Empathy: The Heart of Good Clinical Work

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"Empathy is the 'psychological super-glue' that connects people and undergirds cooperation and kindness" (Abramson, 2021, p.46). Accurate empathy has been considered a central feature of quality work since Rogers highlighted its importance in the 50's. Empathy is a "common factor" that is correlated with treatment effectiveness (Elliott, et al., 2018). Empathy does not involve identification with clients and their suffering, but rather walking with them in their pain (Abramson, 2021). Most of us had training in active listening in grad school. A good therapist listens carefully to the content and the feelings of the client's experience and mirrors that information back to the client. Have we learned more about empathy in the past 20 years?

I Understanding Empathy

Empathy involves being fully present with our clients, being attuned to their feelings, experiences and needs, and resonating with them somatically. Empathy facilitates setting helpful treatment goals. At big empathic therapists are sensitive to breaches in the alliance and address them directly. Wise therapists are aware of the obstacles to continuous empathy.

Neuroscience, advances in clinical theory and the study of mindfulness have greatly increased our understanding of the process of a clinician's connecting with the life experiences of her client. Trauma theory suggests that we gather with our family/tribe when sensing danger. The fight or flight response is better known, yet Porges writes that our first response to danger is often to connect to our loved ones (Siegal, 2010). The toddler runs and falls. His mother comforts him, joining with his pain and soothing his distress. We are wired to respond empathically to the pain of another.

Neuroscience has advanced our understanding through the study of mirror neurons. Scientists doing brain scans on primates were surprised to see brain activity in one chimp watching another chimp eat a banana! There was activity in the motor cortex of the chimp eating as well as in the chimp who was

only watching the other eating. The activity in the brain of the second chimp seemed to mirror the activity of the first chimp. What was initially a serendipitous discovery became a major focus of neuroscience research. We now know that mirror neurons in the insula and the prefrontal cortex (PFC) are active when we are with others for whom we care.

The insula is a small region of the midbrain/temporal lobe which processes interoceptive information (what is happening in our bodies) as well as external information – what is happening to those around us. The insula lets us know if we are feeling uncomfortable or if those around us are relaxed or stressed. The insula is a receiving zone of the brain, picking up information from the skin as well as the internal organs:

- hot or cold
- pain or pleasure
- hunger or thirst.

The insula is the seat of the social emotions:

- lust and disgust
- pride and humiliation
- guilt and reconciliation
- love and fear (Blakeslee, 2007).

Individuals with more self-awareness and interest in others are more likely to connect with the pain of others on a visceral level. Information from the insula is processed through the PFC so that we may act if action is called for.

- Our client weeps at the death of her mother.
- We instinctively feel her distress and validate her pain.

Failure to attend to interoceptive messages of our body can have a negative impact on our therapy relationships and even our own health.

> Many years ago a friend of mine who was a school counselor married a successful drug rep. After about ten years of marriage, he left her for another woman. Although he had been unfaithful, he remained furious at her for years for her failings in the marriage. They did legal battle costing both of them tens of thousands of dollars in divorce court. I understand that marriages sometimes fail. I did not understand his years of animosity toward her. Several years after the divorce, he developed colon cancer which took his life while he was in his 50's. I did not know this man well, but I suspect that he was not in touch with his own body feelings. His lack of body awareness kept him from picking up on GI issues; his lack of empathy kept him in years of warfare with my friend.*

Our mirror neurons fire whenever we approach another. Is she happy or upset? Is he friend or foe? We are intuitively aware of the subtle messages of those around us if we have developed that capacity (Germer, 2009). Of course, not everyone is equally empathic.

- Women tend to be more empathic than men.

- Individuals on the Autistic Spectrum have difficulty in reading social communication.
- Sociopaths may read others well, but have no emotional empathy for their pain.

The Components of Empathy

Empathy can be understood from three perspectives:

- cognitive
- affective and
- somatic.

If I am listening to a pre-teen share their upset at being put down by a classmate at school, I can adopt their perspective and understand their pain at a cognitive level. If a client shares worries that keep them awake at night, I can feel their distress and respond empathically. If I feel the client's distress physically, I am in tune somatically.

> Some years ago I was seeing a young man who was frustrated because of his underemployment and difficulty supporting his young family. He lived with his girlfriend who was a stay-at-home mom, their three-month-old baby and two preschoolers who were from a relationship she had had with a previous boyfriend. He was most concerned about her because she seemed very depressed since she gave birth to their son. I asked him to bring her to the next appointment. When we spoke, I learned that she was suffering from Major Depression; she lacked energy, had suicidal feelings and had a great deal of difficulty in handling her day-to-day responsibilities. She complained about a lack of appetite and even difficulty swallowing. I connected with her pain and noticed some tightness in my throat. I went to drink some water and was unable to swallow it; I choked. After the fact, I was aware that I was resonating with her physically and, like her, was unable to swallow. We talked about the value of her speaking with her OB/GYN to get on an antidepressant. I don't want to suggest I am always physically in touch with my clients. Such is possible if we open ourselves to resonating with our clients.

We used to think of empathy as a fixed trait. We now understand that we can grow in empathy through life experiences and professional development. Daniel Siegal (2010) describes in detail how we can become more empathic as therapists by improving our mindful understanding of the process.

*Clinical examples are composites with identifying information changes to protect the confidentiality of my clients.

The Mindful Therapist

Siegal reminds us that a positive therapeutic alliance is highly correlated with positive outcomes in therapy. Empathic physicians have patients who heal

faster and have more robust immune responses. Mindfulness can be used to increase our empathic connection to our clients. Mindfulness involves

- being fully and intentionally in the present
- without judgement of self or others
- without jumping to conclusions.

Siegal describes the mindful therapist as being fully present to her client. She is calm and breathing slowly, not distracted by her own personal stresses. She is a safe presence for her client, ready to experience with that client whatever pain or joy, hopes or fears she is bringing to the session. If the therapist is doing her own mindfulness practice, she is likely to be

- flexible
- adaptive
- coherent
- energized and
- stable.

By bringing those qualities to therapy with her clients, she has the potential to increase those qualities in the life of the client.

The mindful therapist is attuned to self, other and nature. The mindful therapist lets go of his own tension and calms his own pain so that his feelings do not contaminate his experience of the other. If a client brings tension, he lets himself feel the worry. If the client is sad or angry, he lets himself feel that pain. When we are attuned, we focus fully on the words and feelings of the client. Our mirror neurons help us experience the feelings and energy level of the other. We may calm ourselves by regularly

- walking outside, feeling the breeze
- seeing the many colors of the fall leaves
- listening to birdsong or the rhythms of the crickets.

Our self-care is essential if we are to be attuned to our clients.

Siegal describes resonance as a safe and trusting relationship where two people are emotionally connected and they are unconsciously influencing each other. A child who grows up in a safe home with an attentive parent begins life with

- a sense of safety
- positive self-regard and
- trust of the other.

Too many individuals do not have that secure attachment as the foundation of their lives. Anxious attachments may develop from

- a critical parent
- an intrusive, over-involved parent
- a neglectful parent preoccupied with their own pain or
- an abusive parent who is acting out the abuse he received as a child.

In a therapeutic relationship there is potential for new learning if the therapist brings

- safety
- curiosity
- openness and
- acceptance.

Therapy can be a corrective experience.

- The client is distressed.
- The therapist feels that pain with the client.
- The therapist brings calm and self-esteem.
- Over time the client learns to self-calm and value herself more.

Resonance is the emotional energy flow between the client and clinician that is validating and healing.

The process of presence, attunement, and resonance leads to basic trust. Trust involves safety and connection; trust makes growth possible. When we have compassion for our clients, we teach them to be compassionate toward themselves and their significant others. Siegal teaches a loving kindness meditation (metta) which we will explore later in this paper.
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Empathy and the Therapeutic Alliance

Empathy of course is not a stand-alone feature of a positive alliance. When the clinician is empathic, he understands the client's feelings, perspectives, experiences and motivations (Elliott et al., 2018). He works in sync with the client to identify the treatment goals. Sometimes the goals are obvious:

> I want to find the best anti-depressant to reduce my post-partum depression so I can get up when my baby needs to be fed in the morning.

Sometimes the goal setting is more complex:

> My wife is threatening to leave me because she is tired of my PTSD explosiveness.

The client's hope is that his wife does not leave him, but goals cannot involve the decisions of others. The goals may include:

- I will do daily relaxation exercises to reduce my tension.
- I will leave the house before I explode.
- I will tell my wife I love her daily without doing a guilt trip on her.

When the clinician is empathic with the client's life experiences, goal setting flows from that process (Solovey, 2021).

Effective empathy also includes an awareness that breaches sometimes happen in the relationship. The skilled clinician is sensitive to the ruptures that occur and has the tools to repair the discord. In thinking about this subject, I naively thought that such were unusual in counseling. In an eye-opening meta-analysis by Eubanks et al., (2018), 43% of clients reported a strain in the

relationship or disagreement regarding goals. Ruptures are quite significant because repair of the rupture often resulted in a stronger relationship and better treatment outcomes. Failure to address the discord resulted in more no-shows, treatment cancellations and therapy dropouts and/or poor outcomes. Research based practices include:

- Be alert to ruptures in the relationship; look for expressions of dissatisfaction or withdrawal.
- Acknowledge the rupture directly and non-defensively.
- Empathize with the patient's expression of negative feelings about the therapist or the therapy.
- Accept responsibility for one's participation in the rupture.
- Use consultation to explore countertransference feelings or ruptures in your therapy relationships (Eubanks et al., 2018).

Finally, it would be a mistake to assume that every client welcomes equal expressions of empathy. In our culture men tend to avoid expression of softer feelings; some men who are alexithymic have very little emotional awareness. They may value feedback initially that is cognitive or behavioral rather than a focus primarily on feelings. Greenberg (2021) notes that culture impacts emotional expression. American culture tends to value emotional expression connected with individual needs and preferences. Asian cultures tend to value low arousal emotions centered on the needs of the family or group. Koreans tend to somaticize emotions more than Americans. In Asian cultures interpersonal conflict in marriage is discouraged while it is much more common in American couples. Shame is seen as a negative emotion by most Americans, but it may be positively valued by some Asians. Given that awareness of racism is more accepted by many Americans since the protests of George Floyd's death and Black Lives Matter, discussion of experiences of racism is welcomed by more Black and other clients of color. Sexism, racism and homophobia are more important to address in treatment today.

We would like to assume that the common factors are in fact common. Yet observational studies of mental health professionals are not reassuring. A study of psychiatrists found that fewer than 5% display warmth to their patients. A study of clinical social workers found empathy to be uncommon (Miller, et al., 2021). The good news is that we can learn to be more empathic if we make that a goal of our personal and professional development.

<u>Obstacles to Empathy</u>

Blocks to empathy may be situational or group related. Clinicians who are usually good at resonating with their clients may find themselves less empathic when they are

- hungry

- angry about their own issues
- lonely or
- tired.

AA uses HALT as an acronym to describe when alcohol abusers are more at risk for drinking alcohol. So also we may be less likely to be attuned to our clients when we are

- low energy due to hunger or lack of sleep
- stressed or
- feeling unsupported.

We look we will address good self-care in the next section of this paper.
We are all at risk for compassion fatigue. Years ago, during my last appointment on a Saturday when I had seen six hyperactive boys and their families in a row, I remember my internal tirade:

- Just pay attention.
- Just do as you're told.

My controls are strong, so I did not vent at this boy, but I vividly remember telling myself I would take care not to schedule that many similar clients consecutively on the same day from now on!

