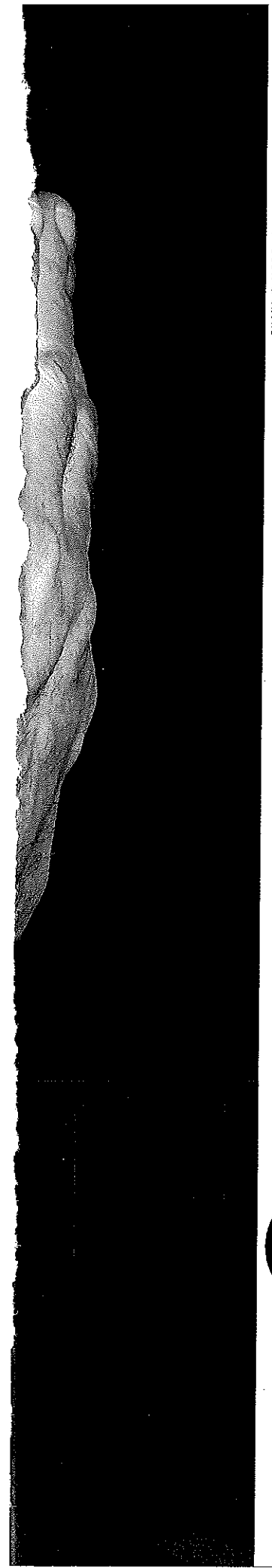

PHOTO © MORGAN DAVID DE LOSSY/CORBIS

ALTHOUGH YOU CAN'T TELL IT FROM THE CASES that appear in publications and training videos, psychotherapy mostly involves talking to clients who like working with us, but find it hard to change. Eventually, rather than helping these clients navigate dramatic whitewater rapids, our main challenge becomes steering the clinical relationship out of the swamps and marshes where it can get stuck, sometimes for years. ■ Our long-term clients might have us banging our heads against the wall at times, screaming, "I can't believe you're making that self-destructive choice again! After all this time, haven't you heard a

HOW TO ESCAPE THE "GROUNDHOG DAY THERAPY" CYCLE

When Therapy is Going owhere

by

WILLIAM DOHERTY

word I've said?" But mostly, they elicit far less dramatic reactions. They're cooperative, agreeable, and attached to us as therapists. They're open to our insights and suggestions, fill a regular time slot in our schedule, and pay their bills. So what's the problem? Nothing—except that not much goes on in sessions: no implosions or explosions, no breakthroughs or backslides, no itching to finish therapy and get on with life. It starts to feel like "till death (or retirement) us do part."

Often when we begin with these clients, our early work generates some movement and change, but then a kind of stagnation sets in. This is the case with my couple who's fully engaged in therapy sessions but "too busy" to try anything different at home, and the woman who uses sessions to recap the ins and outs of her week but never addresses any serious issues. Without much happening—with no real intensity or vitality—ease eventually turns to boredom, at least for the therapist. After months or years circling the same issues, we end up with what I call "Groundhog Day therapy," named after the early 1990s film in which a burned-out TV weatherman played by Bill Murray is doomed to live through the same day, with the same events, over and over again.

So why do therapists tend to get stuck in clinical relationships where we spend session after session spinning our wheels? One reason is that these sessions ensure a predictable, paying slot in our schedule. Another reason, however, is that we usually don't tell anyone about these cases. We reserve supervision or consultation for more compelling crises or direct conflicts in the clinical relationship. Groundhog Day cases, where no one is threatening divorce or suicide, lack the drama of standard consultation cases. We might worry that even our consultation groups will get bored of hearing about the same client who isn't particularly miserable, but isn't leading the life he or she wants, either.

