Therapist Performance Under Pressure

Negotiating Emotion, Difference, and Rupture

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To Jeremy
"You'll Never Walk Alone"
—OSCAR HAMMERSTEIN II

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PREFACE: POSITIONING THE AUTHORS

Over the past 30 years or so, we have seen a marked shift in academia toward providing more autobiographical insight (see N. K. Miller, 1991, for an early call in this regard). Accordingly, here we would like to "get personal" and provide some context to our respective approaches to the subject that we address in this book.

PERSONAL NOTES FROM THE AUTHORS

J. Christopher Muran

For 3 decades, I have been studying "ruptures" in the therapeutic alliance. *Ruptures* are disagreements in the collaboration between patient and therapist, deteriorations in their emotional bond, and breakdowns in the negotiation of their respective needs—as well as their respective identities (Muran, 2019; Safran & Muran, 2000). This focus was founded on the research demonstrating the predictive validity of the alliance (Flückiger, Del Re, Wampold, & Horvath, 2019), with the ultimate aim of providing more insight for the clinician on how the alliance functions, especially when things go awry, which we have demonstrated is quite often (Eubanks, Muran, & Safran, 2019). I began this professional journey in 1989, when Jeremy Safran hired me as his postdoctoral fellow at the Clarke Institute of Psychiatry, University of Toronto. A year later, I took on directorship of the Psychotherapy Research Program at Beth Israel Medical Center (now Mount Sinai Beth Israel) and invited Jeremy to be a principal consultant. Our collaboration flourished with numerous initiatives (supported in part by grants from the National Institute of Mental Health). Our work

attempted to integrate principles from the psychoanalytic, cognitive-behavioral, and humanistic traditions, including findings from contemporary research on cognition and emotion. Arnold Winston and Lisa Samstag played critical roles in our efforts to study ruptures and their relevance for improving treatment success. Over the past 12 years, Catherine Eubanks (with her interest in therapist experience and development) became pivotal in helping us refine our approach to training therapists to resolve ruptures, and she helped me to further my thinking and focus on helping therapists negotiate difficult moments marked by rupture and manage their emotions under pressure.

During this time, my wife, Elisa, and I had a son, Andy, and I found myself spending every free moment with him, playing the role of father–coach. By this, I mean beyond the usual responsibilities and challenges of being a father, I also tried to coach him in his various athletic pursuits—something that is *not* typically recommended (and by and large, I would agree with this). I comanaged his Little League and travel soccer teams, and I coached him on the U.S. Squash junior circuit. Coaching him in squash was a unique challenge: In this individual sport, you can coach the player between games, and often Andy was facing a player coached by a paid professional who had a world ranking. My own background was that I captained varsity tennis and squash in college (a culmination of my junior years in competition), but whatever success I had was part of another era and modest by today's standards. Trying to help your son between games, in the heat of the moment, is no small feat: We had exchanges that no father and son should have; we also had brilliant moments (and I'm happy, proud, and relieved to say that Andy was recruited by and became a highly ranked college athlete at Cornell University—and most important, we have remained very close).

At some point, these father-and-son experiences struck me as remarkably comparable to experiences I had in training therapists to negotiate their emotions and skills in the face of rupture events. My reading of the developing literature on performance science only reinforced this recognition. My professional path intersected with my personal path. Some might wonder why it took me so long to realize this, why I kept them separate or thought they were. (The answer, like many things, is complicated.) This book is a product of this intersection.

Catherine F. Eubanks

When Chris invited me to join him on this book project, I accepted eagerly. I cannot lay claim to the kind of athletic career Chris had—though mine did have enough of an impact on me that I still experience an anxious anticipation when I smell fresh-cut spring grass and can almost feel the high school track under my feet as I wait for the starter pistol to fire.

I began collaborating with Chris and Jeremy more than 12 years ago, and in that time I have developed a deep appreciation for their approach to understanding alliance ruptures. In many ways, it feels as if I "fell into" this work.

Thanks to the wise and impactful teaching of my mentor, Marv Goldfried, I was introduced to Chris and Jeremy's theoretical and empirical contributions to the psychotherapy literature during graduate school. I then had the opportunity of being supervised by Chris during my clinical internship at Beth Israel. I enjoyed working with Chris, so when he invited me to stay on in a postdoctoral fellowship, I agreed; I began collaborating with him and Jeremy on alliance research, and essentially never left.