Sometimes compassion fatigue can become a steady state of PTSD symptoms. When clinicians are treating multiple clients with PTSD, their coping skills can become overwhelmed so that they develop their own PTSD symptoms:

- intrusive thoughts
- nightmares
- hyper arousal
- numbness
- insomnia or
- irritability (Figley, 1995).

Overwhelmed by their secondary reactions to the abuse, rape or war trauma experienced by their clients, they may have difficulty functioning, much less being empathic with the next client who brings intense pain to their place of business. Clinicians with this level of distress are likely to benefit from personal therapy as well as consultation with a colleague about how to diversify their professional activities.

Ethical clinicians are aware they are not competent to treat every client who could request services. We select which client groups we have well-developed skills to treat and which clients we will refer to other clinicians. There are some groups that we can relate to easier and some groups that rub us the wrong way. I find that I relate easily with

- depressed children or adults
- anxious or traumatized children or adults
- ADHD or oppositional youth or adults.

I have more difficulty empathizing with

- anorexics
- clients who abuse drugs or alcohol or
- clients with chronic pain,

so I regularly refer those individuals to other clinicians.

Clients with personality disorders are often challenging. Their behavior and thought patterns are years in the making and are often resistant to change. DSM-5 (American Psychiatric Association, 2013) organizes those with long-term issues by cluster:

- Cluster A
    - Paranoid
    - Schizoid
    - Schizotypal
- Cluster B
    - Antisocial
    - Borderline
    - Histrionic
    - Narcissistic
- Cluster C
    - Avoidant
    - Dependent
    - Obsessive-Compulsive.

We may not think of our clients is having personality disorders because we seldom use those diagnoses for reimbursement. Yet some of our clients bring these issues to our doorsteps whether we name them or not. Many of us seldom see clients who have paranoid, schizoid, schizotypal or antisocial characteristics because they seldom refer themselves for treatment. Those who work in forensic settings are much more likely to see cluster A or B clients. Any of us working with trauma clients are likely to see some with borderline characteristics. I found training in Dialectical Behavior Therapy to increase my empathy and give me effective skills to use with that group (Linehan, 1998, 2014).

I find myself put off with moderate to severe narcissistic clients, so I refer them to therapists skilled with that group. Sperry's book Cognitive Behavior Therapy of DSM-5 Personality Disorders (2016) is an excellent resource for clinicians who want to better understand the thought processes of clients with personality disorders and offer them better coping skills.

Our practice organizations are calling us to become more aware of our biases and more culturally competent to be able to empathize with and treat clients when they are

- Black/African-American
- Latinx
- Asian American

- Native American
- Arab American
- Appalachian

as well as clients with different spiritual backgrounds. Likewise, some clinicians have little understanding of the lives of LGBTQ clients. It is unrealistic to think we can all be knowledgeable and skillful with all of the above groups. Conscientious clinicians decide to specialize with some groups and refer others to better equipped colleagues. In the next section of this paper I will share some resources to help you develop more empathy for various minority groups.

II Paths to Greater Empathy

There are many avenues to greater empathy open to us. Such include:

- *becoming more culturally aware*
- *maturation – middle-aged and old age*
- *experiencing suffering in our own lives*
- *setting better boundaries*
- *growing in mindfulness and self-compassion*
- *growing spiritually*

1) Social Awareness/Cultural Competence

When we think of evolution, Darwin's phrase "survival of the fittest" comes to mind. We think of ourselves as independent strivers working to obtain a mate, occupational success and positive regard in our communities. Yet scientists who have studied human development at the individual and species level tell us that cooperation is the norm. Humans are so dependent at birth that they cannot survive without the almost constant attention/nurture of their parents. Humans in the bush tens of thousands of years ago survived by bonding together in tribes to hunt for game and forage for nuts and berries. Humans must work together with members of their tribe to obtain food and fend off predators (Harari, 2015). We tend to be less ready to help strangers (McCullough, 2020) who are not members of our tribe. Our tribe may be

- white Americans
- middle-class
- Evangelicals or Catholics.
- Democrats or Republicans.
- cis-gender heterosexuals.

Strangers may be

- Blacks or other people of color.
- the poor
- immigrants
- non-Christians

- Southerners
- people belonging to the wrong political party, etc.

We may divide up differently who is in, who is out, who are strangers or of no concern to us.

It is difficult for all of us to be empathic with every person who is seeking our professional assistance. Yet, our professional organizations challenge us to be prepared to understand

- women who are angry and men stuck in patriarchy
- families with low income
- people of color
- people with different religious beliefs than our own
- gender and sexual minorities
- Immigrants with different customs and language than our own.

We know that too many girls have been abused and too many women have been sexually harassed or discriminated against on the job. The #MeToo movement has opened our eyes to learn that abuse and discrimination still happen regularly. Forty-four per cent of women are victims of sexual violence in their lifetimes (FBI, 2019). Domestic violence in which men control, coerce, and batter women is not rare; almost 25% of women are victims of intimate partner violence in their lifetimes (APA, 2018). Too many women have been traumatized as children or adults. It is important that we clinicians ask relevant questions and provide relevant treatment to all our women clients.

Some men remain stuck in a traditional understanding of the male role, which may include

- Stoicism
- competitiveness
- dominance
- aggression
- avoidance of weakness
- disrespect of women and gays (APA, 2018).

Some of these traits may be advantageous for those in the military or first responders. But our culture is changing. More women expect men to communicate as equals. More businesses focus on cooperation and reaching group goals. Good paying blue-collar jobs are much less available now than they were a generation ago. Many of these men are divorced and unemployed or underemployed. They may be angry and adrift and need our compassion. Some are abusing drugs or alcohol; without our assistance they are at risk for "deaths of despair". Economists have documented the dramatic increase in deaths due to cirrhosis, overdose or suicide among working-class white men in their 40s and 50s. This increase in early deaths is especially pronounced in

central Appalachia (West Virginia, eastern Kentucky, and southeastern Ohio) (Bauer, 2020).

Ethnic Awareness

The death of George Floyd made many Americans aware of the brutality Blacks experience at the hands of some police. More of us have learned that Black youth tend to experience more suspensions, expulsions, and arrest in school than their white counterparts. Black adults experience more arrests and incarceration than whites. Read Just Mercy by Brian Stevenson (2015) to deepen your understanding of the bias Blacks tend to face in our criminal justice system. There are those who argue that significant racism ended in the United States in the 60s when the civil rights laws were passed. Yet many Blacks tell us a different story:

- They may face bias when looking for a job.
- They are at a disadvantage when looking to buy a house.
- They often experience overt racism or micro-aggressions in day-to-day interactions with whites.
- If they go to college, they are likely to have higher student loans than whites because of the low level of wealth in most black families (McGee, 2021).

The wealth gap between white and black families is most telling. The median household wealth is 10 times higher for white families than Black families ($171,000 versus $17,000) (McGee, 20, 21). This gap exists because of

- unequal educational opportunities
- the history of redlining (no loans for Black families seeking to live in better white neighborhoods)
- job discrimination
- discrimination in government loans
- lack of wealth passed on from one generation to the next (Taylor, 2018).

If Blacks share experiences of discrimination or micro-aggressions with their clinicians, it is important that we take that seriously. Derald Sue (2019) has written a helpful article exploring options that clinicians may consider when working with minority clients (see handout # 2). Those interested in better understanding the Black experience can read The Sum of Us by Heather McGee (2021), Caste by Isabel Wilkerson (2020) or An American Marriage by Tayari Jones (2018). Those interested in learning more about the strengths of our Black communities are encouraged to read Gaylord–Harder et al. (2018), Okeke-Adejanju, et al. (2014) or Hill (1997).

Latinx Americans are the largest minority group in the US and the most diverse. Eighty per cent are here legally and 20% are undocumented. The latter group includes Dreamers, those born in Latin America, whose parents brought them here at a young age. Some Latinx families have been here since before the pilgrims landed at Pilgrim Rock. Some have come here recently from Central

America seeking asylum. Many Cuban families came to Miami in the '50s when Castro made Cuba Communist. Ramos (2020) has written Finding Latinx, which celebrates

- form workers in central California
- Black Latinx from Haiti or Cuba
- descendants of Mayans living in Georgia who speak a Mayan dialect
- trans and gay Latinx
- Alexandria Ocasio-Cortez and millions of Puerto Ricans living here or on the island.

Many Latin American immigrants are here legally to harvest the food we eat, yet many are paid less than the minimum wage. They do challenging jobs whites prefer not to do (e.g., roofing, meat preparation). Twenty-four per cent of Latinx families live in poverty (versus 10% of whites) (Organista, 2019). Latinx workers tend to work in essential jobs and have died at higher rates due to Covid-19.

Latinx Americans share values that contribute to their resilience:

- determination, courage, drive
- a strong working work ethic
- adaptability
- placing a high value on family and friends
- esperanza – faith that good times will come in spite of hardships (Compos and Kim, 2017; Chavez–Deunas et al., 2019).

Developing a positive alliance with Latinos/as may involve personalismo, sharing respect and enough personal information to be seen as a real person, not just a detached professional. Empathy for a Latina client may involve understanding their pride in owning their own business or sharing compassion for undocumented adults who are seeking asylum. A gripping novel that describes one Mexican family's escape from violence and a treacherous journey to the United States is American Dirt by Jeanine Cummins (2020).

Asian Americans have been somewhat invisible; some call them the "model minority" because many have been financially successful. Asian Americans have experienced more racist taunts or physical attacks the past two years because of being blamed for bringing Covid to the United States. Traditional Asian families tend to be patriarchal and multigenerational. Older adults are seen as wise and valuable to family life. Avoiding bringing shame upon the family is taught to Asian American youth. Some families experience major conflict between parents with traditional values and teens who have grown up embracing American individualism and freedom. Asian Americans may be Christian, Buddhist, Hindu, Muslim, or nonbelievers. Asian American women may be sought out as exotic and/or submissive. Culturally Responsive CBT includes relevant chapters on treating East Asians, South Asians, and Arab Americans

(Iwamasa and Hayes, 2019). Amy Tan (2006) has written popular novels that offer a window into Chinese-American culture, e.g. Joy Luck Club.

Angela called me for an appointment because of too much stress in her life. She was having frequent arguments with her husband and wanted to get feedback on how to cope with him. At her first appointment I learned that Angela had been married to Charlie for ten years. They had two sons, Paul and Don (8 and 5). She enjoys her job as a childbirth and infant care nurse at a local hospital. Charlie sells cars and is often at work or with friends in the evenings or on Saturdays. Paul is bright but strong-willed; he does school work in subjects he likes (Math and Science), but avoids work in English and Social Studies. Don is compliant and tries to please his mother.

In her second appointment, I learned that her parents immigrated to the US from the Philippines when they were in their 20's. Her father is traditional in his outlook. He expects respect from his children. Angela and he argued frequently when she was a teenager because she listened to rap music and wanted to date boys with whom she had interests in common. He wished she would be more religious and subservient. Angela's mother was a caring woman, a stay-at-home mother who deferred to the wishes of her husband. I shared feedback that conflict with immigrant parents is frequent in some families where parents still hold to the values of their country of origin while teens born in this country adopt more independence and American values. Angela smiled and said that was helpful to learn.

In discussing her marriage further, Angela said she met Charlie while she was in nursing school. He was already working, so they had money for movies, concerts, eating out. She appreciated his fun-loving approach to life. Now that she has been married to him for ten years, she is tired of his socializing with friends and working long hours, leaving her to do most of the parenting and household chores. He does mow the lawn in the summer and washes their cars periodically.