Another reason we remain stuck with clients going nowhere in therapy is that most of us keep "progress notes" instead of tracking outcomes. I confess to this habit, especially when it came to a couple I'd been seeing for several years. When I looked through a year's worth of their session notes, more than half of them recorded some improvement from session to session. But when I stepped back and asked the couple to evaluate the progress of their overall relationship, they concurred with me that nothing much had shifted. In fact, a mentor once told me that two-thirds of the records he reviewed for mental health hospitals reported progress, even for patients who never got better overall. As therapists, we like to think we're making headway, and our clients want therapy to be worthwhile, but treatment sometimes shifts without our noticing it from change-oriented work that has an ending to long-term, maintenance-oriented work that doesn't have an end point.

So what do you do when you find yourself with a Groundhog Day case? The commonest mistake—one I've committed myself—is what I call "lurching," or making a sudden, unannounced shift in how you're approaching the client. One form of lurching is shifting abruptly from a therapeutic posture of empathic support to one of hard-nosed challenge. I've seen frustrated therapists who'd been oozing nurturance for months suddenly blurt out, "You have a choice: you can stay miserable, or you can get a divorce." These moves might temporarily shake the client up and reinvigorate the therapy relationship, but they usually end badly. Either the client forgives the unexpected rudeness and therapeutic homeostasis is restored, or the therapeutic relationship spirals downhill until the client fires us.

Another form of lurching is trying out a different, more dramatic type of therapy without preparing the client. It's like when a physician moves from prescribing a simple acid reflux medication to scheduling major esophageal surgery without first stopping to reevaluate the diagnosis or overall treatment plan with the patient. For example, in one couples therapy case I consulted on, the husband wasn't getting over his wife's affair. The therapist, familiar with the current trendiness of traumatology in the field and having just taken an introductory course in Eye Movement Desensitization and Reprocessing therapy, jumped to initiate two trauma treatment sessions with the husband. Both of these sessions failed, and the therapist gave up on the couple.

The commonest **mistake** *is what I call "lurching," unannounced* **shift** *in*

In pulling a new technique out of her hat, this therapist failed to ask herself something basic: how could she uncover what might be causing the husband to cling to his grief and anger? She'd regarded the husband's reaction as a symptom to be expunged, rather than part of a larger narrative. In a sense, she skirted the very heart of talk therapy. But she's not the only one. These days, many of us are overly focused on the flashy public-workshop intervention in which the proponent of some new attachment-based, body-oriented, Buddhist-inspired, or neurophysiological-leaning approach

enthralls us with a new method. When we throw all our energy into the latest fads in the field, we stop working at the essence of what we do: the routine conversational practices of psychotherapy—the skills that keep therapy moving from minute to minute and session to session.

The key to dealing constructively with stuck cases is to treat the clinical relationship pattern first, and only then to consider alternative treatment strategies. The following three steps detail a process I've developed, including the words I tend to use, for gently dislodging stuck clinical relationships, without lurching.

Set time to evaluate progress together. After asking the client for his or her priorities for a particular session, I say something like, "I'd also like to spend some time in this session looking at where you are currently in terms of the problems you came to therapy with, how far you feel you've come, and where our work is now." We decide together whether to start with the client's priorities for the session or with mine. I do this in a matter-of-fact way, not assuming a challenging mode, but letting the client know this will be an important conversation.

or making a **sudden**

how you're approaching the client.

Assess where you are in the course of therapy. After listening to the client's sense of progress and affirming whatever I can agree with, I ask follow-up questions that direct attention to the work we're doing together. An example might be something like this: "Where do you think we are in terms of our work in therapy? Are we in the winding-down phase, the middle phase, past the middle phase?" This question implies that we aren't going to be doing this work forever—that there's a beginning, middle, and end, and that the client has a big say in determining the timing of our work. Generally, I accept whatever the client offers as an appraisal of our current stage of work.

Share your perspective on the "plateau." In the third phase, I share my perspective on the plateau I see in our work. I'll say something like, "As I've been thinking about our work, it seems to me that significant changes were coming in the earlier phases, which is common, and that we reached a plateau a while back. I don't know if you see it that way." *Plateau* is a more positive description than saying therapy is "stalled" or "unmoving," and invites the client to join me in evaluating the recent results of therapy. I focus on "we" and "our work," not just on the client's individual movement. In this way, I acknowledge that I'm part of this system and have a role in everything that goes on; I share space on the plateau. With this framework set up, most clients agree that we've been circling around issues without much forward progress. I sometimes even say that I prefer to work intensively with people and take breaks from therapy, rather than stay on plateaus for too long.

