Episode 062: Therapeutic Alliance Part 5: Emotion

David Puder, M.D.

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There are no conflicts of interest for this episode.

On this week's episode of The Psychiatry and Psychotherapy Podcast, we will be covering part five in the therapeutic alliance series. I will be talking about how to build a therapeutic alliance early on with patients through helping them process emotions.

This series is dedicated to my mentor, Dr. John D Tarr.

Here are the previous episodes on therapeutic alliance. They do not need to be listened to in order:

Episode 028: *Therapeutic Alliance Part 1*

Episode 032: *Therapeutic Alliance Part 2: Meaning and Viktor Frankl's Logotherapy*

Episode 036: *Therapeutic Alliance Part 3: How Empathy Works and How to Improve It*

Episode 041: *Therapeutic Alliance Part 4: What is Transference and Countertransference?*

Emotions & Connection

Therapeutic alliance, the relationship between the mental health professional and their client, continues to be one of the most important aspects of therapy. Experiencing connection with the patient is absolutely paramount, as hundreds of studies have shown us—therapeutic alliance alone can determine the outcome of therapy, positive or negative.

I continuously talk to the medical students and residents in my program about developing connection with their patients. Often, developing that connection can be

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difficult if we don't fully understand how emotions work, how they feel, and how they can help us empathize with even the most difficult patient in our practice that we can't quite seem to understand. Emotions are also what help our patients feel connected to us and be able to establish healthy connections with others.

People often think of emotions as ethereal, complicated depths that are difficult to explore. They are actually just adaptive physical reactions to stimuli. There are a few main categories, and as we will discover, they are concrete and identifiable. Usually, in a healthy therapeutic alliance, they can be discussed, and even when emotions are painful to express or linked with traumatic memories, they can be disarmed and understood.

Problems in affect

Many patients come into our offices, and one of the main commonalities is their inability to control their emotional affect. They might not be able to control their highs and lows—they have anger, anxiety and depression that they don't understand, and it often feels like it has taken over their lives. When you begin to listen to their story, you can identify those recurring emotions and help them identify their triggers and what emotions feel like in their body. Sometimes a patient has been in the mental health system for so long that they might easily label themselves as "depressed" or "anxious" without really connecting to the meaning any longer, or how that actually affects them.

Early childhood plays a large role in our ability to understand and regulate our emotions. As an infant, we learn how to understand, label, or tolerate emotional responses, but if we don't, instead we oscillate between emotional inhibition and extreme lability. Often complicating this is an early trauma or loss, which creates a neurobiological sensitivity and vulnerability, predisposing us to future stress.

As therapists, when we continually help our patients label their emotion, we can help them identify and begin to get in touch with those emotions in a way that gives them a feeling of control of again. Once we help them identify their emotions, we can help them uncover the meaning behind those emotions.

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Epigenetic studies have shown that our early-life emotional environment will even change the expression of different genes in the body. Our attachment experiences shape the early organization of the right brain, which is the neurobiological core of the human unconscious.

If, as therapists, we can create healthy attachments with our patients, we can help them reorganize their emotional life and responses to stimuli. With a positive therapeutic alliance, as the patient discusses distressing occurrences in their lives, their negative emotions get re-metabolized in a healthy way.

"Awareness of the self is minimal unless self is threatened." - Kohut

What is emotion?

Emotions and feelings are built from reactions that promote survival or wellbeing of the person. Our feelings come first in early development and retain a primacy that subtly pervades our mental state for the rest of our lives. We are born with the function of emotions so we can solve automatically (without logical reasoning) many of the basic problems of life. For example, on my daughter's first day of life, she displayed anger when trying to get milk and having difficulty latching on. Anger gives us the energy to overcome obstacles and move toward goals. We almost always want to approach something pleasurable or withdraw from something that would cause us anger, fear, or disgust. Emotions also have the power to activate or deactivate our immune system.

Emotions play out in the body

Emotions deeply affect the HPA axis, metabolism, endorphins, and even inflammation. The brain lights up in MRIs in different places based on our emotional states. People can often write them off as inconvenient, or even suppressible, and many patients don't realize how important they are to pay attention to.

Emotions are simply physical reactions—they are movement towards action, often to withdraw or move towards something.

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I like to think of emotions as problem solvers. Emotions are not good or bad—they have a logic of their own and are responding to a situation. We often think of anger and shame as “bad,” but they are adaptive mechanisms. When we realize this, we can begin to look at the information and the logic and be curious about them.

