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Managing Anxiety: A Therapist Common Factor

Zain A. Shamoon[1] · Sara Lappan[1] · Adrian J. Blow[1]

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Abstract In this paper, we propose that therapist anxiety in the therapy room, especially anxiety stirred up by difficult or triggering clients, represents a challenge to effective therapy, and that effective management of this anxiety be considered as a necessary therapist skill for conducting quality couple and family therapy (CFT). We propose that effective therapists need to be able to manage their emotions, especially their anxiety, in order to truly help their clients. The failure to do this can lead to break downs in the alliance and the flow of therapy, and these deleterious effects can be prevented when therapists actively navigate their internal states through self-awareness and ongoing introspection. Bridging psychotherapy literature, we discuss specific strategies to this end, and make clinical recommendations for CFTs and CFT training programs.

Keywords Self of the therapist · Anxiety · Common factors · Training · Education · Couple and family therapy

For over a decade, couple and family therapy (CFT) scholars have debated the role of evidence-based models of treatment versus common factors of change (Sexton et al. 2004; Sprenkle and Blow 2004), including reflections on the therapist's role in that change process (Blow et al. 2007; Simon 2006). One important conclusion is that who the therapist is and how he/she goes about the practice of therapy is a centrally important component of the change process. In this paper, we explore one essential therapist quality required when doing therapeutic work with individuals, couples, and families: therapist anxiety management.

While we know that some therapists are more effective than others in motivating and facilitating change, there seems to be less clarity about which specific therapist factors contribute to outcomes, especially in couple and family therapy (Blow et al. 2007). In this paper, we propose that regardless of specific talent and experience, therapists who are in-tune with and able to manage their anxiety, are more helpful than those who are not adept at this process. We pull from a range of psychotherapy evidence to make this point, and will offer clinical and training recommendations for how CFTs can manage their anxiety as they work with clients.

While there are many affective states that need to be explored, for clarity, we will focus specifically on one emotion, anxiety, and how therapists navigate it in the realm of therapy. We want to clarify here that we are not talking about clinical manifestations of anxiety that are diagnosable. Rather, we are referring to the human experience of anxiety in a general sense, meaning the discomfort and innate reaction that occurs in response to a given stimulus. For example, a clinical diagnosis of anxiety is not necessary in the case of encountering a home intruder, or in the case of someone spontaneously yelling in a professional meeting. In such cases, the human experience of discomfort, and emotional reaction, is a response system that can occur for anyone. In this paper, we address anxiety in therapists that is evoked in stressful or emotion laden situations, which are typically encountered in couple and family therapy settings. This anxiety (or discomfort) can be

✉ Zain A. Shamoon
zain.shamoon87@gmail.com

Sara Lappan
lappansa@msu.edu

Adrian J. Blow
blowa@msu.edu

[1] Michigan State University, East Lansing, MI, USA

exacerbated when, for example, clients are hostile towards each other, are challenging to the therapist, they talk about extreme (to the therapist) political positions, or when they stir up unresolved issues in the history of the therapist. In most contexts, when this type of emotional response is mismanaged, it can lead to poor outcomes, often observed in interpersonal relationship breakdowns, avoidance of problems, or poor performances in occupation (Darcy et al. 2005; Geffken et al. 2006; Henning et al. 2007; Sanderson and Andrews 2006). The human experience of emotional arousal or tension, in this view, is not a negative experience in and of itself (McDowell 2008). However, when therapists do not have ample resources to manage this anxiety and discomfort, when it is activated in certain client contexts (e.g., high conflict), or find proper outlets for it, negative and iatrogenic clinical outcomes may occur, including alliance break down, therapists working too hard, or therapist burnout. As such, we need to underscore that therapists are not immune to the effects of anxiety and those who work with complex cases, and diverse family constellations, as are often presented to CFTs, have even more opportunities for this type of arousal. These occurrences need to be embraced as an organic part of the work to be navigated.

It is important to note that many variables contribute to poor outcomes in therapy. However, we want to highlight that when the therapist is unable to manage emotions stirred up in therapy, the chances of successful outcomes are compromised. Previous scholars have used research to highlight the maladaptive nature of mismanaged high therapist anxiety. Yulis and Kiesler (1968) asked therapists, who were identified as low or high anxiety practitioners (through an initial assessment), to listen to recordings of client statements that were hostile, sexual, or neutral in content. These therapists were asked about the extent to which they would get personally involved (emotionally engaged) with those cases. Results showed that the type of content did not have a bearing on the level of personal involvement exhibited by the therapist. However, results indicated that therapists who were able to manage their anxiety, or exhibited lower anxiety, become more in-tune and engaged with their clients, with less countertransference than therapists with high anxiety. This suggests that therapists may avoid engaging with their clients or may over-engage with clients, not because of concern for outcomes, but because they are reactive to their own high anxieties.

Billow (2001) reinforces this critical issue, noting that especially when practitioners face clinical uncertainty such as lack of theoretical clarity, they may be challenged to manage their anxieties to a greater extent. The main idea is that no therapist is devoid of reactive emotions, especially when more clients are added in the therapy room. Therapists unavoidably experience emotional arousal during the therapeutic process, including fears of being too emotionally engaged with clients, the arousal of unresolved issues mirroring client content, and wanting validation from clients. Billow asserts that new anxieties may emerge for the therapist as he or she shifts from individual therapy to including more persons in the process, and this has a likeness to couple and family therapy contexts, which often require changing family configurations in therapy and varying level of emotional volatility. Billow discusses that many clinicians avoid group settings for personal, instead of theoretical reasons. Similarly, Billow discusses that a therapist may be tempted to overly identify with a therapeutic process, or vehemently reject it, when they do not manage their discomforts. For the purposes of this paper, these may be viewed as reactive and avoidant responses to therapist anxiety, and occur when therapists are not aware of their emotional reactions or are unable to regulate their internal anxieties.