For one couple I worked with, the pressure of coping with their son's problems had brought them into couples therapy at the recommendation of an adolescent psychiatrist who was alarmed about how divided they were in dealing with their son. Of course, they had marital issues as well, including difficulty with emotional intimacy, which they were trying to tackle. But that phase of the therapy was slow going. They seemed to use the sessions well, but admitted to inertia at home, where they rarely followed through on what they'd learned in our sessions. Despite my best efforts to have them reflect on what might be blocking the energy for intimacy, therapy was bogging down.

Rather than escalate my efforts to break through with this couple, I did my "let's evaluate our work" protocol, which led to a consensus about how therapy had progressed. We agreed that they'd learned to work as a parental team, with their son functioning better for it, and our sessions had given them insight into their marital issues, but without much change on that front occurring at home. I said that a plateau in therapy after good initial work is common, and that it gives us a chance to decide what to do next, including ending our work for now. They seemed relieved that I didn't expect them to manufacture energy for changing their marriage. Earlier in my career, I might have increased my efforts to avoid failure and, as a result, bestowed a sense of failure on them. Instead, after one more session, we finished up with our heads held high.

These "Where are we now?" conversations don't always mean an end to treatment. Sometimes they lead to reinvigorated therapy, as was the case with a woman who'd come to see me in crisis after a divorce. In the beginning of our work, she'd learned how to cope with her ex-husband and kids and to avoid some of the land mines in the divorce process. Gradually, however, I began to get the sense that I was serving more as a trusted confidant than a therapist. She mostly wanted to talk about the ups and downs of her week, along with routine complaints about her ex-husband. After we reflected on her progress and the plateau in our work together, she said she had more issues to focus on and wanted to continue our therapy to work on them. I then asked her the questions I put to all clients who say they want to continue: "What are your priorities for the next phase of our work? What do you feel a

sense of urgency about?"

With these questions, I signal that I want a new contract if I'm going to sign on for another phase of therapy. In this case, since she'd reentered the dating world, the new contract was to work on finding a way for her to have both connections and boundaries in close relationships, and I was able to help her avoid her tendency to overinvest and then cut and run.

Of course, these conversations don't always go this smoothly. Sometimes clients' fears of abandonment and worries about making it on their own will surface. Fortunately, the emergence of these emotions can allow real therapy work to begin again, providing a new focus on issues of loss and autonomy.

Other times when trying to move from a plateau, it takes a while for the conversation to play out and a conclusion to be reached. In the case of a multiyear therapeutic relationship, for example, I may introduce the conversation, but suggest that we reflect on it over time by saying, "I'm not looking for any quick conclusion on this, but it's good for us to keep track of where you are with what you came here to work on, and where we seem to be going now." The idea here is to broach the subject while signaling that there'll be no lurches or quick unilateral decisions. If the conversation is moving in the direction of ending therapy, I always indicate that we're deciding on "stopping for now," explaining that the door is open if clients want to come back for more work in the future.

My attitude is like that of a music instructor whose client has learned the basic scales and a few songs and is satisfied with that progress for the time being. I celebrate the gains and fully accept the client's decision to put his or her energies elsewhere. We both know that there's room for improvement, perhaps the potential to master Rachmaninoff, but that now isn't the time. There's no harm, no foul in taking a time out, even a permanent one.

After a number of months or year.

circling *around the same issues, we car*

therapy," as in the film where burned-ou

doomed to keep

This approach relates to Andy Christensen's Integrated Acceptance model of couples therapy, which includes two phases: one geared toward helping couples change, and one geared toward helping couples accept what's not likely to change. As psychiatrist David Burns points out in his recent Networker webcast "Motivating the Anxious Client" and his other work on motivation, when a therapist and client agree that not much is changing in therapy and the therapist accepts this reality and the reasons for it without trying to "sell" more change, the client is often paradoxically remotivated to change.