Looking back, I hope that my path to a career as an alliance rupture researcher was not simply inertia on my part but rather that I found something that resonates with me. Chris and Jeremy approached alliance ruptures and therapist performance under pressure in a way that felt different and, dare I say, therapeutic for me. Befitting my upbringing as a young woman from the American South, I entered this research collaboration well acquainted with an idea of "grace under pressure" as the appearance of seamless perfection. Chris and Jeremy introduced me to something radically different: the idea that our clinical misfires have the potential to be transformational, that a therapy with ruptures might end up yielding a better outcome than a seamlessly smooth one, that we can admit and own our vulnerability with curiosity and compassion rather than being paralyzed by shame. This is a different way of thinking about grace under pressure—not grace as ladylike perfection but more akin to the kind of grace I hear about on Sunday mornings.

I have spent a lot of time in church pews as well as in classrooms, research labs, and therapy offices, and before I studied psychology, I studied theology. Like Chris, I find that two paths in my life intersect in this work. Alliance ruptures are too awkward to be described as graceful, but perhaps can be seen as full of grace. Chris's and Jeremy's work challenges me to risk making my patient and myself uncomfortable and to dare to have faith in the therapeutic process. I am learning to savor the surprises that come my way when I risk exploring a rupture and seeing what new things can unfold. Grace under pressure is a gift.

ACKNOWLEDGMENTS

We first acknowledge Susan Reynolds of American Psychological Association (APA) Books, who asked me (JCM) at a Society for Psychotherapy Research meeting in Brisbane, Australia, back in 2013, "What are you thinking about these days that excites you?" I was hesitant to say at first, but eventually I expressed my interest in marrying the performance science and psychotherapy research literatures (as just described). I remember adding that I was not ready to undertake this and not sure the excitement I felt wasn't just a passing fancy. "Ask me again in a couple years," I suggested with a smile. And Susan did. Our next conversation was still marked by some hesitancy about taking on what seemed to me a massive undertaking, to which she responded, "What you need is a really good collaborator." Of course! Enter CFE, with whom I had been

working swimmingly for some time and with whom I shared a deep interest in the therapist side of the therapeutic alliance equation. In her gentle and prescient manner, Susan brought this project to fruition.

In addition to the indelible influence of Jeremy Safran, we also acknowledge our many other mentors and colleagues, especially Jacques Barber, Louis Castonguay, Marv Goldfried, Elizabeth Ochoa, Lisa Wallner Samstag, and Arnold Winston, without whom our thinking and writing would not be what it is. We are very grateful to Mount Sinai Beth Israel (and the National Institute of Mental Health, in part) for supporting our research program. There are also the many new colleagues (academic and administrative) at Derner (Adelphi University) and Ferkauf (Yeshiva University). We would be remiss not to recognize our students who questioned us and our patients who challenged us: They taught us so much. Finally, we express our gratitude to our respective families for their inspiration and support. Thank you all!

Therapist Performance Under Pressure

Introduction

Pressure in the Therapeutic Relationship

All real living is meeting.

—MARTIN BUBER

(JCM) had just called down to the reception desk, saying they could let my next appointment come upstairs for our session, when the phone rang. It was another patient who was in a paranoid panic. She had a suspicion or delusion that her former boyfriend was working for the CIA, and she was convinced he was now stalking her. She was freaked out and needed to talk to me. She was calling from nearby—and she conveyed she had gotten a gun to protect herself. I was a doctoral student in my third year of training. I had only a couple minutes before my next appointment would walk through the door. I don't remember what I said to my patient on the phone, but I was able to get off the phone just before I heard a knock on my door. My next patient was a young man close to my age. He dutifully took a seat across from me and pronounced, "I'm having a panic attack." My mind was still racing with thoughts and feelings about my patient *nearby with a gun*. I looked up at my patient in front of me and impulsively replied, "Give me a moment while I get over mine"—at which he broke out laughing, and I joined in. Our shared laugh quickly diffused our respective states of anxiety. My response wasn't driven by any carefully formulated treatment plan or deliberate thought, but it was an invaluable lesson about the role of therapist emotion.