In many respects, acknowledging one's discomfort is adaptive and helpful such as when one has appropriate fear related to a dangerous situation. It is the process by which individuals negotiate anxiety and the extent to which it affects their lives that needs to be taken into consideration. Kahn and Garrison (2009) have demonstrated that even though anxiety is common, those who *deal with* their emotions through disclosure, or some form of expression, have fewer emotional problems, while inhibiting emotional expression can lead to maladaptive functioning. In another study, mindfulness was shown to be one strategy to managing regulatory, reactive, and inhibitory responses to anxiety (Hill and Updegraff 2012). In this study, *mindfulness* was defined as a process where an individual has awareness of his/her current cognitive and emotional state and possesses the ability to acknowledge personal mental and emotional experiences in the present moment. Therapists ideally also need some strategy to manage their anxiety as it comes up in specific sessions or across a range of cases. We posit that those who do will increase their ability to make clear, helpful, and active choices in the therapy room. The central action item becomes finding and utilizing spaces where therapists at any level of experience can navigate these feelings, such as in supervision, personal therapy, and or other forms of personal self-care.

The Detrimental Effects of Mismanaged Anxiety

Marston (1984) suggests that therapists will encounter frustrations during their work, and without coping strategies, this can hinder the effectiveness of their work. Because clients in therapy are often experiencing a range of affective states, therapists will also experience affective

struggles in working with them, and certain clients may activate discomfort in the therapist more than others. For example, working with a couple whose loud arguing reminds a therapist of their own past intimate relationship difficulties might be much more difficult (and emotionally arousing) for the therapist than other couples without the same negative association. Marston argues that if the therapist cannot manage this emotional experience, detrimental outcomes can occur for both the clients and the therapist alike. Marston also notes that there are worlds of frustrations that transpire for therapists working with difficult cases, including internal distractions, and these can have a toll on the therapist unless they are engaged in an ongoing process of self-care. Detrimental outcomes may include countertransference, projection, emotional disengagement, compassion fatigue, demoralization, hesitation, and reactivity toward clients. We fear that when therapists are not able to prevent these reactions, negative outcomes in therapy will result, including therapeutic alliance breakdown and early termination, and for the therapist specifically, burnout and emotional upheaval.

Compassion Fatigue

Compassion fatigue is described by Figley (2002) as a type of burnout experienced by psychotherapists when there is emotional investment or empathic engagement with clients, but no recourse for managing the emotional cost of that investment over time. It often occurs when a psychotherapist has the ability to be empathic, is motivated to help suffering people, is exposed to the suffering of the client, and attempts to respond empathically. This process can take an emotional toll on the therapist that can negatively impact his/her immune system or quality of life. Figley (2002) notes that education about compassion fatigue can help therapists prevent these negative effects. If therapists are given knowledge, including reading materials during their training, regarding the negative outcomes of unmanaged affect, as well as close supervision and mentoring, they will be more equipped to prevent compassion fatigue, negative countertransference, and other consequences. CFT training programs need to train beginning therapists to take active steps to combat compassion fatigue and encourage beginning therapists to take necessary steps to prevent its occurrence early on in their careers.

Negash and Sahin (2011) acknowledge that therapists deal with a wide variety of client content, ranging from moderate to extreme intensity, including presenting problems of relational disharmony, death, divorce, or various forms of trauma, to name a few. In dealing with these issues, empathic connections with clients are crucial in order to deliver beneficial therapeutic services, but these connections may take an emotional toll on the therapist, as described earlier. As a result of persistent emotional arousal or anxiety, a therapist may encounter immense fatigue at times. If the emotions leading to this fatigue are left unattended, therapists may exhibit depersonalization, countertransference, loss of empathy, lack of respect for a client, and ruptures in the therapeutic alliance. This is a serious concern considering that therapeutic alliances have been demonstrated as necessary for positive outcomes in most cases (Blow et al. 2007). In addition, Negash and Sahin (2011) discuss the potential for ethical and professional abuses amongst therapists who are not emotionally regulated, including low quality of care, legal liability, and even client abuse.

Countertransference, Projection, and Unresolved Family of Origin Issues

The earliest therapists (e.g. Sigmund Freud) discussed a concern with therapist *countertransference*, or the projection of their subjective emotions and anxieties upon clients. Certainly, therapists are not exempt from being defensive humans by mere virtue of their profession. As such, therapists should not assume that they will always be able to create utility out of their emotional responses without some concentrated effort. Anxious defensiveness, for example, might lead a therapist to over or under emphasize important client information during the therapeutic process. From a family therapy perspective, Bowen (1976) and colleagues (e.g., Friedman, Titelman) suggested that unresolved issues in one's family of origin would come out in unhelpful ways in the therapy room such as when the therapist overreacts to a presenting family issue or avoids an issue completely. This occurs because therapist anxiety and discomfort get in the way of staying centered throughout the therapy process.

Demoralization, Hesitancy, and Reactivity

Ackerman and Hilsenroth (2001) provide a comprehensive meta-analysis of therapist factors that inhibit positive change for clients. Consistent with our view, these are conceptualized as behaviors exhibited when therapists do not process their own feelings. They highlight the following negative characteristics of therapists that contribute to the erosion of the therapeutic-alliance: rigidity, uncertainty, criticism, distance, and distractibility. When therapists are stirred up, and not in control of their reactions, they may be more likely to practice any one of these behaviors. Ackerman and Hilsenroth also list intervention strategies that contribute negatively to the therapeutic alliance: overstructuring sessions, inappropriate use of self-disclosure, unsuitable use of silence, and overuse of transference interpretations. These negative strategies are all based in

therapist anxiety at some level and, for the most part, are unhelpful to therapy.

