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WHY PEOPLE GET IN THEIR OWN WAY

Clients, patients, consumers, customers, whatever your preference and training about the appropriate appellation, they are all, in a word, *people*. Like non-clients, psychotherapy clients are people with complex and long learning histories that are shaped by and that reciprocally influence their biology and environments. From the chronically mentally ill to the resilient and psychologically healthy, all our clients bring their learning history into the treatment setting. This history is an enormously important context for the therapeutic relationship. On one hand, as with the client who has learned how to trust and be vulnerable with others, it can help treatment move faster and be more effective for some clients. On the other hand, our clients' history can contribute to them doing things that function to interfere with their treatment. This is also true for clinicians, who bring their own unique learning history into the psychotherapy process. Just as our learning history sometimes gets the best of anyone in their everyday lives, it is common across psychotherapies for clients

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and clinicians to do things that can get in the way of treatment progress. In this book, we refer to this as *therapy-interfering behavior*, or TIB.

THERAPY-INTERFERING BEHAVIOR

TIB can be intentional or unintentional, strategic or automatic, calculated or absentminded. It can include being chronically late or noncompliant with treatment, ineffectively expressing or inhibiting emotion during treatment, being overly passive or aggressive interpersonally with the clinician, and so on. Sometimes the very problem the client needs to address occurs in relation to the therapist, such as when the client has social anxiety and becomes anxious and avoidant with the clinician during treatment. At other times the TIB is something different from what is being addressed in treatment. A client may be flirtatious with the clinician, but this may not be something that is being targeted as a problem in treatment. Reduction of depressive symptoms may be the primary treatment goal, but the client may talk excessively during session about her- or himself in ways that are suggestive of narcissistic personality traits. Problems with substance use and avoidant coping may be the focus, but the client may persist in talking about various weekly problems, even crises, with little willingness to directly work on learning how to reduce substance use or change ways of coping.

If you are a clinician, it is likely you have seen TIB. If you see a lot of clients, you probably see TIB every week, maybe every day. The reason, we believe, is that it is common for clients to get in their own way. It also is common for therapists and clinicians to get in their own way of helping clients. This is not something to be upset about. With compassion and curiosity, TIB can be viewed as a predictable opportunity. However, as clinicians, we need tools to help manage the difficult moments when TIB occurs during assessment or treatment for mental health problems.

Any behavior that interferes with the client benefitting from therapy could be considered a TIB. We introduce some ways to conceptualize and manage TIBs later in the book. For now, it may help to think about some common TIBs that occur with clients: the depressed individual who is relentlessly self-judgmental during psychotherapy sessions, the client with generalized anxiety who spins a web of hopeless rumination throughout the session, or perhaps the substance user struggling after being late to the clinic to organize his or her thoughts about what to talk about during the session. The paranoid client is likely, at times, to display behavioral signs of paranoia with you. The mistrusting client at some point will likely lose trust in you. The suspicious client, naturally and inevitably, may suspect that something is amiss with treatment. Whatever the client does with others interpersonally outside

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the therapy setting, she or he may be likely to do with you, the clinician, inside the therapy setting. This is not unique to any one diagnosis, type of client, or model of psychotherapy. People commonly get in their own way in psychotherapy.

It is common for therapists to bemoan the client who consistently exhibits TIB during sessions. As a clinician, there are things you want to talk about and conversations you believe are more or less important to have; perhaps you even have an agenda for your therapy session. However, the client may want to share things he or she thinks are important to him or her. You are trained to listen, to be a professional ear, paid to help your clients understand, make meaning, develop insights, and change the way they live. So when the session that you expected would head in one direction now is steamrolling in another, you recognize what is happening. Each session may be a journey, you tell yourself, but you do not really know where the destination is until you get there. That stance is helpful, but it leaves you wondering how in the world you are going to help this person when he or she is so far afield from talking about what is on the treatment plan.