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Therapist Performance Under Pressure: Negotiating Emotion, Difference, and Rupture,
by J. C. Muran and C. F. Eubanks

Every therapist has experienced moments of pressure, even those marked by bursts of emotion, such as a surge of anxiety when a patient threatens to self-harm, a flash of irritation when a patient is condescending or critical, a pang of hopelessness when nothing seems to be working, or even a more sustained experience, such as a struggle to remain alert while a patient drones on and on and on. Therapists have to perform under pressure every day. The aim of this book is to provide a practical guide for therapists to negotiate the difficult emotional challenges that they frequently face in psychotherapy. In this book, we draw on the performance science literature, including findings from the cognitive and emotion sciences, to provide us with a fresh lens through which to view the psychotherapy literature on therapists' performance under emotional duress. We review the empirical literature on therapist negative emotion, negative interpersonal process in the therapy session, and ruptures in the alliance between therapist and patient. We aim to approach these topics from a pragmatic, integrative stance that will be relevant and relatable for therapists of various theoretical orientations and professional backgrounds.

We consider therapists' negotiation of their own experience of intense or challenging emotional states—from basic to self-conscious emotions, such as anxiety and panic, anger and hate, sadness and despair, embarrassment and shame, guilt and self-doubt, and pride and hubris, as well as other emotional challenges such as boredom and neglect, love and seduction, and misempathy and overidentification. The consideration of each state includes clinical examinations of the processes involved in emotion regulation and alliance rupture resolution. We define strategies for self-care and training based on the empirical evidence. In addition, we highlight case examples from our own clinical experiences to illustrate how we addressed emotional experience and alliance ruptures in our own work.[1] Our ultimate objective is to facilitate therapists' abilities to negotiate these experiences for therapeutic gain.

We also discuss the Rupture Resolution Rating System (3RS; Eubanks, Muran, & Safran, 2015), a useful tool for assessing alliance ruptures and strategies to repair them. The entire 3RS manual is available in the appendix of this book.

BACKGROUND AND JUSTIFICATION

The field of psychotherapy has not always acknowledged the emotional and interpersonal challenges that therapeutic work can pose for the individual therapist. In fact, in many ways our field has promulgated a myth that therapists are uniform dispensers of treatments: If one underwent behavior therapy or psychoanalysis, one received it regardless of who delivered it. More

[1]The case examples are based on actual experiences, so we have taken the proper steps to disguise the identities of our patients to maintain their confidentiality.

than 50 years ago, Donald Kiesler (1966) eloquently argued against this seemingly widespread notion that all therapists are the same. "The therapy" equaled "the therapist"—a perspective that persists today as suggested by the *New York Post* headline "How to Figure Out Which Therapy Is Right for You" (Laneri, 2016). It is akin to the notion that if one asks for a latte at a Starbucks, one gets the same latte—no matter which Starbucks barista one goes to (a key to the company's success).

Where did this idea of therapist uniformity come from? In psychoanalysis, there has long been the notion that the *analyzed analyst* could have all confounding countertransference expunged and could be totally objective—a blank screen for patient transferences or projections—and perfectly capable of implementing a single agreed-upon technique. The notion continues today in the *manualized therapist* (largely though not exclusively promoted by the cognitive-behavioral tradition), who is expected to conduct (or to be trained to conduct) an operationalized treatment protocol in a uniform manner. To some extent, the randomized controlled trial as the gold standard for evaluating the efficacy of an intervention has promoted the possibility of uniformity with its emphasis on operationalization and replicability, but to be fair there has always been a belief that training can produce some kind of uniformity. Maybe the only difference is a shift in emphasis from the promise of personal analysis to that of manual adherence.

In the past decade or so, we have witnessed an increasing interest in the development and measurement of *core competencies* in many fields, including clinical psychology, as evidenced by the "guidelines and principles" (now defined as "standards") by the American Psychological Association's Office of Program Consultation and Accreditation. In the same vein, we have also seen a number of recent considerations of *expertise* in psychotherapy (Hatcher, 2015; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). It is interesting to note the parallel interest in *mastery* across disciplines (see D. Epstein, 2014; Gladwell, 2008). Although these ideas are notably controversial and complex, they highlight the orientation of the field of psychotherapy—and the implicit pursuit of perfection. Not surprising, this pursuit has been linked to the measurement of treatment outcome and the sobering body of research regarding treatment failure rates, which become more alarming when one includes premature termination (Lambert, 2010, 2013).