Silberschatz and Curtis (1993) suggest that therapists help their clients succeed when their attitudes and behaviors match the unique problems and treatment goals of clients. But when therapists are subject to their own reactions, matching with client needs may become more difficult. For instance, Silberschatz and Curtis (1993) find it is advantageous when therapists validate clients for trying to find their way out of pathological self-concepts. In cases when therapists are subject to their own insecurities, it may be easy to avoid these opportunities to support clients' personal efforts. Instead, reactive therapists may avoid or project information during these crucial junctures in the work.

Mismanaged Anxiety Undermines the Process of Alliance Building, Deepening, and Repair

Blow et al. (2007) suggest instead that sensitive and engaged therapists have better outcomes when compared with therapists who are not sensitive towards their clients. It is incumbent on the therapist to establish, deepen, and repair the alliance with clients, and therapists will inadvertently damage their alliances if they are anxious in sessions. Anxiety leads to over-controlling sessions through behaviors such as micro-management instead of relying on process, trying too hard to fix things, and working to please people instead of heal them. It is crucial for therapists to create a safe place for the work of therapy through which change can occur. Therapy needs to be a place where the process of the client system can unfold, and then the therapist can intervene at the right time and in the right way. Anxiety, not managed, can interrupt and sabotage this process. Clients that pick up on therapist anxiety may end up feeling less safe or confident in the ability of the therapist to help as a result.

Awareness of Self: A Resourceful Frame in Delivering Therapy

Self-of-the-therapist work is closely linked to the work of Bowen, and therapist introspection and self-awareness is viewed as an important aspect of therapist development (Aponte et al. 2009; Timm and Blow 1999). This literature suggests that therapist exploration of their personal life histories and experiences works to bring about awareness of issues that can impact therapy. Many common factors of change (e.g., alliance, hope generation) are delivered through the therapist, but when therapist emotions are stirred up, or if therapists become demoralized, the progress or erosion of therapy depends on how the therapist handles the internal affective disruptions. For example, therapists are likely to confront their clients' presenting problems, traits, and relationship styles, and this may stir up the therapist's personal emotions. However, when therapist anxiety builds without proper regulatory outlets or recourse, they may react in extreme ways. For example, a therapist who is stirred up may end up avoiding client content altogether or find themselves over-responding to it in a way that alienates the client system. Bandura (1956) states that anxiety-provoking situations for the client might also be anxiety-laden for everyone else, including the psychotherapist. CFTs need to know "how" successful therapists respond to their own feelings and how these responses are then used to facilitate positive change for clients. In exploring "how", we call for long-time CFTs, CFTs new to the field, and CFT training programs alike to promote and incorporate self-regulation methods related to anxiety and other emotional activation, including meditative practice and mindfulness, to create increased awareness of internal affective arousal during the course of work with couples and families. For graduate and professional training programs, this may mean instituting person of the therapist curricula as part of the mandatory education of all trainees, as well as incorporating therapist affect management as a crucial component of clinical supervision and training.

For those out in the professional world, this may mean entering into an ongoing engagement with mindfulness activities, utilizing personal therapy, and involving themselves in self-care and self-regulation activities on a frequent basis. Active engagement in one's own social support network is another form of respite that may re-energize therapists for the emotionally-laden work that they do. We believe that therapists or training programs not invested in these processes are ignoring crucial therapist factors that inform best practice.

How CFTs Can Use Emotion to Understand Themselves and the Work They Do

Therapist's Self in Relation to Others: Working with Couples, Families, and Groups

Richarz (2008) discusses group therapy, asserting that the leader of the group is part of that group, and must address his or her own experience of being within it. This is an apt description of CFT sessions; CFT therapists are dealing with group dynamics, be they dyads of siblings or couples, triads such as parents and their children, or entire family constellations. In a CFT framework, group, couple, and family therapy all give rise to complex dynamics. This creates an opportunity for complex intersections arousing a

therapist's emotions and subjectivities, as well as the possibility of countertransference occurring in response to multiple parties instead of a singular relationship with an individual client. Because CFTs have their own relational experiences and communication patterns practiced long before they were trained as mental health professionals, family and group dynamics in the room may trigger memories of their own families of origin and other close relationships. Without processing these emotions in response to client content, CFTs may reproduce old relational patterns, and this could be detrimental to the flow of therapy. For example, consider the possibility of a couple's presenting content sharing a likeness to the negative communication patterns of a therapist's parents. Without important attention to this familiarity, the therapist may be vulnerable to reacting to his or her discontent with that pattern, or become triangulated into it. There is of course a solution. Protinsky and Coward (2001) suggest that therapist development is contingent on the synergy between personal and professional realms. For example, therapist awareness of and resolution of their own family of origin pain can serve as a resource to delivering better therapy, as opposed to a hindrance (Timm and Blow 1999).

Elaborating on this synergy of the personal and professional world, Richarz (2008) discusses that therapists have the power to situate the environment of therapy, and at times the clients may be compelled to match the expectations of the therapist rather than informing the process themselves. Since therapy is *for the clients,* therapists need a way to keep their self-interests from interfering with client goals. This means that each therapist should take ownership of their role in the process, and this has much to do with self-awareness about individual and relational dynamics that likely stir their anxieties. Therapists can put this awareness in motion through attention to their feelings when they come up throughout sessions. Therapists can use these moments of physiological arousal to remind them to consider personal matters that might impede client goals. Keeping attuned in this manner is consistent with the goals of mindfulness, which can reduce reactivity.