So you put your session agenda on hold. You feel compelled to listen intently. For the first 10 minutes you interject here and there, trying to discern where the conversation is going, but when your client's story continues to unfold, layer after layer, you end up deciding that it is better to just keep quiet. Surely the story will take the two of you somewhere. The client has all the answers inside him or her, you remind yourself, and your job is to create a safe and nurturing environment for the client to learn how to experience him- or herself and relate to others differently. You remind yourself that you cannot work harder than your client, that change is within her or him, and he or she will change when they are ready. You are meeting he or she where he or she is in that moment, being supportive, kind, gentle, and client-centered. You are a compassionate clinician, and right now, as that client continues to keep sharing his or her thoughts about what happened this week at work or at home, you choose to listen, nod, take notes, and offer brief words of support.

Eventually the session ends. You learned a great deal about how your client experienced him- or herself during some stressful situations last week. You are proud of how he or she handled certain parts of it, but see opportunities to talk about making some changes next week in your session. You are pretty sure that you listened well, reflecting, affirming, paraphrasing, and problem solving. The client seemed to feel trusting of you. He or she told you some new things about her or his past, opening up another layer of vulnerability. This is something you see as progress. Another thing that you chalk up to progress is that the client seemed to describe the events of the past week with more clarity and precision than usual. Emotions were less intense than in previous session you note in the medical record, and you attribute this to

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possible changes in affect regulation. The 45-minute journey is over. You did not end up where you thought you would, but it seems OK.

The next week the same client does the same thing. You drop your agenda again, although you really wanted to tie up some loose ends from the previous session. This time there is another important story for you to hear. Again, like the last one, and all of the stories that will follow, this too is a story that your client would like you to listen to. Listening will help you understand and help the client feel understood. Why in the world would you want to interrupt? This is the journey you are on together, and the process of change can take a lot of time. This may be a reasonable approach for those who can financially afford long-term psychotherapy, but for clients who cannot, or for those whose dysfunction or psychological distress is significant, change may need to move at a faster pace.

If you are a clinician and have done a lot of psychotherapy, you have seen a lot of TIB. If you have just started doing psychotherapy you have already begun to see TIB. Unless you are trained in dialectical behavior therapy, we doubt that you call it "TIB." However, every system of psychotherapy has to contend with TIB. As well they should. A central thesis of this book is that TIB can be hypothesized and conceptualized as clinically relevant. The specific behavior that interferes with therapy can represent a broader class of behavior that is common and problematic in the client's life. That is, TIB can often be what the radical behavioral treatment functional analytic psychotherapy (Kohlenberg & Tsai, 1991) labels as clinically relevant behaviors. Think of TIBs as opportunities to mine for therapeutic gold, to discover with clients how they can change with you in a way that may help them change how they express this TIB when it manifests as life-interfering behavior outside the clinic. Think of how frustrated you have been with clients who do not stop talking or who say almost nothing at all. These are moments in session when TIB can be noticed without judgment, explored collaboratively, and targeted for change using the same new ways of relating to others they are trying to learn outside the clinic. TIBs do not have to come with shock and awe, and they do not have to suddenly stun you. They are sometimes jolting (e.g., "I found a new therapist. I probably should have told you I was thinking about this."), other times subtle (e.g., "I can't remember."). They can be colorful and dramatic (e.g., "I'm only here because the court is making me, but I don't believe talking to you is going to help."), or they can be plain and common (e.g., "Sorry I forgot to tell you I would miss our session last week."). No matter your theoretical preferences, no matter your biases about what constitutes good therapy, we suggest that you expect TIB with all clients.

Chances are if you felt stumped about what to say or do in a therapy session you may have been responding to TIB. When we describe therapist TIB later in the book, we share some stories of times when one of us was treating

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a client and, for one reason or another, we engaged in TIB. TIBs are bumps in the road, potholes in our psychotherapy, and can at times bring relational roads extremely difficult to travel. There is nothing to fear about TIB, nothing to run from, nothing to feel ashamed about, and nothing about which to be judgmental of you or your clients. It is ordinary psychotherapy process. It is common and difficult, but clinicians who can respond well to TIB can be rewarded with extraordinary client changes.