I asked what happens if she tries to engage Charlie in a discussion about her frustrations. She reports he generally ignores her. He has agreed to attend his sons' athletic events when he can. I asked Angela how his avoiding her has affected her. She reports she is angry with him most of the time. Their sex life is infrequent. She is having headaches more and feels guilty when she is irritable with her sons. Sometimes she has difficulty sleeping at nights. She feels on edge most days. I asked her about exercise, her social life and religious participation. Angela told me she walks with friends some days at work. She rarely has time for seeing friends because Charlie is gone so much. She regularly attends church with her sons and she finds that comforting. She wishes Charlie would go with her to church more often.

I asked Angela if she would like Charlie to join us for some sessions since many of her frustrations were focused on her relationship with him. She said she has already asked him to attend sessions together and he refused. I asked her for her permission for me to invite him to join us. She agreed. When I spoke to Charlie, I asked him to join us for one session so that I could get his perspective. He said she had no interest in their sex life, so he had no interest in coming to her sessions. He said he hoped I could help her become a more

responsive wife. I shared with Angela my observation that Charlie was walling her off emotionally.

Angela cried a bit. She said she tried to be a good wife, cooking and cleaning, caring for their children, yet Charlie seemed to take her efforts for granted. I asked how often they had a date. She said only a few times a year; they would go out with friends. Generally Charlie preferred to be with his friends rather than make time with her. I said we would focus on her self care first and as she relaxed more we could explore addressing their relationship.

I did some educational work with her about the sympathetic and para-sympathetic nervous system. She wanted to be more relaxed and so I did relaxing imagery with her. She enjoyed "being at" the beach on a warm day, imagining the rhythm of the waves, and letting go of the tension in her body. I encouraged her to make time to relax daily.

At our next session, Angela said she was relaxing daily and that was helping her mood and her sleep at night. I asked her to share some of her thoughts and feelings. She said she felt lonely since Charlie makes little time for her. She revealed she was not close to her father growing up. Now her husband avoids her. It was painful. I asked her how she interpreted distance from her father and Charlie. She responded that she tried to please both of them, but what she did was never enough. Her father wanted to tell her how to live, which she would not allow him to do. I noted that she valued her independence like most American teens. Charlie wants to do his own thing and seems to care little for her. I mentioned that it all sounded very painful.

At our next meeting, Angela was quite distraught. She said Charlie left her for another woman. She wept freely. I empathized with the pain of her loss. She said Charlie told her she was not the person he thought he married. She was cold and did not meet his needs. Angela felt crushed by his rejection. I asked if she felt any anger at Charlie. She said she thought Charlie loved her when they dated. He was fun-loving and attentive to her on dates. After they married, he expected her to wait on him, to meet his sexual fantasies. She said she made tasty meals, kept a clean house, worked hard as a nurse and took good care of their children. She drew the line on being ready for bedroom play at his every whim, because she felt so neglected. She felt her needs did not matter to him. He acted like she was his geisha and she would not accept that.

I said some men buy into the stereotype that Asian-American women are subservient and are sexual slaves (Sue et al., 2007). Angela said she wanted him to make time for her, to care about her feelings. I replied what you wanted is what everyone wants in marriage. She responded that it just hurts so much.

For the next three months Angela and I had regular sessions in which she grieved the loss of her dreams and the disruption to their family life. She came to see Charlie as preoccupied with his own needs and as having little awareness of the need for mutuality in marriage. She grew in self-compassion and understanding. We shifted to monthly booster sessions and I affirmed Angela for being an attentive mother and gaining more insight into her own needs.

Appalachians who live in the central and southern sections of that oldest of mountain ranges in the United States can be seen as an important ethnic group. The Appalachian Mountains were originally populated by the Cherokee and Shawnee. After the Revolutionary war, Scots Irish, German and other immigrants from Europe began to fill the mountains. The early industries there were coal and lumber. Now most of the coal and original trees are gone. Unemployment has been high since the 70s. Government programs like the Tennessee Valley Authority have helped some areas, but much of central and southern Appalachia is still burdened by poverty (25% in central Appalachia versus 15% in the United States generally in 2017) (Appalachian Regional Commission, 2019).

Many Appalachians have major health challenges, e.g. black lung, diabetes, obesity, or COPD. Many southern and central Appalachians experience depression, anxiety and/or substance abuse. As was mentioned above, white unemployed/underemployed men are dying at a young age due to suicide, overdose or cirrhosis. They need validation and intense treatment to have the possibility for a better life. Hanna et al. (2021) highlight the importance of conveying a personal interest in each client's story and avoiding being condescending or somehow superior due to class or education when working with Appalachian clients. Career counseling may also be essential. J. D. Vance's book (2016) A Hillbilly Elegy is a humorous autobiography describing the problems of central Appalachia. Appalachian Reckoning gives a more balanced and scholarly view of the region (Harkins et al., 2019). Barbara Kingsolver and Wendell Berry are two of my favorite authors with Appalachian roots.

Understanding the Poor

The poor tend to be invisible in our land except for a few homeless people seeking donations on our street corners. Few of us in private practice offer services to many low income families because we are not eligible to bill or choose not to accept Medicaid. Yet families of generational poverty are chronically stressed and in need of counseling services. Most of us buy the American dream which boasts that anyone who is willing to work hard can succeed in America. Yet structural/historical conditions make climbing out of poverty problematic for many:

- poor government support for the poor compared with other developed countries
- racial/ethnic discrimination
- Imprisonment of black and brown men
- weak schools in poor areas
- no inherited wealth (Crawley et al., 2019).

You may learn more about the lot of the poor by reading The Broken Ladder by Payne (2017), Ehrenreich's Nickel and Dimed (2011) or watching the TV series The Maid on Netflix.

Low income women who are often single parents are at higher risk for
- domestic violence
- sexual violence
- homelessness
- poor health
- job loss
- depression
- substance abuse (APA, 2019a).

Black and brown women with low income face the additional challenges of ethnic discrimination (APA, 2019b).

Children from low income families are at higher risk for ACExperiences and so bring loss, fear, and learned helplessness to school (APA, 2019c). Many have not observed good problem-solving skills by their parents or guardians and so may be distractible, disorganized or reactive. They will benefit from schools with trauma focused staff and/or those trained in Social and Emotional Learning (Sauers, 2016).

Embracing Gender and Sexual Minorities.
Thankfully we are past the days when conversion therapy was popular to transform gay clients become fully heterosexual. Yet, lack of knowledge about sexuality and gender is still prevalent:
- Sex education in middle school and high school, focuses too much on anatomy and abstinence into little on psychological development and birth control.
- Although Kinsey's research in the 40s show that many adolescents and young adults experience heterosexual and gay sexual fantasies, our street culture still communicates that being gay or straight are the only options.
- Too many churches and politicians do not accept being transgender as a legitimate life choice (staff of History.com, 2019; APA, 2012; APA, 2015).

We clinicians have a key role in sharing up-to-date information about sexuality and gender with teens, young adults and parents.
- Adolescence is a time of exploring possibilities –
    - Am I straight, gay, or bisexual?
    - Am I cis-gender, gender fluid or trans?

Parents can be encouraged to allow exploration while maintaining safety.
- At 15 you may find yourself attracted to your sex or the opposite sex?
- At 15, you are not allowed to date adults of either sex.

- o Some youth consider a trans lifestyle during their teen years, but most will be cis-gender as adults.
- o Youth considering being gay may have to work through significant shame, given the homophobia still present in our culture.

Gender and sexual minorities (GSM) may need our assistance to explore possibilities and let go of their self-criticism. GSM youth experience more belittling and sexual/physical violence than their cis-gender, straight peers. They are at higher risk for parental shaming or rejection, as well as depression and suicidal ideation. GSM males tend to smoke more, abuse substances more and be at higher risk for HIV/AIDS (Pachankis, 2014 & 2015). Joe Kort (2017) is a gay social worker who offers excellent training on GSM issues and has written and informative books, (e.g. 2008). This Is How It Always Is, is an enjoyable novel, which details some of the challenges for trans youth and their parents (Frankel, 2017). It Gets Better is a gay affirmative website that many youth find valuable.

Alex had fallen hard for Paul when they first met at a mutual friend's party. Alex, who was slender and dark hair, found Paul's tall muscular build, and blonde hair to be very sexy. Alex was an interior designer whose business whacked and waxed and waned with the economy and with the whims of his clientele. Paul was a successful accountant who had a steady income with a midsized firm. Alex and Paul moved in together after dating for about six months; it was the late late 90s when marriage was not an option for gays and lesbians.

The first year of their relationship went well. Alex enjoyed decorating their apartment in a hip neighborhood. He liked cooking for Paul who had a healthy appetite; Paul put on a few extra pounds from Alex's good cooking.

In their second year, Alex became quite depressed. He felt unattractive; he was too thin. His business was shrinking, so his take-home income was down. He worried that Paul would leave him. He stayed home more and did not socialize with friends as much was normal. He heard about me through a friend who had seen me a year earlier. He contacted me and requested individual and couples counseling with Paul.

In our first interview, I learned that Alex had experienced intermittent depression in late teen and early adult years. His father had been highly critical of him for being more artistic than athletic. In high school, as Alex experimented with dating and experienced zero chemistry with any of the girls, it became increasingly clear to him that he was gay. He kept that a secret, knowing his dad would belittle and humiliate him if his attraction to men came to the surface. Later, while attending an arts college, Alex came out with his peers, but continued to be in the closet with his parents. He was easily accepted among the other LGBT students. Alex told me he had experienced episodic depression since puberty, which had responded well to Zoloft, an SSRI antidepressant; I encouraged Alex to consider beginning Zoloft again.

I did cognitive work with Alex and his affect brightened. He was able to let go of some of the negative thoughts from his father and fully embrace his attraction to men. I met with him and Paul several times. Paul supported Alex's emotional growth. As Alex improved, he surprised Paul with an unexpected request: he wanted an open relationship. The three of us discussed how gay men frequently permitted each other the freedom of sex on the side as long as its object was physical release, not an emotional connection. Paul agreed after discussion of ground rules: don't advertise one night stands; be discreet, but admit such behavior if asked. Alex and Paul were communicating well. Alex was no longer depressed. He canceled our next session, leaving me that message that all was well.

Year and half later, Alex called me for another appointment. He was depressed again and fearful he was losing Paul. Alex had stopped taking the antidepressant nine months earlier because he was feeling so strong. He and Paul had been getting along well, but that changed when Paul started weightlifting. Paul lost the 20 pounds he had gained and was bulking up nicely. Alex obsessed that Paul was getting ready to leave him. Then Alex learned that Paul had been having a physical relationship with a younger man he had met in a local bar. When Alex was depressed and isolating himself. In our joint sessions, Paul insisted that his relationship with Anthony just involved casual sex, but Alex would hear none of it. He was certain Paul was about to leave him.

Alex came in for the next month for individual sessions. I strongly encouraged Alex to return to taking the Zoloft to improve his mood and reduce his obsessions. Alex spoke of his fear that he could not meet the expectations of those he loved. He recounted how his father had berated him for his lack of athletic ability, for his average grades. Alex's gifts were an art, but his father had no respect for Alex's drawings or designs. Alex came to see that his low self-esteem contributed to his depressive thoughts, and a sense of himself as needing others to take care of them. He began to get in touch with his own strengths, his affect brightened.

