A Client-Centered Approach to

Difficult Client Experiences*

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In recent years, psychologists have become increasingly aware of the active role that clients play in their own healing (Bohart & Tallman, 1999). After an exhaustive review of the research on therapeutic effectiveness, Bergin and Garfield (1994) declare that

> …it is the client more than the therapist who implements the change process. If the client does not absorb, utilize, and follow through on the facilitative efforts of the therapist, then nothing happens. Rather than argue over the question of whether "therapy works" we could address ourselves to the question of whether the "client works"! (p 825)

Following this train of thought, Bohart and Tallman (1999) suggest that both directive and nondirective forms of therapy work because they

> …assist and promote change by helping clients mobilize, focus and use their own resources for self change…What therapists do is help clients use these resources more efficiently…(p. 14).

Client-centered therapy is quite distinct in that it focuses almost exclusively on clients' internally generated capacities for change. These include natural tendencies to

--process experience

--develop a cohesive sense of self

--develop a personally meaningful sense of agency

Carl Rogers (1957, 1961) proposes that, given these and other natural tendencies toward 'actualization', a relationship that is genuine, empathic and prizing is both "necessary and sufficient" for producing therapeutic change. A cluster of therapies influenced by Carl Rogers, often referred to as the "person-centered approach," emphasize these sorts of capacities for self-directed change. Classically client-centered therapists are the most strongly client-directed of all of the person-centered therapies, emphasizing sensitive empathic responding to clients' process as it develops

spontaneously within therapy. Experiential and process-experiential psychotherapists often take additional steps to teach or facilitate processing steps when processing seems blocked. In this paper I will speak out of my experiences as a classically-oriented client-centered therapist, though the key points being made apply to the whole family of person-centered therapies and in more indirect ways to the practice of psychotherapy in general.

The premise that clients are capable of self-directed change still seems wildly improbable to many psychotherapists. How could a psychotherapy in which the therapist doesn't offer new advice, new ways of looking at things, structured ways of implementing change in any systematic way result in positive outcomes? Yet, the most recent meta-analyses of therapeutic outcomes find client-centered and experiential psychotherapies to have equivalent outcomes to those of behavioral, cognitive-behavioral and psychodynamic approaches (Elliott, 2002; Elliott, Greenberg, & Lietaer 2004). These findings give powerful testimony to the existence of some sort of inherent human capacities and tendencies toward change.

Some clinicians assume that this demonstrated effectiveness of client-centered therapy could not be expected to hold for more severely disturbed clients. They assume that clients in more extreme states of distress, who have more irrational thoughts or more out of control behaviors must need stronger, more interpretive therapeutic interventions. The clinical experience of client-centered therapists has been the opposite of this. We find that levels of structure and guidance that may be used productively by clients in less severe distress are actively problematic for clients in the midst of more difficult experiences. Even quite moderate interventions can:

- distance clients from the life experiences which have the most positive potential

for change

- bring intensified symptoms
- create relationship ruptures

On the other hand, we find that an empathic relationship combined with a very close empathic following of the most difficult client experiences allows for deep healing. This is true in the short run, as close empathic responding seems to lower clients' sense of existential aloneness while it helps clients tolerate difficult experiences with less anxiety. In the long run, the impact is much greater. An empathic relationship creates a safe space in which clients can stay connected to difficult experiences. This allows fundamental developmental tendencies to reconnect. In this presentation I am focusing on one particular human change capacity, a quality that client-centered therapists call "processing." I suggest that client-centered therapy tends to strengthen processing capacities in clients whose experience is most difficult. As processing abilities become stronger, clients are more able to interact in productive ways with other people, holding a sense of their own experience and that of another person at the same time. Symptoms are lessened, experience becomes more integrated, a variety of life ventures become more productive.

What is Processing?

The concept of "processing" was elaborated by Carl Rogers and colleagues (1961) and further developed in the work of Eugene Gendlin (1964, 1968, 1995). Processing refers to the kinds of immediate experiential changes that human beings naturally go through as they make sense of life situations.

To explore the concept of processing, let us look at the kinds of experiential changes people typically go through as they try to make sense of experience. Some experiences seem clear immediately. They "make sense." The sun is coming up, it's time for me to go to work; a family member is making breakfast.