The unfortunate consequence of such efforts is the depersonalization of the clinician. The relational turn in psychotherapies (an integrative movement that aimed to bridge the *interpersonal* with the *intrapersonal*) has challenged this with the introduction and careful consideration of the therapist's subjectivity, personality, and emotionality (see Aron, 1996; Mitchell, 1988; Ogden, 1994; Wachtel, 2008)—an appreciation that has expanded across theoretical orientations (Muran, 2001c, 2007a; see also L. S. Greenberg & Paivio, 1997; Guidano & Liotti, 1983; Safran, 1998, for further transtheoretical considerations—cognitive and humanistic). Accordingly, the therapeutic relationship has become more figural to the change process and understood as a

cauldron of desires and emotions contributed to by both patient and therapist. The turn was toward greater mutuality and intimacy—and to recognizing a new relational (Safran & Muran, 2000) or corrective emotional (Alexander & French, 1946) experience in the context of the therapeutic relationship.

The seeds of this movement were sown in the early contributions of Sándor Ferenczi (1932/1988) with regard to *empathic reciprocity* and Harry Stack Sullivan (1953) with regard to *reciprocal emotion* in the psychotherapeutic encounter. And various threads of thought are associated with it, including *social constructionism* (the recognition that meanings are developed in dialogue with others rather than separately within each individual; see Gadamer, 1960/1975) and relatedly *intersubjectivity* (the consideration of subject–subject relations in contrast to subject–object relations in human communication; see Habermas, 1971, and see Buber, 1923/1958, for his comparable "interhuman" perspective). The feminist impulse, which recognized and privileged the personal from the "I" of subjective experience (see Dinnerstein, 1976), is another major thread drawn in consideration of the psychotherapy process as an "intersubjective negotiation" (J. Benjamin, 1990; Pizer, 1998), in which patients and therapists are continuously negotiating their respective subjectivities—that is, their respective wishes about how they will work together (at a more explicit level), as well as their identities and desires to be mutually recognized (at a more implicit level).

The relational movement has been supported in part by considerable research demonstrating that not only are the nature and quality of the therapeutic relationship strong predictors of treatment success (Muran & Barber, 2010; Norcross & Lambert, 2019a) but therapists' individual differences may be an even stronger predictor (Wampold & Imel, 2015). In other words, (a) some therapists are consistently more helpful than others, (b) differences in therapist ability seem to be more important than type of psychotherapy, and (c) the more helpful therapists appear better able to facilitate the development and management of an alliance. This movement has also been supported by research on interpersonal complementarity (Kiesler, 1996) and by emotional communication (Tronick, 2007) that demonstrates the interactional nature of behavior and emotion. The empirical literature in psychotherapy suggests that developing therapist skills in negotiating the alliance may be a worthwhile way to redress psychotherapy failure rates (Eubanks, Muran, & Safran, 2018, 2019; Muran, 2019).

In our own work, we have identified *ruptures* in the alliance as both critical risk factors for failure and opportunities for therapists to improve outcomes. We have defined these events as marking the increased tension or conflict between the respective desires or needs of the patient and therapist (Safran & Muran, 2000). They indicate a breakdown in purposeful collaboration and a deterioration in the emotional bond between patient and therapist. Research has demonstrated that patients and therapists (whether in psychodynamic or cognitive behavior therapy) report ruptures in up to 50% of their sessions, whereas observers report them in as many as 30% to 100%; rupture frequency has been linked to negative process and treatment failure,

and their resolution to treatment completion and success. Other research has shown that ruptures pose significant emotional challenges to therapists, who too often engage in iatrogenic activities to manage or avoid them (Eubanks, Muran, & Safran, 2018, 2019).

There is increasing research on strategies to develop therapists' abilities to negotiate these ubiquitous challenges. Our own efforts in this regard have concentrated on developing therapists' emotion regulation skills, such as mindfulness and emotion labeling in relation to the other, and shown promising results, specifically decreasing negative process, such as hostility and control, and increasing positive process, such as expressiveness and affirmation (see Muran, 2019; Muran, Safran, & Eubanks-Carter, 2010; Muran, Safran, Eubanks, & Gorman, 2018). Research also links ruptures to the notion of microaggressions from the multicultural literature (e.g., Chang & Berk, 2009; Hook, Davis, Owen, & DeBlaere, 2017), suggesting that rupture resolution training has relevance for developing cultural competence. Now there is a developing literature regarding the notion of cultural humility (Hook, Davis, Owen, & DeBlaere, 2017), which promotes an open orientation to the other (sensibility oriented rather than knowledge based) and is in line with such notions as *allocentricity* (Schachtel, 1959), *beginner's mind* (S. Suzuki, 1970), and *courting surprise* (D. B. Stern, 1997), as well as the intersubjective and interhuman perspectives just presented.