Several sessions later, Alex came to my office looking sad and lonely again. He said Paul had abruptly moved out. Over the next two months we worked on decreasing as negative self-talk and owning his career success. We also talked more about Paul's childhood. Alex put some pieces together. He realized Paul had grown up, the older of two children of a divorced mother. She had been chronically depressed. Perhaps Paul's attraction to Alex soured as Paul saw Alex cycle into and out of depression. Perhaps Alex had been correct that Paul got his act together, had a brief sexual relationship of the younger man, and made the break with Alex. Given his history with the depressed mother perhaps Paul just couldn't deal with Alex's depression and went out the door. Alex relaxed more as he came to see that Paul's leaving was because of Paul's issues. Alex was able to embrace himself as lovable, artistic and sensitive. He would continue to use his antidepressant and his strong coping skills as he explored other relationships. Alex saw himself as on top of his game again.

2) <u>Maturation</u>

Empathy involves walking in the footsteps of another. Younger adults may be at a disadvantage in this regard because of their fewer life experiences. Most young adults have not lived through

- physical pain due to arthritis or repetitive injuries
- potentially terminal illnesses such as cancer or heart disease
- the death of parents.

Middle Age Growth

Those of us who have reached middle-aged may experience
- the stress of raising teenagers
- chronic health issues like arthritis, obesity, diabetes, or heart disease
- caretaking responsibilities as our parents age
- divorce and all its stresses.

As we passed through the middle years, it is easier to feel compassion for others facing similar challenges.

Jung (1985) was the first to identify age-related growth in some middle-aged adults who had embraced traditional roles. Writing in the 30s Jung observed that some women who had devoted their lives to raising their children in their 20s and 30s seemed to expand their horizons in middle-age. Some of these women began careers as their children left the nest, or they devoted themselves to making a difference in their communities through volunteering. They became more assertive and task oriented as the "masculine" side of their psyche emerged. Jung wrote that some men matured in the opposite direction. While they were career oriented as young adults and may not have displayed much softness, in middle-age, they may become more aware of their feelings and become more nurturing with their children or grandchildren. I who never cried as a young adult began to shed tears in both joyous and sad situations in my 50s! As they grow older men may get in touch with a wider range of their own feelings and may become more empathic with their families, friends and clients.

Of course, fewer Americans are now socialized in traditional sex roles. Many women embrace careers and must be assertive to succeed in the world of work during their early adult years. Many men now who were socialized in less stereotypic ways are accepting of soft feelings and are more involved in nurturing their children.

Growing Older

As many of us boomers enter old age, we face new challenges:
- loss of health and physical strength.
- the intensifying of chronic disorders such as arthritis or heart disease
- the onset of potentially terminal disorders like cancer, strokes or COPD
- care-taking for ill spouses
- vision and hearing problems

- cognitive difficulties such as poor attention, difficulty with name or word recall.

Facing these challenges, it is easier to be empathic with those experiencing chronic pain or illness, with those experiencing major losses.

It is important that professionals working with older adults avoid ageism, inaccurate stereotypes regarding seniors e.g.,

- Most older adults have dementia.
- Most older adults are depressed.
- Most older adults are unable to contribute in the workplace.
- Most older adults are inflexible and unchanging.
- Most older adults are socially isolated and have no interest in emotional or physical intimacy (APA, 2014).

Most older adults enjoy positive relationships with their family and friends. Many are employed, have started their own businesses or volunteer, continuing their productivity past 65. Although almost all older adults have health issues, most of them make the needed adjustments to have rewarding lives well into their 70s. Most older adults living independently have fewer mental health issues than younger adults.

We who have reached old age may find it easier to walk with those facing terminal illness or the loss of a sibling or parent because we have faced those challenges ourselves. However, it is important not to be myopic about old age. Some older adults have great difficulty with these challenges. Older white men who have lost their spouses or who have a terminal illness are at risk for depression and suicide. Their pain is intense and sometimes their coping skills are inadequate. They may need intensive intervention to prevent suicide (Bryant and Rudd, 2018).

When working with older adults, it is important to factor in how intersectional factors impact that age group:

- Older women tend to live longer than men, but are more likely to live in poverty.
- Older Blacks are more likely to be poor and have health issues, e.g., obesity, diabetes, cancer or heart disease.
- Older Latinx are also more likely to be poor and have health issues.
- Older gender and sexual minorities may lack family support as they age. They are also more likely to have health issues such as HIV/AIDS. Some face discrimination and are not welcome in long-term care facilities (Clay, 2014; APA, 2019a).

3) Suffering

Life is full of bumps and bruises:

- As children we fall and skin our knees.
- In middle school we are teased in a hurtful way.
- As adults we ask someone out for a date who turns us down.

Buddhists say life is out of balance. At times we suffer. Our bodies change as we age. Pleasure comes and goes. The only constant in life is change (Tirch, et al., 2016).

Trauma is suffering at a different level. Trauma is overwhelming and disorienting. Trauma may involve sex abuse at the hands of a trusted relative. Trauma may involve rape by an unknown stranger or by a "trusted friend". Trauma may be a serious injury in a motor vehicle accident. Trauma may involve the unexpected loss of a loved one. We relive the situation in nightmares or flashbacks. We are numb and feel nothing. We experience rage, terror, or despair. We feel out of control and wonder if the pain will ever end.

We have all suffered at times in our lives. Most of us have experienced trauma as children or adults. We have seen clients disabled for years after abuse, violence or injury in war. Some spiral downward to hopelessness, substance abuse, or despair. Others are resilient; they bounce back even after major trauma. Some seem eventually to grow from the experience of trauma, what is now called posttraumatic growth.

Posttraumatic Growth

in years past, when we clinicians began treating our female clients who had endured horrific sex abuse and suffered for years, the notion that trauma might help some grow stronger would have seemed absurd. Yet as treatments for trauma have improved, we are seeing some trauma victims not only survive, but truly grow stronger. Tedeschi et al. (2021) highlight five areas of growth that researchers have observed in some adults who have experienced trauma:

- improved relationships with others – more disclosure, empathy and compassion
- increased personal strength – more self-reliance and courage
- a greater appreciation for life – gratitude for little things
- new possibilities for growth – new roles or understanding of life
- spiritual/existential change – new meanings or direction.

Clinicians who offer the possibility of a better life too soon after trauma are likely to be seen as completely out of touch by their clients. When one is in the darkest of pits, being told there is light at the end of the tunnel is a nonstarter. Yet as time passes, we or our clients come to understand that symptoms are to be

expected. As we learn to relax and gain some sense of control over our feelings, we move past death or despair as the only outcomes. As we express and explore our pain, it softens over time. We can no longer accept the old platitudes:

- Good things happen to good people.
- The bad get what they deserve.

We are challenged to accept the complexity of life. We may develop more empathy for those who suffer greatly, for the poor, the lonely, or those imprisoned unjustly.

We clinicians who have experienced major life trauma may gain a deeper understanding, a deeper level of compassion, if we have worked through the pain of our own trauma. Many years ago my 35-year-old wife died unexpectedly of a brain hemorrhage. After experiencing shock and denial, I entered the dark night of Major Depression. I functioned joylessly. I struggled to nurture my three children who were six, four, and two at the time. Intermittently I considered ending my pain by ending my life. Fortunately, an excellent therapist walked with me through the pain. Over many months my depression lifted and I heard my children laugh again. I believe I became a very different clinician, more able to empathize with darkness and despair, less quick to suggest cognitive restructuring as the best answer to life's pain. I believe many of us who counsel others have experienced trauma and have grown more empathic and more complex in our understanding of the world. We can help some of our traumatized clients gain the same growth.

The Wounded Healer

Years ago Jung (1985) coined the term "wounded healer" to describe many of us called to do clinical work. Barr (2014) found in a survey of practicing therapists that 74% had experienced one or more trauma:

- child abuse
- a highly conflicted divorce
- life-threatening illness
- death of a family member.

Those who have been wounded and have healed may be more able to walk with clients in their suffering.

Henri Nouwen (1996), a priest and counselor, wrote:

> You have been wounded in many ways. The more you open yourself to be healed, the more you will discover how deep your wounds are. Many tears still need to be shed. But do not be afraid. The greatest challenge is living your wounds through instead of thinking them through. Then you can live them through and discover that they will not destroy you. Your heart is greater than your wounds (p. 39).

Nouwen encourages us to think of our wounds as a hurt child. When the child is embraced and comforted by a loving parent, the child can relax and heal. So also when we embrace our own pain, we can heal.

Nouwen adds:

> Paradoxically, therefore, healing means moving from your pain to the pain. When you keep focusing on the specific circumstances of your pain, you easily become angry, resentful, even vindictive…. Real healing comes from realizing that your own particular pain is a share in humanity's pain. That realization allows you to enter into a truly compassionate life (p. 41).

Healing involves working through the specifics of our trauma and understanding our memories in a new way. It means letting go of self-blame and shame and embracing the pain of humanity. We are all wounded. We have all suffered. We are all in need of a loving parent's consolation. As we let go of the specifics of our own pain, we can embrace all who suffer.

4) Boundaries and Self-disclosure

We all need effective psychological boundaries to have enjoyable relationships. Some of our clients come to us because they are oversensitive and are hurt easily. Others are walled off and have difficulty with having intimate relationships. Terry Real (2008) describes in The New Rules of Marriage how we can be more aware of our own boundaries and help our clients develop better boundaries for their own lives. Boundaries have two functions: protection and self-control. The person with low self-esteem, whose boundaries are too porous, is easily injured. If this person is criticized for dressing too ostentatiously or for weighing too much, she is hurt deeply. It is as if her own sense of herself does not matter; the opinions of others must be correct. People with poor boundaries who tend to take the one up position in interaction can be overbearing or aggressive. (See handout #3 The Relationship Grid). The person who is walled off and one down tends to be defensive or withdrawn. The person who is walled off and one up tends to be dismissive, critical, or uninvolved.

Healthy boundaries enable us to be protected and connected at the same time. They help us monitor our own reactions and self-regulate. As clinicians, if we are too walled off, we do not fully enter the emotional world of our clients. We may be protected, but we are too little connected. If our boundaries are too porous, we may become overinvolved in the emotional lives of our clients and develop secondary PTSD. We are connected, but not protected. Real promotes the healthy middle path for us and our clients:

- We are empathic and centered.
- We feel our client's pain, but are not overwhelmed by their distress.
- Our self-esteem is internally set, not impacted by the feedback of our clients.

- We use client feedback to modify our behavior or help the client explore his reactions.

Therapy schools have debated the appropriate amount of self-disclosure, since Freud saw his first patients over a hundred years ago. He advocated that physicians present a blank screen so that patients could project their issues onto the person of the physician. He also learned that some physicians were having sexual relationships with their patients, and he strongly discouraged that behavior.

On the other hand, humanistic therapists tend to encourage more self-disclosure to enhance the genuineness and authenticity of the counseling relationship. Years ago a good deal of sexual activity occurred between more "progressive" therapists and their clients. Nude group sessions were considered highly therapeutic. Those activities have been shut down. Now Falender et al. (2013) thoughtfully encourage careful self-disclosure for the benefit of the client. Clinicians share their theoretical approach as well as some of their attitudes and values with their clients. Limited self-disclosure is valuable when working with clients who prefer a personal approach, such as some Blacks, Latinos or Appalachians. Guidelines for self-disclosure include:

- Sharing personal information is only for the benefit of the client.
- Disclosure can be used to validate reality, to normalize client experiences, to model appropriate behavior, or to strengthen the therapeutic alliance (Falender, et al., 2013).