Yet other experiences bring a sense of challenge. Feelings, thoughts, experiences, bodily reactions come up that we don't expect. They don't immediately make sense to us. "Processing" is what happens when an individual stays with an experience that is troublesome or not-yet-clear. This desire and capacity may seem obvious until you think about it. How is it that human beings make sense of experience? What is happening when people can't make sense of experience? How does this desire and this capacity develop? Let me give you a fairly simple, day-to-day example. A client says:

> I was so excited to get my new job. It's just what I have always wanted. So I don't understand why I feel so bad. I have just a tight feeling in my stomach. PAUSE I have the image that I'm very small and the building where I work is huge. Like I'll be swallowed up and never get out. My stomachache just got stronger when I said that. I have the image of my father's face when he said, "Why don't you ever study as hard as your sister? You are never going to amount to anything." So THAT's what it is. It feels like no matter how hard I try, I'll fail. Somehow I'll never be as good a she is.

So, let's notice what this client did:

1. She notices an experience that is troublesome, but not yet clear to her.
2. She pauses and attends to the totality of her sense of the situation.
3. She stays with experiences that emerge—holding them in attention without strongly judging or condemning them in herself.
4. She senses feelings relating to the experience, but she is not flooded with these feelings.
5. More experiences that are related to her concern come to her spontaneously.

--an immediate feeling in her body that relates to her concern becomes more vivid to her. She feels the pain in her stomach. Eugene Gendlin would call this a "felt sense" (1968).

--images come to her that capture her whole sense of the situation

--memories come that are related to her current experience of the situation

6. Out of such new experiences the client forms a new version of what is happening and why and in the process relieves some amount of bodily stress.

Having a new version often offers the client a clearer way forward, a sense of what steps to take next. Gendlin (1964, 1968) emphasizes that making sense (or carrying forward into meaning) is a whole body process. There is no mind-body split. Note that in this case, the client's problem is not solved. But she has a new clearness as to what the feeling is about for her. So this brings us to a simple, but crucial observation about human experience that has emerged from within the client-centered tradition. If a person is able to hold a troublesome experience in attention at a moderate level of intensity and judgment, more is likely to come and what comes is likely to be relevant to making sense of the experience.

Let me give you another processing example, one that involves making sense during a two-person interaction.

> A friend promises to meet a colleague in the evening to help with a project that is very important to the colleague , but the friend never comes. The next day the man runs into the friend, and barely wants to talk to him because he feels so hurt and angry. The friend explains that his child was injured in an accident and he was so worried about his child that he forgot his promise to help. The man still feels some hurt at being forgotten, but is able to put that aside enough to feel how frantically worried his friend must have been about his child.

This interaction involves another, crucial step. The man is able to be aware of his own reactions, but is also able to let himself feel what the experience of his friend must have been like for him. The processing question is this: What if people CAN'T hold their own experience and shift attention in such a way as to be able to take in another's experience? This would leave individuals with a very difficult choice. If they stay with their own experience, they will have a kind of tunnel vision, in which they have great difficulty taking in the experiences or perspectives of others around them. On the other hand, if they stay with the experience of the other person, they will be left with a sense of inner emptiness that can feel like personal annihilation.

Processing, then, can be seen to be a core human capacity. Integrating material from a variety of literatures and from clinical experience, I (Warner 2005, 2006) have come to the following conclusions:

Processing is:

- a universal human inclination and latent capacity
- a capacity grounded in the biological structure of the organism
- a capacity that develops naturally within optimal early-childhood relationships **and in** later relationships that have similar qualities

Processing is relational in that it

- requires attachment relationships in infancy to develop, and it
- is essential to the personally-meaningful and effective functioning of relationships in adulthood (Warner, 2005, 2006).

How Does Processing Develop?

. Findings from developmental psychology suggest that all human beings are organized to develop these sorts of processing capacities (Warner, 2000). But, certain sorts of facilitative conditions are needed for these capacities to manifest fully—notably, ongoing interchanges with attentive care-giving adults in early childhood. The development of processing capacities seems particularly dependent on a steady atmosphere of safety and care as well as a partnership with the infant in holding experience in attention, modulating the intensity of experience and naming experience. Under optimal conditions the young child gradually internalizes these as relatively autonomous capacities. Let us take a look at how processing capacities develop.

How do infants come to hold experience in attention?

Infants left to themselves become cranky very quickly—they aren't very good at keeping a pleasurable focus of attention on their own. Yet, from their earliest days infants seek out the faces of adults. If an attentive adult is present, they will keep their focus on nonverbal interactions for increasingly long periods of time. You will recognize the common scene in which a baby wrinkles her nose, and a parent wrinkles her nose back and they both burst into laughter. It turns out that these simple, pleasurable interactions are crucial to brain development. Fogel (1982) finds that in the first year of life, securely attached infants stay engaged with pleasurable interactions for longer and longer periods of time. Numerous studies have shown that parents of securely attached infants show high levels of moment-to-moment attunement, both in initiating interactions and in responding to distress (Sroufe, 1996). On the other hand, caregivers of less securely attached infants tend to be non-responsive or to respond in ways that leave the infant frustrated or over-stimulated.