Common Mistakes with Therapeutic Plateaus

Another form of stuck clinical relationships involves the client who keeps making self-destructive choices, ones the therapist is on record as having repeatedly warned against. One therapist in a workshop I led talked about her long-term therapy with a woman who kept bringing new men home from AA groups, living with them for a time, and then feeling used and abandoned when they didn't need her any longer. I don't know how many sessions the client spent talking about this pattern and *agreeing* about how harmful this behavior was for her. She'd always conclude that she wasn't going to do it anymore, and then, bingo, a few weeks later, there'd be a new sad sack living at her house. Another classic scenario is the woman who continually returns to an abusive husband or boyfriend in the hope that, this time, his apology indicates real change, or the married man who's had a series of affairs and resists talking to his wife about his unhappiness

in the marriage because he doesn't want to deal with the fallout of those conversations.

The big challenge for these clinical relationships isn't that the client is behaving in a self-defeating way—it's the client's life, after all—but that these individuals cling to therapy, desperately asking for help but declining to take the responsibility to extricate themselves from toxic situations.

In my own clinical experience, Cindy stands out. She enjoyed therapy and had inherited enough money to work or not as she pleased. She'd made strides in her single parenting—the kids were now raised—but continued to allow herself to be used by one man after another. Each time, she worked in therapy to extricate herself from the relationship, but whenever a new questionable character came along, she was impervious to my fervent attempts to get her to pay attention to the multiple red flags whipping in the wind. I'm not talking about subtle signals here: one man asked her for a good-sized loan after three dates, another offered to pay her younger daughter's college tuition (never having met the girl) and then asked for a "bridge loan," and yet another flirted openly with Cindy's adult daughter. When I'd ask if she saw a familiar pattern, she'd reply, "Well, I have a different sense this time. I'm stronger, and this man is really not like the others."

end up with **"Groundhog Day** *TV weatherman Bill Murray is* **repeating** *the same day over and over.*

These are our Dr. Phil cases, when we want to ask, perhaps with a snarky, self-satisfied smirk, "So how's that working out for you?" Except we're not on TV. We're caught up in an ongoing clinical relationship, and it's important that we not make the following common mistakes:

Acting as if the client's decisions reflect our competence. This is the central mistake behind most lapses in the therapist's craft when working with challenging clients. The truth, of course, is that we're responsible only for how we conduct ourselves in the therapy room, not for how our clients behave in their own lives. But it's hard to hold on to our boundaries when we see clients drive their cars over cliff after cliff while begging us for driving tips.

Acting like disapproving parents. Schooled in avoiding direct advice, most therapists ask screwdriver-like questions such as, "What was going on in your mind when you invited another man to move in with you after meeting him just twice?" The client gets the underlying drift: *The therapist thinks I'm an idiot.*

Assigning pejorative clinical interpretations. When therapists lose their boundaries, feel overresponsible, and don't really know what to do, they often default to poking at the function of the symptom with questions like "Why do you think you need men to treat you so badly?" When the client denies needing to be abused, the therapist doubles down: "If you don't like it, then why do you think you keep putting yourself in this situation?" The client then translates this statement as *You're even more messed up than either us thought before.*

Threatening to end therapy. Usually we fire the client in indirect ways like "I don't see how this therapy is really helping you." I know of one frustrated therapist, however, who said outright that she couldn't work with a client as long as the client chose to stay in an abusive marriage. In another case, the frustrated therapist waited until a husband, following another marital argument in the session, blurted out, "We're not getting anywhere in this therapy." The therapist saw an opening and said, "If you don't think the therapy is helping, then maybe we shouldn't keep meeting. Why don't you think about whether you want to continue and call me back if you want to schedule an appointment?"