No matter the therapeutic orientation, this book is intended to help you, the clinician, in times when things are not going quite the way you envisioned, when behavior in the therapy room, TIB, arrests and holds hostage the client's progress. Lateness to session, forgetting what was talked about in the past session, and not doing therapy homework are common TIBs. Starting the session with a story about something unrelated to treatment, extreme talkativeness, apparent disinterest in how therapy can help, serial crises, ambiguous could-be crises, and crises avoided until the last few moments of the session are also common TIBs. Other common TIBs include conflict avoidance, chitchat, long latencies to respond to questions, deftly changing the topic when emotions arise, unrelenting catharsis for 45 minutes, and deliberate efforts to inhibit emotional expression.

One reason people get in their own way in therapy is that they do not know what is expected of them. When people come to therapy for the first time, they do not know what the therapeutic process is supposed to look like. They may have expectations, desires, or assumptions. They may have been told by a friend what it is like, seen a recent movie, or read a book where they learned how a therapy client behaves. So when they walk in for the first time, curious, ambivalent, and anxious, they may be ready to follow your lead.

We ask new clients whether it is their first time doing psychotherapy or counseling. For those who are new to therapy, this is an opportunity to orient them to what is expected and most helpful in the process of talking to a therapist. This is the time to strike while the proverbial iron is hot to reduce some of the anxiety about what is expected of them, to increase a sense of controllability and predictability in a vulnerable setting. This first session is when clinicians can begin to talk about possible TIB in a nonjudgmental, compassionate, and straightforward manner.

For example, in the first appointment clients sometimes do or say things that are signs of probable TIB on the horizon. If the client expresses disinterest in attending sessions, or perhaps even disdain for therapy on the basis of past experiences, the first appointment is a wonderful time to begin attending to such feelings and experiences. This happened recently, when a young woman with borderline personality disorder (BPD) features came for an evaluation after being referred to receive dialectical behavior therapy. The client had received psychotherapy from several clinicians in the past, was suffering

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tremendously, and was open about her distrust of psychotherapy. It became clear during the evaluation that ignoring these comments (e.g., "I just don't trust any of you therapists") was insufficient and perhaps invalidating of her experience. Thus, the concept of TIB was introduced instead:

> If I ever say or do something to lose your trust, or to suddenly gain your trust, would you be willing to let me know? Because trust is one thing that is very important in our work together, if you lose trust in me, it is likely that you might end up doing or saying things that could get in the way of your own treatment. Think about it, if you didn't trust me, would you be as open, honest, or vulnerable than if you did have trust in me?

From our perspective, a trick to this process is not to blame or pathologize, but instead to be straightforward and humbly frame the potential TIB as completely understandable, normal, or ordinary. To begin, pick a TIB that is likely to be nonthreatening to the client. It will help keep emotional arousal in the room low enough that your message can be heard, and the client can become open to exploring TIB with you later on. Build from this example to explain that, more generally, part of treatment involves noticing and attending to TIB as needed to help the client get better faster. When TIB is expected, it can be conceptualized a priori, preparing the clinician, facilitating a strategic response with intention to help clients meet their own goals. Instead of letting TIB interfere with therapy, the planful clinician collaboratively uses TIB to help accelerate progress. Instead of TIB, it can become treatment-accelerating behavior. The very thing getting in the way becomes that which paves the way.