How do infants come to be able to modulate the intensity of experiences?

Of course, infants initially have almost no capacity to modulate the intensity of distress. If a baby is cold and wet and hungry, and no adult comes to help, the experience quickly comes to feel like torture. On the other hand, the infant's body naturally starts to regulate the intensity of feeling within attuned interactions with adults. Ideally, adults come and take steps to alleviate any sources of bodily distress experienced by an infant, as well as engaging the infant in pleasurable nonverbal interactions. Schore (1994) notes that through repeated experiences of arousal increase and modulation the brain increases its ability to dampen high arousal and to regulate emotion in general. The orbital, prefrontal area of the brain, that allows a young child to shift from high to low levels of arousal, undergoes a spurt of growth during the end of the first year and into the second year of infancy. (Schore, 1997; Sroufe, 1996).

As a result, securely attached infants learn that bodily-felt experience is by in large a good thing and that interactions with others tend to make experience more manageable and more pleasurable. Less securely attached infants seem to come to an opposite set of learnings: that it is difficult to maintain emotionally engaged attention in a way that leads to sustained positive experiences; that situations of high arousal are likely to lead to overload and disorganization; and that caregivers aren't very effective in soothing distress when it does occur.

How do infants come to name experiences?

Initially, an infant's experience is intensely felt in an immediate way that is, of course completely nonverbal. Gendlin (1964) calls these implicit meanings.

> ...the "implicit" or "felt" datum of experiencing is a sensing of bodily life. As such it may have countless organized aspects, but this does not mean that they

> are conceptually formed...we complete and form them when we explicate (pp.113-114).

Early on most parents begin to engage in a particular sort of empathic interaction in which they begin to name infant's experiences and to offer hypothesized reasons for these experiences--perhaps saying that the baby is "tired" when she cries or that she thinks "spinach is disgusting" when she spits it out. Essentially, parents are offering verbal symbols that could carry the infant's implicitly felt experience forward into explicit meaning if the infant had words. At some point children come to recognize a matching or mismatching between words and own felt experience. Of course, there is great variation in the quality of parental empathy in this early naming of infant experience and the clarity of reasons offered for such experiences. Such experiences that have never been received empathically in childhood are likely to feel unreal or, in some mysterious way bad or poisonous to the person as an adult.

How Do Children Come to Understand and Respond to Others' Experiences?

As children grow older, they are increasingly expected to respond to demands of others and to understand others' experiences. A 5 year old will be expected to stop playing and come into school. She may have been very engaged and excited playing a game, and need and lower her intensity and excitement to shift her attention to be able to be part of a reading group. As cognitive abilities develop, children are increasingly expected to have some understanding of what others' experiences are like for them, even when in the midst of emotionally complex interactions. A child is expected to understand that she will hurt another's feelings if she is rude, or that another family member needs something even if she really wants it herself.

E.T. Gendlin (1964), pp. 113-114.

From observing clients I have come to a core processing observation. This last ability—the ability to take in the experiences and perspectives of other people—is dependent on the earlier development of processing capacities. If a person has difficulty holding a key experience in attention, moderating its intensity or naming the experience, he or she is very likely to have great difficulty shifting attention to anything from the frame of reference of other people without great distress. It is important to note that this is different from the situation in which a person could understand another's experience but doesn't because of selfishness or emotional laziness. If people are in the midst of fragile process they can't take in other people's experience without having the sense of annihilating their own.

Making sense of experience is so fundamental to human functioning that anything that interrupts these core capacities is likely to be exceedingly disruptive to human living. A number of adult disturbances can be seen as manifestations of processing difficulties. Let us take a brief look at three of these: fragile process, dissociated process and psychotic process.