Greenberg (2021) notes that research has documented the positive correlation between therapist disclosure of feelings and positive client outcomes. In Emotion Focused Therapy, Greenberg highlights the centrality of the therapist being aware of her own feelings during the sessions with her clients. Does she weep when her client discloses the death of a child? Is she irritated when a client is frequently late for an appointment? Does she become anxious as a client describes a panic attack? Therapist feelings are important to factor in to understand how the client may be impacting others. Whether the therapist expresses his feelings will depend on the needs/issues of the client and the time left in the session. Some emotional reactions may not be helpful to the client, e.g. my attraction to the client or my fatigue at the end of a long day. I will not share those feelings. Greenberg suggests that sharing feelings of hurt or anger can be therapeutic if done skillfully – not from a one up position, but as an opening to explore more of the client's experience. The therapist may share I find myself feeling frustrated now. Would you share how you are feeling? The therapist sharing is not to blame the client, but to promote the client's deeper examination of their own feelings.

5) Mindfulness

As Siegel (2010) described above, mindfulness can be a pathway to increased empathy and connection in counseling relationships. Self-care is now known to be an important goal for all clinicians. Mindfulness can be an important component of better self-care, stress reduction and reduce burnout (Rudaz et al., 2017).

A Way of Living

Siegel describes mindfulness as being fully and intentionally in the present, without judging self or others. Mindfulness is both a way of life and a meditation practice. The Buddhists tell us life is out of balance. We all suffer at times. We find pleasure in new things or activities, but pleasure fades. Contentment comes from

- letting go of cravings
- letting go of anger
- letting go of illusions, our negative thoughts (Tirch et al., 2016).

We humans are wired to always want more:

- more clothes
- a newer car
- a bigger home
- a vacation to Europe
- more powerful drugs.

Pleasure fades quickly. The hedonic treadmill is a dead end. Enjoying what you have is a virtue – and is good for the planet!

Chronic anger is also poisonous. Brief anger can be important in relationships.

- I am here. Don't tread on me.

When anger becomes a way of life – in our relationships, in our community, in our political discourse, we all suffer. Holding a grudge is taking a bit of poison every day and waiting for your enemy to die!

Aaron Beck meditated regularly, and the Dalai Lama has studied Cognitive Therapy (Tirch et al., 2016)! Our negative thoughts can weigh us down:

- I am not charismatic.
- I am not lovable.
- I am not effective.
- People just don't appreciate me.
- I don't want to live without her/him.
- Life is a wasteland, then you die.
- Disaster is waiting around the next corner.

When negative thoughts bring to light a problem and we address the problem, we move forward. Too often negative thoughts lead to rumination and self-

doubt, or revenge and retaliation. The more we can be aware of our negative thoughts and let them go, the more peace we will have in our lives. See John Kabat-Zinn (1994) or Thich Nhat Hanh (1996) for more insights into living mindfully.

<u>A Meditation Practice</u>

Mindfulness is an excellent path to self-awareness. Many Americans stay busy to avoid their emotional pain:

- busy with social media
- busy with work
- busy with entertainment, etc.

Stopping the merry-go-round can be frightening; our demons surface, so

- we eat more carbs,
- we drink more alcohol,
- we take stronger opiates,
- we gamble more money,
- we obsess over more provocative porn.

Exiting the merry-go-round can be frightening for some people:

- Traumatic memories may emerge.
- Fears may come to light.
- Shame may fill our day.
- Unresolved anger may make us bitter.

Sometimes people have very good reasons for staying on the merry-go-round. Yet that trip is exhausting. Facing the pain can add years to your life.

Our clients may need to do significant work before they are ready to try mindfulness. When working with Black clients, Harrell (2018) suggests using soulfulness as a synonym for mindfulness. Soulfulness is being fully alive. Soulfulness includes an awareness of the trials of life, as well as the joys God sends our way.

Hopefully, most of us clinicians have done enough personal therapy to be able to practice mindfulness. Mindfulness can start with 10 minutes of quiet focus on the breath, letting go of distractions. Over time we can work up to 20 or even 40 minutes of time daily to let our minds clear and experience more peace. When we are at peace, we can be more fully present and attuned to our loved ones and to our clients. Siegel (2010) reports mindfulness practice regularly can improve our executive function skills of the medial prefrontal cortex:

- regulating the body.
- attuned communication
- emotional balance
- response flexibility
- fear modulation

- insight
- empathy
- morality
- intuition.

There is no drug on the planet that can do all that!

<u>6)</u> Compassion for Self and Others

Self-Compassion

Most of us are well aware of our weaknesses:

- We are impatient.
- We worry too much.
- We eat too many carbs.
- We exercise too little.
- We are too self-critical.

We may berate ourselves for having too little self-control. The inner critic rules too much of our lives. There is a different path to deal with our pain and our weaknesses. We can respond with self-compassion. If we imagine our weaknesses as our inner child struggling to deal with our stresses, then it is easier to imagine comforting that child. Self-compassion is the ability to soothe oneself with kindness. Self-compassion in Compassion Focused Therapy, Mindfulness-based Cognitive Therapy and Acceptance and Commitment Therapy is linked to less depression and anxiety, and improved psychological well-being (Wilson et al., 2019).

In The Mindful Path to Self-Compassion, Germer (2009) writes that self-compassion involves developing a new relationship with our feelings and especially with our pain. In contrast to cognitive work or problem-solving, which involved an attempt at changing the client's experience, self-compassion is acceptance work. It is moving from mental work to heart work. It is giving up the struggle to feel better and learning to love ourselves in our suffering. "Self compassion is simply giving the same kindness to ourselves that we would give to others" (p. 33f).

Germer describes moving to a new relationship with pain in stages:

1. Aversion -- we resist or avoid pain or, conversely, we brood, deepening our suffering;
2. Curiosity -- we look at our pain with interest;
3. Tolerance -- we begin the process of accepting our pain;
4. Allowing -- we let go of old resistance and allow our pain to come and go;
5. Friendship -- we fully accept our pain and see the value in suffering.

Grammar gives the example of a mother who lost her son who died from a heart attack at the age of nine, due to a rare heart condition. Initially she was so

severely depressed that she stopped functioning as a mother for her other child. She avoided her depression by being numb, by staying in bed 20 hours a day. She knew she could not stop living, so she entered therapy. She was helped to tolerate short periods of pain. Over time she came to allow her grief to come and go. Finally, she felt a connection to all mothers who have lost children due to illness, accident, or war. She still grieved the loss of her child, but was able to function for her other child, and she learned to nurture herself when pain.

Grammar encourages us to locate painful emotions in our bodies. Anger may be felt as tension in the neck or arms. Sadness may be experienced as emptiness in the stomach or tightness in the chest. Fear may be felt as once heart racing or as paralysis. Emotions are experienced differently by different people. The first steps to accepting pain are:

- acknowledging the discomfort
- naming the pain and
- locating painful sensations in the body.

Acknowledging pain is almost countercultural for most Americans! We need to program ourselves and our clients to be aware of subtle discomfort. Naming the pain is the next obvious step; parents teach children to "use your words", when they are upset. Brain scans have documented that emotions soften when words are accessed to describe the feeling (less amygdala activation – sympathetic response).

Gerber describes five pathways to self-compassion:

- softening into your body
- allowing your thoughts
- befriending your feelings
- connecting to others and
- nourishing your spirit.

Regularly doing a body scan is a valuable behavior that we can all use daily. When an area of discomfort is identified, we can breathe into that area and move towards relaxation. Accepting the pain or tension and letting it go is a natural process – not willing relaxation, but rather letting it happen.

Thoughts may be pleasant, neutral, or negative. Germer encourages us to allow all our thoughts. Once we stop avoiding or resisting negative thoughts, they tend to soften and pass. Some thoughts do become obsessive; they do not pass easily. Germer suggests visualization or use of mantras for obsessive thoughts. Visualize negative thoughts as leaves flowing down the stream or as clouds floating by. Mantras that help some people are "one day at a time", or "This too will pass." For shame he suggests "How could I have known?" A humorous mantra for fear of disapproval is "So sue me"! Repetition of a mantra may be soothing for those troubled by obsessions.

Feelings vary from joy to awe, from anguish to rage. Germer encourages us to care for our pain; that does not equate with brooding or acting out. It can be essential to offer forgiveness to oneself. Sometimes it helps to ask oneself "What my best friends say about that problem?" The religious may ask themselves what would Jesus (David, Mohammed, Buddha, etc.) say? Choosing a pleasant activity may also help a negative emotion to shift.

Some raise objections to self-compassion:

- Self-compassion is self-centered and narcissistic.
- Self-compassion is a sign of weakness.
- Self-compassion will make me passive and complacent.

Kristin Neff (2015) responds that self-esteem can vary with successes and failures. Self-compassion is not evaluative; it is loving and forgiving. Admitting weakness is positive; loving oneself through pain or hardship is healing. Self-compassion is more effective for personal motivation than self-punishment. People who are more nurturing of themselves tend to be more loving of their significant others. That love can spread outward. Loving kindness can expand to reach all humanity.

Loving Kindness for Others

Connecting with others can be healing at multiple levels; connecting, by definition, reduces our isolation. Kindness to others often is uplifting; generosity results in the release of oxytocin, the bonding hormone associated with nursing or the afterglow of having sex.

Grammar sees loving kindness (metta) is the central path to self-compassion and love of others. "In its fullest expression, metta is universal, unselfish, all embracing love" (p. 130). Loving kindness is an attitude and a set of practices developed within Buddhism. Thich Nhat Hanh, a Vietnamese monk, who spent many years teaching both in this country and abroad is a proponent of loving kindness. He sees this Buddhist teaching as parallel to the teachings of Jesus – be without worry like the lilies of the field, love your enemies, forgive those who have wronged you. Loving kindness focuses on compassion for the one who is in pain, whether ourselves or others whose paths we have crossed.

Loving kindness is an intentional meditative practice that can be life-changing. It's mantras are very simple:

- May I be safe.
- May I be happy.
- May I be healthy.
- May I live with ease.

These words are to be uttered slowly, prayerfully. The meditator may alter them to better fit the situation:

- May I love myself as I am.

- May I find peace in this chaotic world.
- May I let go of sorrows.
- May I let go of physical suffering.
- May I love and be loved.
- May I be happy and content.

The primary focus of self-compassion is on learning to nurture oneself in a healthy way. Yet we can have no true peace if we are locked in conflict with significant others, or if grudges about past wrongs take up considerable space in our psyches. Loving kindness needs to be extended to others, initially to one's family and friends, ultimately to all humanity. "Changing our relationships to the people in our heads is the first step toward working with them in real time" (p. 161).

Grammar is aware that relationships vary in how rewarding or how conflicted they are. In practicing metta meditation, he suggests beginning with someone who makes you smile. You may begin by focusing on a pet or a much loved child or grandchild. Do the loving kindness meditation focused on this favored animal or person:

- Breathe.
- Bring this person or pet clearly to mind.
- Say to yourself, "Just as I wish to be happy and free from suffering, may you be happy and free from suffering".
- Repeat the metta mantras with the focus on the object of your affection:
  - May you be safe.
  - May you be happy.
  - May you be healthy.
  - May you live with ease.
- If you become distracted or worried with your beloved, note your feeling and return to the mantra.
- Before you end the meditation say:
  - May I and all beings be safe.
  - May I and all beings be happy.
  - May I and all beings be healthy.
  - May I and all beings live in ease.

Germer recommends that you proceed to do a loving kindness meditation focused on a neutral person, then a stranger and finally on a person you find difficult. Regarding a person who abused you in the past, you may need to do significant therapy to work through the feelings of shame, anger and/or guilt before you are ready to forgive the person and practice loving kindness toward him or her. If the difficult person is a person currently involved with you who is acting out or addicted, you may object that this person should change first. Loving kindness does not mean accepting negative behavior, but it can mean

wishing for healing: "May _________ heal their inner wounds and find a path to happiness."