Glebova et al. (2012) use data from a longitudinal study to explore the role of therapist comfort during the delivery of home-based therapy using Multisystemic Therapy (MST). Comfort is conceptualized as the extent to which therapists felt safe working in certain neighborhoods, as well as in dealing with multi-stress issues such as juvenile delinquency, and substance abuse. Note, this context and presenting problem is often quite anxiety provoking to therapists, as it would be to many people. These researchers found that a solid working alliance with clients was correlated with higher therapist comfort. In this study, therapists did not become more comfortable throughout the course of treatment, suggesting that it is not something that will increase on its own. Instead, comfort is something to be actively developed.

Bridging the Gap: How Does the Therapist Succeed?

Personal introspection and affect regulation are key components of effective therapy practice. Affect management is necessary, but does not account for all of a therapist's development and quality. Moreover, there are certainly mindful, introspective people who do not make good therapists, suggesting that other therapist factors need to be explored and studied. In addition, mismanaged anxiety does not underscore all threats to quality therapy.

There are multiple ways that counselors and therapists can work on regulating their feelings, during their training and afterward. Utilizing both training and personal methods to do this is a necessary buffer against aforementioned countertransference, reactivity, hesitation, compassion fatigue, or projection that may occur on the part of the service provider. Affect regulation is an ongoing commitment, and is part of the larger aim to engage in personal insight, needed to make better choices towards positive outcomes for our clients in the therapy room.

The following section will propose specific ways for therapists of all developmental stages to practice affect regulation in general and anxiety management specifically. Included are focused strategies for CFT training programs.

Strategy One: Embrace your Anxiety

Our first suggestion is that CFTs need to be in touch with their humanness, which includes their vulnerabilities and insecurities that can show up in their professional work. Existentialism is an apt theory to frame this acceptance, because it implies a focus on *being* and *existing* (Smith 2000). This theory outlines three core principals in human functioning: (1) human beings often find themselves inside a tension (anxious pull) between feeling free and feeling constrained, (2) reactivity to one of the extremes (i.e. hyper impulse or extreme inhibition) promotes human dysfunction, and (3) moderation of the tension between the extremes promotes well-being. This theory emphasizes the importance of human agency and the capacity to promote positive change. This theory suggests that therapists need to learn to sit with this tension to allow it to resolve, and underscores our view that anxiety is a common experience for all human beings that needs to be confronted. Schneider and May (1995) reinforce this notion; in their view, *experiencing* things becomes a focal point of interest in human life. Schneider and May define dysfunction as the *byproduct* of resisting that experience, instead of

embracing it. A therapist's lack of competence may function as a byproduct of resisting emotional experiences that are aroused during the process of delivering therapy. Therapists who are unable to allow themselves to experience and work through this discomfort may end up making poor therapy decisions or may find themselves engaging in unconscious behaviors, such as avoidance of client content, and in this way they may end up undermining the goals of therapy. In a clinical training program, this may mean helping therapists practice a non-judgmental attitude towards their own affective states. For example, a trainee in a CFT graduate program, as part of a course or in supervision, may be asked to reflect on a case while closing their eyes, and paying attention to feelings that come up about that case. When certain feelings arise, such as anger or anxiety, the trainee may be asked to note, acknowledge, and get to know that feeling instead of doing something to try to get rid of it. The point here is that when we try to get rid of feelings, we may be doing so in ways that project on or react to our clients, since our central focus is the removal of those feelings. Instead, viewing and embracing that affective state as natural helps us normalize and move forward. One might consider this as a way of being "in tune" with oneself, enough to slow down and make process oriented choices that are helpful for our clients in the moment.

Schneider and May (1995) offer therapeutic directives to help clients moderate affective reactions. These include: (1) *presence* and (2) *invoking the actual* (*here and now experiences*). The first prescription implies deep and ongoing engagement with client's needs. The second prescription to *invoke the actual* implies being aware of the real-life experiences one is having (such as anxiety or sadness that is aroused) while delivering therapy, and navigating these experiences in some active manner. One might accomplish this by being curious about what is happening to oneself rather than jumping to judgment and a need to get rid of that feeling. Of course, how one accomplishes this depends on the context they are in, whether they are in a training setting, professional setting, or otherwise. Each setting requires its own strategy of managing and embracing affective states. In coursework, this may mean picking a feeling that is triggered and writing a reflection paper on it. In supervision, this may mean talking with one's supervisor about a case that is especially triggering, and using that supervision space to own and process those feelings.

Strategy Two: The Use of Feedback Mechanisms

An emerging bright spot in CFT curricula is the implementation of client-feedback assessments into the trainings of accredited programs (Karam et al. 2016; Sparks et al. 2011). The purpose of this is to make therapists accountable to their clients in a direct way, such that better outcomes are produced. Consistent with an emphasis on internal therapist mechanisms, proponents of this assessment strategy contend that there is more to being trained than taking classes and accruing clinical hours. Historically, there have not been adequate client-therapist feedback mechanisms incorporated into training programs. As such, therapists in training remained only passively accountable to their clients by way of supervisor critique. The appropriate use of these mechanisms may spark necessary affective states in therapists that afford an opportunity to continually practice reflection and management of those states. We note, for example, that discomfort may come about when a therapist finds out that a client isn't progressing as they would like. However, the client's view of progress matters the most, no matter how it makes the therapist feel. This means that the therapist needs to be accepting of the client's actual view of progress, which means they need to be accepting of discomfort that may arise when hearing this. Feedback assessments, such as the ones presented in Sparks et al. (2011), are a form of outcome management (OM). OM focuses on the effectiveness of therapy, and clients' experiences of the therapist and the therapy process. The use of these methods, while evoking anxiety, also pushes therapists to shift the process to meet the goals and needs of clients.