Fragile Process

Clients who experience what I call "fragile process" have difficulty in controlling the intensity and focus of their experience (Warner, 2000). This may include the following difficulties:

- holding experience in attention
- modulating the intensity of experience
- naming experience

- taking in the experience of others without feeling a sense of personal annihilation

Clients who have a fragile style of processing tend to experience core issues at very low or high levels of intensity. They tend to have difficulty starting and stopping experiences that are personally significant or emotionally connected. And, they are likely to have difficulty taking in the point of view of another person while remaining in contact with such experiences. I am not talking about moderate levels of emotional distress. I am talking about moments in which the client's consciousness is flooded with experiences whose intensity is hard to control combined with very high levels of vulnerability and shame. In the midst of these experiences the client is unable to take a broader perspective without a sense of personal annihilation. Most people experience fragile process at the most vulnerable edges of their experience. Some people experience fragile process in relation to a large number of personal experiences, so that it affects large parts of their lives.

For example, a client may talk about day-today events for most of a therapy hour and only connect with an underlying feeling of grief at the very end with the sense that she could sob forever. At this point it may be exceedingly difficult for the client to stop the session and to go out into the world alone, much less return to work. Clients with low-intensity fragile process are likely to experience personal reactions as subtle emotional shadings, as threads of experience that they can barely catch and hold onto. Yet, if they do touch them they feel intensely shameful and hard to stay with. If distracted or contradicted, they are likely to give up on the idea that such experiences have any

significance. Clients experiencing a high-intensity fragile process feel their experience as overwhelming and potentially never-ending. A person may feel a bottomless well of sadness, or anger so overwhelming that the person might destroy his or her surroundings.

Because of this vulnerability to volatile, shameful, personally overwhelming experience, clients often live with a considerable barrier between their daily living and their responses to core emotional issues. Or, they may live very volatile, chaotic lives. In either case, if some life situation or some therapist response touches fragile issues, their reactions may instantly become overwhelmingly present with high levels of vulnerability and shame.

Empathic understanding responses are often the only sorts of responses people can receive while in the middle of fragile process without feeling traumatized or disconnected from their experience. The ongoing presence of a soothing, empathic person can be essential to the person's ability to stay connected without feeling overwhelmed. If a therapist is able to stay with the client's experience in a way that is sensitive and attuned, this can help the client stay with the experience him or herself with less sense of shame and isolation. Being responded to by a trusted, empathic person can help the client tolerate the level of intensity and/or bring the level intensity to a somewhat more moderate level.

In a certain sense, clients in the middle of fragile process are asking if their way of experiencing themselves at that moment has a right to exist in the world. Any misnaming of the experience or suggestion that they look at the experience in a different way is experienced as an answer of "no" to the question.

This brings a crucial choice in work with clients in the midst of fragile process. Therapist comments, interpretations or structured interventions are likely to intensify fragile process in a way that feels extremely overwhelming and shameful to the client while at the same time making it difficult for the client to receive or understand experiences from the therapist's perspective. In this sort of situation, clients are likely to experience ruptures in their relationships with therapists and be drawn to a variety of self-destructive behaviors as they attempt to respond to their high levels of distress. Object relations therapists such as Kernberg (1984) tend to accept or even stimulate these sorts of escalation of feeling and the related blocking of understanding of other's perspectives by the client. Rather than avoiding these escalations, they are likely to use the feelings stimulated in the client and in the therapist as an occasion for interpretation.

Theorists in the client-centered tradition, on the other hand, propose that processing capacities have a natural and spontaneous tendency to develop under facilitative relationship conditions even much later in life (Warner, 2000). Frequent or severe escalation of misunderstandings between client and therapist, rather than being a useful ground for interpretation, are seen as having the potential to interfere with this sort of process development. Empathic responding allows clients to stay in contact with fragile experience while minimizing ruptures in the therapeutic relationship. Self-psychology theorists, while not addressing process directly, make a similar point in talking about the development of selfobject functions (Kohut, 1984).

Therapists often greatly underestimate how sensitive clients are when they are in the middle of fragile process. In general, client-centered therapists focus on empathic responding and avoid even moderately directive questions, suggestions or interpretations.

Yet, at vulnerable moments a client may need even more precise forms of empathic understanding responses—for example, the client may need to hear the therapist's understanding in almost his or her exact words to feel understood. Or, when a client is attending to something that is unclear, open-ended words like "something" or somehow" may let the therapist "make space" for the unclearness in what the client is saying without adding any contrary meaning. For example,

CL. The situation at work is a hopeless weight on my life

Th. A hopeless weight. Something about that whole situation at work is a hopeless weight.

CL. Yes, exactly. (tears)

Even paraphrasing a client's words may result in her losing the ability to hold the experience and lead to a feeling that the experience (and possibly her self in relation to the therapist) has been annihilated—leading the client to feel enraged or to give up on the interaction and withdraw. For example,

Cl. The situation at work is a hopeless weight on my life.