7) Spirituality

Religious beliefs, by definition, are subjective and not subject to scientific inquiry. Yet, for those who believe, such beliefs are powerful motivators of prosocial behavior. I offer some of what I have learned over the years in my study of four of the world's great religions:

- Buddhism
- Judaism
- Christianity
- Islam.

Not everyone finds value in religious beliefs. Those who are not religious may read this section to broaden their understanding of these four religions.

Buddhism

Siddhartha Gautama was born a prince in what is now Nepal about 600 BCE. His father, the king, provided a life of luxury for him, shielding him from even seeing poverty or suffering during his growing years. Siddhartha reached adulthood and journeyed outside the palace, only to discover poverty, suffering and death. He was profoundly moved by what he saw. He renounced the throne and devoted the rest of his life to understanding the causes of suffering and to learn the path to contentment. He studied with the local monks and rejected the polytheism of Hinduism. Buddhism offers no specific beliefs regarding the divine, but it is compatible with theistic religions.

Siddhartha came to see the pursuit of sensual pleasures as a dead end. He learned that meditation is a path to less suffering. Being awake is a path to more peace. He became known as Buddha, the awake one. He developed the four Noble truths as a path towards more understanding and contentment.

Buddha developed the Four Noble Truths:

1. Life is often out of balance. Suffering happens to us all.
2. Much suffering comes from cravings. We crave possessions, power, fame, and relationships. As we learned above, much emotional pain comes from envy, anger and illusions (negative thoughts).
3. We can reduce our suffering through meditation, flexibility and wise action.
4. Enlightenment comes from walking the Middle Path, being mindful, compassionate and free from addictions (Tirch, et al., 2016).

We have already discussed how mindfulness and compassion can be personally liberating as well as increase our empathy for others. Tirch et al. (2016) describe how Buddhist psychology can enrich mindfulness-based interventions and Compassion Focused Therapy.

A misconception about Buddhism is that it results in social passivity and an overfocus on the self. The Dalai Lama has traveled the world to encourage enlightenment and wise action. He advocates for freedom for his native Tibet from oppression by the Chinese government. Thich Naht Hanh (1996) has advocated for peace, for reductions in military armaments, and for the building of loving communities.

Judaism

Judaism is the oldest monotheistic religion, dating back to Abraham who experienced the one God in what is now Iraq in about 1800 BCE. Religious Jews pray the Shema daily to the one God, the creator of the universe (Deuteronomy 6). In the book of Deuteronomy God commands the Hebrews, whom he rescued from slavery in Egypt to be loving toward each other and their neighbors:

- They are to refrain from work on the Sabbath – their children, their animals, even their slaves.
- Hebrew slaves (those who owe debts to their masters) were to be treated humanely and freed when their debts were paid or they served seven years.
- Hebrews were to be generous with the poor and the powerless, especially orphans, immigrants and widows.

The prophets regularly exhorted the Israelites to act justly to the poor and the suffering.

- Amos condemned the rich for living lives of luxury, while the poor suffered without life's necessities. He wrote "Let justice roll down like waters and righteousness like an ever flowing stream"(5:24) – quoted by Martin Luther King Jr.
- Isaiah wrote of God's distaste for animal sacrifice, while the Israelites ignored the needs of the poor. "I am sick of the holocaust of rams…. Your hands are covered with blood…. Cease to do evil, learn to do good, search for justice, help the oppressed, be just to the orphan, plead for the widow"(1:11 – 17) (Brueggemann, 2003).

Tikkun olam – healing the world/healing the wound – is a Jewish belief acknowledging the brokenness of our world. Many Jews see themselves as expected by God to give alms and advocate for contemporary healing in our society, whether Black civil rights, LGBT issues, or other social change (My Jewish

Learning, 2020). Any study of the Torah and the prophets can enhance our empathy for suffering in the world and the need to act to heal the wound.

Christianity

Jesus was the ultimate outsider. He was born a Jew to a poor, but reverent Jewish couple. He grew up in Nazareth of Galilee, not in Jerusalem, the political and religious center of Israel. Nazareth was a small town in Galilee, known as a Gentile area. He was not allied with the Romans, the hated political masters in Israel. He was not a Pharisee, the purists of the law, nor the Sadducees, the wealthy who collaborated with the Romans, nor the Zealots who worked to defeat the Romans militarily. He preached the Good News to the poor and the marginalized (Luke 4). He healed the deaf and the lame.

In the Gospel of Mark, Jesus' central message was "Repent, the kingdom of God is at hand." At the simplest level, that message can be understood as

- Turn your life around.
- Repent for your sins.
- God is near.

Richard Rohr (2009) writes about the deeper meaning of that message. Jesus wants us to open our minds to a new way of seeing:

- connecting with the divine in us
- letting go of black or white thinking, becoming more open to alternative views
- focusing on union with God, rather than asking for favors
- acting to co-create God's kingdom here and now – no more hunger, no more violence, embracing all humans as children of God.

Jesus taught his followers to be compassionate as the Father is compassionate (Luke 6). He taught that love of neighbor should cross ethnic and religious lines (the parable of the good Samaritan, Luke 10). He broke bread with common people. As his followers experienced Jesus' death and resurrection, they came to see him as the face of the living God. Jesus' disciple Paul described Jesus' followers as the living Body of Christ (1 Cor 12), acting now in his stead, to heal the sick, lift up the poor and bring peace to the entire world. We Christians fail too often to live his message, but we strive to do better, with God's grace, in every generation.

> In 1999, I counseled a married couple, Richard and Sherry, who were dealing with many stresses. Richard had suffered a traumatic brain injury where he worked, and he had mood swings. Sometimes he was quiet and despondent; on other occasions he would be angry and lash out at his wife. Sherry was also quite emotional. She was close to her mother who was developing memory problems. Sherry was bright and quite religious; she was a lay minister in her Pentecostal church. She read the book of Daniel, the Gospels and the book of

Revelation and became convinced that the year 2000 would initiate the Rapture in which the blessed (conservative Christians like herself) would be taken up to heaven directly and those left behind would suffer greatly. Sherry preached her convictions to me at every session and to many of the local Pentecostal churches in our area.

For weeks Sherry preached to me that the End was near, and I sat silently. I had a very different understanding of the meaning of the apocalyptic literature in the Bible, but I knew any attempt on my part convey a different understanding of those messages would've been rejected out of hand by Sherry. I would let her speak her mind on and on, waiting for her to finish so I could move our discussion to practical matters such as getting disability for her husband or helping her cope with her mother's possible Alzheimer's.

After sessions of feeling helpless with this couple, I brought the case to the consultant that I used to process difficult cases. My colleague asked me to list the current stressors in the life of this couple:

- Richard's moodiness and outbursts
- their financial difficulties
- Sherry's physical pain from repetitive injuries at the factory where she worked
- Sherry's emotional dependence on her mother
- Sherry's fear of her mother's developing Alzheimer's.

I gained the insight: this woman's world is falling apart. It is out of her control. She is finding meaning in the apocalyptic belief that the End is near. Her preaching about the Rapture is giving her positive attention and some sense of meaning in her life, which is highly chaotic. Instead of arguing with Sherry in my head and sitting silently, I can empathize with her realistic fear that her world was falling apart.

When I did offer that interpretation to Sherry, she relaxed and said I finally understood. I could join her in her anxiety. Her preaching the Rapture in her church continued, but she did not have to convince me that she felt real fear and helplessness and trusted God would open doors for her. The year 2000 did not result in the Rapture, but Sherry was able to shift to problem-solving regarding how to get disability for Richard and how to manage her mother's increasing dependence. My developing empathy for Sherry's sense of chaos helped us get unstuck from her continuously lecturing me.

Islam

The prophet Mohammed was born in Mecca about 570 CE when most Arabs were polytheistic in their beliefs. He experienced Allah (God in Arabic), revealing a new set of truths to him which became the Quran. Allah is most gracious and most merciful.

Islam became a religious and political movement which swept across the Middle East, northern Africa and the Iberian Peninsula (Spain and Portugal). Muslims respected Christians and Jews as children of Abraham like themselves;

they permitted religious diversity in the areas they governed unlike some extreme Muslims of today (e.g. Isis).

The Five Pillars of Islam are

- belief in the one God (Allah) and Mohammed as his prophet
- praying five times a day
- fasting during the month of Ramadan
- giving alms to the poor
- making the Hajj, a pilgrimage to Mecca (Smith, 2001).

During Ramadan, Muslims neither eat nor drink from sunrise to sunset to strengthen their ability to control their cravings and to learn empathy for the poor. Imagine having nothing to eat when Ramadan is in June from 6 AM to 9 PM. You are very hungry every day for a month to experience what is like to be poor. Muslims are encouraged, especially during Ramadan, to give generously to the poor, from one's income and one's wealth. Making the hajj is encouraged at least once-in-a-lifetime; some make the trip every year. One travels to Mecca to join millions of Muslims to circle the Ka'bah in prayer to Allah. Kings and peasants come as equals to Mecca, wearing white robes, being as one.

Eboo Patel (2007), an American Muslim who works for understanding between peoples of faith, writes that "Islam is best understood as a story that begins with Adam and continues through us…. The core message of Islam is the establishment of an ethical, egalitarian order on earth" (p. 111). Patel embraces the values of Dorothy Day, Martin Luther King Jr., the Dalai Lama and his own Ismaili Muslim tradition. Like many Jews, he sees his vocation as healing the wound.

III Encouraging More Nurturing Environments

We can encourage empathy in our clients by being more mindful and compassionate and how we offer treatment. We can promote empathy by

- *training teachers in Social and Emotional Learning*
- *setting up a Restorative Justice program in our schools*
- *teaching parents skills in listening, play, positive limit setting*
- teaching *parents mindfulness*
- *using Gottman techniques to improve couple connectedness and reduce chronic conflict.*

We can promote more nurturing environments.

We clinicians tend to focus our energies on individuals and families, on the treatment of mental/emotional disorders. Yet the science of prevention tells us that sound psychology and health research give us the tools to make a broader

impact on our communities, our society. Children and adults flourish more when growing in nurturing environments. Biglan et al. (2020) describe converging research from psychology, public health, and economics to pinpoint the key elements of nurturing environments:

- They minimize toxic social and biological conditions.
- They limit opportunities for problem behavior.
- They richly reinforce prosocial behaviors.
- They promote psychological flexibility.

Children who grew up in homes that are unstable, abusive, or low income tend to have more anxiety or depression, more behavioral or learning problems. They are at risk for school failure, drug abuse or criminal involvement.

Adults in families with intimate partner violence, high conflict relationships or poverty tend to have higher rates of depression, anxiety, substance abuse and/or divorce.

Our low income communities with fewer resources tend to have fewer grocery stores with healthy foods, schools that are underperforming and more adults with health issues that are not being successfully addressed. Some of these communities have more crime and men of color who are incarcerated.

Nurturing in Individual Counseling

This paper has focused on encouraging the development of more empathy for a broader range of clients. The more we model accurate empathy, the more our clients are likely to increase their own empathy for others. If we teach our clients mindfulness, they are more likely to live in the present with less judgment of self and others. If we teach compassion for others, they are more likely to listen more effectively and respond more appropriately. We can teach flexibility and wise action, being awake to our own needs and the needs of others.

Forgiveness

We have not addressed the issue of forgiveness, which is conducive to better quality of life and better relationships. We are all injured at times in our relationships. Sometimes we express our hurt, the other person apologizes and we move on. More often though, hurt is not expressed, no apology is given and relationships suffer.