Strategy Three: Self-of-the-Therapist Courses

Aponte et al. (2009) present another way to utilize therapist feelings in promoting the welfare of clients. They discuss the inclusion of formal *self-of-the-therapist* courses in CFT training. Aponte et al. (2009) present the *Person-of-the-Therapist Training* (POTT) model as the guiding framework for the course. A basic premise of the model is that therapists are fully human, with vulnerabilities that must be considered in order to help them deliver quality therapeutic services. Aponte et al. (2009) discuss the large curricular gap at family therapy training programs regarding self-of-the-therapist issues. Responding to this gap, Aponte and colleagues suggest that the mastery of *self* is related to affective responses when encountering challenging content from clients. They assert that emotional aspects of self are likely to become aroused during therapy or as we state, therapists are likely to become more anxious in the midst of certain therapeutic contexts. Aponte et al. (2009) theorize that positive changes in a therapist's *self* are related to positive changes in the spaces they occupy, such as the therapy room. If therapists are committed to aspects of their self, this may have an isomorphic influence on the client. Because therapists expect their clients to encounter their real-life difficulties, therapists need to be willing to do the same.

The purpose of the self-of-the-therapist course proposed by Aponte is to extract the therapist's anxieties and wounds that may impede the therapeutic process if they continued to be ignored. The stages of this course occur in the following order: (1) allowing students to identify personal issues and struggles; (2) encouraging students to identify when these issues manifest during the course of their clinical experience; and (3) encouraging students to plan and actualize the use of *self* in therapy with clients. This does not imply that students need to disclose their personal matters with clients. However, it *does* imply they must be aware of those personal matters, and learn to utilize them in a manner that is consistent with positive outcomes for the people they serve. One of the major goals of the course is to help students become more comfortable with, and accepting of, themselves. The outcomes of this course include increases in students' abilities to regulate their affect and manage anxiety. Of course, in order to implement a course like this, Aponte et al. (2009) encourage the use of a confidentiality protocol for students. For instance, in the pilot course, students were required to keep each other's information in confidence. An additional prescription is to encourage faculty to shift their attitude about student learning. Instead of being corrective about student problems, they suggest that faculty help students reframe their struggles as opportunities for growth and greater competency. This will allow a framework to persist where students can safely confront their vulnerabilities in the context of training.

We charge the CFT graduate curriculum at large to highly consider making courses like this a regular part of their curriculums, either salient across coursework or in a specific classes mandatory to all beginning therapists.

Strategy Four: Ongoing Introspection

Rober (2005) discusses the concept of dialogical self, implying a self-reflective and receptive process wherein the therapist is listening to his/her inner voice. One of his recommendations is that therapists can take a stance of "not-knowing" when there is a gap in their expertise. When therapists are honest that they don't know something, they open themselves up to a process of genuine inner dialogue. Here, they make room for client's needs, instead of their *urge* to respond with expert knowledge. Therapists need be okay with the anxious arousal that occurs when they don't know something, because this is a likely occurrence, especially when something perplexes them, or when client content puts them in a daze because it is far too familiar to their personal experience. This process allows therapists to step back from their most intense feelings, brought up during the course of therapy, and to use this space to make more helpful decisions with and for their clients. It is possible to conduct a simple reflective task as part of clinical supervision nights in training programs, or part of group meetings at any clinical practice.

Being able to understand what is happening to oneself is crucial, and beginning therapists may not know that they should make a concerted effort to interrogate what is happening to them. Aponte and Kissil (2014) drive this point home when they discuss *signature themes,* which refer to core issues that come up for the therapist in the process of delivering therapy. Rather than conceptualizing this as unhelpful noise that needs to be put aside, Aponte and Kissil (2014) say that these signature themes are crucial assets in therapy room. The important shift being that one does not try to run from their vulnerabilities (which can manifest by way of countertransference, compassion fatigue, reactivity, avoidance, etc.), but instead work towards an acceptance of self that leads to the utilization of one's own issues as a resource in helping others heal. Knowing about our own human suffering and human struggling can deepen our ability to assist others who are also going through challenges. Reflective questions by a facilitator in group supervision, individual supervision, or in a graduate course can catalyze this process of introspection. A supervisor or professor can simply ask trainees or students to reflect on the directive: Y happens to me when X happens in the therapy room with my clients. How to best accomplish this reflective task is up to the creativity of those supervisors and teachers in charge of this task.

Much of what we have described in Strategy Four has been accounted for by mindfulness directives, which would be crucial to incorporate into clinical practices and training programs. Mindfulness is defined as the ability to observe one's own experience in real time without judgment (Eubanks-Carter et al. 2014). The aim is to increase curiosity about oneself and others, as passing moments of reality without assigning evaluation in those moments. Gehart and McCollum (2008) showcase how mindfulness can function through existing practicum structures, engaging students with readings, in-class mindfulness exercises, journaling, and daily student practice of mindfulness. McCollum and Gehart (2010) provide some suggestions regarding the best use of mindfulness training with students. For one, when mindfulness is part of the supervision process, supervisors must also practice it. Teaching and practicing in a group is the best way, as it may create solidarity and safety for participants. It can be beneficial to require just a small amount of mindfulness practice at a time, so that students are encouraged to be steadfast instead of overwhelmed by the practice all at once. It is also important to let the students know that they don't have to be perfect in practicing it and that everyone struggles with it. Teachers of the practice need to be clear that this is part of improving therapeutic skills, and need to make sure not

to impose specific religious or spiritual understandings of this practice upon their students.

Several researchers (e.g., Anderson and Worthen 1997; Fauth and Williams 2005; Turner 2009) suggest that self-awareness is a useful tool in interpersonal engagement and the establishment of the therapist-client alliance. When therapists experience this awareness increasing, they tend to see themselves as more helpful, and this leads to more interpersonal engagement with their clients. However, the task of self-management extends beyond the therapy room. We define any reductive form of mindfulness in the room as mismanagement, because self-introspection must be an ongoing conviction, not a one-time attempt to manage all of one's self issues. We aren't calling for therapists to be tracking their thoughts and feelings in a homework-like sense, but to be present with their emotions as a larger life skill. Boellinghaus et al. (2013) agree that it is crucial to engage in a deep emotional introspection, and this will allow therapists to work more effectively than ones who do not engage in such processes.