Coming on too strong. In a number of my couples cases, one spouse's individual therapist seemed to have taken such a hard position in favor of divorce that the client was too ashamed to continue therapy and attempt to reconcile the marriage. In reality, it's unlikely that the individual therapist likes to promote divorce. Instead, I imagine that the therapist was sick of seeing no movement, but lacked a more skillful way of dealing with the impasse.

Listening too closely to the negativity of our consultation group. It often happens that a consultation group feels it's listened too long to your stories about an impossible client and wants to put both you and the client out of misery. I remember a case consultation when a colleague leaned in toward me, lowered her voice, and said, "Maybe you should ask your client what she gets out of being so unhappy? What's in it for her?" The problem here wasn't her advice; it was the negative energy behind it that I inadvertently absorbed. Having consulted yet again on this particular client's case, I probably should have carried a big sign with me when I walked into our next therapy session—Warning: Lurch Risk Ahead.

How to Get Therapy Moving Again

So how do we effectively shift gears with stuck clients who repeatedly make unfortunate choices? Here are some approaches I've learned from respected colleagues and developed to use in my own clinical work.

Return regularly to the client's need to stay on course and honor the client's stance. Virginia Satir used to talk about

the two universal drives operating simultaneously in people in distress: the desire for growth, which means change, and the desire for stability. As therapists, we have to address both drives. For my client Cindy, choosing yet another inappropriate boyfriend gave her more pain, but reassured her in a way: *even at age 50, I can attract guys, and I'm never without one.*

In the case of a woman who can't stop bringing home new men from AA meetings despite a series of disastrous relationships, I'd prepare myself to see something positive and honorable or wise and smart in her choices. For example, I might say, "You're somebody who doesn't want to give up on men, even though you've had bad experiences in the past. An important value for you is to bring yourself fresh to each new relationship and not assume this guy must be a jerk because some other guys have been jerks." If she seemed to feel understood by this reflection, I might add, "And you believe deeply in AA and its philosophy, so AA meetings seem like a good place to find a man who's making a fresh start in his life." (I should note that actually believing what you say is critical to pulling this off.) As psychiatrist David Burns's work with therapeutic motivation and resistance-to-change has shown, this exchange would almost certainly lead her to express the other side of her ambivalence: the dashed hopes, the feeling of being used, the sense of futility in making the same poor choice over and over.

When a woman continues to stay with an abusive partner, therapists often make the mistake of focusing solely on her vulnerability or her "codependency." A better approach is to start by honoring her commitment to keeping her family together: "Lynne, I see you as someone who cares deeply about keeping your commitments to your marriage and your family. You know your kids love their dad, and you want to keep your family together if it's possible. You're not someone who cuts and runs when times get tough in a relationship." Notice that there's no *but* at the end of this statement. It's important to let her take it in and talk with her about that side of her experience for a while without pouncing on the risk or pathology associated with it. If you can honor her commitment in this way, you're telling her that you see her as a strong person who cares about those around her—and not as a helpless victim. If you work this side of the coin in a heartfelt way, she's likely to be open to exploring the other side, which involves her feelings of not deserving to be treated better or her worries that keeping the family together may actually be harming the children.

When challenging clients, it's critical not to come across as a parent about **choices** *they're making, it's good that acknowledge*

Bookend major challenges with autonomy-granting comments. When challenging a client, it's critical not to come across as a parent. If I feel I must confront clients about choices they're making, I usually begin with words that acknowledge their autonomy. To a married man having a career- and marriage-threatening affair with a drug-using coworker, I said, "Doug, I'm going to say something challenging here. I'm going to offer it with an understanding that this is your life and that I don't get a vote in your decisions. Here's what I'm concerned about. . . ." Another way to set up these challenges is to start with something like, "I'm sure you've thought about what I am going to say." The idea is to signal respect before getting pushy. After the challenge comes another autonomy statement such as "That's just how it looks from where I'm sitting. You're the one who gets to decide." This bookend approach to challenges makes it less likely that the client will have a you're-not-the-boss-of-me response.