Spring (2012) has written at length on forgiveness. She highlights several myths regarding forgiveness:

- Forgiveness happens completely, all at once.

- When you forgive, your negative feelings are replaced by positive feelings.
- When you forgive, you admit that your negative feelings were wrong or unjustified.
- When you forgive, you ask for nothing in return.
- When you forgive, you forget the injury.

Forgiveness is a process that takes place over time, assuming that the injury is significant, e.g., an affair, deception about money or angry outbursts.

Some never forgive. They hold on to their grievances for years. Some offer cheap forgiveness, denying the pain, to avoid conflict.

> Years ago I worked with a couple after the husband developed a crush on a young woman who worked at a Starbucks where he regularly went for coffee. One morning, he impulsively gave the woman a long kiss, which she welcomed. Haunted by guilt, he confessed the infatuation and kiss to his wife two days later. The wife was infuriated with him; she was very threatened by his attraction to a younger woman. He apologized and said he would get his coffee elsewhere; he would never see the young woman again. In our second session, the woman said she was a good Christian and forgave him. I cautioned that forgiveness is not a one-time event; it is a process that takes time. She assured me she had forgiven her husband, they longer needed my services.
>
> A year later I received a call from the same woman. She admitted developing an infatuation with the trainer at her fitness center. They had kissed. Now she was feeling guilty. I saw her and her husband for six months; we took the time to work through the reasons behind both infatuations and developed strategies to keep the relationship alive and engaging. This time when they forgave one another, I did not receive more calls about boundary violations.

Genuine forgiveness takes time. It involves the injured person expressing their hurt, pain or anger. The person whose action harmed the other person does some reflection to identify reasons for their acting out and/or how they will behave differently in the future. They apologize from the heart and take action to avoid acting out in the future, e.g., leaving a job where they met the other woman, committing to avoid casinos, or getting Anger Management.

Sometimes the injury is major and the injuring party denies that the acting out even occurred, e.g. a stepfather denies that he molested the daughter when she was a teen. There is no possibility for full reconciliation because of the stepfather's denial. Some will decide to cut off the relationship completely. Others will continue the relationship at arms length. Perhaps the daughter would lose the relationship with her mother if she refused to speak with her stepfather. Spring discusses acceptance as an option in these difficult situations.

Spring (2012) writes that acceptance involves these steps:

- honoring and processing all the emotions around the injury

- giving up the wish for revenge
- seeing the offender's behavior in terms of his or her own issues
- stopping obsessing about the injury and re-engaging with life
- carefully deciding what relationship they want with the offender
- showing themselves compassion.

Acceptance is not forgiving and forgetting. If the stepfather molested the daughter and refuses to admit his action, the daughter may visit her mother and stepfather, but she will not let her children visit them without her being physically present.

If our clients work through their pain regarding their injuries, they are able to move on and not be stuck in angry ruminating. If they are grieving a divorce, they can, over time, move through the pain and appreciate their own independence.

Promoting Nurturing Schools

Our Surgeon General recently published Protecting Youth Mental Health in which he highlights the 40% increase in depression or hopelessness among high school youth from 2009 to 2019 (Murthy, 2021). Covid has disrupted the families of many youth and made in person learning impossible for months at a time. Murthy has identified the groups at highest risk for anxiety, depression, behavioral problems or reduced learning:

- youth with intellectual or developmental disabilities
- racial/ethnic minority youth including Blacks, Latinos, Asian Americans and Native Americans whose families have experienced more harassment, poverty, or death
- gender and sexual minority youth.
- low income or rural youth.
- youth who are homeless or involved in foster care or the juvenile justice system.

We clinicians who work in schools can train our teachers In Social and Emotional Learning (SEL) so that they have the understanding to respond appropriately to youth with mental health issues. Research demonstrates that teaching SEL skills explicitly does improve student learning (effect size of .62, Frey et al., 2019).

Social and Emotional Learning skills include a focus on

- agency
- emotion regulation
- cognitive regulation
- social skills and
- public spirit (Frey et al., 2019).

Too many of our minority, low income or traumatized children come to school with a defeatist attitude, learned helplessness, believing that they cannot learn. Teachers who respond with a Growth Mindset communicate understanding of being discouraged and counter with the message: you can learn more if you work at it. Just like Michael Jordan went from being a benchwarmer on his high school basketball team to one of the best shooters at UNC and in the NBA, you can improve your game by working on your schoolwork every day.

Teachers can learn more about the issues that youth bring to school:

- food insecurity
- abuse or neglect
- lack of Wi-Fi access
- fear of domestic violence or community violence
- self-doubt due to undiagnosed ADHD or learning disabilities.

Teachers can learn to understand and validate the feelings of their students, whether fear or anger, anxiety or helplessness. They can learn to refer students for a physical or mental health evaluation when necessary. They can teach self-calming skills and impulse control skills in the classroom, so fewer students are subject to discipline. Teachers can promote social skills in the classroom, such as listening, taking turns, or building friendships. Some may object the teacher should focus only on academic skills given the epidemic of underachievement in our schools. Yet researchers show us that teaching SEL skills reduces disciplinary problems and increases self-esteem and academic learning!

Restorative Justice

Too many schools have too few resources to deal with troubled youth. Their administrators view acting out, especially blind black youth, as crimes rather than cries for help. These children are arrested rather than counsel. They enter the school to prison pipeline and end up in prison, rather than graduating from high school.

The ACLU has documented that 1.6 million students attended a school that had a police officer, but no counselor. Police in schools do what they are trained to do: they handcuff and arrest students. Black students are three times as likely to be arrested as their white classmates. Students with disabilities are nearly 3 times as likely to be arrested as able students. Black and Latino boys with disabilities represent 3% of students nationally but 12% of school arrests. If our society wants to have fewer youth of color in prison, we need better alternatives than arrest, suspension and expulsion for misbehavior. Having a counselor in every school is a place to start. Having teachers who have been trained about the dimensions and impacts of trauma can also change the mindset of how school misbehavior is viewed. Training teachers and student leaders in restorative justice can change the culture of the school for the better.

Since Columbine, many schools have adopted a zero tolerance policy about misbehavior, not just for guns at school, but also for disrespect and defiance of the teacher. Zero-tolerance results in more arrests, suspensions and expulsions, especially for youth of color and those with disabilities. Restorative Justice programs are being used in 12 states to dramatically reduce students being ushered into the school to prison pipeline (Fronius, et al., 2019). In Restorative Justice schools, teachers and students with leadership potential received training in community building and peacemaking. RJ focuses on building tolerance and respect between students and also between students and teachers. Skills in active listening and problem-solving are taught. In RJ peace building circles, a student who was defiant of a teacher or who bullied another student is asked to face the person he disrespected. The victim is encouraged to share the negative impact of the aggressor's behavior. The aggressor is encouraged to take responsibility and make amends or restitution. Rather than focus on behavior change through punishment, the RJ approach encourages face-to-face communication between aggressor and victim. If the victim shares the impact of a hurtful comment, it is hoped that the aggressor will gain some understanding of the other's experience and gain some empathy for the person's pain (Fronius et al., 2019).

Benefits of RJ programs include:

- fewer arrests and suspensions
- better relationships between aggressors and victims
- prosocial leadership among students
- better climate for learning
- less boasting and bullying (Lyubansky, 2016).

Parent Child Interaction Therapy (PCIT)

Eyberg designed PCIT using attachment theory and social learning theory to treat young children with disruptive behavior problems. Barkley (1997) has also used PCIT with adjustments to treat ADHD youth and their parents. I found this approach most useful because the primary focus is to improve the attachment between the parent and child, teaching the parent skills to assist the child to learn improved attention, following directions and emotion regulation. I individualize the intervention, picking from the available PCIT modules or adding additional modules:

- Psychoeducation
- Special Time
- Praise
- Giving Effective Commands

- Attending to Independent Play
- Time Out
- Using School Behavior Communication
- Doing Grief Work
- Naming Feelings
- Emotion Coaching

Psychoeducation is often critical when working with parents and children. Parents may feel alone in their failure. Knowing that other parents often also feel helpless to assist a depressed and/or a defiant child can reduce some of their guilt and child blaming. Education about depression and defiance can give the parent hope that progress is possible.

Special Time is usually enjoyable for the parent and child – regular, positive playtime. I ask the parent how often she plays with the child individually doing something the child wants, excluding TV, videogames and computer time. Parents with only one child may say daily; those with two or more children may say several times a week. Some parents admit they seldom do that; they do fun things with their entire family. Single parents may admit that finding time to play individually with each child can be difficult. I explain that children blossom when given individual play time with a parent. I ask the child if he/she could do anything they want for 15 to 20 minutes at home with a parent, what would they enjoy? They may respond with watching a movie or going to an amusement park. I explain that parents do not have a lot of time most days. Play time is 15 minutes at home. With parental assistance, they can think of:

- kicking a soccer ball
- tossing ball
- wrestling
- playing cards
- drawing a picture
- playing with action figures.

Of course, there are many more possibilities. I explain that the parent will pick the time and the child will pick the activity. Dads tend to be more into playful wrestling which young children enjoy. Moms tend to like art projects or dolls, but parents need not be bound by stereotypes.

During the play time, the parent is to bring enthusiasm and love for the child. The parent offers color commentary on what the child is doing:

- Nice move!
- Great choice of colors!
- Your good guy really leveled the bad guy.

Your tone of voice is to convey your affection for your child. If you are having a

stressful day, put play time off until later or bring your best acting skills. Play fair, but let the child win some. Parents are not to use this time for questioning, correction, problem-solving (unless it is to coach the child on how to play the game well). Have several activities available like UNO cards, Legos, art supplies or checkers. It is helpful to have a practice session with the parent and child at your office. If a parent strongly objects to having fun with their child, they may be too depressed or too scarred from their own abuse to offer unconditional love. That parent may need their own treatment before they are ready to do this work in a way that nurtures the child. If a single parent objects that they do not have the time for individual play time with each child, I ask them to decide what they could do. Weekly individual play time is better than none. Older children (10+) often prefer Special Time to be longer, but less often. Special Time is not withheld if the child has misbehaved during the day. It is a time of unconditional love. Special Time strengthens the bond between the parent and child – the central goal of PCIT.

At our next session, I ask the parent and child how the Special Time went. If there were difficulties, we problem solve how to handle whatever the issue was. Occasionally children misbehave during Special Time, e.g., throwing checkers after losing a game. I coach the parent to give the child feedback: "It's OK to be upset if you lose a game, but it's not OK to throw checkers. No one likes to lose, but I don't like it when you throw checkers at me. If you say you're sorry and pick up the checkers, we can play another game. If not, our play time is over for today."

The module on Praise for good behavior is important for parents of depressed, hyperactive and/or defiant children. Parents tend to comment more on negative behavior – Stop hitting your sister – than on positive behavior – You are playing well with your sister. An axiom of behavioral training for teachers and parents is:

Catch them being good!!!!

Depressed and/or defiant children display more negative than positive behavior. Attention increases behavior. When a parent corrects a child more than praising that child, they may be inadvertently increasing the negative behavior!

Praise works better when it is specific and immediately follows the behavior. Not You're a good boy, but:

- Thanks for picking up your toys.
- You are sharing with your sister!
- I appreciate your starting your homework when I ask.

Many parents were corrected more than praised as children. Praise works to build the bond with the child and increase positive behavior. Some children

may need a token program, which will be described later in this course, to effect much change.