Emotion regulation has been defined as the capacity to alter the trajectory of emotions and to tolerate intense emotions, including negative states such as anxiety, anger, and sadness (Gross, 1998; Gross & Thompson, 2007). It can involve various cognitive (reappraisal, distraction, suppression, distancing, and labeling) and behavioral (practice-based and exposure-based) strategies and has implications for communication and performance. Emotion (and affect) regulation has received significant attention with regard to patient personality and dysregulatory disorders (Fonagy, Gergely, Jurist, & Target, 2002; Linehan, 1993a) but much less so with regard to the therapist—and specifically therapist performance under pressure (and negotiation of ruptures). There is a growing body of research on performance under pressure in other disciplines and contexts, specifically investigating the cognitive and emotion science of such performance and examining strategies to promote emotion regulation, which can contribute to advancing performance science for the psychotherapist (e.g., see reviews by Beilock, 2010; Johnston & Olson, 2015; Kahneman, 2011).

In our research on rupture resolution and on how therapists can effectively negotiate negative emotions, we developed and evaluated a stage-process model (Eubanks, Muran, & Safran, 2018, 2019; Muran, 2019; Safran & Muran, 1996, 2000) that confirmed the effect of metacommunication—that is, communication by both therapist and patient about the communication process in which they are engaged. This technical principle involves therapists and patients putting words to their emotional experience and thus promoting emotion regulation for both. We have also demonstrated a positive effect of training

therapists with regard to this stage-process model and technical principle: Our research suggests that the movement to a more expressive position by both therapists and patients has therapeutic implications for rupture resolution and treatment outcome (Muran et al., 2018; Muran, Safran, Samstag, & Winston, 2005). We consider this movement as bringing intersubjective negotiation into relief and making *mutual recognition* more possible—that is, an intimate interhuman meeting between therapist and patient, a new relational experience for both.

CONCEPTION OF THE BOOK

As expressed in our preface, the conception of this book was based on professional and personal experiences. From our professional experiences in practice, research, and training, we have come to appreciate that therapists vary in their abilities to negotiate their relationships with patients, and this variability can be attributed to many factors: personal, familial, and cultural. You can see this variability by trait (across cases) and by state (within each case). We have devoted considerable time and effort to studying this variability, and in recent years we have concentrated on training therapists to better negotiate the emotional challenges they face in relation to their patients. From our personal experiences, we have come to appreciate the trials and tribulations involved in our various pursuits, which has made us recognize the challenges that are common to performance in many contexts. We have also come to appreciate that, for a variety of reasons, there is much to learn from other disciplines. As suggested by the ancient Indian parable of the blind men who each touch and describe a different aspect of an elephant from their limited perspective, there are multiple perspectives with equal truth claims; bringing them together increases the possibility of describing a more complete truth. Therefore, we should always be careful to study a topic with some regard for other worlds and eras. This book was conceptualized as one such effort that aims to integrate various sciences on performance, including and promoting that which concerns psychotherapy.

STRUCTURE OF THE BOOK

With this introduction, we characterize the therapeutic relationship as a cauldron of emotions that poses significant challenges for therapists, which we describe as alliance ruptures—breakdowns in collaboration and deteriorations in relatedness. Accordingly, therapists invariably face pressure to perform and to negotiate these critical events. In this regard, we propose careful consideration and integration of the science on performance, cognition, and emotion to advance our understanding and approach to psychotherapy. We suggest

an intersubjective and interhuman perspective founded on formulations from other disciplines and on findings from our own psychotherapy research program.

