more powerful influence on the student than lengthy, intellectualized discussions of the role of emotion in supervision.

This paper would be incomplete without one final note about the role of emotion in supervision. While it is true that the content of therapy is often painful and difficult, it is also equally true that there is significant joy and happiness that occurs over the course of treatment. We believe that it is essential to also make these positive emotions a part of the supervision process. Our supervision team has had the opportunity to work with a number of wonderful clients and we celebrate their joys and successes in therapy and life. Experiencing the full range of the emotional spectrum allows us to stay true to the nature of life's experiences and balances the difficulty of the work that we do. Tears of sadness and laughter have been an important part of our group's experience, and all of us are the richer for those experiences.

## References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Follette, V. M. (1994). Survivors of child sexual abuse: Treatment using a contextual analysis. In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy* (pp. 255–268). Reno, NV: Context Press.

Follette, V. M, Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25*, 275–282.

Follette, V. M., Ruzek, J. I., & Abueg, F. R. (1998). *Cognitive behavioral therapies for trauma*. New York: Guilford.

Follette, W. C., & Callaghan, G. M. (1995). Do as I do, not as I say: A behavior analytic approach to supervision. *Professional Psychology: Research and Practice, 26*, 413–426.

Greenberg, L. S., & Goldman, R. L. (1988). Training in experiential therapy. *Journal of Consulting and Clinical Psychology, 56*, 696–702.

Hayes, S. C., & Gifford, E. V. (1997). The trouble with language: Experiential avoidance, rules, and the nature of verbal events. *Psychological Science, 8*, 170–173.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy*. New York: Guilford Press.

Hayes, S. C., & Wilson, K. G. (1994). Acceptance and Commitment Therapy: Altering the verbal support for experiential avoidance. *The Behavior Analyst, 17*, 289–303.

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152–1168.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy: Creating intense and curative therapeutic relationships*. New York: Plenum.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.

Machado, P. P. P., Beutler, L. E., & Greenberg, L. S. (1999). Emotion recognition in psychotherapy: Impact of therapist level of experience and emotional awareness. *Journal of Clinical Psychology, 55*, 39–57.

Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling* (2nd ed.). San Francisco: Jossey-Bass.

Stoltenberg, C. D., McNeill, B. W., & Crethar, H. C. (1994). Changes in supervision as counselors and therapists gain experience: A review. *Professional Psychology: Research and Practice, 25*, 416–449.

Vasquez, M. J. T. (1992). Psychologist as clinical supervisor: Promoting ethical practice. *Professional Psychology: Research and Practice, 23*, 196–202.

Wegner, D. M. (1988). Stress and mental control. In S. Fisher & J. Reason (Eds.), *Handbook of life stress, cognition and health* (pp. 683–697). New York: Wiley.

Wegner, D. M. (1994). *White bears and other unwanted thoughts*. New York: Guilford.

Wegner, D. M. (1997). When the antidote is the poison: Ironic mental control processes. *Psychological Science, 8*, 148–150.

Wegner, D. M., & Erber, R. (1993). Social foundations of mental control. In D. M. Wegner & J. W. Pennebaker (Eds.), *Handbook of mental control* (pp. 36–56). Englewood Cliffs, NJ: Prentice Hall.

Wegner, D. M., & Pennebaker, J. W. (1993). Changing our minds: An introduction to mental control. In D. M. Wegner & J. W. Pennebaker (Eds.), *Handbook of mental control* (pp. 1–12). Englewood Cliffs, NJ: Prentice Hall.

Address correspondence to Victoria M. Follette, Department of Psychology, University of Nevada, Reno, Reno, NV 89557; e-mail: vmf@equinox.unr.edu.

*Received: May 4, 1999*
*Accepted: March 1, 2000*

◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆

# Therapist Emotional Responses to Patients: Building a Learning-Based Language

Rachel E. Kimerling, *University of California at San Francisco, San Francisco General Hospital*
Antonette M. Zeiss and Robert A. Zeiss, *VA Palo Alto Health Care System* and *Stanford University School of Medicine*

*In this paper we address the thesis that affective responses of the therapist in the therapist-patient interaction are common and have potential to influence decision points in psychotherapy interventions. We discuss the importance of directly addressing these emotional responses, especially in the training of new cognitive behavioral therapists. We suggest a framework for conceptualizing emotional responses from a social learning theory perspective. This conceptualization highlights interactions between therapist, patient, and the psychotherapy context. We also propose a terminology for discussing therapist emotional reactions as nonpathological constructs and propose relevant guidelines for the supervision of therapists in training.*

A GRADUATE STUDENT in clinical psychology, B., is implementing a cognitive behavioral treatment package with a patient he has recently diagnosed with an anxiety disorder. Despite a careful assessment, functional analysis of target behaviors, and a seemingly collaborative treatment contract with the patient, B. does not see the efficacy of the treatment package suggested by the large body of research he has carefully collected and read. First of all, his patient does not respond as the patient in the treatment manual does. Topics that the manual seems to cover simply and efficiently in only part of one session take B. several sessions to adequately cover. At times, the patient does not complete assignments to which he gladly accedes during the previous session. B. feels frustrated at

**Cognitive and Behavioral Practice 7, 312–321, 2000**
1077-7229/00/312-321$1.00/0
Copyright © 2000 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.

**Continuing Education Quiz located on p. 373.**