Giving Effective Commands is a central module for parents of defiant children, but can be omitted for depressed, compliant children. Too often mothers ask their child to complete a task and do nothing but nag if the child is not compliant. Effective commands are specific. Not: Clean your room, but I want you to pick up your toys and make your bed. If the child is not compliant, he is not allowed to play with the toys or watch TV. Nothing happens until the child follows the direction. We can practice the parent giving the direction and the child following the direction in my office, e.g., bring Mom a tissue, then the parent enthusiastically praises the child for doing what was asked.

Naming Feelings can be very helpful to use with young children who are depressed. Boys seem to have more difficulty with this task. With young children, I keep it simple, focusing on:

- mad
- sad
- happy
- afraid or worried.

I discuss with the child and parent examples of when the child might feel each of those feelings. With older children, I add more feelings such as embarrassed, guilty, ashamed or numb.

Emotion Coaching is a critical tool parents can learn to teach the child emotion regulation. John Gottman (1997) has described in detail the benefits of Emotion Coaching in Raising an Emotionally Intelligent Child. The steps in Emotion Coaching include:

- Be aware of your child's emotions – her words, her moods, her behavior, her other non-verbal communication.
- Understand that the child's upset can be an opportunity to connect at a deeper level with the child and teach the child tools to cope with feelings.
- Listen and validate your child's feelings.
- Set limits, while you help your child learn to accept the situation or problem solve.

Parents may miss a child's depressive feelings, and they may see anger as a threat to their authority. They can be encouraged to value all feelings as normal. Parents can practice being empathic with their child in session. If the child feels sad, helpless or frustrated, all those feelings can be validated. Parents may need to be taught that they can validate a feeling even if they do not see the situation the same way that the child does. The child says she is sad because her friend did not talk to her at school today. She says the girl is no longer her friend. The parent can be empathic with the child's sadness or hurt.

Then the parent may offer different possibilities. Maybe the other girl was having a bad day; maybe she was thinking about a problem at her home. Instead of writing off the other girl as a friend, the parent may encourage her daughter to reach out to the girl to keep her friendship. It is possible the other girl no longer wants to be her friend. Clinicians interested in learning more about Eyberg's or Kazdin's approach to Time Out and other behavioral techniques to increase compliance are encouraged to read their treatment manuals.

Mindful Parenting

In this training, we have discussed using mindfulness to enhance the therapeutic relationship as well as teaching mindfulness to our adult clients to help them reduce their stress and be more centered. Now we will examine the work of Duncan et al. (2009), who teach mindfulness with stage specific parenting skills to parents to enhance their attention to and compassion for their children.

When parents focus on control as their primary strategy with their children, they're not being child oriented and focusing on the needs of their child. When parents are motivated by automatic, self-focused or hedonic drives, the quality of the parent-child relationship is diminished.

Duncan started with an empirically researched program for parents in middle school students – The Strengthening Parents Program (SPP). The SPP is an educational, prevention focused, seven session program aimed at increasing parents' understanding of the need for love and limits, as well as improving communication between parents and youth. Duncan added mindfulness education and practices to each session:

- listening with full attention.
- nonjudgmental acceptance of the self and child
- emotional awareness of the self and child
- self-regulation by parents
- compassion for self and child.

Listening with full attention involves more than verbal attention. When I had the opportunity this summer to assist with parenting my newest granddaughter a few weeks after her birth, I observed that she really valued skin to skin contact. Like my older grandchildren, when I placed her on my shoulder, she would scoot closer to my face so that her face would rest against mine. I have noticed my two older grandchildren did the same thing shortly after birth. Sad to say, I do not remember if my own children many years ago did the same thing. I am a more attentive grandfather than I was an observant father.

Listening with full attention to a middle school student involves attention to what the youth says or does not say, the tone of his voice, his body language, and his

moods. It is observing how he dresses, his interaction with friends (or lack of it), the time he spends on homework, the music he enjoys. It may mean being on the lookout for signs of drug or alcohol abuse. It will mean being aware of the time he spends on video games and how violent they are. It involves being aware of the time on social media and its impact on your child.

Nonjudgmental acceptance of the self and child involves letting go of frequent criticism by the parent of their own behavior as well as less criticism of the child. It includes learning more of the child's traits, seeing the strengths and weaknesses of oneself and one's child.

The next component involves assisting the parent to be more aware of her own emotions and that of her child. If this child is sad, fearful or defiant, the parent is able to focus on the needs of the child and not just react defensively.

The parent is encouraged to use appropriate self-regulation skills so that the parent is not overreacting to the child's desires or moods. Parents can learn self-calming skills so they do not make difficult situations worse.

Finally, parents are taught to be compassionate to themselves and their children. They can comfort themselves if having a stressful day. They can express empathy for their child if the child is fearful, discouraged, hurt or defiant. They can forgive themselves if they react poorly. They can be more forgiving of their children who are only learning to manage feelings, relationships and responsibilities.

When parents are being more mindful as they show attention/affection and set age-appropriate limits, Duncan found

- parent-child relationships to be more positive
- youth to display less depression and anxiety
- youth to show fewer behavior problems and
- youth to abuse drugs and alcohol less.

Attentive parents are likely to use wiser actions in responding to their children, and parents and youth are more likely to value one another.

Teaching Empathy in Relationship Work

Couples typically seek out counseling when one or both partners are highly distressed. Perhaps one of the partners is considering leaving the relationship. Positive feelings have dissipated and hostility or disengagement are the order of the day. Emotion Focused Therapy has been shown to help couples rebuild the relationships (Johnson, 2011). I've done more work using Gottman's approach to relationship dysfunction; his Sound Relationship House has been shown to be

quite effective with a wide range of couples (1999). He teaches couples to be better observers of each other and to communicate more effectively.

Most couples make repeated attempts to connect with each other during the day (Gottman calls these "bids to connect"). Most are simple:

- "Good morning"
- a good-bye kiss
- "How was your day?"
- "I heard a good joke at work today. Are you interested in hearing it?"
- A touch on the arm
- A pat on the butt.

Spouses can respond by Turning Toward their partner:

- "How did you sleep last night?"
- Responding to the kiss
- "I had a busy day at work. Paul was on vacation so I had lots of calls to make".

When the spouse is Turning Toward their partner, a connection is made, affection is expressed, information is shared.

When a couple is distressed, responding spouses may turn away. They may ignore the bid and read the paper, look at their email or walk out the door. If the distance is habitual, the responding spouse may be oblivious to the pain they are causing their partner.

Other distressed partners respond to a bid with an attack (turning against the spouse offering to connect):

- "It's not a good morning. Your chipper attitude is such a turn off".
- Not kissing their spouse goodbye
- "My day just got worse, coming home to spend time with you".

I explain to couples that as humans, we are wired to connect. Children as young as one or two years of age learn to connect to a parent or to avoid or to attack when stressed. Attachment literature, based on hundreds of studies initially with young children, but more recently with adults, suggests that humans who turn toward one another feel safe and loved. Humans who are anxious when close avoid or attack. If we want to promote feelings of safety, connection and love in our significant relations, we make positive bids for connection with our partners and we respond positively to our partner's bids. I have couples practice making bids and Turning Toward in the office with me and then at home.

Even when couples are attentive to each other, differences will arise. Some are resolved easily. Other chronic differences can turn into regular battles that are

not resolved. Gottman teaches the couple how to Dialogue about Perpetual Problems. All couples, happy and conflicted, have perpetual problems. It is only a fantasy that each person has a soul mate with whom they will have no significant differences. Perpetual problems could include:

- Ella is very neat; James drags dirt into the house on a regular basis.
- Ramon is a saver who plans for the future; Maria loves fashionable clothes and lives for today.
- Ricky wants sex far more often than Jennifer does.
- Anthony wants to raise their children as Catholics. Alice is committed to raising their children as Jewish.
- Olivia is an extravert who would party every night if she could. Sarah is an introvert who loves to stay home and read.
- Ron is a retired Marine who demands compliant behavior from their children. Julie is more laid back and she sees children as benefitting from more freedom.

Any differences that have led to years of arguments may well be perpetual problems. Gottman's unique approach to undoing the gridlock involves helping each partner understand the dreams hidden in each conflict. He assists the couple to feel safe with each other while communicating together in his office. Gottman explains that the goal of this session is not to solve the problem, but rather to understand the values, dreams and experiences of each partner.

Ella grew up an only child in a happy home; both her parents were very neat. For her, a clean and orderly house is a sign of a stable, loving home. James is a teacher and he loves reading and gardening. His mind is usually on some idea or project for his classes or his garden. He is not naturally neat, and he finds clutter comforting. He yearns for a relaxed, casual home environment where people are free to be themselves. Relaxation and loving connectedness are his dreams for his family.

Gottman helps the couple to see that their dreams are based on their own early experiences. Emotionally intelligent couples find a way to honor each other's dreams. Both Ella and James value quality family time, with the expression of love and appreciation. Gottman encourages them to focus on their mutual desire for calm and connectedness. They join on working on their shared dream first. Some weeks later they do some problem solving on the edges of the issue. James agrees to help with straightening the house during the work week. Ella agrees to be more relaxed about a little disorder over the weekends. Both work to honor the dream of their partner and use humor to lighten tension that may develop on this issue.

Some couples benefit from reading a list of possible dreams (see handout #6 Examples of Dreams within Conflict). Gottman emphasizes that, if one partner's "victory" in a conflict crushes the other partner's dream, there is only

resentment. I have described only two of the many interventions available to those who obtain training in Gottman's program because the above interventions focus on building empathy and positive connection.

IV Final Thoughts

Those of us who work in the cognitive tradition tend to see emotions as tigers that need to be tamed. Too much fear, anger, shame, or despair can take away from the quality of our lives and damage our relationships. So we self-calm and help our clients soften their emotions through various cognitive behavioral techniques. Yet we may have much to learn from our colleagues in the humanist tradition:

- Emotions are at the core of what it means to be human.
- Emotions help us take action in times of threat.
- Emotions help us nurture our children and make passionate love to our partners. Emotions point to deeply felt human needs such as safety, comfort or connection.

Greenberg (2021) teaches us to see emotions as the heart of what we grapple with in therapy.

Effective counseling may involve specific interventions such as grief work, exposure or behavioral activation. Yet quality work involves a relationship with attention, attunement and empathy, not just in the critical first session, but throughout the course of the work. New issues, new emotions may emerge in session 5, 10 or 20. We need to feel with the client, being open to new understandings from the beginning of treatment to the last session.

Miller et al. (2021), developers of Motivational Interviewing, caution that therapists usually do not improve with practice, that the "common factors" of effective therapy are not all that common. Yet intentional growth can help all of us improve our ability to connect with the emotional lives of our clients. Effective counseling is not wrestling! We do not coerce our clients to grow! Counseling is a partnership. It is dancing together. It is different with every client. How close do we get? How quickly do we move? An approach that works well with one client will be felt as intrusive by the next client. Learning to adjust our approach with each client is central to our success.

We can all grow in our capacity to walk a mile in our client's shoes:

- We may study Siegel and become more mindful.
- We may seek training in Emotion Focused Therapy and learn to do more affect centered work.
- We become more knowledgeable about the history and current challenges of people of color.

- We may grow emotionally as we move through middle age or experience trauma and posttraumatic growth.
- We may become more attuned to our own boundaries, learning to be more open or better defended.
- We may embrace our spiritual values to become more empathic.

We may build more nurturing environments by
- modeling empathy in our individual work
- training teachers in Social and Emotional Learning
- training parents to be more mindful
- encouraging couples to listen more empathically and learn about each other's dreams.

Offering high quality therapy involves a lifetime of continued growth and effective balance of work, family and personal responsibilities. It is a special calling.

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