Chapter 1. The Science of Performance Under Pressure

We begin with a review of the science on decision making and judgment. We consider cognitive research on the various heuristics and biases that facilitate and interfere with our abilities to navigate ambiguity. Here we review the foundational work on naturalistic decision making (G. A. Klein, 1998) and counterfactual thinking (Kahneman, 2011) and outline the paths to mastery and pitfalls to failure. With regard to heuristics, we highlight overconfidence (Kahneman, 2011) and implicit bias (Greenwald & Banaji, 2017) as particularly pernicious and recommend greater humility and reflection in clinical practice. We examine the research on stress and its effect on attention, memory, appraisal, and judgment (Staal, 2004) and acknowledge the complex relationship of stress to performance, depending on the task and context. Then we turn to the role of emotion in performance—with particular attention to emotion regulation (Gross, 1998; Gross & Thompson, 2007), including its role in adapting to adversity and developing resilience (Bonanno, 2004). We also present the literature on deliberate practice and reflective practice (Ericsson & Pool, 2016; Schön, 1983) toward maximizing performance, which is integral to our later consideration of professional development.

Chapter 2. The Science of the Therapist Under Pressure

One of the most consistent findings in psychotherapy research literature is that the alliance between therapist and patient predicts treatment outcome (Flückiger, Del Re, Wampold, & Horvath, 2018). In Chapter 2, we review the research on how therapists fare in challenging clinical situations, with a focus on what therapists need to do to maintain strong alliances with their patients. We note factors that can contribute to therapist burnout, and we review the research literature on how therapists' difficulties managing their blind spots can contribute to problems in the alliance, with specific attention to countertransference (J. A. Hayes, Gelso, Goldberg, & Kivlighan, 2018), therapist attachment style (Strauss & Petrowski, 2017), and therapist microaggressions (Hook et al., 2017). We explore key findings from research on how therapists can contribute to negative process in therapy (e.g., Strupp, 1998), and the importance of therapists' skills under pressure (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016). We then turn our focus to the research on alliance ruptures (Eubanks et al., 2018), with particular attention to our own program (see Muran, 2002, 2019; Muran et al., 2009; Muran et al., 2018; Muran et al., 2005; Safran & Muran, 1996; Safran, Muran, Samstag, & Winston, 2005). We provide an operational definition of ruptures as specific patient behaviors or

communications, highlight our stage-process model of rupture resolution processes supported by task-analytic and other research, and present findings that aim to sensitize clinicians to critical interpersonal markers of rupture and possible trajectories of repair or resolution.

Chapter 3. From Emotion to Rupture

In recent years, we have witnessed an explosion in the study of emotion and a marked shift in emphasis on emotion in psychotherapy. We introduce current considerations from emotion researchers (Barrett, Lewis, & Haviland-Jones, 2016) that conceptualize emotion as state and process, basic and complex, and personal and interpersonal. We present a contemporary perspective of the research that basic emotions should be understood as componential and constructed (Barrett, 2017); that is, a basic emotion such as anger may have multiple systems and response tendencies that are constructed from previous experience and social influence. This perspective oriented toward the complex, from the intrapersonal to the interpersonal, leads to consideration of the interaction between emotions and emotion regulation (Gross, 2014a). We review the research on emotion regulation and then integrate the literature on multiplicity and intersubjectivity. We define emotion with regard to self schemas and self states and how these interact with those of another, how they reflect implicit needs for agency and communion, and how the negotiation of these needs relates to confrontation and withdrawal ruptures (Muran, 2001a, 2007b). We return to the concept of rupture; introduce its consideration in terms of therapist interpersonal markers; and then further our conceptualization as expressions of dissociative disconnections, interpersonal transformations, affective misattunements, vicious circles, and power dynamics in the process of intersubjective negotiation (J. Benjamin, 1990; Pizer, 1998). Both Chapters 3 and 4 represent a culmination of decades of clinical experience and advice. They synthesize some of the most important points from our previously published works and significantly update them to provide a fresh perspective on how to address emotional ruptures and repair them.

Chapter 4. From Emotion to Repair

We consider the principle of metacommunication (i.e., communication about the communication process) with fundamental features as a rupture resolution strategy that promotes emotion regulation and mutual recognition in the therapeutic relationship (Kiesler, 1988; Safran & Muran, 2000). In earlier chapters, we present various interpersonal markers (patient and therapist communications) of rupture: In Chapter 4, we introduce intrapersonal markers with regard to therapist emotions or internal experience. We present various basic to self-conscious emotions that therapists experience and provide clinical illustrations for each that demonstrate the principle of metacommunication and possible pathways toward regulation and recognition. Specifically,

we consider (a) basic emotions, such as anxiety and panic, anger and hate, sadness and despair; (b) self-conscious emotions, such as embarrassment and shame, guilt and self-doubt, pride and hubris; and (c) other emotional challenges, such as boredom and neglect, love and seduction, and misempathy and overidentification. We present brief vignettes with the understanding that emotional experience is complex and idiosyncratic and with the aim to illustrate *regulation-in-action* and *recognition-in-action*.