One practice that can be conducted in therapists' supervision comes from a Shapiro et al. (2007) study that suggests that mindfulness-based stress reduction (MBSR) can help students learn to manage their affective states. This study showed reduction of rumination amongst participants engaged in MBSR. Rumination can be understood as an attempt to handle, and fix, one's feelings and cognitions, rather than to be aware of them and accept them. Certainly, focusing on oneself in this obsessive manner can be exhausting, doesn't lead to relief, and will distract one from delivering quality care. A proper focus on self has to do with being honest or mindful about one's emotional state, rather than overcompensating for it or fixing it immediately in an attempt to discard the feeling. Because beginning therapists-in-training are likely to be focused on competence in clinical programs and graduate schools, supervision becomes an important site where they can learn the difference between fixing (a self-centered directive) and processing. We challenge therapists to regulate themselves in a way that re-centers the client, and they need good supervisors who can help them learn how to do this.

Strategy Five: Ongoing Supervision and Support Groups

When therapists perceive strong support from supervisors, they experience less burnout, reduced emotional exhaustion, and increased personal accomplishment (Gibson et al. 2009). Moreover, this support is related to increased therapeutic self-efficacy. Watkins (2012) contends that beginning therapists are able to accept themselves and develop into confident healers when they have safe spaces such as supervision to grapple with ambiguities and discomfort involved in conducting therapy. Watkins also suggests that demoralization among therapists is a natural part of the therapist developmental process leading to optimal identity formation, and views supervision as a process that can provide a *re-moralization* for therapists, especially therapists who are early in their careers. When supervisors provide a nurturing experience, conveying that they believe in the therapist's potential, the experience can be one of growth for the supervisee. This includes all of the therapist concerns about lack of competence and confidence. The supervisory relationship helps them work through times of real or perceived crisis and failure.

The use of group supervision or similar support groups can provide the necessary context for therapists to process their anxieties and come to a place of resolve. Moss (2008) discusses the value of supervision, and of attending groups, that can help therapists manage emotions catalyzed in therapy sessions. When these intense projections intersect with the therapist's personal anxieties, this can hurt the therapeutic process. As such, therapists need safe space to reflect on their work. Supervision groups need to be established with safe ground rules, and with supervisors who operate with thoughtfulness, reflection, and motivation for their supervisees. The supervisor who leads these groups must be aware of, and know how to manage, projections and reactions in the group process. Otherwise, group dynamics are likely to be mismanaged, in the same way therapists might mismanage their own sessions with clients if they do not remain thoughtful and reflective.

Moss (2008) reflects on the processes of *holding* and *containment*, which are elements of the group supervision process that help therapists regulate their reactions to therapy work. Holding refers to bearing intense feelings without reaction or projection, much like the goals of mindfulness. The object is for one to hold or sit with alertness towards their feelings. Containment refers to producing an interpretation of that experience. Holding and containment, if practiced, allow the therapist to slow down the process of introspection when encountering intense feelings, such that active and productive choices can be made in their life and therapeutic work. Learning how to sit with and interpret feelings can be accomplished in a quality support group or supervisory context. This slowing down is especially a needed skill in the midst of a therapy session, because it allows a therapist to take time in processing what is happening—without practice, they may quickly react to triggering content that arises in sessions.

Strategy Six: Self-Care

Psychotherapists often ignore their own wellness when they focus on the health of their clients. Macchi et al.

(2014) studied the impact home-based family therapy (HBFT) experience and workload upon HBFT therapists' professional quality of life. Professional quality of life is defined as the extent to which a therapist is satisfied in their work and if they are at free from risk for burnout or compassion fatigue. Macchi et al. (2014) were interested in looking at what might prevent these negative outcomes, and what variables increase therapist satisfaction. The results of this study indicate that experience and self-care functioned as two protective factors against negative affective outcomes for therapists, such as burnout or compassion fatigue. Frequent supervision also seemed to function as an important protective factor. Here, we find that self-care can help buffer against the negative impact of perceived high workload upon quality of life for therapists, where therapists need to be dedicated to their wellness inside and outside of their workplace. There are many ways that therapists can practice self-care. We suggest the following: (1) Do something that's strictly for oneself outside of therapy, such as watch a movie, read a good book, or commit to a hobby that one finds pleasing, (2) Protect ones sleep and eating habits—it is difficult to encourage good behavior for our clients without dedication those things in our own lives, (3) Seek therapy or do something that involves you getting help rather than delivering help, such as personal or group therapy, (4) Don't be your family's therapist; you need the energy to be there for your clients, and (5) Practice healthy boundaries—do not take on cases that trigger you intensely, or more cases than you can handle.

Consistent with our recommendations, Marston (1984) states that there are external and internal methods of coping through the frustrations of therapy. External self-care methods may include those that the therapist engages in that don't focus on the job task of therapy itself. This means that there are ways to self-care without disengaging from professional work, but rather, engaging in other professional endeavors. For example, someone might practice shifting one's professional work to include teaching or being a reviewer for papers. In this way, one's professional satisfaction is not hinging solely on managing the stresses of delivering therapeutic services, but also influenced by other professional experiences that make up one's daily and weekly life.

Strategy Seven: Model Flexibility and Heightened Self-Identity

Davis and Piercy (2007) demonstrate that having a model can help therapists tackle client problems by creating an order and structure for dealing with various presenting issues. By using a specific model as a tool for conceptualization, therapists can organize their interventions throughout treatment in a clear and organized fashion. However, it is our view that rigid adherence to one model is not robust enough to guard against mismanaged anxiety. Therapists cannot only rely on their specific model to help them with every presenting issue that might trigger them. It is plausible that strict unwavering adherence to a model may even keep a therapist from being present with their own affective state. Davis and Piercy (2007) note that they call for model use, but that therapists should be flexible beyond those models to ensure that the process of therapy is helpful for specific clients.