Expecting TIB makes it less surprising and more rewarding for both clinician and client. It may sound strange, but it can be quite useful to tell your clients who have problems with trust that you expect and hope that they have moments where they lose trust during your work together. Other therapists may not want to have to deal with suspiciousness, mistrust, and the like, and you might not want to either, but by dealing with TIB directly, you will be addressing precisely the behavior that the client struggles with outside of the session. If you have a suspicious client with relationship difficulties, how in the world can you expect him or her not to become suspicious with you? And if you accept that it is likely she or he will become suspicious with you, why not openly and compassionately plan for this behavior?

What about clients who have been in psychotherapy before? Whenever a new client who has been in therapy before comes to the clinic, it is helpful to know how the process of previous therapies was experienced. Clients may not know which brand of psychotherapy (e.g., cognitive behavior, psychodynamic) their past therapists were using, but they do remember what it was like to be in the room with the therapist. Who did most of the talking? What

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were the targets of change? What kinds of things did the therapist include in the treatment plan? Was there a treatment plan? Did the therapist mostly listen and give encouragement, talk about learning principles and ways to change behavior, or discuss patterns of attachment in childhood and the subsequent difficulties the client has with empathic attunement?

In our experience, the most common reaction to these questions, by a landslide, is that clients pause, sigh, and then say politely that they are not really sure what the treatment was, that the therapist was very nice and supportively listened, offered advice, and helped resolve life stressors, but that they became concerned because they did not feel as though they got much better. They then typically go on to explain that they want someone to help them make some changes in their life. They want a therapist to listen and be supportive, while also providing direct help in changing how they experience themselves and the world, how they relate to people, or how they cope with their emotional distress. In short, clients often want a therapist who is empathic, supportive, and compassionate, without being passive. They want a strong listener who understands the centrality of the therapeutic relationship and who can motivate, direct, and provide learning experiences in therapy sessions to directly change dysfunctional behavior and provide relief from emotional suffering. This is just the type of therapist who can attend to TIB thoughtfully with clients' values and goals in mind.

TIB can take many forms and be incredibly challenging. As clinicians, we need solutions for these challenges. However, what we need are solutions that are both conceptual and practical and that can be applied flexibly across diverse clients and diverse treatments. This book is for clinicians and those interested in learning how to address difficult behaviors that occur during mental health assessment and treatment. It is for students across the scope of mental and behavioral health training. Clinical psychologists, psychiatrists, clinical social workers, addiction counselors, nurse practitioners, licensed professional counselors, marriage and family therapists, licensed substance abuse specialists, and other clinicians all may find it helpful to learn ways to manage TIB.

DIALECTICAL BEHAVIOR THERAPY

Throughout this book, we emphasize how to conceptualize TIB using an approach from an evidence-based cognitive behavior therapy for BPD called *dialectical behavior therapy* (DBT). DBT was developed several decades ago by Dr. Marsha Linehan at the University of Washington. It was the first empirically supported behavioral treatment for BPD, and since the first randomized trial was published (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), DBT has been disseminated nationally and internationally as an intervention

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for BPD. Throughout this book we orient you to DBT principles and strategies, with the assumption that you are not already an intensively trained DBT clinician. For now, it is useful to highlight that in DBT, therapists are trained to expect client TIBs and are prepared with a conceptual framework and behavioral strategies so that, no matter which TIB occurs, the therapist is ready to respond effectively. Our experiences as DBT clinicians, researchers, and supervisors have led us to conclude that therapists who are not trained in or using DBT would also benefit from learning how to respond effectively to TIB. After all, TIB occurs for most, if not all, clients; individuals meeting criteria for BPD are not the only ones to get in their own way during treatment.