When challenging stuck clients, use subjective, personal, and "ordinary" language. Saying things like "I see you enacting the same self-destructive pattern you learned in your family of origin" is therapy-speak and won't resonate with the client. It's better to use subjective phrases like "I'm worried for you" and "This is what I'm concerned about." In an impasse, I say things like "I'm worried for you right now. I'm worried that a very positive part of you—your openness to each person who comes into your life—is getting you into one bad relationship after another. Each time this happens, you seem to go deeper into a pit of despair. That's what I'm worried about for you." This comes across as a personal, caring challenge delivered in human terms. It's not a clinical insight subject to agreement or disagreement, and most clients can take it in. This kind of challenge is also not parental if it's sandwiched between autonomy-granting statements. Step 1: I respect you as an adult. Step 2: I care about you and am worried for you. Step 3: It's your choice, and I don't get a vote.

Learn how to recover when you've come on too strong. Cindy, the woman who'd been with a series of mooching men, had started seeing yet another new guy who talked money early on. She knew well my concerns about her

pattern and shared them. After a particularly challenging session in which my conversational craft had slipped into badgering, I knew I needed to do repair work.

So I began the next session by saying, "You know, I came on pretty strong last time with my concerns about this new relationship. How are you feeling now about the stance I took in our last session?" She acknowledged that my concern made her feel cared for, but she worried that she was disappointing me. We then processed the clear reality that I was skeptical about a choice she was making and talked about how we could live with that tension and still do good work together. In fact, she thought I was probably right, but then revealed for the first time that she saw herself as a "betting woman," who was OK with long shots when it came to relationships. She thought she'd decline to lend money to this current guy, but would keep open the possibility that this could be a good relationship. This exchange helped repair a frayed clinical relationship, in which I'd almost become overresponsible and not therapeutic.

Stop pushing for change, and wait for another opening when life teaches lessons. Cindy and I moved on to work on ways she could keep as healthy an emotional balance as possible in a relationship I thought was basically unhealthy. At some point, one of us would be proven right by the outcome of the episode. The result was that most of my frustration melted away because I didn't define my goal as getting her out of this relationship. Rather, I tried to help her learn what she could from the situation she'd chosen to be in.

Not having to defend her decision allowed Cindy to appraise the relationship realistically as it developed. She eventually came to focus on the fact that the man wouldn't let her see his apartment. With my support, she dug in her heels on this one. I coached her on how to talk with her boyfriend about her feelings and how not to back down when he claimed his place was so shoddy that he didn't want to disrespect her by taking her there. Finally, she decided to tell him that she wanted her loan repaid and that she wasn't going to give him any more money, whereupon he disappeared from her life.

When we processed all of this, she saw clearly how she'd blinded herself to red flags that had come up in the relationship. Recently, about 15 years after we'd finished therapy, I got an email from her saying that her life was good, that she'd had better relationships with men in recent years, and that none of them had borrowed money from her.

parent. *If you must confront clients to begin with words their* **autonomy.**

Becoming a Therapeutic Craftsperson

If the risk for new therapists is falling on their faces because they're still learning their craft, the risk for experienced therapists is being captured by our competence. We become habituated to the role of "pretty good therapist," and we stop getting better. The research behind this idea is sobering: clinical outcomes aren't related to the therapist's experience level. Overall, experienced therapists have no better success than newbies. However, unless we can compare our work with fellow therapists on similar cases and find that others have succeeded where we've failed, we're tempted to assume that when therapy falls short, the fault is with the clients. We might tell ourselves that they just aren't motivated, that they have an Axis-II diagnosis, or that their marriage was doomed anyway. Often our colleagues help foster our inflated sense of capacity, rushing to reassure us that our clinical failures are either not failures or not our fault, because we're competent therapists.