Early emotional development

The whole of childhood development is unconsciously focused on the enhancement of self-regulation (Fonagy and Target). The essential task of the first year of human life is to create secure attachment bonds between the infant and their primary caregiver. In order to enter into this communication, the mother must be psycho-biologically attuned to the dynamic shifts in the infant's bodily-based internal states of central and autonomic arousal. The attachment relationship mediates the dyadic regulation of emotion, wherein the mother co-regulates the infant's postnatally developing CNS and ANS.

On fMRI, adult attachment activates in the right inferior frontal cortex, which is also involved in control processes and emotional regulation (Buchheim et al). Relational experiences are encoded in the unconscious internal working models in the right brain.

"The self-organization of the developing brain occurs in the context of a relationship with another self, another brain." - Allan Schore

Split Brain Patient

A split-brain patient was able to read words with both hemispheres, although he could only speak through his left hemisphere. When something was shown to the left hemisphere, he could tell what the stimulus was and whether it was good or bad. When the right hemisphere was presented the stimuli, he was unable to say what it was, however, he could say if it was good or bad. For example, a picture of a devil was "bad" whereas a picture of his mother was "good." Somehow, the emotional significance of the stimuli leaked across the hemispheres. (Ledoux, 1996)

When instructing the right hemisphere to wave, the patient would wave, but when asked why he was waving, he would make something up, like someone he knew was waving

at him. When the right hemisphere was told to laugh, the left made up the reason, "you guys are funny guys."

This study shows that the emotional processing can take place outside of awareness, unconsciously.

The power of therapeutic alliance

"The most intense affects make us the most vulnerable. In failures to be understood, we feel disconnected. This may induce a profound shame. Shame precedes rage. Moments of disconnection are inevitable. How does the patient learn to tolerate such vulnerability?" - My mentor, Dr. John Tarr

There are three types of therapy for borderline personality disorder which work, which can seem very different, but have close relationships that form over a protracted period and focus on emotions in different ways.

- Dialectical behavioral therapy
- Transference therapy
- Mentalization based therapy

As therapists, we focus on the affective dynamics of the right brain, which are activated during a therapeutic alliance. The therapeutic alliance forms in a similar way as the implicit attachment regulatory function matures. The empathic therapist's capacity to regulate the patient's arousal state within the affectively charged non-conscious transference-countertransference relationship, is critical to clinical effectiveness (Shore).

When we pay attention to our patients' body movement, posture, gestures, facial expressions and prosody, we can help them adjust their emotional state and develop healthy connection with someone even within their trauma story. Our affect attunement will regulate the patient's affect.

Helping someone identify their emotions with words, and connect them to the body sensations that tell us what emotion they are feeling, is incredibly important. If a patient is intellectual, has been in therapy, or is even a mental health professional, they may try to make their emotions purely intellectual. If they haven't been able to identify their

emotions at all, or don't have names for how they feel, it can also help to verbally identify where their feelings are coming from and why they are adaptive.

As therapists, it is our job to help our patients put names and body sensations to their emotions. When someone ignores their emotional cues, or has experienced a traumatic event and is in shutdown mode in certain areas, they might not have been able to be congruent with the emotion expression they needed at the time.

Listen to: Emotional Shutdown—Understanding Polyvagal Theory

Microxpressions are how emotions are expressed on the face in micromovements. When we can identify our patients' microexpressions, we can help them begin to identify their own emotions and get back in touch with how they are feeling. I'd highly recommend any therapist study microexpressions. I dive more into microexpressions in three different podcasts you might want to listen to:

1. Microexpressions to Make Microconnections Part 1
2. Microexpressions: Fear, Surprise, Disgust, Empathy, and Creating Connection Part 2
3. Using Microexpressions in Psychotherapy

How do you connect with a patient in their emotion?

Here are a few things I like to use and/or do in order to make sure I am developing a real connection with my patients to create a positive therapeutic alliance. My main goal in these questions is to help my patients understand that their emotions all have a goal—they are feeling this way for a reason. Emotions aren't nonsense; they have a purpose. When we help them identify the purpose, they can begin to untangle the event that made them emotional, and the meanings they assigned to that event. When we, as therapists, are with them in that, mirroring their emotions, we can build a bridge between the right and the left brain, and a bridge where the patient is in healthier connection with others.