This book is for clinicians trained across diverse theoretical schools of psychotherapy. Psychodynamically trained therapists have various terms for processes that are germane to TIB: resistance, transference, countertransference, unconscious defenses, and the like. The process of transference is a core component of the therapeutic process for many clinicians and provides a different conceptual framework from what we outline. Client-centered approaches, embodying the stance that clients have the answers and all capabilities within them, may provide nurturance and support, open-ended statements and affirmations, reflections, paraphrasings, and summarizations during discourse with the client. A straightforward cognitive therapy response to TIB might be to examine the underlying cognitions, attitudes, rules, and beliefs related to the TIB. A behavioral treatment, functional analytic psychotherapy (Kohlenberg & Tsai, 1991), offers a detailed approach for the management of clinically relevant in-session behavior, which is similar in certain ways to what we outline when discussing how to manage TIB from a DBT perspective. And, as we detail in this book, in DBT, one member in the ever-growing family of cognitive behavior therapies, there are explicit strategies for managing TIB.

Although DBT is a contemporary cognitive behavior therapy, an aim of this book is to provide strategies that are principle-driven and practical, tools that nearly any clinician can use to help them competently manage TIB. We do not believe that DBT is the first or best model for conceptualizing or changing TIB. Those are empirical considerations best left to laboratories and randomized trials. We do not believe any one theory or brand of psychotherapy is the best way to manage TIB. However, we do think the strategies and techniques used in DBT to attend to TIB may be helpful to therapists beyond those already doing DBT.

In this volume we provide specific examples of tools and strategies used in DBT to manage TIB, with the goal of helping clinicians, especially those who are not trained in DBT already, to develop new ways to respond to difficult-to-manage TIB. Chapters 1 through 4 provide the basic framework needed to

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address any TIB, whereas Chapters 5 through 12 collectively address common client and therapist TIB in psychotherapy and ways to overcome specific and expected challenges when addressing TIB.

To be more specific, in Chapter 1, we set the context for the challenges clinicians face when addressing TIB by answering the question: Why do clients sometimes get in their own way in psychotherapy? In Chapter 2, we provide detailed descriptions of core DBT principles used to conceptualize and relate TIB to other problems being addressed in therapy. In Chapter 3, the therapist's boundaries and limits are discussed, with an emphasis on ways that clinicians can observe and work within their own personal limits when TIB occurs. Chapter 4 outlines primary tools and strategies from DBT that are used to manage TIB. In Chapters 5 (missing therapy visits), 6 (not completing therapy homework), and 7 (hostility or anger during psychotherapy), we delve into specific applications of DBT strategies and techniques for particular TIB. Chapter 8 provides detailed suggestions for ways clinicians can decide when and how to directly talk about TIB with clients. In Chapter 9, we discuss the common problem of client avoidance of unpleasant emotions, thoughts, and particular topics during psychotherapy. Chapter 10 is devoted to considering ways to conceptualize and respond to potentially sexually related behavior during psychotherapy. Chapter 11 addresses common TIB that occurs during the process of terminating psychotherapy. Finally, in Chapter 12, we discuss the critical role that therapist TIB can have on the psychotherapy process, and we offer solutions to manage these situations.

By using DBT-based strategies for managing TIB, we hope you will be able to improve your psychotherapy skills with some new tools for dealing with some of the more difficult moments clinicians face. As you read through the rest of this book, we recommend that you think about some of the more difficult clients you have treated, asking yourself whether there is anything different that could have been done in their care by changing how you addressed any TIB. By the end of this book you will not be a DBT therapist and you will not be an expert in treatment of BPD, but you will have learned some of the core ways in which we who practice DBT effectively handle TIB in our clients with BPD. If TIB can be addressed successfully with those who have BPD, we are confident these same strategies can be used with other clients. Before thinking the way you do psychotherapy is simply incongruent with behavioral therapies, cognitive behavioral therapies, or with DBT specifically, we encourage you to keep reading, to think about how you have dealt with common TIBs in the past, and to openly consider ways you might respond to them in the future.

No matter your theoretical orientation or training in psychotherapy, for this moment, think about your own experience with TIBs. Bring to mind a client you are currently treating or have recently treated. Identify the top

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three most frustrating moments during these therapy sessions. What did the client do or say just before you became frustrated? What happened when you were frustrated? What did you want to happen instead? What was the problem the client wanted help with, and how did that problem show up during psychotherapy? What TIBs were there, and how could you have been more effective dealing with them? As you think about this, consider a case when TIB was significant, impossible to ignore, yet difficult to overcome.