We agree with Blow et al. (2007) that therapists need to center their work on the clients' needs, and this includes choosing a model that best suits those needs. While therapist comfort might be maximized if they had only one theory to learn and draw from, this is an idealized view that does not reflect the non-linear dance of real world therapy. Clients have so many different needs, cultural nuances, and therapy contains so many unexpected variations that therapists would benefit from having a host of approaches they feel confident to practice. Varied approaches are needed when working with clients whose lives differ from ours, whose worldview deviates from our own, and whose presenting issues do not represent our own lived experiences.

Conclusion

There is high potential for any therapist to encounter in their clients emotionally charged content, including some matters all too familiar with their own personal experiences. Taking ownership of times that we become reactive or uncomfortable, and learning how to effectively manage these moments in therapy is crucial in ensuring positive outcomes for clients. Because the therapist-client alliance is a central component needed for positive change, this relationship becomes a sensitive element in therapy that needs to be preserved. When therapist feelings and affective states are ignored or mismanaged, this alliance is likely to erode or keep from forming in the first place. Other consequences may also emerge such as lack of progress, and harming our clients emotionally. However, the concept of therapist affect management provides an opportunity to include *self-of-the-therapist* knowledge to the *common factors* conversation, where lessons can be learned about how therapists can remain attuned to what happens to their feelings as they do this work. We have emphasized how the mishandling of anxiety is detrimental to clients in therapy, and demonstrated several ways that it can be managed to maximize the benefit of psychotherapy. Further exploration on therapist factors needs to ensue, including researching specific internal and introspective skills that successful therapists possess. Scholarship and research on distinct

emotional states amongst therapists need to be observed in the future (i.e. sadness, depression, anxiety, attraction to clients, etc.). In this paper, we sought to underscore the natural experience of discomfort and anxiety that is likely to arise in any emotionally charged work, especially in psychotherapy. We encourage CFTs and the psychotherapy field at large to consider incorporating a stronger emphasis on therapist anxiety management in training, and in ongoing practice.

References

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy, 38*(2), 171–185. doi:10.1037/0033-3204.38.2.171.

Anderson, D. A., & Worthen, D. (1997). Exploring a fourth dimension: Spirituality as a resource for the couple therapist. *Journal of Marital and Family Therapy, 23*(1), 3–12. doi:10.1111/j.1752-0606.1997.tb00227.x.

Aponte, H. J., & Kissil, K. (2014). If I can grapple with this I can truly be of use in the therapy room: Using the therapist's own emotional struggles to facilitate effective therapy. *Journal of Marital and Family Therapy, 40*(2), 152–164. doi:10.1111/jmft.12011.

Aponte, H. J., Powell, F. D., Brooks, S., Watson, M. F., Litzke, C., Lawless, J., et al. (2009). Training the person of the therapist in an academic setting. *Journal of Marital and Family Therapy, 35*(4), 381–394. doi:10.1111/j.1752-0606.2009.00123.x.

Bandura, A. (1956). Psychotherapist's anxiety level, self-insight, and psychotherapeutic competence. *The Journal of Abnormal and Social Psychology, 52*, 333–337. doi:10.1037/h0043075.

Billow, R. M. (2001). The therapist's anxiety and resistance to group therapy. *International Journal of Group Psychotherapy, 51*(2), 225–242. doi:10.1521/ijgp.51.2.225.49856.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy, 33*(3), 298–317. doi:10.1111/j.1752-0606.2007.00029.x.

Boellinghaus, I., Jones, F. W., & Hutton, J. (2013). Cultivating self-care and compassion in psychological therapists in training: The experience of practicing loving-kindness meditation. *Training and Education in Professional Psychology, 7*(4), 267–277. doi:10.1037/a0033092.

Darcy, K., Davila, J., & Beck, J. G. (2005). Is social anxiety associated with both interpersonal avoidance and interpersonal dependence? *Cognitive Therapy and Research, 29*, 171–186. doi:10.1007/s10608-005-3163-4.

Davis, S. D., & Piercy, F. P. (2007). What clients of couple therapy model developers and their former students say about change, part I: Model-dependent common factors across three models. *Journal of Marital and Family Therapy, 33*(3), 318–343. doi:10.1111/j.1752-0606.2007.00030.x.

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2014). Alliance-focused training. *Psychotherapy,*. doi:10.1037/a0037596.

Fauth, J., & Williams, E. N. (2005). The in-session self-awareness of therapist-trainees: Hindering or helpful? *Journal of Counseling Psychology, 52*(3), 443–447. doi:10.1037/0022-0167.52.3.443.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433–1441. doi:10.1002/jclp.10090.

Geffken, G. R., Storch, E. A., Duke, D. C., Monaco, L., Lewin, A. B., & Goodman, W. K. (2006). Hope and coping in family members of patients with obsessive-compulsive disorder. *Journal of Anxiety Disorders, 20*, 614–629. doi:10.1016/j.janxdis.2005.07.001.

Gehart, D. R., & McCollum, E. E. (2008). Teaching therapeutic presence: A mindfulness-based approach. In S. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship* (pp. 176–194). New York: Guilford.

Gibson, J. A., Grey, I. M., & Hastings, R. P. (2009). Supervisor support as a predictor of burnout and therapeutic self-efficacy in therapists working in ABA schools. *Journal of Autism and Developmental Disorders, 39*(7), 1024–1030. doi:10.1007/s10803-009-0709-4.