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- Check in with yourself before you go into any therapy session. How are you feeling? That way, you can have a baseline of what is transference, what is the patient, what is your own emotional state as you feel into their experience.
- Once you enter the therapy session, listen, feel and watch the patient's moment to moment change in emotions. As you see and feel the shifts, you will be able to tell what words, events, or emotions might be triggering for them.
- Try to enter a bit into their feeling, be present with them, mirror the emotion/feeling, use their own words as you repeat back to them for clarification.
- Ask them to find their own words to describe how they are feeling.
- If you don't understand why they are sad, then stay with the topic, ask them more questions, have them deepen your understanding of it. Once they feel you truly understand the affect will change. When people feel heard, deeply understood, it is pleasurable to them, and they will begin to shift their own emotional experience.
- Give the patient the power to own their emotions.
- I like to remind them:
    - "You are entitled to your emotions. We will put them to words. We will not necessarily act upon them."
    - "What does your emotion want to accomplish?"
    - "Where do you feel that _____ in your body?"
- When they experience **shame**, I like to talk about it with them:
    - "I can understand why talking about this must be difficult."
    - "Perhaps as you talk about this you feel___."
    - Try to find the adaptive function:
        - "I hear switching to a new doctor is hard, I think that is a common experience, I think it is adaptive to be hesitant at first in what you share since we are just meeting."
    - My mentor, Dr. Tarr, when he talks to patients that are feeling shame, says, "I am particularly concerned when embarrassment, self-consciousness, or apprehension about disclosing something that reduces self-esteem makes a patient hesitate to talk about something, or induces excessive inhibition about sharing-ness. The patient may anticipate being shamed.
        - He will say things like:

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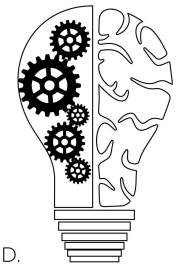

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    - "When you feel uncomfortable in thinking about something, or like avoiding a topic, it will be valuable for us to become aware of your hesitation."
    - "Of course it's hard to share with me something that you feel disappointed or discouraged about; what undesirable feelings might you have if you were to talk about it?"
    - "There are some things we would much rather not bring into the open; we can beneficially learn a lot about what makes us feel distressed about ourselves."
    - "It is natural to wonder if I will be disappointed in you."
    - "Revealingness about oneself is often difficult."
    - "Do we ever really want to say out loud all the things that we think about and feel? Learning about uncomfortableness can be very worthwhile and helpful."
    - "Sometimes feeling naked and exposed makes it hard to talk and be open."
    - "Even though we try to be open with each other, of course we sometimes feel inhibited and cautious."
    - "Perhaps you felt a little ashamed as you were thinking about that. Our learning together about your distress that may be embarrassing can be most valuable and helpful to us."
    - "A feeling of being looked down on by someone can be quite humiliating, let's look at how that develops."
    - "Are you afraid that you may be disappointing me and that I may not feel approving and accepting of you?"
    - "Sometimes we feel that being looked at will disappoint someone or oneself."
    - "It is worthwhile to try as much as possible to have unconditional positive regard and self-acceptance most of the time."
- When they experience **anger and frustration**, I like to say things like:
    - "Would you say as you mentioned this you feel frustrated?"

    - Find the adaptive function of anger: “Your anger here seemed to have the goal to protect you and your family.”
    - “Your anger likely kept you alive!"
- When they experience **sadness**, I like to say things like:
    - “Perhaps you are feeling sad as you say this?”
    - Find the adaptive function: “It makes sense that you feel sad here, I think crying and feeling sad shows how much you valued your dad and therefore the loss hurts that much more."
- When they experience **disgust**, I like to say things like:
    - “I am wondering if you feel disgusted by this?”
    - “I hear you feel disgusted…?” (with a questioning tone)
    - “Perhaps as you discuss this you feel some revulsion.”
    - Find the adaptive function: “Feeling disgusted by how your sisters turned on you and cast you out of the family makes sense, maybe it sickens you to see the level of their resentment and bitterness."
- When they experience **fear**, I like to say things like:
    - “I hear a deep concern or perhaps fear regarding this.”
    - “Might there be a deep concern or perhaps fear regarding this?”
    - Find the adaptive function: “After your traumatic event, it makes sense that you would no longer want to put yourself in that situation; it sounds like you are trying to protect yourself."
    - As that happened what did you fear I might think or feel?

Here is a chart to help you identify different emotions and how they feel in the body:

(due to formatting issues it is in the resource library under resources for episode 062- sign in here)

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In conclusion

Connecting with our patients in their emotions is what creates a good therapist. We want to give someone the ability to feel heard and understood. The goal is for our patients to feel connected, because feeling connected, even in distress, brings pleasure. We want to create the understanding that connection can be safe and give pleasure, because we want them to be able to develop healthier attachments to others in their lives.