BETH: A CLIENT WHO GOT IN HER OWN WAY

Several years ago, I (MZR) was doing psychotherapy with a client who, sadly, got in her own way.[1] Beth was a woman in her late 30s presenting with obesity and binge eating, posttraumatic stress disorder (PTSD), and problems with substance use. She had been in treatment with me for several years, on and off, doing cognitive behavior interventions for her various problems. Beth was extremely bright and endearing, kind to a fault, both with her therapist and with others. In hindsight, when she eventually got in her own way during treatment, it should have been predictable and easy to see coming. But, as it often turns out, the luxury of hindsight was not there at the time, and it felt a bit surprising. Until she got in her own way one too many times, it seemed clear to me that she had been a treatment success.

Beth had been through 2 years of DBT, including individual sessions and group skills training. She did not like going to group, but week after week, month after month, she had kept on coming, dutifully learning the skills and improving. She was better at regulating her emotions and tolerating emotional distress; she had improved her ability to be nonjudgmental and experience unpleasant emotions mindfully and had mastered several interpersonal effectiveness skills. After she finished group skills training and most of her out-of-control behaviors (recurrent urges to self-harm, binge eating, impulsivity) were under control for a long period of time, we decided it was appropriate to do an evidence-based treatment for PTSD. This is a common next step after the first stage of DBT. She had held off on addressing her PTSD symptoms for several years, afraid to directly talk about when she had been drugged and raped in her teens. Prolonged exposure is a gold standard behavioral treatment for PTSD (Foa & Rothbaum, 1998). The randomized

[1]The key details in all case studies in this volume have been altered to protect clients' confidentiality. No real names are used, and in all instances the descriptions used are prototypes of experiences across multiple clients and/or details have been changes about specific cases such that the case described does not reflect or identify any one specific former client.

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controlled trials suggested it should work well for many people. Having implemented this intervention many times before with multidiagnostic and difficult-to-treat clients, I felt confident in my ability to deliver the intervention. And Beth was now ready to do the work.

I followed the treatment manual shamelessly, opening it up during exposure sessions and using it frequently as a resource to structure the therapy sessions and psychotherapy homework. As a DBT therapist, the implementation of prolonged exposure meant another opportunity to model therapist imperfections as acceptable and ordinary. This demonstration of therapist fallibility happened here and there as treatment continued with as much fidelity as feasible, given usual life circumstances. Beth traveled and missed sessions. She overslept or had other appointments that kept her from regularly coming to our sessions. Therapists have lives too, so when family vacations or work meetings happened on our scheduled appointment days, more therapy sessions were missed. Still, by the end of several months of prolonged exposure, to her great surprise, the PTSD symptoms were nearly gone. Naturally, she still had some problems to resolve, but the nightmares were gone, the avoidance was minimal, she was less agitated, was sleeping better, and so on. After years of suffering, her diagnosis of PTSD was no longer appropriate.

First the focus had been on DBT skills, then on PTSD and prolonged exposure. She was improved, happier, and finding more satisfaction with work and dating. This was evidence that perhaps despite her core sense of self as broken and irreparable, as goods damaged by shattering sexual traumas, treatment was helping her to get better in many ways. We looked at changes in her self-reported PTSD symptoms over time on psychometrically validated PTSD symptom scales. We celebrated her victory overcoming the crippling shame that she had kept for so long. She no longer blamed herself. She no longer believed she had deserved to be taken advantage of by her perpetrators. Beth had been secretly drugged and sodomized and was still emotionally scarred, but she knew now that she was not at fault. These changes were profound and were the result of session after session, exposure after exposure, grinding away at the conditioned emotional responses of PTSD. New learning, extinguished emotional responses, and more flexibility in how she experienced her negative emotions and related to others all characterized her newly forming sense of self. It was, it seemed at the time, the treatment outcome we wanted. What began as a host of diverse psychiatric symptoms, life dysfunction, and psychological distress was now about as good an outcome as could be envisioned. It was time to either end our work together or identify newly attainable goals.