Glebova, T., Foster, S. L., Cunningham, P. B., Brennan, P. A., & Whitmore, E. (2012). Examining therapist comfort in delivering family therapy in home and community settings: Development and evaluation of the therapist comfort scale. *Psychotherapy, 49*(1), 52–61. doi:10.1037/a0025910.

Henning, E. R., Turk, C. L., Mennin, D. S., Fresco, D. M., & Heimberg, R. G. (2007). Impairment and quality of life in individuals with generalized anxiety disorder. *Depression and Anxiety, 24*(5), 342–349. doi:10.1002/da.20249.

Hill, C. L., & Updegraff, J. A. (2012). Mindfulness and its relationship to emotional regulation. *Emotion, 12*(1), 81–90. doi:10.1002/da.20249.

Kahn, J. H., & Garrison, A. M. (2009). Emotional self-disclosure and emotional avoidance: Relations with symptoms of depression and anxiety. *Journal of Counseling Psychology, 56*(4), 573–584. doi:10.1037/a0016574.

Karam, E., Blow, A., Davis, S. D., & Sprenkle, D. H. (2016). Strengthening the systemic ties that bind: Integrating common factors into MFT curricula. *Journal of Marital and Family Therapy,*. doi:10.1111/jmft.12096.

Macchi, C. R., Johnson, M. D., & Durtschi, J. A. (2014). Predictors and processes associated with home-based family therapists' professional quality of life. *Journal of Marital and Family Therapy, 40*(3), 380–390. doi:10.1111/jmft.12016.

Marston, A. R. (1984). What makes therapists run? A model for analysis of motivational styles. *Psychotherapy: Theory, Research, Practice, Training, 21*(4), 456–459. doi:10.1037/h0085988.

McCollum, E. E., & Gehart, D. R. (2010). Using mindfulness meditation to teach beginning therapists therapeutic presence: A qualitative study. *Journal of Marital and Family Therapy, 36*(3), 347–360. doi:10.1111/j.1752-0606.2010.00214.x.

McDowell, B. M. (2008). Katts: A framework for maximizing nclex-rn performance. *Educational Innovations, 47*(4), 183–186. doi:10.3928/01484834-20080401-04.

Moss, E. (2008). The holding/containment function in supervision groups for group therapists. *International Journal of Group Psychotherapy, 58*(2), 185–201. doi:10.1521/ijgp.2008.58.2.185.

Negash, S., & Sahin, S. (2011). Compassion fatigue in marriage and family therapy: Implications for therapists and clients. *Journal of Marital and Family Therapy, 37*(1), 1–13. doi:10.1111/j.1752-0606.2009.00147.x.

Protinsky, H., & Coward, L. (2001). Developmental lessons of seasoned marital and family therapists: A qualitative investigation. *Journal of Marital and Family Therapy, 27*(3), 375–384. doi:10.1111/j.1752-0606.2001.tb00332.x.

Richarz, B. (2008). Group processes and the therapist's subjectivity: Interactive transference in analytical group psychotherapy. *International Journal of Group Psychotherapy, 58*(2), 141–161. doi:10.1521/ijgp.2008.58.2.141.

Rober, P. (2005). The therapist's self in dialogical family therapy: some ideas about not-knowing and the therapist's inner

conversation. *Family Process, 44*(4), 477–495. doi:10.1111/j.1545-5300.2005.00073.x.

Sanderson, K., & Andrews, G. (2006). Common mental disorders in the workforce: Recent findings from descriptive and social epidemiology. *Canadian Journal of Psychiatry, 51*, 63–75.

Schneider, K. J., & May, R. (1995). *The psychology of existence: An integrative, clinical perspective*. New York: McGraw-Hill.

Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multilevel- process models of therapeutic change in marriage and family therapy. *Journal of Marital and Family Therapy, 30*(2), 131–149. doi:10.1111/j.1752-0606.2004.tb01229.x.

Shapiro, S. L., Brown, K. W., & Biegel, G. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*(2), 105–115. doi:10.1037/1931-3918.1.2.105.

Silberschatz, G., & Curtis, J. T. (1993). Measuring the therapist's impact on the patient's therapeutic progress. *Journal of Consulting and Clinical Psychology, 61*(3), 403–411. doi:10.1037/0022-006X.61.3.403.

Simon, G. M. (2006). The heart of the matter: A proposal for placing the self of the therapist at the center of family therapy research and training. *Family Process, 45*(3), 331–344. doi:10.1111/j.1545-5300.2006.00174.x.

Smith, A. F. (2000). Existential applications to practice: Can existentialism integrate psychotherapy? *Journal of Theoretical and Philosophical Psychology, 20*(1), 80–86. doi:10.1037/h0091348.

Sparks, J. A., Kisler, T. S., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital and Family Therapy, 37*(4), 452–467. doi:10.1111/j.1752-0606.2011.00224.x.

Sprenkle, D. H., & Blow, A. J. (2004). Common factors are not islands–they work through models: A response to Sexton, Ridley, and Kleiner. *Journal of Marital and Family Therapy, 30*(2), 151–157. doi:10.1111/j.1752-0606.2004.tb01230.x.

Timm, T. M., & Blow, A. J. (1999). Self-of-the-therapist work: A balance between removing restraints and identifying resources. *Contemporary Family Therapy, 21*(3), 331–351.

Turner, K. (2009). Mindfulness: The present moment in clinical social work. *Clinical Social Work Journal, 37*(2), 95–103. doi:10.1007/s10615-008-0182-0.

Watkins, C. E., Jr. (2012). On demoralization, therapist identity development, and persuasion and healing in psychotherapy supervision. *Journal of Psychotherapy Integration, 22*(3), 187–205. doi:10.1037/a0028870.

Yulis, S., & Kiesler, D. J. (1968). Countertransference response as a function of therapist anxiety and content of patient talk. *Journal of Consulting and Clinical Psychology, 32*(4), 413–419.