Th. You feel really frustrated at work

Cl. I DIDN"T SAY I FELT FRUSTRATED!!! WHY DID YOU SAY THAT??? YOU DON"T UNDERSTAND ME AT ALL.

Even more so, therapist comments that are intended to be helpful and to advance the client's self exploration are likely to backfire. For example, the client might simply disconnect from feeling and comply with the therapist:

Cl The situation at work is a hopeless weight on my life

Th. Why do you feel that way?

Cl Well I suppose I shouldn't feel that way, doctor. You know more about these things than I do. Should I just act more cheerful???

The risk here is that therapists can easily see clients' anger or withdrawal as the client's problem—without seeing that the therapist's behavior has a great deal to do with the client's response. Therapists assume that clients could turn off fragile process if they wanted to, and then proceed to view clients as tricky or manipulative.

Dissociated Process

Dissociated process usually results from physical or sexual trauma in the first seven years of life (Warner, 2000). ***)*** In response to such traumatic experiences, children split experience into separate personas. At such early ages children have high levels of hypnotic suggestibility. Faced with overwhelming trauma and lacking the more complex ways of coping with experiences available to older children, our clients seem to have stumbled on dissociation as a solution. One client, for example, found that when she stared at dots on the wallpaper she could separate herself out from the terror and anguish of being raped by her father. Some clients describe experiencing themselves as out of their bodies and watching the events from the ceiling.

Understandably, dissociation under these circumstances is extremely reinforcing. Children go from an extreme of anguish to a lack of intense pain and an ability to put the whole thing out of their minds the next day. Typically our clients describe having felt helplessness, terror, pain and anguish that were so intense that they felt that they could die from those feelings. In this they simultaneously felt afraid of dying and wished that they

could die. They felt intense rage and wished that they could do violence to the perpetrator. Still, they wished that they could hold onto the times when their parents seemed loving or nurturing.

In the helpless part of their feelings they were terrified of the violence of their angry feelings. From the angry part of their feelings, they felt disgust and shame at their reactions of helplessness. In their wish that they could hold onto some normal life, they wished that both the angry and the helpless, anguished reactions would disappear. Probably as a result of these contradictions, a number of different clusters of experience separated out within their dissociated experiences. These clusters of experience came to have a very distinctive sort of "person-like" experience of themselves, each with their own feelings, history, and way of looking at the world.

Clients may experience the edges of these personality parts as quite aberrant experiences—such as hearing voices, seeing altered versions of reality, having odd body sensations. Or, they may sense them as personas acting within them over which they have little control. For example one client said to me “I didn’t come to this session, the child part brought me.” Or, if they switch into a personality part they may experience the therapy situation almost as if they were a different client. So, the fact that one part of the client knows and trusts the therapist doesn’t necessarily mean that another personality even knows who the therapist is, much less trusts her.

Several key points emerge here. Trauma issues that need to be resolved are held within personality parts that are quite separate from the client’s everyday persona. So, deep change will not happen unless the client feels safe enough to let him or herself connect with these separated personality parts. Yet, the edges or the first manifestation of

these alternate personas may seem quite psychotic—the client may hear voices, have unusual body experiences, see things and the like. Experiencing the edges of personality parts, the client may be afraid of going crazy—it is important that the therapist isn't alarmed by the experiences. Very close empathic responding to these "psychotic-like" experiences at the edge of dissociated personas often lets the client stay with them and open them to change. And, connecting with the parts is ultimately the client's strongest route to healing.

These parts are separate enough that ultimately the therapist does well to think of the relationship almost as if it were family therapy---with each personality part being equally valuable in its attempts to cope with an impossible childhood situation.

If the client feels safe with the therapist, alternate personas are likely to begin to manifest themselves on their own—both because there is an inner impulse to integrate experiences and because life circumstances are likely to trigger responses from the parts. Inside the personality parts, the client is likely to feel a great deal of fragile process.

When therapists can connect with these various personas, the client is able to process the original trauma. And as the trauma is less frightening the personas have less need to stay separate from each other and the person is likely to re-integrate into a single personality.

Psychotic Process

Let us look at a third sort of difficult process—psychotic process.