Even without any acutely debilitating problems, Beth decided to continue psychotherapy. She talked animatedly about how much therapy had helped her. She proclaimed to have been treated by the "best therapist"

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she had ever had. She seemed genuine, even heartfelt, without being inappropriate. Therapy had been a long slog for Beth; it was emotionally draining and challenging all along, and she recognized it. As can be guessed, however, her declaration about having the best therapist portended, as this statement often does, an unfortunate turn of events soon to come in her treatment.

As we rounded the corner into the next phase of treatment, Beth still struggled to regulate her emotions. Her affective lability was sharp and unpredictable. Her rumination was prodigious. In addition to the index trauma we had processed, Beth had been raped multiple times by other men. The process of exposure therapy revealed that she believed, in every cell of her being, that she was fundamentally unlovable. It did not matter that her PTSD symptoms were gone. She still needed help.

Beth was a storyteller, and the story her mind told her is one that many clients tell. Her psychological narrative was clear, crystallized as truth, and not something any therapy would easily change. Her mind was like an insufferable radio personality, hyperbolic self-loathing streaming for so long that she had become convinced that she was defective, biologically predetermined to fail, incapable and unworthy of being loved. Her mind had persuaded her to believe in a particular narrative: She was and would always be irreparably damaged biologically, and this would make her fundamentally undesirable interpersonally. Her mind was a used car salesman, and it had sold her a poisonous lemon.

Worse, Beth disclosed during one highly emotional session that she believed being drugged and raped many times by multiple men was, put simply, something she deserved. She experienced herself as a relational reject. Somehow she thought she was supposed to be treated poorly by others and fail in relationships. Success was anathema to her, always out of reach and ego-dystonic. Not surprisingly, her shame during treatment sessions was persistent. She would study the floor as she talked to me, her eyes averting mine; tears would flow regularly, and she would berate herself at every chance for not being a good client.

Beth was ashamed about her inability to be productive at work, ashamed that she could not reliably show up on time for her appointments, especially the ones on Fridays, or do the behavioral homework she had agreed in our sessions to do. She was ashamed about "wasting" time in therapy and about many things. Now, with the acute symptoms gone, it was time to help her learn to relate to people better. This meant that we would need to confront and change how she experienced herself, and her shame, in the context of meaningful relationships. In hindsight, it is embarrassingly easy to see how this would end.

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We would have to treat the shame Beth was feeling in the therapy session. We would have to pay attention to her shame—the thoughts, physical sensations, action tendencies, and associated feeling states that she would feel whenever shame would show up in the therapy session. We would have to be intentional, deliberate, and collaborative. We would have to do this to help her develop insight and the resultant new patterns of relating to others without the emotion of shame being the cause or consequence of interactions. And we would have to change this long-standing pattern slowly, one context and experience at a time, starting with me in our sessions. Plans were made and we collaboratively predicted that she would invariably feel badly about herself at some point in each session, and in processing her feelings of shame she would likely feel uncomfortable. Being proactive about how to change her shame in sessions would provide a working framework to deal with what was already happening anyway. This seemed like a pretty good plan. We had been through so much together, and her chronic self-judgments and overlearned shame during our sessions surely could not stop us.