Chapter 5. A Way to Therapist Training

Historically, the literature on training has been limited, especially compared with the literature on practice and with regard to empirical support (Hill & Knox, 2013). In recent years, however, there has been much more attention given to this subject. In Chapter 5, we review several models of supervision (Falender & Shafranske, 2017; Hill, 2020; Ladany, Friedlander, & Nelson, 2016) and the literature on supervisory responsiveness (e.g., Friedlander, 2015). We concentrate on the presentation of our training program that was developed with support from the National Institute of Mental Health (Eubanks et al., 2015; Muran et al., 2010, 2018). The program targets emotion regulation as the essential therapist skill and implements principles and strategies consistent with those described with regard to deliberate and reflective practice (Ericsson & Pool, 2016; Schön, 1983). We highlight the program's training principles: (a) recognizing the relational context, (b) emphasizing self-exploration, (c) establishing an experiential focus, (d) practicing in simulated conditions and under pressure, (e) being responsive, and (f) practicing what you preach. We describe the program's training strategies: (a) didactic training on various theoretical lenses, evidence-based stage-process models, and process coding schemes, plus feedback through video analyses; (b) experiential training through mindfulness meditation and awareness exercises. We discuss the supervisory alliance and ruptures within it. We conclude with a presentation of a supervision illustration, specifically the application of an experiential or awareness exercise.

Chapter 6. A Way to Therapist Self-Care

Emotion regulation is also at the heart of our consideration of therapist self-care. We review relevant literature on self-care and self-development (see Bennett-Levy, 2019; Norcross & VandenBos, 2018) and draw from the performance science literature (covered in Chapter 1). We present recommendations for therapists to care for themselves and manage the emotional pressures and stress of psychotherapy. Specifically, we identify certain attitudes that we consider necessary for self-care: (a) maintaining humility, (b) cultivating compassion, (c) courting curiosity, (d) being patient, and (e) balancing with positivity. We also suggest a number of strategies: (a) mindfulness exercises (before sessions), (b) emotion journal (after sessions), (c) audio/video review (between sessions), (d) critical inquiry (search for contrary data; read about

probability theory, cognitive heuristics/implicit biases, and negative process), (e) practice under pressure (awareness-oriented role-plays), and (f) a competence constellation—a network of colleagues who provide guidance and support.

Conclusion: In the Pressure Cooker

Tennis great Billie Jean King famously noted, "Pressure is a privilege." Drawing on this quote (a good example of reappraisal and reframing that can emotionally regulate), in our conclusion chapter we return to our consideration of the emotional pressure inherent in the therapeutic relationship, and we elaborate on our narrative to normalize the experience of the negative emotions covered in this book and to emphasize the importance of embracing them for therapeutic gain. We have identified emotion regulation as an essential therapist skill with significant interpersonal implications, namely, for facilitating mutual regulation and mutual recognition—an intimate, interhuman meeting of the minds. We close by providing some definition to *what we know we know* and *what we know we don't know*, plus some speculation about *what we don't know we don't know* regarding therapist performance under pressure.

AIM OF THE BOOK

As fans have come to recognize when a team manager in baseball calls for a closer, the outcome is not always certain—not all closers are the same. Not every closer can deliver under pressure like New York Yankee great and Hall of Famer Mariano Rivera. And not always did the great Mariano deliver. Similarly, therapists vary in their abilities (both between and within) to negotiate experiences of intense emotions. By bringing together the performance literature and the psychotherapy literature in an accessible and engaging way, we aim to provide therapists with both conceptual and practical tools to help them mind and mine their own emotional experiences in high-pressure psychotherapy situations so that they too can perform with greater success under pressure.

Our target audience includes clinicians-in-training (graduate and postgraduate students in the range of mental health disciplines) during their academic education and practicum supervision, as well as more experienced clinicians who wish to reconsider and refine their approach to the ubiquitous experience of emotional stress, identity difference, and alliance rupture.