How do we avoid being captured by our competence? I've learned that the key is never to stop being a student. It's hard to habituate while being a graduate student because there's always something new coming at you; there's always someone who knows more than you and is paid to teach it to you. The challenge after leaving school is to learn how to keep learning. Anthropologist and cyberneticist Gregory Bateson's research showed that dolphins figured out how to create novel jumps and flips when they realized they'd only be rewarded for originality, not for doing their old tricks. Bateson called this "second-order learning"—learning how to learn. Therapists, too, need to bring this type of learning into practice.

The therapists I've admired most in my career have been those who continually change and develop while holding onto the core of who they are as therapists. They're interested in new models and new evidence, but not in serially reinventing themselves with each new fad. What I've come to see recently is that learning new models counts for little if therapists don't continually improve their basic craft, the day-to-day skills of their work. Not focusing on the basic craft is like being a surgeon who learns advanced techniques without being good at making incisions and preventing infections.

Another strategy for avoiding decades on a clinical plateau is to be a perfectionist without being immersed

Continued on page 62

DOHERTY *from page 31*
in self-criticism. I always question whether I could have done better with a difficult case, but I rarely beat myself up over it. I experiment with the small details of therapy (like how to frame key questions) and with the structure and flow of therapy (like how to open sessions and to blend individual and couples conversations). I'm a sponge for nuance and details when I see master therapists share their work. However, I pay more attention to what they do—their craft—than to how they theorize it.

I get a rush when I pick up a gem from a colleague who has a skilled turn of phrase or way of structuring an intervention. For example, a colleague recently recounted a small intervention he'd made with a stuck case: he'd invited the client to begin sitting in a chair different from the one she'd used for years in the therapy room. The client's energy in the session shifted noticeably, and my colleague capitalized on the new energy to move the work forward again. Talk about breaking the power of habituation!

These days, I'm having the most fun of my career trying to hone my craft in "discernment counseling," a specialized way to work with mixed-agenda couples in which one partner is leaning out of the relationship and the other one wants to save it. What I enjoy the most is making adjustments in the protocol because a new wrinkle has shown itself.

Discernment counseling opens with a two-hour session that starts with the couple, then goes to each individual separately, and ends with each spouse sharing with the other the takeaways from their individual sessions. I'd always started out the individual spouse conversations by talking to the leaning-out spouse, assuming that this person is ambivalent both about the marriage and the counseling. I'd strive to build a connection and learn more about what's driving this person out of the marriage, so that I could fold that into the individual conversation with the leaning-in partner, who presumably is already on board to work on the relationship. Sounds sensible, right?

Well, I began to notice cases in which the leaning-out spouses were quite clear about what it would take to fix the marriage and their role in the problems, while the leaning-in spouses were pretty clueless about the problems and not sure what working on the marriage would even entail. One leaning-in but clueless husband, for instance, didn't realize that his temper and outbursts were a serious problem for his wife. In this case, I adjusted my thinking and met with him first to get a clear picture of what he understood, so I'd know how to proceed with his leaning-out wife. While I was talking with him alone, he had a revelation that led me to make another shift in my thinking: Why wait until the end of the session to ask him to summarize for his wife what he'd realized with me? Why not have him share the new realization with his wife right away? That way, I could fold her response into my individual time with her.

Rather than offering a commentary on my experience with discernment counseling, my point in relaying this story is to give an example of how I continue to hone my craft as a therapist. In this case, I saw where my approach was breaking down and experimented with a more successful alternative.

I find this kind of self-correction great fun, and I revel in sharing my experiences with colleagues so they can experiment with the change in protocol if it makes sense to them. Experienced therapists have had enough training to avoid serious undertows or completely capsizing the therapeutic conversation, but the more we strive to learn how other therapists practice the nuances of their craft, the more skillful we ourselves will be at navigating out of the bogs and marshes where our clinical relationships get stuck. ■

William Doherty, Ph.D., is a professor of family social science and the director of the Minnesota Couples on the Brink Project at the University of Minnesota, www.mncouplesonthebrink.org. Contact: bdoherty@umn.edu.
Tell us what you think about this article by email at letters@psychnetworker.org, or at www.psychotherapynetworker.org. Log in and you'll find the comment section on every page of the online Magazine.