As you can probably guess, it did not go well. We identified and agreed on several treatment goals. All of them included using cognitive and behavioral skills to improve her interpersonal relationships. It is important to stop here and point out that this woman desperately wanted to feel less ashamed. She wished she could break free from the bind that shame had seemed to wind around her. Shame was both her noose and hangman, emotionally ambushing her on a daily basis. She had many moments during the day when she truly hated herself, and yet at the same time, Beth knew quite well that this was irrational. Like many clients, she had lots to love about herself. Smart, generous, and funny, with a wry British wit, she was easy to like. She had three siblings who were doctors, and elderly parents who had been wildly successful in the corporate world. This was part of the problem. Beth was born into a family full of apparent success. By Beth's way of seeing it, her parents and siblings had everything that she did not. They were successful, but she could never be. They had the good genes. She did not. They were the lucky ones. She drew the short straw.

At this point in our treatment Beth did not need any further psychoeducation. She was not experiencing "information deficit disorder," and no detailed explanations of this or that model of psychopathology would elevate her sense of self. She did not need to learn any more about how to challenge cognitive distortions. She did not need to keep rehearsing interpersonal effectiveness skills. She knew how to be assertive, knew how to look people in the eyes and ask for what she wanted. She was not aggressive and hostile, at least not in therapy, though she could be emotionally turbulent, prickly, or even surly. What Beth seemed to need was to learn through relational experiences

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that she was not a failure and that her shame responses in therapy were both expected and capable of being changed. Like a lot of clients, Beth needed to learn through her relationship with her therapist to feel less ashamed and more interpersonally confident. In realizing this, it became more important than ever before to consistently create and maintain a safe and trusting environment for her so that she could eventually come to experience herself as OK. But this is where she got in her own way.

Beth let her shame keep her from coming to treatment. She missed an appointment, oversleeping, as she explained. She was apologetic and promised not to do it again. The next week she cancelled the appointment, saying she had no money for the co-pay. The following week she described major life changes that had happened since the previous therapy session. It took most of the therapy session to discuss these new developments: a new boyfriend, new job, new friends, a fresh new outlook on herself. She smiled and said she felt the best she had felt in a long time. Picking up the conversational pace, she continued: PTSD symptoms were in remission, there had been no binge eating, and she was sleeping well and not feeling anxious anymore. This was all great news, except that the new boyfriend was 20 years older than her, a recovering drug addict who she impulsively fell for and, consistent with her core belief that she was unworthy and unlovable, who was awfully cruel to her. In addition, her close colleague at work had recently turned on her, berating and belittling Beth in front of coworkers at a holiday party. Beth declared that she was going to stand up to this aggression, not involve herself with this colleague any longer, and maybe even tell her off. She boldly asserted that she did not deserve to be emotionally abused. Those days were over. Her primary psychiatric symptoms were gone, she had a new boyfriend, and she was ready to stand up and defend herself. Things were looking good to Beth.

Except that there was still a problem. She disclosed anxiously at the end of the session that because she was doing so well now, she had decided not to return to the emotion regulation skills group after recently agreeing to do so. As she talked about her decision not to go the skills group and her unwillingness to comply with our agreement, she sharply looked away. She started to cry. She apologized shamefully, saying that she was a disappointment, a waste of time, and that other clients deserved this therapy hour more than she did. Shame squeezed her again, tears racing down her cheeks, but as soon as the emotional faucet had turned on, she turned it off. She wiped her tears, giggled, and said she knew she was being irrational. The session wound down, we scheduled for the next week, and parted. She did not come back to therapy for a long time. What had happened? Beth's shame was tied to escape behavior. When she felt intense shame, she prepared herself to exit the situation. She did not think she deserved the help. She chose not to comply with

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the therapy. She tried to avoid talking about this by detailing extensively all of the new and fabulous things in her life. But when she slipped into the shame spiral that last session, she was preparing to escape. The very problem she needed help for, the very problem we agreed to work on, had become the problem that interfered with her treatment. Her shameful sense of herself in relationships brought her to therapy. That same shame was there throughout treatment. We chipped away at it, but her fundamental sense of self had not changed enough. In the end, her shameful sense of herself in relationships had become the TIB that ended her treatment. It ended her treatment, and it helped to jump-start this book.