Clients experiencing psychotic process have a different sort of difficulty in that they aren't using more common, reality-based forms of experiencing. Such clients often

experience voices, hallucinations, delusions or thought disorder that are neither culturally accepted nor are easy to process (Prouty, 1994, 2001, 1986). Such clients are described by Prouty (1994, 2001) as having impaired contact with "self", "world" and "other." Psychotic experiences emerge as a result of a broad variety of circumstances:

- genetic aberrations
- prenatal difficulties
- extreme life stress
- biological deterioration later in life

Still, various client-centered therapists who have worked with psychotic process have found that psychotic experiences tend to be meaningful and have the potential to process into more reality oriented forms (Rogers, 1957; Prouty 1994, 2001; Binder 1998; Van Werde, 1999; Warner, 2007). Prouty (1994) suggests that when clients are out of more ordinary, reality-based contact, therapists often do well to respond with "contact reflections" that stay exceedingly close to clients' concrete expressions. Prouty's basic contact reflections are

1. word-for word

   Cl. The gates aren't switching right. I think it's because of the knee-twister. I think my cousin might be involved

   Th. So, that seems to be true. The gates aren't switching right and you think it's because of the knee-twister, and you really think your cousin might be involved.

2. facial

   Cl. (smiling silently while looking at the wall)

Th. You're smiling. You're looking at the wall.

3. bodily

Cl. (sitting silently shaking her hand)

a. Th. You're shaking your hand (therapist shakes own hand)

4. environmental

Client turns toward lamp

Th. You turned toward the lamp. You're looking at the light.

5. reiterative

CL. My head hurts when my father speaks

Th. Your head hurts when you father speaks

Long silence

Th. Your head hurts when your father speaks.

Again, therapists often underestimate how closely they need to stay with client's expressions for the client to stay in contact with them. Simple comment or questions like "why do you feel that" or "are you upset because your mother is coming to visit today" can easily be completely unintelligible if a person is out of contact. Typically, the reason that staying close to psychotic expressions is important to clients is different from the reason that staying close to fragile process is helpful. With fragile process, the client tends to have difficulty staying with experience and letting it go through changes because of the fragility and volatility of emotional responses. With psychotic process, while such emotional fragility may be present, the difficulty is often much more cognitive. Clients are confused and alarmed by therapist interactions that don't stay close to their exact expressions and gestures because they find it difficult to understand

whether the therapist's words relate to their own words.. And since words may have a very particular personal meaning, therapist paraphrases are likely to misrepresent the client's meaning.

Prouty and other client-centered therapists find that when therapists are able to connect with psychotic experience it tends to process. The therapist is, in effect, joining the client in his or her own language, rather than demanding that the client speak the (often quite foreign) language of the therapist. This lowers the sense of existential aloneness of the client. And, when the client is able to stay with psychotic experiences they tend to go through changes.

- hallucinations often shift toward memories or relevant current experiences
- seemingly nonsensical words turn out to have personal meaning
- experiences evolve to a more reality-oriented understanding of situations.

Long-Term Benefits of Work with Difficult Process

Client-centered therapists have come to a number of conclusions in working with various kinds of difficult client process. Experiences that initially seem most difficult and irrational are often central to the person of the client. You can't skip them without taking away the client's core self. Yet attempts to direct or explain or to teach different ways of being with these experiences often backfire—clients withdraw or become more distressed or at risk of hurting themselves or others.

On the other hand, we have found that if it is possible to stay connected with difficult client process in a sensitive way, this often relieves the stress and aloneness that clients are feeling. When therapists can stay with client experiences, clients become more and more able to stay connected to these experiences themselves. This allows

experiences to process and resolve themselves. And, over time, when therapists and clients are able to connect with difficult process in a safe relationship, the processing capacities themselves tend to develop and become stronger. Clients become more able to

- stay connected to experiences of distress without being totally shamed or overwhelmed by the experience.
- let more experiences come so that insights emerge
- talk to other people outside of therapy about experiences that had previously seemed private and shameful
- begin to move out of the "tunnel vision" of their own initial reactions, becoming able to take in other people's perspectives
- become increasingly able to engage in work and in personal relationships in productive and mutually satisfying ways

Even if there is physiological damage that is irreversible, processing capacities develop to the extent that this is physically possible. Often clients develop alternate pathways that allow them to process to a significant degree.

Deep changes in "difficult process" require relatively long, empathically sensitive therapeutic relationships. Yet, in considering the extent of this investment, it is important to remember just how personally debilitating difficult process is in the lives of clients. Clients in the midst of difficult process have high risks of suicide, extremely high levels of personal distress, loss of ability to work and loss of ability to maintain personal relationships. Taken together, the effects of difficult process can be as debilitating and as life-threatening as having a heart-attack or cancer. Therapeutic work can be life-saving, and seems well worth the cost.

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